

**BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA**

**In the Matter of the First Amended  
Accusation Against:**

**Joshua David Holland, M.D.**

**Case No. 800-2019-057220**

**Physician's and Surgeon's  
Certificate No. G 61203**

**Respondent.**


**DECISION**

**The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.**

**This Decision shall become effective at 5:00 p.m. on January 14, 2021.**

**IT IS SO ORDERED January 7, 2021.**

**MEDICAL BOARD OF CALIFORNIA**

  
\_\_\_\_\_  
**for: William Prasifka      REJI VARGHESE**  
**Executive Director      DEPUTY DIRECTOR**

1 XAVIER BECERRA  
Attorney General of California  
2 JANE ZACK SIMON  
Supervising Deputy Attorney General  
3 State Bar No. 116564  
4 455 Golden Gate Avenue, Suite 11000  
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E-mail: Janezack.simon@doj.ca.gov  
6 *Attorneys for Complainant*

7  
8 **BEFORE THE**  
**MEDICAL BOARD OF CALIFORNIA**  
9 **DEPARTMENT OF CONSUMER AFFAIRS**  
10 **STATE OF CALIFORNIA**

11 In the Matter of the First Amended Accusation  
Against:

Case No. 800-2019-057220

12 **JOSHUA DAVID HOLLAND, M.D.**  
13 5651 W. Talavi Blvd, Suite 150  
Glendale, AZ 85306

**STIPULATED SURRENDER OF  
LICENSE AND ORDER**

14 Physician's and Surgeon's Certificate No. G 61203

15 Respondent.  
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17 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-  
18 entitled proceedings that the following matters are true:

19 **PARTIES**

20 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of  
21 California (Board). This action was brought and maintained solely in the official capacity of the  
22 Board's Executive Director, who is represented by Xavier Becerra, Attorney General of the State  
23 of California, by Jane Zack Simon, Supervising Deputy Attorney General.

24 2. Joshua David Holland, M.D. (Respondent) is representing himself in this proceeding  
25 and has chosen not to exercise his right to be represented by counsel.

26 3. On August 31, 1987, the Board issued Physician's and Surgeon's Certificate No. G  
27 61203 to Joshua David Holland, M.D. (Respondent). The Physician's and Surgeon's Certificate  
28 expired on May 31, 2019, and has not been renewed.

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1 Respondent hereby gives up his right to contest that cause for discipline exists based on those  
2 charges.

3 10. Respondent understands that by signing this stipulation, he enables the Board to issue  
4 an order accepting the surrender of his Physician's and Surgeon's Certificate without further  
5 process.

### 6 CONTINGENCY

7 11. This stipulation shall be subject to approval by the Board. Respondent understands  
8 and agrees that counsel for Complainant and the staff of the Board may communicate directly  
9 with the Board regarding this stipulation and surrender, without notice to or participation by  
10 Respondent. By signing the stipulation, Respondent understands and agrees that he may not  
11 withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers  
12 and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the  
13 Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this  
14 paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not  
15 be disqualified from further action by having considered this matter.

16 12. The parties understand and agree that Portable Document Format (PDF) and facsimile  
17 copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures  
18 thereto, shall have the same force and effect as the originals.

19 13. In consideration of the foregoing admissions and stipulations, the parties agree that  
20 the Board may, without further notice or formal proceeding, issue and enter the following Order:

### 21 ORDER

22 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 61203, issued  
23 to Respondent Joshua David Holland, M.D., is surrendered and accepted by the Board.

24 1. The surrender of Respondent's Physician's and Surgeon's Certificate and the  
25 acceptance of the surrendered license by the Board shall constitute the imposition of discipline  
26 against Respondent. This stipulation constitutes a record of the discipline and shall become a part  
27 of Respondent's license history with the Board.  
28

**2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.**

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in First Amended Accusation No. 800-2019-057220 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in First Amended Accusation No. 800-2019-057220 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

## ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

**DATED:**

**JOSHUA DAVID HOLLAND, M.D.**  
*Respondent*

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**ENDORSEMENT**

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted  
for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: December 1, 2020

Respectfully submitted,

XAVIER BECERRA  
Attorney General of California

*Jane Zack Simon*

JANE ZACK SIMON  
Supervising Deputy Attorney General  
*Attorneys for Complainant*

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**Exhibit A**

**First Amended Accusation**

**No. 800-2019-057220**

1 XAVIER BECERRA  
Attorney General of California  
2 JANE ZACK SIMON  
Supervising Deputy Attorney General  
3 State Bar No. 116564  
455 Golden Gate Avenue, Suite 11000  
4 San Francisco, CA 94102-7004  
Telephone: (415) 510-3521  
5 E-mail: Janezack.simon@doj.ca.gov  
6 *Attorneys for Complainant*

7 **BEFORE THE**  
8 **MEDICAL BOARD OF CALIFORNIA**  
9 **DEPARTMENT OF CONSUMER AFFAIRS**  
10 **STATE OF CALIFORNIA**

11 In the Matter of the First Amended Accusation Against: Case No. 800-2019-057220

12 **JOSHUA DAVID HOLLAND, M.D.**  
5651 W. Talavi Blvd., Suite 150  
13 Glendale, AZ 85306-1884

**FIRST AMENDED  
ACCUSATION**

14 Physician's and Surgeon's Certificate  
No. G 61203

15 Respondent.

16 **PARTIES**

17 1. William Prasifka (Complainant) brings this First Amended Accusation solely in his  
18 official capacity as the Executive Director of the Medical Board of California, Department of  
19 Consumer Affairs (Board).

20 2. On August 31, 1987, the Medical Board issued Physician's and Surgeon's Certificate  
21 Number G 61203 to Joshua David Holland, M.D. (Respondent). The Physician's and Surgeon's  
22 Certificate is delinquent, having expired on May 31, 2019.

23 3. The Physician's and Surgeon's Certificate was the subject of prior disciplinary action  
24 by the Board. On January 29, 2010, the Board issued an Order Issuing Public Letter of  
25 Reprimand, based on a 2009 Consent Agreement for Decree of Censure issued by the Arizona  
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1 Medical Board. The basis for the Decree of Censure was Respondent's failure to adhere to  
2 the standard of care, inappropriate prescribing and inadequate medical records for two chronic  
3 pain patients.

#### 4 JURISDICTION

5 4 This First Amended Accusation is brought before the Medical Board of California  
6 under the authority of the following sections of the California Business and Professions Code  
7 (Code) and/or other relevant statutory enactment:

8 A. Section 2227 of the Code provides in part that the Board may revoke, suspend for a  
9 period not to exceed one year, or place on probation, the license of any licensee who has  
10 been found guilty under the Medical Practice Act, and may recover the costs of probation  
11 monitoring.

12 B. Section 2305 of the Code provides, in part, that the revocation, suspension, or other  
13 discipline, restriction or limitation imposed by another state upon a license to practice  
14 medicine issued by that state, or the revocation, suspension, or restriction of the authority  
15 to practice medicine by any agency of the federal government, that would have been  
16 grounds for discipline in California under the Medical Practice Act, constitutes grounds for  
17 discipline for unprofessional conduct.

18 C. Section 141 of the Code provides:

19 "(a) For any licensee holding a license issued by a board under the  
20 jurisdiction of a department, a disciplinary action taken by another state, by any  
21 agency of the federal government, or by another country for any act  
22 substantially related to the practice regulated by the California license, may be  
23 a ground for disciplinary action by the respective state licensing board. A  
24 certified copy of the record of the disciplinary action taken against the licensee  
25 by another state, an agency of the federal government, or by another country  
26 shall be conclusive evidence of the events related therein.

24 "(b) Nothing in this section shall preclude a board from applying a  
25 specific statutory provision in the licensing act administered by the board that  
26 provides for discipline based upon a disciplinary action taken against the  
27 licensee by another state, an agency of the federal government, or another  
28 country."

27 ///

1 D. Section 2228.1 of the code provides, in pertinent part, that the Board shall require  
2 a licensee who is disciplined for inappropriate prescribing resulting in harm to patients  
3 and a probationary period of five years or more, to disclose to his patients information  
4 regarding his probation status. The licensee is required to disclose: Probation status, the  
5 length of the probation, the probation end date, all practice restrictions placed on the  
6 license by the Board, the Board's telephone number, and an explanation of how the  
7 patient can find further information on the licensee's probation on the Board's Internet  
8 Website.

9 **FIRST CAUSE FOR DISCIPLINE**

10 **(Discipline, Restriction, or Limitation Imposed by Another State)**

11 5. On June 10, 2019, the Arizona Medical Board issued an Interim Findings of Fact,  
12 Conclusions of Law and Order for Summary Restriction of License (Summary Restriction)  
13 against Respondent's license to practice medicine in Arizona. The Summary Restriction included  
14 interim factual findings that Respondent deviated from the standard of care in his treatment of  
15 multiple patients. Respondent's Arizona license was summarily restricted, in that he was  
16 prohibited from prescribing, administering or dispensing controlled substances or weight loss  
17 medication. A copy of the Interim Findings of Fact, Conclusions of Law and Order for Summary  
18 Restriction of License issued by the Arizona Medical Board is attached as Exhibit A.

19 6. On May 8, 2020, the Arizona Medical Board issued a Decree for Censure, Probation  
20 With Practice Restriction and Consent to the Same (Arizona Decree.) The Arizona Decree  
21 includes factual findings that Respondent deviated from the standard of care in his treatment of  
22 multiple patients. The care in question involved Respondent's medical weight loss practice, and  
23 the prescribing of controlled substances. For one patient Respondent documented a "markedly  
24 abnormal" EKG as normal, and prescribed weight loss medication that was contraindicated for  
25 her cardiovascular condition without an appropriate diagnosis and without examining the patient  
26 or requesting a cardiac consultation. The patient suffered an adverse reaction to the medication  
27 prescribed by Respondent. Respondent's prescription of controlled substances was found to be  
28 inappropriate, in that he prescribed controlled substances to multiple patients without indication

1 or appropriate justification, without appropriate monitoring, for prolonged periods of time.  
2 Respondent failed to consider alternatives, failed to address abnormal findings, and failed to  
3 maintain adequate medical records. A site inspection of Respondent's clinic revealed that  
4 Respondent's medical assistants and office manager saw patients while he was out of state, and  
5 dispensed drugs, provided follow-up care, gave testosterone injections and ordered lab tests. The  
6 Arizona Board's findings noted that actual patient harm was present in one case, and the potential  
7 for harm was identified in several other cases. Under the terms of the Arizona Decree, a Decree  
8 of Censure was issued, and Respondent was placed on probation for a minimum of ten years.  
9 Terms of probation include a practice restriction prohibiting Respondent from prescribing  
10 controlled substances or weight loss medications; a requirement that he complete continuing  
11 medical education regarding medical recordkeeping; and, a requirement for chart review. A copy  
12 of the Decree for Censure, Probation with Practice Restriction and Consent to the Same is  
13 attached as Exhibit B.

14 7. Respondent's conduct and the actions of the Arizona Medical Board, as set forth in  
15 paragraphs 5 and 6, above, constitute cause for discipline pursuant to sections 2305 and/or 141 of  
16 the Code.

#### 17 PRAYER

18 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
19 and that following the hearing, the Medical Board of California issue a decision:

20 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 61203,  
21 issued to Joshua David Holland, M.D.;

22 2. Revoking, suspending or denying approval of Joshua David Holland, M.D.'s authority  
23 to supervise physician assistants and advanced practice nurses;

24 3. Ordering Joshua David Holland, M.D., if placed on probation, to pay the Board the  
25 costs of probation monitoring;


26 4. Ordering Respondent, if placed on probation, to provide patient notification in  
27 accordance with Business and Professions Code section 2228.1; and

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5. Taking such other and further action as deemed necessary and proper.

DATED: AUG 05 2020

  
\_\_\_\_\_  
WILLIAM PRASIFKA  
Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
*Complainant*

**EXHIBIT A**

**ATTACHMENT D**



## Arizona Medical Board

1740 W Adams St. Suite 4000 Phoenix, AZ 85007 • website: [www.azmd.gov](http://www.azmd.gov)  
Phone (480) 551-2700 • Toll Free (877) 255-2212 • Fax (480) 551-2702

### Governor

Douglas A. Ducey

### Members

R. Screven Farmer, M.D.  
Chair  
Physician Member

James Gillard, M.D.  
Vice-Chair  
Physician Member

Edward G. Paul, M.D.  
Secretary  
Physician Member

Jodi Bain, Esq.  
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Physician Member

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Physician Member

Teresa Connolly, D.N.P.  
Public Member

Laura Dorrell, M.S.N., RN.  
Public Member

Gary R. Figge, M.D.  
Physician Member

Pamela E. Jones  
Public Member

Lois E. Krahn, M.D.  
Physician Member

### Executive Director

Patricia E. McSorley

I, Michelle Robles, of the Arizona Medical Board, hereby certify that I am the official custodian of the records of the agency; and that the attached documents are true and complete copies of the documents requested regarding:

Physician Name: Joshua D. Holland, M.D.

License Number: 17551

Attached are the following document(s):

**Document Name:**  
Physician Profile

Interim Findings of Fact, Conclusion of Law and Order for Summary Restriction of License  
Dated: June 10<sup>th</sup>, 2019

**Document #11 of Pages:**

Dated this July 9<sup>th</sup>, 2019

ARIZONA MEDICAL BOARD

*Michelle Robles*  
Michelle Robles  
Custodian of Records

MD PROFILE PAGE



## Arizona Medical Board

gls.azmd.gov

Printed on 07/09/19 @ 09:14

## General Information

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**Joshua David Holland MD**

Holland Center For Family Health

5651 W Talavi Blvd

Ste #150

Glendale AZ 85306

Phone: (602) 978-8477

License Number: 17551

License Status: Active with Restrictions

Licensed Date: 04/15/1988

License Renewed: 06/05/2018

Due to Renew By: 05/22/2020

If not Renewed, License Expires: 09/22/2020

## Education and Training

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Medical School: KECK SCH OF MED OF THE USC  
Los Angeles, California

Graduation Date: 05/09/1986

Residency: 06/30/1986 - 07/01/1987 (Internal Medicine)  
UNIVERSITY OF NEVADA SCHOOL OF MEDICINE  
RENO, NV

Area of Interest Family Practice  
Area of Interest General Practice

The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at <http://www.abms.org> to determine if the physician has earned a specialty certification from this private agency.

## Board Action

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08/05/2009  
06/10/2019

Decree of Censure  
Summary Restriction

A person may obtain additional public records related to any licensee, including dismissed complaints and non-disciplinary actions and orders, by making a written request to the Board. The Arizona Medical Board presents this information as a service to the public. The Board relies upon information provided by licensees to be true and correct, as required by statute. It is an act of unprofessional conduct for a licensee to provide erroneous information to the Board. The Board makes no warranty or guarantee concerning the accuracy or reliability of the content of this website or the content of any other website to which it may link. Assessing accuracy and reliability of the information obtained from this website is solely the responsibility of the user. The Board is not liable for errors or for any damages resulting from the use of the information contained herein.

Please note that some Board Actions may not appear until a few weeks after they are taken, due to appeals, effective dates and other administrative processes.

Board actions taken against physicians in the past 24 months are also available in a chronological list.

Credentials Verification professionals, please click [here](#) for information on use of this website.

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 JOSHUA D. HOLLAND, M.D.

4 Holder of License No. 17551  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona.

Case No. MD-18-0295A

INTERIM FINDINGS OF FACT,  
CONCLUSIONS OF LAW AND ORDER  
FOR SUMMARY RESTRICTION OF  
LICENSE

7 INTRODUCTION

8 The above-captioned matter came for discussion before the Arizona Medical Board  
9 ("Board") at its June 7, 2019 teleconference meeting, where it had been placed on the  
10 agenda to consider possible summary action against Joshua D. Holland, M.D.  
11 ("Respondent"). Having considered the information in the matter and being fully advised,  
12 the Board enters the following Interim Findings of Fact, Conclusions of Law and Order for  
13 Summary Restriction of License, pending a formal hearing or other Board action. A.R.S. §  
14 32-1451(D).

15 INTERIM FINDINGS OF FACT

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

18 2. Respondent is the holder of license number 17551 for the practice of  
19 allopathic medicine in the State of Arizona and Dispensing Registration No. D00306.

20 3. The Board initiated case number MD-18-0295A after receiving a complaint  
21 from a 36 year-old female patient ("KK") alleging that she had been provided a  
22 prescription for weight loss medication without being seen by Respondent, and that she  
23 subsequently suffered an adverse reaction.

24 4. Respondent reported to the board in his response submitted May 21, 2018,  
25 that he provides hands-on supervision and meets and evaluates all new patients,

1 including KK. He further stated that a history was taken and reviewed by him and that he  
2 performed a physical exam and reviewed KK's EKG.

3 5. Based on the complaint, Board staff requested Medical Consultant ("MC")  
4 review of Respondent's care and treatment of KK and five other patients. The MC  
5 identified deviations from the standard of care with regard to all six patients.

6 6. With regard to KK, the patient was noted on February 21, 2018 to have a  
7 body mass index ("BMI") of 25 and a history of cardiac disease. An EKG taken by  
8 Respondent's medical assistant ("MA") on that day was noted by the computer as  
9 "markedly abnormal." Respondent documented that the EKG was normal. The MC found  
10 that Respondent deviated from the standard of care by prescribing KK weight loss  
11 medication that was contraindicated for her cardiovascular condition without an  
12 appropriate diagnosis and without examining the patient or requesting a cardiac  
13 consultation.

14 7. Actual harm was identified regarding Patient KK in that she suffered an  
15 adverse reaction to the medication prescribed by Respondent.

16 8. Patient HW was an established patient for Respondent with a normal BMI  
17 for whom Respondent prescribed phendimetrazine 105SR through September, 2018.  
18 The MC found that Respondent deviated from the standard of care by prescribing a  
19 controlled substance to a patient when it was not indicated.

20 9. Patient EB/BB established care with Respondent on September 15, 2014.  
21 Respondent initially prescribed the patient phentermine 30 mg/day, which Respondent  
22 later increased to 37.5 mg/day. EB/BB's BMI reduced from 35 to 33 within the first two  
23 years of treatment, but the patient did not experience any additional significant  
24 improvement. Respondent continued to prescribe EB/BB phentermine and in 2018 added  
25 phendimetrazine. The MC found that Respondent deviated from the standard of care by

1 continuing to prescribe controlled substance medications to the patient without significant  
2 improvement in EB/BB's weight status. The MC also stated that Respondent deviated  
3 from the standard of care by prescribing weight loss medications in combination with each  
4 other without adequate justification, exposing the patient to increased risk of  
5 cardiovascular side effects without any additional benefits.

6 10. Patient AS was an established patient of Respondent to whom Respondent  
7 prescribed phentermine. As of September 28, 2018 Respondent prescribed AS 15 mg  
8 per day of phentermine, when her weight was 196 lbs. The MC determined that  
9 Respondent deviated from the standard of care by prescribing phentermine on a long  
10 term basis without adequate justification and by failing to consider alternative weight loss  
11 options.

12 11. Respondent's prolonged prescribing of phentermine may have exacerbated  
13 AS's hypertension.

14 12. Patient CC established care at Respondent's weight loss clinic for weight  
15 control on April 29, 2014 with a BMI of 39. Respondent initially prescribed CC  
16 phentermine 30 mg once a day. By December 16, 2014, CC's BMI was 29.3.  
17 Respondent continued to prescribe patient CC with phentermine and phendimetrazine  
18 through March 13, 2018. The MC found that Respondent deviated from the standard of  
19 care by prescribing CC weight loss medications without an adequate physical  
20 examination including an EKG and by not timely reexamining the patient despite BMI  
21 stabilization.

22 13. The use of two noradrenergic drugs in combination exposed CC to  
23 additional potential cardiovascular side effects while not providing any additional weight  
24 loss benefit.

1        14. Patient RB was an established patient of Respondent's clinic for whom  
2 Respondent prescribed weight loss medication. The MC found that Respondent deviated  
3 from the standard of care by failing to perform appropriate physical examinations prior to  
4 prescribing medications and by continuing to prescribe weight loss medications to the  
5 patient when no longer indicated thereby exposing her to potential adverse effects from  
6 the medication.

7        15. A Second MC reviewed Respondent's care and treatment of six patients for  
8 whom Respondent was providing treatment for chronic pain. The Second MC identified  
9 deviations from the standard of care with regard to four of the patients.

10       16. Patient RJ was an established patient of Respondent with a history of back  
11 pain and headache, to whom Respondent prescribed Soma and opioid medication.  
12 Between July, 2015 and January, 2016 RJ was prescribed Hydromorphone by another  
13 provider, despite ongoing prescriptions for both Soma and Oxycodone by Respondent.  
14 The Second MC found that Respondent deviated from the standard of care by failing to  
15 review RJ's CSPMP on a regular basis and by failing to perform UDSs in order to ensure  
16 compliance with the medication regimen.

17       17. Patient RG was an established patient of Respondent with a history of 3  
18 vessel CABG procedure, arthritis pain, headache and anxiety for whom Respondent  
19 prescribed opioid and benzodiazepine medications. As of April 10, 2014, Respondent  
20 provided ongoing prescriptions for temazepam, clonazepam and Vicodin. The Second MC  
21 found that Respondent deviated from the standard of care by continuing to prescribe  
22 benzodiazepines and opioid medications on a long term basis without adequate  
23 evaluation, consideration of alternatives, or ongoing care plan, and by failing to properly  
24 address a February, 2015 finding of diabetic neuropathy.

1        18. Patient KP was an established patient of Respondent with complaints of soft  
2 tissue injury from a car accident, fibromyalgia, and anxiety that Respondent was treating  
3 with opioids, benzodiazepines and Soma. A note on March 2, 2016 indicates that a pain  
4 management provider took over KP's chronic pain treatment, and would prescribe  
5 medications except Soma. Respondent called in a prescription for Soma for KP. The  
6 Second MC noted instances of refills for medications allowed by Respondent based on  
7 phone consultations, early refills of controlled substance medications, and attempted  
8 consultations by KP's pain management provider with regard to CDC guidelines for opioid  
9 and benzodiazepine prescriptions. The Second MC found that Respondent deviated from  
10 the standard of care by prescribing high doses of clonazepam solely for anxiety.

11        19. Patient RB was an established patient for whom Respondent prescribed  
12 opioid and benzodiazepine medications. On February 24, 2014, Respondent noted that  
13 he was prescribing RB Vicoprofen for cervical strain/chronic intermittent pain and muscle  
14 contraction type headache. The Second MC noted that through the course of  
15 Respondent's subsequent treatment, RB obtained early refills of Vicoprofen and Ativan,  
16 as well as increases in RB's Ativan without adequate documented rationale. The Second  
17 MC found that Respondent deviated from the standard of care by failing to address  
18 aberrant behavior, and by prescribing opioids for back pain without an adequately  
19 identified pain generator or pain management contract.

20        20. A physician is required to maintain adequate legible medical records  
21 containing, at a minimum, sufficient information to identify the patient, support the  
22 diagnosis, justify the treatment, accurately document the results, indicate advice and  
23 cautionary warnings provided to the patient and provide sufficient information for another  
24 practitioner to assume continuity of the patient's care at any point in the course of  
25 treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate in that they were

1 inaccurate and/or incomplete, often failing to document exams, reasoning and a plan  
2 regarding controlled substance prescribing.

3       21. During a site inspection at Respondent's clinic on November 20, 2018, Board  
4 staff determined that patients were being seen by Respondent's staff for treatment on a  
5 date that Respondent was absent from his office. At that time, 3 medical assistants and  
6 the office manager were present. Respondent's staff reported that he was in California.  
7 The CSPMP revealed that patient DW was prescribed and dispensed phentermine on the  
8 date in question, attributed to Respondent. Additionally, the patient log indicated that 10  
9 patients were seen for follow-up, testosterone injections, and labs. The MAs were not  
10 providing authorized procedures under the direct supervision of a physician or physician  
11 assistant as required by A.R.S. § 32-1456(A) and R4-16-402, as Respondent was out of  
12 state.

13       22. During the Board's consideration of the above captioned matter on June 7,  
14 2019, Board staff presented the foregoing, and the Board members considered the  
15 Investigation Report. Additionally, Board members noted Respondent's previous Decree  
16 of Censure from 2009 for inappropriate prescribing. Based on the evidence presented, the  
17 Board found that the public health, safety or welfare imperatively required emergency  
18 action and voted to summarily restrict Respondent's license.

19                               **INTERIM CONCLUSIONS OF LAW**

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

22       2. The conduct and circumstances described above constitute unprofessional conduct  
23 pursuant to A.R.S. § 32-1401(27)(a) ("Violating any federal or state laws, rules or  
24 regulations applicable to the practice of medicine."), i.e., A.R.S. § 32-1491(E) ("A doctor  
25 shall dispense only to the doctor's own patient and only for conditions being treated by that

1 doctor. The doctor shall provide direct supervision of a medical assistant, nurse or  
2 attendant involved in the dispensing process. For purposes of this subsection, 'direct  
3 supervision' means that a doctor is present and makes the determination as to the  
4 legitimacy or the advisability of the drugs or devices to be dispensed.").

5 3. The conduct and circumstances described above constitute unprofessional conduct  
6 pursuant to A.R.S. § 32-1401(27)(e) ("Failing or refusing to maintain adequate records on  
7 a patient.").

8 4. The conduct and circumstances described above constitute unprofessional conduct  
9 pursuant to A.R.S. § 32-1401(27)(r) ("Committing any conduct or practice that is or might  
10 be harmful or dangerous to the health of the patient or the public.").

11 5. The conduct and circumstances described above constitute unprofessional conduct  
12 pursuant to A.R.S. § 32-1401(27)(jj) ("Exhibiting a lack of or inappropriate direction,  
13 collaboration or direct supervision of a medical assistant or a licensed, certified or  
14 registered health care provider employed by or assigned to the physician.").

15 6. The conduct and circumstances described above constitute unprofessional conduct  
16 pursuant to A.R.S. § 32-1401(27)(kk) ("Knowingly making a false or misleading statement  
17 to the board or on a form required by the board or in a written correspondence, including  
18 attachments, with the board.").

19 7. The conduct and circumstances described above constitute unprofessional conduct  
20 pursuant to A.R.S. § 32-1401(27)(ll) ("Failing to dispense drugs and devices in compliance  
21 with article 6 of this chapter.").

22 8. The conduct and circumstances described above constitute unprofessional conduct  
23 pursuant to A.R.S. § 32-1401(27)(tt) ("Prescribing, dispensing or furnishing a prescription  
24 medication or a prescription-only device as defined in section 32-1901 to a person unless  
25



1 the licensee first conducts a physical or mental health status examination of that person or  
2 has previously established a doctor-patient relationship.").

3 9. Based on the foregoing Interim Findings of Fact and Conclusions of Law, the public  
4 health, safety or welfare imperatively requires emergency action. A.R.S. § 32-1451(D).

5 **ORDER**

6 Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth  
7 above,

8 **IT IS HEREBY ORDERED THAT:**

9 1. Respondent's license to practice allopathic medicine in the State of Arizona,  
10 License No. 17551, is summarily restricted. Respondent is prohibited from prescribing,  
11 administering or dispensing controlled substances or weight loss medication until he  
12 applies to the Board and receives permission to do so.

13 2. The Interim Findings of Fact and Conclusions of Law constitute written notice  
14 to Respondent of the charges of unprofessional conduct made by the Board against  
15 Respondent. Respondent is entitled to a formal hearing to defend these charges as  
16 expeditiously as possible after the issuance of this Order.

17 3. The Board's Executive Director is instructed to refer this matter to the Office  
18 of Administrative Hearings for scheduling of an administrative hearing to be commenced  
19 within sixty days from the date of the issuance of this Order, unless stipulated and agreed  
20 otherwise by Respondent. A.R.S. § 32-1451(D).

21 DATED AND EFFECTIVE this 10<sup>th</sup> day of June, 2019.

22  
23 ARIZONA MEDICAL BOARD

24 By Patricia E. McSorley  
25 Patricia E. McSorley  
Executive Director

1 EXECUTED COPY of the foregoing mailed  
2 this 10<sup>th</sup> day of June, 2019 to:

3 Joshua D. Holland, M.D.  
4 (Address of Record)

5 Melissa Ho, Esq.  
6 Polsinelli PC  
7 CityScape One East Washington Street, Suite 1200  
8 Phoenix, Arizona 85004  
9 Attorney for Respondent

10 ORIGINAL of the foregoing filed  
11 this 16<sup>th</sup> day of June, 2019 with:

12 Arizona Medical Board  
13 1740 West Adams, Suite 4000  
14 Phoenix, Arizona 85007

15 Michelle Robles  
16 Board staff  
17  
18  
19  
20  
21  
22  
23  
24  
25

**EXHIBIT B**

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 JOSHUA D. HOLLAND, M.D.

4 Holder of License No. 17551  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona.

Case No. MD-18-0295A

**DECREE FOR CENSURE, PROBATION  
WITH PRACTICE RESTRICTION AND  
CONSENT TO THE SAME**

7 Joshua D. Holland, M.D. ("Respondent") elects to permanently waive any right to a  
8 hearing and appeal with respect to this Order for Decree of Censure, and Probation with  
9 Practice Restriction; admits the jurisdiction of the Arizona Medical Board ("Board"); and  
10 consents to the entry of this Order by the Board.

11 **FINDINGS OF FACT**

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

14 2. Respondent is the holder of license number 17551 for the practice of  
15 allopathic medicine in the State of Arizona and Dispensing Registration No. D00306.

16 3. The Board initiated case number MD-18-0295A after receiving a complaint  
17 from a 36 year-old female patient ("KK") alleging that she had been provided a  
18 prescription for weight loss medication without being seen by Respondent, and that she  
19 subsequently suffered an adverse reaction.

20 4. Respondent reported to the board in his response submitted May 21, 2018,  
21 that he provides hands-on supervision and meets and evaluates all new patients,  
22 including KK. He further stated that a history was taken and reviewed by him and that he  
23 performed a physical exam and reviewed KK's EKG.

24 5. Based on the complaint, Board staff requested Medical Consultant ("MC")  
25 review of Respondent's care and treatment of KK and five other patients. The MC  
identified deviations from the standard of care with regard to all six patients.

1           6.     With regard to KK, the patient was noted on February 21, 2018 to have a  
2 body mass index ("BMI") of 25 and a history of cardiac disease. An EKG taken by  
3 Respondent's medical assistant ("MA") on that day was noted by the computer as  
4 "markedly abnormal." Respondent documented that the EKG was normal. The MC found  
5 that Respondent deviated from the standard of care by prescribing KK weight loss  
6 medication that was contraindicated for her cardiovascular condition without an  
7 appropriate diagnosis and without examining the patient or requesting a cardiac  
8 consultation.

9           7.     Actual harm was identified regarding Patient KK in that she suffered an  
10 adverse reaction to the medication prescribed by Respondent.

11          8.     Patient HW was an established patient for Respondent with a normal BMI  
12 for whom Respondent prescribed phendimetrazine 105SR through September, 2018.  
13 The MC found that Respondent deviated from the standard of care by prescribing a  
14 controlled substance to a patient when it was not indicated.

15          9.     Patient EB/BB established care with Respondent on September 15, 2014.  
16 Respondent initially prescribed the patient phentermine 30 mg/day, which Respondent  
17 later increased to 37.5 mg/day. EB/BB's BMI reduced from 35 to 33 within the first two  
18 years of treatment, but the patient did not experience any additional significant  
19 improvement. Respondent continued to prescribe EB/BB phentermine and in 2018 added  
20 phendimetrazine. The MC found that Respondent deviated from the standard of care by  
21 continuing to prescribe controlled substance medications to the patient without significant  
22 improvement in EB/BB's weight status. The MC also stated that Respondent deviated  
23 from the standard of care by prescribing weight loss medications in combination with each  
24 other without adequate justification, exposing the patient to increased risk of  
25 cardiovascular side effects without any additional benefits.

1           10. Patient AS was an established patient of Respondent to whom Respondent  
2 prescribed phentermine. As of September 28, 2018 Respondent prescribed AS 15 mg  
3 per day of phentermine, when her weight was 196 lbs. The MC determined that  
4 Respondent deviated from the standard of care by prescribing phentermine on a long  
5 term basis without adequate justification and by failing to consider alternative weight loss  
6 options.

7           11. Respondent's prolonged prescribing of phentermine may have exacerbated  
8 AS's hypertension.

9           12. Patient CC established care at Respondent's weight loss clinic for weight  
10 control on April 29, 2014 with a BMI of 39. Respondent initially prescribed CC  
11 phentermine 30 mg once a day. By December 16, 2014, CC's BMI was 29.3.  
12 Respondent continued to prescribe patient CC with phentermine and phendimetrazine  
13 through March 13, 2018. The MC found that Respondent deviated from the standard of  
14 care by prescribing CC weight loss medications without an adequate physical  
15 examination including an EKG and by not timely reexamining the patient despite BMI  
16 stabilization.

17           13. The use of two noradrenergic drugs in combination exposed CC to  
18 additional potential cardiovascular side effects while not providing any additional weight  
19 loss benefit.

20           14. Patient RB was an established patient of Respondent's clinic for whom  
21 Respondent prescribed weight loss medication. The MC found that Respondent deviated  
22 from the standard of care by failing to perform appropriate physical examinations prior to  
23 prescribing medications and by continuing to prescribe weight loss medications to the  
24 patient when no longer indicated thereby exposing her to potential adverse effects from  
25 the medication.

1        15. A Second MC reviewed Respondent's care and treatment of six patients for  
2 whom Respondent was providing treatment for chronic pain. The Second MC identified  
3 deviations from the standard of care with regard to two of the patients.

4        16. Patient RJ was an established patient of Respondent with a history of back  
5 pain and headache, to whom Respondent prescribed Soma and opioid medication.  
6 Between July, 2015 and January, 2016 RJ was prescribed Hydromorphone by another  
7 provider, despite ongoing prescriptions for both Soma and Oxycodone by Respondent.  
8 The Second MC found that Respondent deviated from the standard of care by failing to  
9 review RJ's CSPMP on a regular basis and by failing to perform UDSs in order to ensure  
10 compliance with the medication regimen.

11       17. Patient KP was an established patient of Respondent with complaints of soft  
12 tissue injury from a car accident, fibromyalgia, and anxiety that Respondent was treating  
13 with opioids, benzodiazepines and Soma. A note on March 2, 2016 indicates that a pain  
14 management provider took over KP's chronic pain treatment, and would prescribe  
15 medications except Soma. Respondent called in a prescription for Soma for KP. The  
16 Second MC noted instances of refills for medications allowed by Respondent based on  
17 phone consultations, early refills of controlled substance medications, and attempted  
18 consultations by KP's pain management provider with regard to CDC guidelines for opioid  
19 and benzodiazepine prescriptions. The Second MC found that Respondent deviated from  
20 the standard of care by prescribing high doses of clonazepam solely for anxiety.

21       18. A physician is required to maintain adequate legible medical records  
22 containing, at a minimum, sufficient information to identify the patient, support the  
23 diagnosis, justify the treatment, accurately document the results, indicate advice and  
24 cautionary warnings provided to the patient and provide sufficient information for another  
25 practitioner to assume continuity of the patient's care at any point in the course of

1 treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate in that they were  
2 inaccurate and/or incomplete, often failing to document exams, reasoning and a plan  
3 regarding controlled substance prescribing.

4 19. During a site inspection at Respondent's clinic on November 20, 2018, Board  
5 staff determined that patients were being seen by Respondent's staff for treatment on a  
6 date that Respondent was absent from his office. At that time, 3 medical assistants and  
7 the office manager were present. Respondent's staff reported that he was in California.  
8 The CSPMP revealed that patient DW was prescribed and dispensed phentermine on the  
9 date in question, attributed to Respondent. Additionally, the patient log indicated that 10  
10 patients were seen for follow-up, testosterone injections, and labs. The MAs were not  
11 providing authorized procedures under the direct supervision of a physician or physician  
12 assistant as required by A.R.S. § 32-1456(A) and R4-16-402, as Respondent was out of  
13 state.

14 20. During the Board's consideration of the above captioned matter on June 7,  
15 2019, Board staff presented the foregoing, and the Board members considered the  
16 Investigation Report. Additionally, Board members noted Respondent's previous Decree  
17 of Censure from 2009 for inappropriate prescribing. Based on the evidence presented, the  
18 Board found that the public health, safety or welfare imperatively required emergency  
19 action and voted to summarily restrict Respondent's license.

#### 20 CONCLUSIONS OF LAW

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

23 2. The conduct and circumstances described above constitute unprofessional conduct  
24 pursuant to A.R.S. § 32-1401(27)(a) ("Violating any federal or state laws, rules or  
25 regulations applicable to the practice of medicine."), i.e., A.R.S. § 32-1491(E) ("A doctor



1 shall dispense only to the doctor's own patient and only for conditions being treated by that  
2 doctor. The doctor shall provide direct supervision of a medical assistant, nurse or  
3 attendant involved in the dispensing process. For purposes of this subsection, 'direct  
4 supervision' means that a doctor is present and makes the determination as to the  
5 legitimacy or the advisability of the drugs or devices to be dispensed.").

6 3. The conduct and circumstances described above constitute unprofessional conduct  
7 pursuant to A.R.S. § 32-1401(27)(e) ("Failing or refusing to maintain adequate records on  
8 a patient.").

9 4. The conduct and circumstances described above constitute unprofessional conduct  
10 pursuant to A.R.S. § 32-1401(27)(r) ("Committing any conduct or practice that is or might  
11 be harmful or dangerous to the health of the patient or the public.").

12 5. The conduct and circumstances described above constitute unprofessional conduct  
13 pursuant to A.R.S. § 32-1401(27)(jj) ("Exhibiting a lack of or inappropriate direction,  
14 collaboration or direct supervision of a medical assistant or a licensed, certified or  
15 registered health care provider employed by or assigned to the physician.").

16 6. The conduct and circumstances described above constitute unprofessional conduct  
17 pursuant to A.R.S. § 32-1401(27)(kk) ("Knowingly making a false or misleading statement  
18 to the board or on a form required by the board or in a written correspondence, including  
19 attachments, with the board.").

20 7. The conduct and circumstances described above constitute unprofessional conduct  
21 pursuant to A.R.S. § 32-1401(27)(ll) ("Failing to dispense drugs and devices in compliance  
22 with article 6 of this chapter.").

23 8. The conduct and circumstances described above constitute unprofessional conduct  
24 pursuant to A.R.S. § 32-1401(27)(tt) ("Prescribing, dispensing or furnishing a prescription  
25 medication or a prescription-only device as defined in section 32-1901 to a person unless

1 the licensee first conducts a physical or mental health status examination of that person or  
2 has previously established a doctor-patient relationship.").

3 **ORDER**

4 IT IS HEREBY ORDERED THAT:

- 5 1. Respondent is issued a Decree of Censure.  
6 2. Respondent is placed on Probation for a *minimum* period of ten years with  
7 the following terms and conditions:

8 **a. Practice Restriction**

9 Respondent's practice is restricted in that he shall be prohibited from prescribing  
10 controlled substances or weight loss medications for the duration of this Probation.

11 **b. Continuing Medical Education**

12 Respondent shall within 6 months of the effective date of this Order obtain no less  
13 than 10 hours of Board Staff pre-approved Category I Continuing Medical Education  
14 ("CME") in an intensive, virtual participation course regarding medical recordkeeping.  
15 Respondent shall within **thirty days** of the effective date of this Order submit his request  
16 for CME to the Board for pre-approval. Upon completion of the CME, Respondent shall  
17 provide Board staff with satisfactory proof of attendance. The CME hours shall be in  
18 addition to the hours required for the biennial renewal of medical licensure.

19 **c. Chart Reviews**

20 Board staff or its agents shall conduct periodic chart reviews to monitor  
21 Respondent's compliance with this Board Order.

22 **d. Obey All Laws**

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

1                   e. Tolling

2           In the event Respondent should leave Arizona to reside or practice outside the  
3 State or for any reason should Respondent stop practicing medicine in Arizona,  
4 Respondent shall notify the Executive Director in writing within ten days of departure and  
5 return or the dates of non-practice within Arizona. Non-practice is defined as any period of  
6 time exceeding thirty days during which Respondent is not engaging in the practice of  
7 medicine. Periods of temporary or permanent residence or practice outside Arizona or of  
8 non-practice within Arizona, will not apply to the reduction of the probationary period

9                   f. Probation Termination

10          Prior to any Board consideration for termination of Probation, Respondent must  
11 submit a written request to the Board for release from the terms of this Order.  
12 Respondent's request for release will be placed on the next pending Board agenda,  
13 provided a complete submission is received by Board staff no less than 30 days prior to  
14 the Board meeting. Respondent's request for release must provide the Board with  
15 evidence establishing that he has successfully satisfied all of the terms and conditions of  
16 this Order.

17          The Probation shall not terminate except upon affirmative request of Respondent  
18 and approval by the Board. The Board may require any combination of examinations  
19 and/or evaluations in order to determine whether or not Respondent is safe to prescribe  
20 controlled substances and the Board may continue the Practice Restriction or take any  
21 other action consistent with its authority.

DATED AND EFFECTIVE this 28th day of May, 2020.

By Patricia E. McSorley  
Patricia E. McSorley  
Executive Director

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

5. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

7. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

8. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

9. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

10. Any violation of this Order constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(s) ("Violating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter.") and 32-1451.

11. Respondent acknowledges that, pursuant to A.R.S. § 32-2501(16), Respondent cannot act as a supervising physician for a physician assistant while Respondent's license is on probation.

**12. Respondent has read and understands the conditions of Probation.**

JOSHUA D. HOLLAND, M.D. DATED: SSP

1 EXECUTED COPY of the foregoing mailed  
2 this 8<sup>th</sup> day of may, 2020 to:

3 Carol M. Romano, Esq.  
4 Resnick & Louis, P.C.  
5 Attorney for Respondent  
6 8111 East Indian Bend Road,  
7 Scottsdale, AZ 85250  
8 Attorney for Respondent

9 ORIGINAL of the foregoing filed  
10 this 8<sup>th</sup> day of may, 2020 with:

11 Arizona Medical Board  
12 1740 West Adams, Suite 4000  
13 Phoenix, Arizona 85007

14 Michelle Robles  
15 Board staff  
16  
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