

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 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
San Francisco, CA 94102-7004
Telephone: (415) 510-3521
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6 *Attorneys for Complainant*

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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.
16

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.

1 **JURISDICTION**

2 4. First Amended Accusation No. 800-2019-057220 was filed before the Board, and is
3 currently pending against Respondent. The First Amended Accusation and all other statutorily
4 required documents were properly served on Respondent, who timely filed his Notice of Defense
5 contesting the First Amended Accusation. A copy of First Amended Accusation No. 800-2019-
6 057220 is attached as Exhibit A.

7 **ADVISEMENT AND WAIVERS**

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

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

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

20 **CULPABILITY**

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

24 9. For the purpose of resolving the First Amended Accusation without the expense and
25 uncertainty of further proceedings, Respondent agrees that, based on the discipline imposed by
26 the Arizona Medical Board, Complainant could establish at hearing a factual basis for the charges
27 in the First Amended Accusation and that those charges constitute cause for discipline.
28

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.

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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
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
Attorneys for Complainant
6

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

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

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

**FIRST AMENDED
ACCUSATION**

13 Physician's and Surgeon's Certificate
14 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
26
27
28

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:

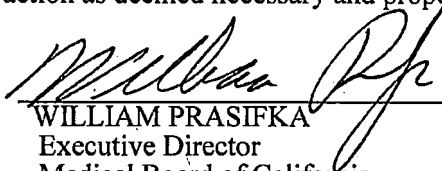
- 20 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 61203,
21 issued to Joshua David Holland, M.D.;
- 22 2. Revoking, suspending or denying approval of Joshua David Holland, M.D.'s authority
23 to supervise physician assistants and advanced practice nurses;
- 24 3. Ordering 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
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

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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
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.

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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,

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.

25

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.

25

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 10th day of June, 2019.

22 ARIZONA MEDICAL BOARD

23
24 By Patricia E. McSorley
25 Patricia E. McSorley
Executive Director

1 EXECUTED COPY of the foregoing mailed
2 this 10th 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 16th day of June, 2019 with:

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

15 Michelle Rhodes
16 Board staff
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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.

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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.

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

3 DATED AND EFFECTIVE this 9th day of May, 2020.

4 ARIZONA MEDICAL BOARD

5
6 By Patricia E. McSorley
7 Patricia E. McSorley
8 Executive Director

9 **CONSENT TO ENTRY OF ORDER**

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

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

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

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

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

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

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


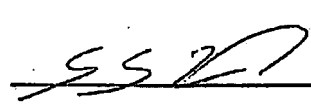
9 8. If any part of the Order is later declared void or otherwise unenforceable, the
10 remainder of the Order in its entirety shall remain in force and effect.

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

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

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

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

22
23
24  DATED: 
JOSHUA D. HOLLAND, M.D.

25

1 EXECUTED COPY of the foregoing mailed
2 this 8th 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 8th 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

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