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. Physician's and Surgeon's Certificate No. G 61203 Respondent.	Case No. 800-2019-057220

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
Executive Director

REJI VARGHESE
DEPUTY DIRECTOR

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
State Bar No. 116564
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
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Attorneys for Complainant

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.** 5651 W. Talavi Blvd, Suite 150 Glendale, AZ 85306 Physician's and Surgeon's Certificate No. G 61203 Respondent.	Case No. 800-2019-057220 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

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

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

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

JURISDICTION

4. First Amended Accusation No. 800-2019-057220 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent, who timely filed his Notice of Defense contesting the First Amended Accusation. A copy of First Amended Accusation No. 800-2019-057220 is attached as Exhibit A.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in First Amended Accusation No. 800-2019-057220. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to be represented by counsel, at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands that the charges and allegations in First Amended Accusation No. 800-2019-057220, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the First Amended Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, based on the discipline imposed by the Arizona Medical Board, Complainant could establish at hearing a factual basis for the charges in the First Amended Accusation and that those charges constitute cause for discipline.

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

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

CONTINGENCY

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

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

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

ORDER

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

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

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: 12 / 20

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

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

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.** 5651 W. Talavi Blvd., Suite 150 Glendale, AZ 85306-1884 Physician's and Surgeon's Certificate No. G 61203 Respondent.	Case No. 800-2019-057220 **FIRST AMENDED ACCUSATION**

PARTIES

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

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

3. The Physician's and Surgeon's Certificate was the subject of prior disciplinary action by the Board. On January 29, 2010, the Board issued an Order Issuing Public Letter of Reprimand, based on a 2009 Consent Agreement for Decree of Censure issued by the Arizona

Medical Board. The basis for the Decree of Censure was Respondent's failure to adhere to the standard of care, inappropriate prescribing and inadequate medical records for two chronic pain patients.

JURISDICTION

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

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

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

C. Section 141 of the Code provides:

> "(a) For any licensee holding a license issued by a board under the jurisdiction of a department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or by another country shall be conclusive evidence of the events related therein.
>
> "(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by the board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

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

FIRST CAUSE FOR DISCIPLINE

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

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

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

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

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

PRAYER

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

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

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

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

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

///

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

DATED: AUG 0 5 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
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 Gilliard, M.D.
Vice-Chair
Physician Member

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

Jodi Bain, Esq.
Public Member

Bruce A. Bethancourt, M.D.
Physician Member

David C. Beyer, M.D.
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 10th, 2019

Document #11 of Pages:

Dated this July 9th, 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

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

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

08/05/2009	Decree of Censure
06/10/2019	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.

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **JOSHUA D. HOLLAND, M.D.** Holder of License No. 17551 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-18-0295A **INTERIM FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR SUMMARY RESTRICTION OF LICENSE**

INTRODUCTION

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

INTERIM 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 17551 for the practice of allopathic medicine in the State of Arizona and Dispensing Registration No. D00306.

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

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

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

5. Based on the complaint, Board staff requested Medical Consultant ("MC") 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INTERIM CONCLUSIONS OF LAW

1. 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)(a) ("Violating any federal or state laws, rules or regulations applicable to the practice of medicine."), i.e., A.R.S. § 32-1491(E) ("A doctor shall dispense only to the doctor's own patient and only for conditions being treated by that

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

3. 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.").

4. 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.").

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

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

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

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

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

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

ORDER

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

IT IS HEREBY ORDERED THAT:

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

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

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

DATED AND EFFECTIVE this 10th day of June, 2019.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed this 10th day of June, 2019 to:

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

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

ORIGINAL of the foregoing filed this 10th day of June, 2019 with:

Arizona Medical Board
1740 West Adams, Suite 4000
Phoenix, Arizona 85007

Michelle Robles
Board staff

EXHIBIT B

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **JOSHUA D. HOLLAND, M.D.** Holder of License No. 17551 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-18-0295A **DECREE FOR CENSURE, PROBATION WITH PRACTICE RESTRICTION AND CONSENT TO THE SAME**

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

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 17551 for the practice of allopathic medicine in the State of Arizona and Dispensing Registration No. D00306.

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

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

5. Based on the complaint, Board staff requested Medical Consultant ("MC") 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSIONS OF LAW

1. 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)(a) ("Violating any federal or state laws, rules or regulations applicable to the practice of medicine."), i.e., A.R.S. § 32-1491(E) ("A doctor

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

3. 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.").

4. 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.").

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

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

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

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

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

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Decree of Censure.

2. Respondent is placed on Probation for a ***minimum*** period of ten years with the following terms and conditions:

a. Practice Restriction

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

b. Continuing Medical Education

Respondent shall within 6 months of the effective date of this Order obtain no less than 10 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in an intensive, virtual participation course regarding medical recordkeeping. Respondent shall within **thirty days** of the effective date of this Order submit his request for CME to the Board for pre-approval. 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 biennial renewal of medical licensure.

c. Chart Reviews

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

d. 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.

e. **Tolling**

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

f. **Probation Termination**

Prior to any Board consideration for 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.

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

DATED AND EFFECTIVE this 4th day of May, 2020.

ARIZONA MEDICAL BOARD

By Patricia E McSorley
Patricia E. McSorley
Executive Director

CONSENT TO ENTRY OF ORDER

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.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

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.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

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.***

DATED: 5 5 17

JOSHUA D. HOLLAND, M.D.

EXECUTED COPY of the foregoing mailed this 8th day of May, 2020 to:

Carol M. Romano, Esq.
Resnick & Louis, P.C.
Attorney for Respondent
8111 East Indian Bend Road,
Scottsdale, AZ 85250
Attorney for Respondent

ORIGINAL of the foregoing filed this 8th day of May, 2020 with:

Arizona Medical Board
1740 West Adams, Suite 4000
Phoenix, Arizona 85007

Michelle Robles
Board staff