COLORADO MEDICAL BOARD
STATE OF COLORADO

Case Nos. 2017-9, 2018-5302, 2021-2652

Colorado Medical Board,
Petitioner,

v.

Jonathan Singer, D.O., License Number DR-0029309,
Respondent.

FINAL BOARD ORDER

This medical license discipline matter is before the Colorado Medical Board, Hearings Panel B, to review the Administrative Law Judge's Initial Decision, duly served upon the parties with the Board Procedural Order. The Initial Decision is attached as Exhibit 1 and is incorporated as set forth herein. Respondent filed exceptions to the Initial Decision and designated the record for review. Inquiry Panel A filed a response to the exceptions.

Considering the administrative record as a whole and oral arguments presented by the parties, the Hearings Panel unanimously enters this Final Board Order under §§ 12-240-125 and 24-4-105, C.R.S., for violations of § 12-240-121(1)(j), (n), (v), C.R.S., revoking Respondent's license to practice medicine in Colorado.

A. Standards of Review & Legal Authority

The purpose of regulating physicians under the Medical Practice Act is to protect the public against improper practice of the healing arts. §§ 12-240-102, 12-

240-106(1)(b).[1] The Hearings Panel possesses the authority to determine generally accepted standards of professional practice based on expert testimony in the record on a case-by-case basis. *See Bd. Med. Exam'rs v. McCroskey*, 880 P.2d 1188, 1194 (Colo. 1994). An administrative law judge's ("ALJ") determination of such standards is a mixed question of law and fact that the Hearings Panel reviews for a reasonable basis in law and substantial supporting record evidence. *Id*.

Where violations of the Medical Practice Act have been proven against a physician licensee, the Hearings Panel determines the extent of the discipline, first considering sanctions that are necessary to protect the public and only after it considers sanctions may it consider requirements designed to rehabilitate the licensee. § 12-240-125(5)(c)(III). Determining final disciplinary sanctions is a discretionary function of the agency. *Bd. of Med. Exam'rs v. Ogin*, 56 P.3d 1233, 1240 (Colo. App. 2002).

B. Discussion

No party asserts that any finding of fact is contrary to the weight of the evidence. The Hearings Panel adopts the Findings of Fact in their entirety. Next addressing Respondent's challenges to the ALJ's findings that Respondent violated the Medical Practice Act, the Hearings Panel determines that such findings are supported by substantial record evidence and a reasonable basis in the law.

1. Respondent's care failed to meet generally accepted standards of practice in violation of § 12-240-121(1)(j), C.R.S.

[1] No party disputes citation to the current version of the Medical Practice Act.

Respondent contends that the opinion testimony of the Inquiry Panel's expert witness, who was qualified in family practice medicine, is insufficient to support the ALJ's conclusions that Respondent's treatment of Patients A and D fell below generally accepted standards because the expert does not practice alternative medicine. The Hearings Panel disagrees.

Colorado licensees are required to exercise the same degree of knowledge, skill, and care as exercised by other physicians in the same "field of medicine," which standard must be established by expert testimony. *Bd. Med. Exam'rs v. McCroskey*, 880 P.2d 1188, 1194 (Colo. 1994).

The Hearings Panel first rejects Respondent's contention that, based on the language of § 12-240-121(5)(a), alternative medicine is the applicable field of medicine. Section12-240-121(5)(a) provides that "alternative medicine" means those health-care "methods of diagnosis, treatment, or healing that are not generally used but that provide a reasonable potential for therapeutic gain in a patient's medical condition that is not outweighed by the risk of the methods." The operative word in this provision is that alternative medicine is a "method" of diagnosis or treatment, without reference to those methods as a field of medicine. Giving effect to the plain meaning of the words used consistent with the purpose of the Medical Practice Act, the Hearings Panel declines to interpret this provision to establish alternative medicine as a field of medicine. This decision is consistent with other states that have expressly addressed the issue. *See, e.g., State Bd. of Reg. for Healing Arts v. McDonagh*, 123 S.W.3d 146, 149 (Mo. 2003) (upholding discipline against doctor of

osteopathy using alternative medical treatments in family practice and concluding "the relevant field must be determined not by the approach a particular doctor chooses to take, but by the standards in the field in which the doctor has chosen to practice"); *Gant v. Novello*, 302 A.D.2d 690, 693 (N.Y. 3d Dept. 2003) (applying standard of care applicable to all licensed physicians, regardless of difference in treatment regimes, and rejecting licensee's argument that practice in nonconventional field cannot be held to same standards as traditional medicine); *Gonzalez v. N.Y. State Dept. of Health*, 232 A.D.2d 886, 888-889 (N.Y. 3d Dept. 1996) (reasoning that alternative medicine practitioners must possess same basic scientific knowledge of nature of disease and disease process).

The Hearings Panel next rejects Respondent's assertion that reliance on the expert testimony of a family medicine practitioner contravenes the Medical Practice Act's express authorization to practice alternative medicine. Despite Respondent's rationale for preferring epinephrine because it is found in the body naturally, the Hearings Panel notes that nothing in the record establishes that the treatment of asthma, or the use of epinephrine to treat asthma, constitutes the practice of alternative medicine. *See, e.g.,* Initial Decision, Findings of Fact ¶¶16, 44. Based on substantial record evidence, the ALJ correctly found that the generally accepted standards for assessing and treating asthma involve using a spirometer, measuring forced expiratory volume and flow, disfavoring the use of epinephrine as a first-line treatment because of the risk of cardiac overstimulation, and serially monitoring oxygen levels for at least one hour. *See id.* Findings of Fact ¶¶36-38. The ALJ

properly concluded that Respondent failed to meet generally accepted standards of medical practice when assessing Patient A's condition using a subjective pitch test, administering epinephrine, and failing to properly monitor the patient's condition afterwards. *See id.* Findings of Fact ¶¶15-24, Conclusions of Law pp.15-16.

Concerning Patient D, the ALJ properly relied on expert testimony that the generally accepted standard requires timely referral concerning pelvic pain, made more urgent by potential findings from a CT scan, and hormone level testing before ordering discontinuation of prescribed progesterone. *See id.* Findings of Fact ¶¶59, 69-70, Conclusions of Law, p 16. The ALJ properly concluded that Respondent failed to meet generally accepted standards of medical practice by failing to timely address the findings of Patient D's CT scan, failing to convey to Patient D the seriousness and implications of the CT findings, failing to timely refer Patient D to an obstetrician/gynecologist, and stopping Patient D's progesterone without required blood testing for hormone levels. *See id.* Conclusions of Law p.16.

Based on its own review of the record concerning Respondent's care of Patients A and D, the Hearings Panel concludes that the ALJ properly considered expert testimony from the family medicine practitioner, that the ALJ's conclusions of law are supported by substantial record evidence, and that this result is consistent with § 12-240-121(5)(a).

2. Respondent violated a valid board order under § 12-240-121(1)(n), C.R.S.

Respondent next contends that because he prescribed hormones to Patient D in Wyoming, the conduct is not subject to the practice restriction on his Colorado

license. The Hearings Panel concludes that the ALJ's findings are properly based on Respondent's conduct in Colorado.

Both the 1999 Order and the 2016 Order place restrictions on Respondent's Colorado medical license and prohibit Respondent from providing hormone replacement therapy (other than progesterone and estrogen) to patients. Hearing Exhibits 18 (¶40) and 19 (¶¶3-7). The restriction specifies that the authority of Respondent's Colorado license—distinct from the authority to practice under Respondent's Wyoming license—includes Respondent's "medical decisions and orders" when physically located in Colorado. Hearing Exhibits 19 (¶6) and 18 (¶42).

On April 16, 2018, Respondent made medical decisions in Colorado to prescribe the hormone testosterone to Patient D and directed Patient D to obtain the prescription at Respondent's Wyoming office. *See* Initial Decision, pp.16-17. Though Respondent did not physically write the prescription in Colorado, Respondent's treatment of Patient D included making medical decisions while physically present in Colorado to treat Patient D with a hormone that he was restricted from prescribing in Colorado. By making medical decisions contrary to the prescribing restrictions, Respondent violated a valid Board order.

3. Respondent's documentation violates § 12-240-121(1)(v), C.R.S.

Regarding Respondent's 2014 documentation in Patient A's records, Respondent asserts for the first time that the Board is estopped from imposing discipline by the 2016 Order. The Hearings Panel disagrees.

The 2016 Order resolved seven cases. *See* 2016 Order, ¶4. Respondent does not assert that Patient A's case was one of the cases listed and resolved in the 2016 Order or identify any record evidence that the Inquiry Panel knew of the acts involving Patient A at the time the Order was issued. There being no legal basis to apply estoppel to the circumstances here, the Hearings Panel declines to extend the express terms of the 2016 Order to preclude discipline concerning Patient A.

The Hearings Panel further determines that the ALJ's conclusion—that Respondent engaged in unprofessional conduct by falsifying or repeatedly making incorrect essential entries or repeatedly failing to make essential entries on Patient A's records—is supported by a reasonable interpretation of the law and substantial record evidence. *See* Initial Decision, Findings of Fact ¶¶29, 48.

4. Revocation is required to protect the public.

Respondent contends revocation is not appropriate and that other disciplinary terms, such as continued monitoring, will satisfy public protection needs. The Hearings Panel determines that Respondent's violations of the Medical Practice Act warrant revocation.

In the 2016 Order, Respondent agreed that if it was established at a hearing that Respondent committed any act or omission constituting unprofessional conduct under the Medical Practice Act, the "final sanction *shall be* revocation." *See* 2016 Order, ¶23 (emphasis added). Given the violations established in this matter, revocation is the appropriate discipline in accordance with terms of the 2016 Order.

Even in the absence of the stipulated revocation term, revocation is proper based on the nature of the violations. Respondent's violation of the practice restriction, by directing Patient D in 2018 to obtain a prescription from him in Wyoming, is purposeful in nature. It also reflects Respondent's decision-making concerning patient care to have included all but the physical writing of the prescription in Colorado without adhering to the practice restriction that Respondent had agreed to and was ordered by the board.

The Hearings Panel concludes that revocation would be warranted on this basis alone.

Aggravating circumstances also exist. First is Respondent's repeated violation of valid board orders. In 2010, Respondent violated the same prescribing restriction contained in the 1999 Order. *See* 2016 Order, ¶6(a) (Respondent prescribed a hormone in violation of the practice restriction). Separately, Respondent failed to provide required practice monitor reports in violation of the 1999 Order. *See* Initial Decision, Finding of Fact ¶7 (admonishing Respondent in 2001). Similar to Respondent's conduct with Patient D, the Hearings Panel further notes Patient A's testimony describing Respondent's manner of prescribing contrary to the practice restriction. *See* Hearing Exhibit 40, p.42 (Patient A testified that Respondent recommended hormone replacement therapy with instruction to obtain a prescription from Respondent in Wyoming).

Second, Respondent's Colorado medical license has already been subject to severe and significant sanctions, with reasonable opportunities to rehabilitate. For

instance, the practice restriction is a result of Respondent's substandard care of numerous patients, namely administering thyroid hormone without adequate justification and without adequate monitoring of thyroid function, and adrenal cortex injection without medical justification. *See* 1999 Order, ¶3(a), (c).[2] The 1999 Order imposed a 30-day suspension, five-year probationary period, assessment and learning plan through Colorado Personalized Education for Physicians, and monthly practice monitoring.

The 2016 Order reflects discipline for additional substandard care and documentation, plus inappropriate conduct towards a patient in Wyoming. For this conduct, disciplinary terms included: the continued practice restriction, a second five-year probationary period, practice monitoring, monthly practice monitor chart reviews and reports, treatment monitoring, required written disclosures to patients, and required chaperones for female patients.

Given the prior admonishment, suspension, two five-year periods of practice monitoring and treatment monitoring, and other terms designed to rehabilitate the licensee, the Hearings Panel concludes that additional monitoring terms would not serve the public.

The Hearings Panel agrees with Respondent that his documentation violation in this case is remote in time and is mitigated, at least in part, by Respondent's

[2] The Hearings Panel notes the agreed-upon mechanism for Respondent to petition to rescind the restriction. *See* 2016 Order, ¶28.

subsequent remediation with a practice monitor in 2016[3] and Respondent's recognition of the deficiency. *See* Initial Decision, Findings of Fact ¶¶29, 41. But as recounted above, this documentation issue is one of multiple documentation deficiencies resulting in discipline against Respondent's license, demonstrating deficiencies that recurred despite practice monitoring and chart reviews under the 1999 Order. *See* 1999 Order, pp.3-6; 2016 Order, ¶6(c)-(d).

Respondent asserts further mitigation through letters of support provided for the first time on exceptions. *See* Respondent's Exceptions, attachments. Because this information was not presented to the ALJ, they are not properly within the administrative record, *see* § 24-4-105(15)(a), and the Hearings Panel does not consider them.

The Hearings Panel concludes that Respondent's various violations of the Medical Practice Act in this case present a range of issues, from care departing from generally accepted standards at the assessment, treatment, and monitoring stages, to improper documentation and lack of adherence to the terms of his agreed-upon practice restriction. Given the seriousness of the violations established in this matter, the history of discipline spanning 25 years, and the agreed-upon revocation provision in the 2016 Order in the event of further unprofessional conduct, the

[3] The ALJ made no express findings concerning deficiencies in Respondent's recordkeeping for Patient D that occurred after the 2016 Order, *see, e.g.,* Hearing Tr. (8/1/2023) 272:5-18, 274:3-17, 275:5-8, and the Hearings Panel concludes none are needed to decide this matter.

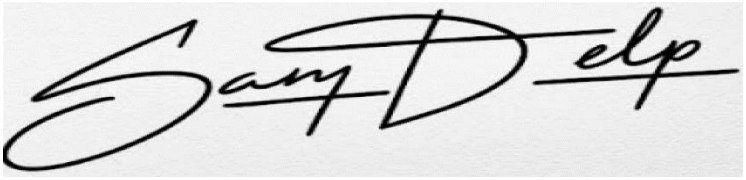
Hearings Panel determines that revocation is necessary to protect public health and safety, which cannot be achieved by means other than revocation.

C. Order

As discussed above, Hearings Panel B adopts the Findings of Fact and Conclusions of Law in the Initial Decision. Based on Respondent's acts or omissions that failed to meet generally accepted standards of medical practice, violation of a valid board order, and repeatedly failing to make essential entries on patient records in violation of the Medical Practice Act, § 12-240-121(1)(j), (n), (v), C.R.S., and pursuant to § 12-240-125(5)(c)(III), the Hearings Panel hereby revokes Respondent's license to practice medicine in Colorado.

Ordered this 5th day of June, 2024.

FOR THE COLORADO MEDICAL BOARD
HEARINGS PANEL B



SAM DELP
DIVISION DIRECTOR

This decision becomes final upon mailing. Any party adversely affected or aggrieved by any agency action may commence an action for judicial review before the Court of Appeals within forty-nine (49) days after the date of the service of this order. §§ 12-20-408, 12-240-127, and 24-4-106(11), C.R.S.

STATE OF COLORADO **OFFICE OF ADMINISTRATIVE COURTS** 1525 Sherman Street, Denver, Colorado 80203	
COLORADO MEDICAL BOARD, Petitioner, VS. **JONATHAN SINGER,** Respondent.	▲ **COURT USE ONLY** ▲ **CASE NUMBER:** **ME 2018 0012**

INITIAL DECISION

The Colorado Medical Board ("Board") seeks to revoke the medical license of Dr. Jonathan Singer, DO ("Respondent"). Hearing in this matter was held before Administrative Law Judge ("ALJ") Tanya T. Light from the Office of Administrative Courts ("OAC") on August 1, 2, 3, 4 and 9, 2023 by video and Google Meet. Present at hearing and representing the Board were Brian J. Uranker, Assistant Attorney General II, and Jenna H. Anderson, Assistant Attorney General II. Respondent appeared and was represented by Kari Hershey, Esq. of Hershey Decker Drake. At hearing, the ALJ admitted into evidence the following stipulated exhibits: 7, 11, 18, 19, 22, 30, 32, 39, and 40. The ALJ also admitted exhibits 1-6, 8-10, 12, 15-17, 29-31, 33 and 34. Some of the admitted exhibits were admitted with redactions or were admitted only in part. The parties filed a "Combined Exhibit List" that the court adopts in full which sets forth in detail the portions of the exhibits that were admitted and the portions that were redacted or omitted. The hearing was recorded by Google Meet.

Procedural History

This case has a long history at the OAC. On October 2, 2018, the Board filed the first pleading in this case, its Formal Complaint of the Attorney General, Notice of Duty to Answer, Notice to Set, and Notice of Hearing ("First Formal Complaint") asserting three counts of violations of C.R.S. §§ 12-240-101, *et. seq*, the Colorado Medical Practice Act ("Act") and requesting an Initial Decision revoking Respondent's medical license. The matter was set for hearing on December 9 through 12, 2019. On July 8, 2019, the Board filed an unopposed Combined Motion for Leave to File Amended Formal Complaint and Unopposed Motion to Continue and Vacate the Scheduled Hearing and Reset ("Amended Formal Complaint"). In the Amended Formal Complaint, the Board sought to add allegations concerning another patient, "Patient D." The court granted the Unopposed Motion to Continue and Vacate the Scheduled Hearing and Reset, and the hearing was rescheduled for November 30 through December 3, 2020.

On August 29, 2019, Respondent filed an Answer to the Amended Formal Complaint. Also on August 29, 2019, Respondent filed a Motion to Dismiss Count II

Exhibit 1

pursuant to Rule 12(b)(5) of the Colorado Rules of Civil Procedure ("CRCP"). Count II alleged that Respondent had engaged in unprofessional conduct by violating a valid Board order. After reviewing the response and reply, on January 2, 2020, the undersigned denied the Motion to Dismiss Count II.

On October 2, 2020, the Board filed the "Panel's Forthwith Motion to Quash Subpoena to Produce Documents" ("Motion to Quash") which requested the undersigned quash a September 28, 2020 subpoena seeking Patient D's medical records. While the Motion to Quash was waiting resolution by the court, on October 6, 2020, the Board filed a new case against Respondent, which was docketed as OAC case number ME 2020-0010. On October 15, 2020, the undersigned stayed case 2018-0012 (this case) pending resolution of case ME 2020-0010. The stay vacated the hearing dates set for November 30 through December 3, 2020. On December 17, 2020, the parties filed a Proposed Amended Case Management Order in case ME 2018-0012, which the court granted on December 22, 2020. The Amended Case Management Order lifted the stay of this case, and rescheduled the hearing for May 20, 21, 24, and 25, 2021.

Concerning the Board's October 2, 2020 Motion to Quash, that issue was ripe for ruling on January 26, 2021, when the undersigned held oral arguments. On February 25, 2021, the court issued an order granting in part and denying in part the Board's Motion to Quash, and the Board appealed the portion denying in part the board's Motion to Denver District Court. On March 31, 2021, the parties filed an Unopposed Motion to Stay Proceedings pending the resolution of the Board's appeal of the Motion to Quash ruling to Denver District Court. On April 1, 2021, the undersigned granted that motion and this case was stayed pending resolution of that issue.

On September 28, 2022, Denver District Court Judge Honorable Andrew P. McCallin issued his ruling vacating the undersigned's discovery orders concerning Patient D's medical records in Denver District Court case number 2021CV31003. Based on that ruling, this court lifted the stay in this proceeding and set the matter for hearing at the OAC for August 1 through 4, 2023. As stated above, hearing was held on those days, plus an additional day on August 9, 2023. At close of hearing, the parties requested written closings, and the court granted that requested and imposed a deadline of September 12, 2023. On that date, the parties filed a Stipulated Motion to Extend Submission of Written Closings, requesting an extension of the deadline to September 18, 2021, which the court granted. On September 18, 2023, the Board field its written closing argument. Respondent filed motions to extend the deadline beyond September 18, 2023, to September 21, 2023, which the court granted in part and denied in part. Respondent filed his Amended Closing Statement on September 21, 203, and the record closed on that date.

ISSUE

Whether the Board has proven by a preponderance of the evidence that Respondent violated the Act, and if so, whether Respondent's medical license should be revoked, or if a lesser form of discipline is warranted.

FINDINGS OF FACT

Respondent

1. Respondent graduated from the University of Wisconsin with a bachelor's degree and a master's degree in food science. He attended the University of Iowa College of Osteopathic Medicine and graduated with honors. Respondent then served in the Air Force from 1984 to 1987. Upon honorable discharge from the Air Force, Respondent established a medical practice in Wyoming and was first licensed as a doctor in Wyoming in 1985. Respondent has continuously maintained his Wyoming medical license and practice to this day. Exhibits 10 and 18.

2. Respondent was first licensed as a physician in Colorado on January 19, 1989, and maintains a practice in Greenwood Village, Colorado. Respondent typically spends one day per week at his Cheyenne, Wyoming office, and the rest of the week at his Greenwood Village office.

3. According to Respondent, he was "a pioneer" in combining traditional and alternative medicine. He attends more than 100 hours of continuing medical education annually in the field of Integrative/Complementary/Functional medicine. Respondent testified that from early in his education, he has been interested in natural substances and functional/alternative medicine. *Id.*

4. According to Respondent, his functional medicine practice entails him finding and treating the underlying causes of disease as opposed to the western medical model of treating illnesses.

Discipline History and Practice Restrictions

5. Respondent has a long history of Board discipline. On April 22, 1999, the Board issued a Final Board Order to Respondent, and on May 24, 1999, the Board issued an Amended Final Board Order against Respondent's medical license. Notably for this case, Paragraphs 2 through 4 of the Amended Final Board Order state:

> 2. The practice restriction set forth in paragraph 3 of the Order is a permanent restriction which goes beyond the five-year probationary period set forth in paragraph 2 of the Order. Unless the monitoring Panel specifically rescinds the restriction pursuant to the provisions of paragraph 3 of the Order, it will remain in effect permanently.
>
> 3. With respect to the extent of the practice restriction, Respondent may provide Progesterone and Estrogen to patients. However, Respondent is prohibited from providing all other types of hormone replacement therapy to patients.
>
> 4. All patients for whom Respondent provides other types of hormone replacement other than Progesterone or Estrogen therapy must be referred

Exhibit 1

to another health care provider who may legally provide this type of therapy. The Hearing Panel advises Respondent to identify and notify affected patients in writing and strongly suggests that this patient population be transferred to another health care provider prior to Respondent's return to practice. Exhibit 19.

6. Paragraphs 6 and 7 of the Amended Final Board Order make distinctions concerning Respondent's medical practices in Colorado and in Wyoming. Paragraph 6 explains that when Respondent is physically located in Colorado, "all medical decisions and orders, including the prescription of medications by telephone, and regardless of the location of his patient constitute the practice of medicine in Colorado. Therefore, as long as and whenever, Respondent is physically located in Colorado, he can provide only those medical services permitted by this Amended order." *Id.* at ¶ 7. In contrast, the Amended Final Board Order states, "The terms of the Order and the Amended Order do not apply to Respondent's practice in Wyoming." *Id*.

7. On September 6, 2001, the Board issued a Letter of Admonition ("2001 LOA") to Respondent for failing to provide practice monitoring reports as required by the April 22, 1999 Final Board Order. Exhibit 22.

8. On February 2, 2010, the Wyoming Medical Board issued an order approving a November 12, 2009 Consent Decree involving Respondent's conduct toward a patient. Respondent successfully completed all the Consent Decree requirements. *See* Exhibit 18 at ¶ 6b.

9. On or about May 18, 2011, the Board and Respondent entered into a Second Interim Practice Agreement in lieu of summary suspension. *See Id.* 18 at ¶ 3.

10. On September 14, 2016, the Board and Respondent entered into a Stipulation and Final Agency Order (the "2016 FAO"). Pertinent terms of the 2016 FAO included five years of probation and monthly practice monitoring during the probation; treatment monitoring by CPHP[1]; and certain chaperoning requirements. Exhibit 18.

11. Paragraphs 38 through 40 of the 2016 FAO stated:

> 38. Respondent is permanently restricted from providing any type of hormone replacement therapy to patients. Respondent may petition the monitoring panel to rescind this restriction. The decision to rescind the practice restriction shall be at the sole discretion of the monitoring panel. The monitoring panel may only rescind the restriction if Respondent first establishes to the satisfaction of the monitoring panel that he is fully educated and proficient in evaluating and treating conditions requiring hormone replacement medications.

[1] The FAO does not indicate what the acronym CPHP stands for; it is assumed the parties are familiar with the term.

39. Respondent may provide Progesterone and Estrogen therapy to patients. However, Respondent is prohibited from providing all other types of hormone replacement therapy to patients.

40. All patients for whom Respondent provides other types of hormone replacement therapy other than Progesterone or Estrogen must be referred to another health care provider who may legally provide this type of therapy. Respondent is to identify and notify affected patients in writing and strongly suggest that this patient population be transferred to another health care provider. Exhibit 18.

12. Paragraphs 42, 43, and 54 of the FAO stated:

42. At all times during which Respondent is physically located in Colorado all medical decisions and orders, including the prescription of medications by telephone, and regardless of the location of his patient, constitute the practice of medicine in Colorado. Therefore, as long as and whenever, Respondent is physically located in Colorado, he can provide only medical services permitted by this Order.

43. The terms of this Order to not apply to Respondent's practice in Wyoming.

54. This Order shall be admissible as evidence at any proceeding or future hearing before the Board. Exhibit 18.

Patient A

13. Respondent began treating Patient A on October 1, 2010 in his Greenwood Village office. She presented to him complaining of asthma. Patient A was short of breath and breathing rapidly and had difficulty speaking. Exhibit 7 at Bates 0017.

14. On October 1, 2010, Patient A signed Respondent's "Informed Consent" form, which stated in part:

> I understand my treatment may involve, but not be limited to, traditional, nontraditional, alternative or complementary diagnostic and therapeutic techniques…some of these therapies may not be approved or officially sanctioned by the FDA, AMA, traditional medical practitioners or the Colorado Board of Medicine for the purposes used in this practice.
>
> Alternatives to Dr. Singer's methods are use of traditional medical diagnostics and therapeutics. Risks of Dr. Singer's methods are felt to be minimal since his techniques are more specific and detailed than that of traditional medical diagnostics and therapeutics. I

understand and consent to treatment by Dr. Singer in the aforescribed manner. Exhibit 7 at Bates 0024.

15. Respondent first treated Patient A with epinephrine. He also listened to the sound of air coming out of her mouth, or an "audible forced expulsion test." He referred to this method as a "pitch test." He listened to her breathing with his stethoscope. Respondent checked her oxygen, or "O2" level.

16. Respondent testified that epinephrine, also known as adrenaline, is his preference because it is a natural substance found in the body, and he prefers to use what the body uses. Respondent testified that he feels adrenaline is not used because it is not patentable like cortisol is for asthma. Respondent placed Patient A on 1 millimeter and then .2 millimeters of epinephrine. Respondent testified that he believes epinephrine is a better first line treatment than the albuterol.

17. Respondent did not treat Patient A with albuterol. He did not perform serial, or sequentially repeated, measurements of her pulse.

18. Respondent also testified that it is not necessary to use a nebulizer with asthmatics because epinephrine can be used instead.

19. Physicians treating asthmatic patients commonly use a measurement of lung function called "FEF1," which stands for forced expiratory flowrate over one second. "PEF" stands for peak expiratory flowrate and is also a measurement used. A device called a spirometer measures the airflow going in and out of an asthmatic patient. The spirometer measures the FEV.

20. Respondent testified that FEV is not a treatment used for patients having acute asthma attacks because it could worsen their condition. He explained that he did not use the PEV of FEF1 with Patient A because she was having a moderately severe asthma attack. He agreed that it is appropriate to use the FEV and FEF1 on a patient who is having a mild exacerbation of asthma.

21. Respondent testified that he could determine the severity of an asthmatic patient's attack by listening; that after many years of practice, he can determine a patient's condition by their physical presentation alone, and he does not need to use the FEV, FEF1 or a spirometer. Respondent never tested Patient A's asthma using the FEV or FEF1. He testified that he relied on his ears to distinguish a difference in an audible pitch or tone to assess Patient A's condition.

22. Respondent has not presented any scientific or peer-reviewed studies that support performing an audible forced expulsion test instead of a peak flow meter.

23. Respondent's handwritten notes of Patient A's January 29, 2014 visit are mostly illegible. However, it is clear that he used an incorrect date of January 30, 2014 as her appointment date. At hearing, Respondent could not determine from his

handwritten notes whether he took her vital signs that day. *See* Exhibit 7 at Bates 0031.

24. Respondent testified that Patient A had a good response with epinephrine and therefore he used that and did not need to use a peak flow meter. Respondent could not remember if he called Patient A within 24 hours of her January 29, 2014 appointment to check on her condition.

25. On February 7, 2014, Respondent saw Patient A again. He indicated in his medical notes that she went to an urgent care center the previous week for bronchitis, and was using Advair, Proventil, and mints to keep her airway open. Exhibit 7 at Bates 0037.

26. On September 22, 2014, Respondent saw Patient A at his Cheyenne, Wyoming office. She appeared to be in acute distress from an asthma attack and her O2 saturation was only 82%, which is dangerously low. Respondent testified that he gave her oxygen at the appointment; however, his SOAP[2] note for that day does not indicate this was the case. He also did not use a spirometer, FEV, or FEF1. Rather, he testified that he used his ears again instead – the audible forced expiration, or "pitch" test. He did not prescribe albuterol, and he testified that Patient A did not like how albuterol made her feel. Exhibit 7 at Bates 0034.

27. Respondent's September 22, 2014 SOAP note for Patient A states:

> Chief Complaint: Acute flair of asthma, short of breath, needs treatment today. recheck asthma. Appt time: 10:45 AM (arrival time: 10:52 AM). Note transcribed from chart with additional information added from recall and for clarity on 1/12/17 at 6:44 PM. (Emphasis added).
>
> Subjective: Patient is having an acute asthma attack and requests immediate treatment. Hard to breathe, not sure what triggered this attack this morning, weather change possibly. More stress as well. Not using asthma meds regularly only prn.
> Objective: Patient in acute distress, retractions present, nasal flaring, audible wheeze, bilateral wheeze with diminished airflow bilaterally. Heart RR at 100, BP normal. Skin no perioral cyanosis or fingertip changes. Neurol-normal cognition, not obtunded.
> Assessment 1. Acute asthma attack, moderately severe. 2. Allergies.
> Plan: 1. Primatene mist, pt prefers to albuterol.
> 2. Oxygen at home at hs and prn, O2 sat at rest on room air in office is 82.
> 3. Epinephrine 0.2 ml sq stat, good relief within a minute
> 4. Epipen for home use
> 5. Needs full pulmonary workup, patient declines, can't afford right now
> 6. F/U 1 week or sooner if needed. ER stat if worsens.
> Exhibit 7 at Bates 0034.

[2] "SOAP" is an acronym for "Subjective, Objective, Assessment, Plan" and is the common method for medical providers to document their treatment of patients.

28. As seen above, Respondent did not write the SOAP note for the September 22, 2014 appointment with Patient A until January 12, 2017, after he received a "30-day letter" from the Board concerning a complaint filed by Patient A. Exhibit 7 at Bates 0034.

29. Concerning Respondent's SOAP note of Patient A, he admitted at hearing that his documentation did not meet the generally accepted standard of care. He testified that his documentation is better now that he has been working with a practice monitor. His documentation in 2014 was performed prior to working with a practice monitor.

30. On September 23, 2016, Patient A was seen by Respondent. She subsequently filed a complaint against him on December 27, 2016, in which she wrote:

> I requested copies of all medical records multiple times since 9/23/16. Dr. Singer treated me for breathing difficulties for several years. He treated me for asthma without ever testing me. I kept getting much worse. I had lung cancer. Exhibit 1.

31. The Academy of American physicians recommends treating mild asthma as follows:

> Initial PEF or FEV1 PEF greater than or equal to 70 percent of predicted or personal best. Clinical course: usually treated at home. Prompt relief with inhaled short-acting beta, agonist. Possible short course of oral systemic corticosteroids. Exhibit 16 at Bates 1497.

32. When asked if he followed the above recommendation in his practice, Respondent testified he did not.

Dr. Tarek Arja, D.O.

33. Dr. Tarek Arja, D.O. has an undergraduate degree in chemistry and is a doctor of osteopathy. He graduated with his DO in 1991 and completed his family practice residency at Presbyterian St. Luke's hospital in Denver. He has been board-certified in Family Practice since 1998.

34. Dr. Arja is currently on the medical staff of two hospitals. He served on the Board of Medical Examiners and on the Colorado Medical Board. Dr. Arja does not practice holistic medicine.

35. Dr. Arja was deemed an expert witness in the practice of family medicine at hearing.

36. Dr. Arja testified that the publication "National Heart, Lung and Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, Full Report 2007" is used by emergency room physicians treating asthmatic patients. The report states, "nonselective

agents (i.e. epinephrine, isoproterenol, metaproterenol) are not recommended due to their potential for excessive cardiac stimulation, especially in high doses." Exhibit 17 at Bates 1877.

37. Dr. Arja testified that a normal pulse oximeter reading is 89 or 90%, and that anything below that level is concerning because a patient could become hypoxic. He explained that during a severe asthma attack, the provider should start with a beta agonist treatment and should be taking serial pulse oximeter measurements every 15 minutes or so for at least an hour. Dr. Arja testified that there was no evidence in the record that Respondent performed serial pulse oximeter testing with Patient A, but that rather, he just sent her home.

38. In Dr. Arja's expert medical opinion, Respondent's treatment of Patient A did not meet the generally accepted standard of care.

Dr. Floyd Russak, MD

39. Dr. Floyd Russak, MD, is a physician practicing in Denver. He grew up in Denver and received a bachelor's degree in biology from Northwestern University. In 1981 he received his medical degree from George Washington Medical School, and his residency was completed at Harvard. Dr. Russak currently has a large, full-time internal medicine practice as well as a holistic internal medical practice. Dr. Russak was deemed an expert witness in internal medicine and holistic and alternative medicine at hearing.

40. Dr. Russack served as Respondent's practice monitor. *See* Exhibit 15.

41. Concerning Respondent's documentation, Dr. Russak testified that he saw improvement in record keeping with Patient D (who will be discussed below in the findings of fact) between 2014 and 2018, and that he saw a definite improvement between Respondent's notetaking for Patient A verses Patient D. Patient A was seen before Respondent entered into a stipulation with the Board, and Patient D was seen after the stipulation.

42. Concerning notetaking, Dr. Russak credibly testified that doctors do not always finish notes, and that notetaking and documentation are important, but are second after patient care.

43. Concerning treatment of asthmatic patients, Dr. Russack testified that medical devices are not always necessary – that physicians can use their senses and do not always have to use a peak flow device.

44. Concerning a nebulizer Beta 2 agonist verses the use of epinephrine, Dr. Russak testified that it was reasonable for Respondent to use epinephrine first; it works a bit faster and lasts a little longer. Dr. Russak testified that it was not outside the standard of care for Respondent to use epinephrine first with Patient A.

45. Concerning Respondent's failure to take serial pulse oximeter readings, Dr. Russak testified that he presented a study that indicated not doing so was acceptable.

46. Dr. Russak testified that a physician can "very much so" determine how well a patient is breathing by just listening. He explained that using a device (such as a spirometer or peak flow meter) could be helpful but is not necessary.

47. Dr. Russak testified that Respondent's care and treatment of Patient A on February 7, 2014 was reasonable.

48. Dr. Russak testified that he would have supplemented Respondent's September 22, 2014 SOAP note in the same manner Respondent did when he added to it in 2017. However, he testified that he would have provided more documentation such as indicating her oxygen levels before and after treatment.

49. When asked if Respondent's treatment of Patient A was within the generally accepted standards of care, Dr. Russak testified that he thought Respondent's care of Patient A was "quite good." However, he testified that Respondent's documentation of his treatment of Patient A could have been better.

Patient D

50. Patient D's first appointment with Respondent was on March 19, 2018 in Greenwood Village office. She wrote on the intake paperwork, "I believe I am progesterone deficient and excess estrogen or estrogen dominant." Exhibit 11 at Bates 1189.

51. On Respondent's March 19, 2018 SOAP note, he wrote:

> Subjective: Patient is here today for multiple problems including PMS, insomnia, painful tender breasts, infertility, anxiety, night sweats, hot flashes, problems with her memory, mood swings, foggy thinking, fatigue, midcycle pain, vaginal dryness, no libido and for about 3 weeks a month, pelvic pain and pressure which extends into her thighs. Patient believes she is progesterone deficient and estrogen dominant. *Id.* at Bates 1241.

52. Respondent had Patient A undergo testing and met with her in his Greenwood Village office on April 9, 2018 to review the lab results. On the SOAP note, he wrote, "Objective: [patient] tearful, very upset, begs me to fix her problems and asks many times if I think I can help her and fix what is wrong." Exhibit 11 at 1240.

53. On April 16, 2018, Respondent and Patient D had a telephone consultation in which she conveyed she was not doing any better. Respondent was in his Greenwood Village office. His SOAP note indicated as part of the Plan that Patient D, "F/U Cheyenne if she desires for low testosterone." *Id.* at 1239.

54. Respondent denied at hearing that he told Patient D during the April 16, 2018 telephone consultation to visit his Wyoming office if she wanted testosterone. He testified that he told all his patients that he could not prescribe them testosterone in Colorado, and that if they wanted a prescription they would have to go to his Cheyenne office. Respondent testified he never coerced patients to go to his Wyoming office and always disclosed to them his past history of discipline.

55. On May 1, 2018, Respondent treated Patient D in his Cheyenne office. He wrote that her chief complaint was low testosterone, and that she was there for replacement therapy. On Respondent's SOAP note for that appointment, he wrote:

> Subjective: Patient has had 24 h UH testing and has been on E2E3 and Progesterone replacement but not testosterone. She is here in Cheyenne today to see me and get a prescription for that written from my Wyoming office. Her ROS is unchanged and main symptoms of low testosterone levels are fatigue, weakness, poor stamina, chronic low back pain and low libido. She has no contraindications for replacement therapy. *Id.* at 1238.

56. On May 4, 2018, Respondent had a telephone consultation with Patient D from his Greenwood Village office. She reported she was still having problems, and that she ached in her low back and thighs midcycle. *Id.* at 1237.

57. On May 14, 2018, Respondent and Patient D had a telephone consultation out of Respondent's Greenwood Village office. He wrote, "[Patient D] having heavier flow, more [undecipherable], more pelvic pain, breasts are sore. Menses every 2 weeks." His assessment was that she had a hormonal imbalance, and his plan was to stop E2E3, continue progesterone, and recheck her urine hormone when she was "more stable." Exhibit 11 at Bates 1236.

58. On May 16, 2018, Patient D had an office visit with Respondent in his Greenwood Village office. In his SOAP note of that day, Respondent wrote:

> Subjective: More pain in the lower back, continues to have pelvic pain like she has for the last 15 years.
> ---
> Assessment:
> 1. Hormone imbalance
> 2. Low libido
> 3. Pelvic pain, chronic
> 4. LLQ [lower left quadrant] pain, not acute or critical.
> Plan:
> 1. CT abdomen and pelvis at Invision.
> 2.Urine hormone test, ZRT 5/28/18.
> 3. Get pelvic, pap, breast exam with Kaiser PCP
> 4. Sexual abuse counseling books suggested.

5. F/U after 1. Exhibit 11 at Bates 1235.

59. On May 24, 2018, Patient D had a CT scan of her abdomen and pelvis with intravenous contrast. The results were the following:

> Impression:
> 1. Heterogeneous enhancement of the uterus with small amount of pelvic free fluid and possible left hydrosalpinx. Findings could indicate pelvic inflammatory disease. Recommend clinical correlation and consider further evaluation with dedicated pelvic ultrasound as deemed clinically appropriate.
> 2. Otherwise no suggestion of acute process within the abdomen or pelvis.
> *Id.* at Bates 1186 (emphasis added).

60. On July 2, 2018, Respondent wrote on his SOAP note that he had an office visit with Patient D at his Greenwood Village location, but also wrote he had a teleconference with her. Concerning her chief complaint, Respondent wrote, "[Patient D had] telecon…to review ZRT urine metabolites test as well as CT abd [abdomen] and pelvis. Now has urinary urgency, frequency without pain. Also hip and LBP last half of menstrual cycle, chronic." *Id.* at 1234.

61. The July 2, 2018 SOAP note further stated:

> Subjective: Patient is now having hot flashes and 3 weeks of urinary urgency, frequency but without pain. No fever or chills or flank or bladder pain. Went off E2E3 and testosterone cream before doing the ZRT hormone test, still taking 25 mg cap of progesterone at hs. Emotional too and not sleeping well. Pain in lower abdomen and pelvis is better off hormones, flared up more on L side by ovary when she was on the estrogen.
> ---
> Assessment:
> 1. Urinary urgency and frequency, painless, new onset last 3 weeks. Etiol uncertain, hormonal?
> 2. Hydrosalpinx, L, etiol uncertain, w/u to be done at Kaiser.
> 3. Elevated am cortisol, etiol uncertain, stress likely.
> 4. Hormone imbalance, on BHRT
> 5. LBP [lower back pain], chronic, with bilat hip pain, last half of menstrual cycle.
> 6. Hot flashes.
> Plan:
> 1. Reviewed CT Abd pelvis in detail with patient. Has a tortuous L hydrosalpinx on scan, ddx, PID, STD, old laparoscopy for endometriosis fulguration scar, tubal neoplasia. Referred to Kaiser gynec to further w/u and treat.
> 2. Cheyenne – Change BHRT, stop progesterone, use E2E3 0.05/0.05 1 caap po at hs only. Stop testosterone cream. *Id.* (emphasis added).

Exhibit 1

62. At hearing Respondent testified that he was not sure whether he engaged in this telephone consultation from his Greenwood Village office – that he may have just recorded the SOAP note on his Greenwood Village SOAP note letterhead.

63. Respondent saw Patient D on July 6, 2018. She was there to discuss how she was doing on new medication. Respondent's SOAP note indicated:

> Subjective: hips hurting less on new BHRT. More tired, but falls asleep and stays asleep now without difficulty. Still has breast tenderness and moodiness. Going to see gynecologist at Kaiser in 4 days. Needs an updated CT report that includes mention of her ovaries on it.
> Objective: Still sounds very emotional but better.
> Assessment
> 1. Anxiety and depression, same.
> 2. Menopausal symptoms, better,
> 3. Hormone imbalance, better.
> Plan:
> 1. Continue BHRT, E2E3 only at hs.
> 2. FU after gynec visit next week.
> 3. Called Invision Radiologist for addendum to report to include mention of ovaries. Please have them fax us a copy of the addendum and send to patient. Exhibit 11 at 1233.

64. On July 10, 2018, Patient D filed a complaint against Respondent with the Board, stating in pertinent part:

> I went to Dr. Singer with certain medical issues that I had hoped he could help me with. Under his care I have had my prescriptions changed multiple times. Some of my symptoms have only gotten worse, and I've gotten new symptoms. I've told him my personal family history with breast and ovarian cancer and I feel like he is just throwing hormones at me and seeing what sticks. He has tested me multiple times only to be told that the test was performed at the wrong time and prescriptions were prescribed in error… I question why having to cross state lines to get a testosterone prescription only to find out that it could have been prescribed in the state of Colorado. I've never experienced a Dr. that has such a hard time remembering dates that were provided to him, test results that were ordered by him, and remembering to order prescriptions that he has prescribed.
> ---
> On April 16, 2018, I called Dr. Singer's office to see if my Complete Hormones (24HR) results were back yet…Dr. Singer called later that evening and stated…that…my testosterone levels were zero….He also stated that I will need to go to his office located in Cheyenne, Wyoming in order to get a prescription for testosterone. When I asked him why do I have to go to Wyoming for testosterone, he mumbled something about

> Colorado law and said that I needed to become a Wyoming patient in order to get the prescription that he said I needed.
>
> During the teleconference he seemed to not know what he was instructing me to do treatment wise in the past. He didn't seem to know what he had prescribed/advised me to take/not take…After discussing the results of the CT scan that he didn't know was already performed, he instructed me to F/U with a gynecologist for further investigation/testing. He also requested that I F/U with him in 5 days to see how treatment was going. On July 6, 2018, I spoke to Dr. Singer about how the estrogen only treatment has been going since starting on 7/2/18. I informed him that I was having hot flashes and he instructed me to continue treatment for 3 more weeks. Exhibit 8.

65. Respondent did not coordinate care of Patient D with her primary care physician. He testified that he asked for her medical records but did not receive them.

66. Respondent testified that he encourages his patients to follow up with their traditional doctors.

67. Concerning the CT scan results, Respondent testified that they were not urgent or an emergency, and that Respondent did not show signs of any acute illness.

68. PID, or pelvic inflammatory disease, is a serious condition that can lead to sepsis and death. It can also lead to scarring and infertility. Pelvic pain can be a sign of PID.

69. Dr. Arja testified that there was a five week delay from the time Patient D complained about pelvic pain until Respondent referred her to an obgyn, and that this delay "absolutely" did not meet the generally accepted standard of care.

70. Dr. Arja's was also concerned that Respondent had Patient D stop taking progesterone on July 2, 2018. He explained that the standard of care would be to take a blood test first to determine her hormone levels.

71. Dr. Russak testified that the lab tests of Patient D that Respondent ordered were appropriate and within the standard of care for doctors practicing alternative medicine. He further testified that having Patient D obtain a CT scan of her abdomen for pelvic pain was within the standard of care, and that he would have ordered a CT scan as well. He testified that it was reasonable for Respondent to order Patient D to follow up with her primary care physician at Kaiser after the CT scan because any abnormal results or acute findings should be seen by a primary care physician. Dr. Russak also testified that it was reasonable for Respondent to have Patient D stop taking progesterone for one week.

72. Dr. Russak testified that although the CT scan result was concerning about PID, it was not highly suggestive of that condition, and was not an urgent or emergent result.

73. Dr. Russak testified that Respondent's treatment of Patient D was within generally accepted standards of both alternative and traditional care.

CONCLUSIONS OF LAW

Burden of Proof

Section 12-240-125(5)(a) of the Act adopts the Colorado Administrative Procedure Act ("APA") for hearings concerning licensing and discipline of physicians. Pursuant to section 24-4-105(7) of the APA, the proponent of an order has the burden of proof, which shall conform "to the extent practicable" with that in civil non-jury district court cases, which is a preponderance of the evidence. The Board is the proponent of an order disciplining Respondent; therefore, the Board has the burden of proof.

The Asserted Violations in the Amended Formal Complaint

The Amended Formal Complaint is the operative pleading in this case. Count I alleges that Respondent engaged in unprofessional conduct by failing to meet generally accepted standards of care, in violation of what was at the time codified as section 12-36-117(p), and is now codified as section 12-240-121(1)(j). That section states, "Unprofessional conduct as used in this article 240 means any act or omission that fails to meet generally accepted standards of medical practice."

Count II of the Amended Formal Complaint alleges Respondent violated then-section 12-36-117(u), now codified as section 12-240-121(1)(n), which states, "Unprofessional conduct as used in this article 240 means violation of any valid board order or any rule promulgated by the board in conformance with law."

Finally, Count III asserts that Respondent violated then-section 12-36-117(1)(cc), now-codified at section 12-240-121(1)(v), stating, "Unprofessional conduct" as used in this article 240 means falsifying or repeatedly making incorrect essential entries or repeatedly failing to make essential entries on patient records."

Discussion

While both expert witnesses had impressive education and experience, the court found Dr. Arja's testimony more persuasive. Dr. Arja relied on peer-reviewed studies that have been accepted and used by the medical establishment for many years, such as the National Heart, Lung and Blood Institute's 2007 Full Report on the Guidelines for the Diagnosis and Treatment of Asthma.

Concerning Count I, the court concludes the Board has met its burden of proving

Respondent's conduct failed to meet generally accepted standards of medical practice in violation of section12-240-121(1)(j). Respondent's use of his "pitch" test to determine Patient A's status failed to meet generally accepted standards of care. Respondent provided no studies or scientific articles that supported the use of this test. The test appears to be subjective and entirely dependent upon Respondent's hearing, but not based on any objective standard. The court is persuaded that a spirometer, FEV, and FEF1 tests are the generally accepted standards of care in patients presenting as Patient A presented, but Respondent chose to solely rely on his pitch test in lieu of those tests. Furthermore, Respondent chose to use epinephrine as his first-line treatment of Patient A's asthma, when the literature clearly states that epinephrine is not recommended due to its potential for excessive cardiac stimulation. Dr. Arja's persuasive testimony was that a beta agonist should have been the first line treatment for Patient A, followed by serial pulse oximeter readings every 15 minutes for at least an hour. There is no indication in the record that Respondent took serial pulse oximeter readings of Patient A before sending her home. This failure is especially concerning given that Patient A's O2 reading was dangerously low at 82%. His failure to monitor Patient A's condition, especially after administering a cardiac-stimulating substance like epinephrine and especially considering the 82% O2 reading, failed to meet the generally accepted standards of care.

Respondent also failed to meet the generally accepted standard of care with Patient D. The CT scan indicated Patient D may have had PID, a serious and potentially fatal condition. There is no indication in the record that Respondent conveyed to Patient D the seriousness and implications of this finding. Respondent may have been focused on other issues as a practitioner of alternative medicine, but the PID finding happened on his watch, so to speak, in that he was the first medical provider other than the radiologist to see this result. Also, Patient D had been repeatedly complaining to Respondent of symptoms indicative of PID, such as the frequent pain she was experiencing, but even with this knowledge, Respondent failed to timely discuss the serious implications of PID with Patient D and failed to timely refer her to an ob/gyn. The court concludes that referring Patient D to her ob/gyn when he did, without communicating to her the risks associated with PID, fails to meet generally accepted standards of care. Moreover, the court concludes that the fact that Respondent instructed Patient D to immediately stop taking progesterone without first taking a blood test to determine her hormone levels failed to meet generally accepted standards of medical care. The court finds Dr. Arja's testimony more persuasive on this point. Although Dr. Russak testified that it was reasonable for Respondent to have Patient D stop taking progesterone for one week, that testimony was not persuasive. It appears to the court, as it appeared to Patient D, that Respondent was subjectively ordering her on and off various hormones without scientifically-based, objective reasons for doing so. For these reasons, the court concludes that the Board has met its burden of proving Respondent's conduct concerning his treatment of Patient D failed to meet generally accepted standards of medical care in violation of section12-240-121(1)(j).

Concerning Count II, the court concludes the Board has met its burden of proof. The Board ordered Respondent not to prescribe testosterone from his Colorado office. The court is persuaded by the evidence in the record that Respondent violated this Board

order when he specifically directed Patient D to his Cheyenne office in order for her to receive testosterone. Respondent denies that on April 16, 2018 during a telephone consultation with Patient D from his Greenwood Village office that he told her she had to travel to Cheyenne if she wanted testosterone. However, his testimony and his SOAP note conflict. The note states that the "Plan" was for Patient D to "F/U Cheyenne if she desires for low testosterone." Also, Patient' D's complaint states that "he also stated that I will need to go to his office located in Cheyenne, Wyoming in order to get a prescription for testosterone." When Patient D asked why this was so, Respondent "mumbled something about Colorado law and said that I needed to become a Wyoming patient in order to get the prescription that he said I needed." Based on this evidence, it simply is not credible to the undersigned that Respondent did not tell or direct Patient D to travel to Wyoming to receive testosterone. Nor is it persuasive to the court that instructing Patient D to travel to Wyoming to receive testosterone does not violate the Board order. The Board order is clear that if Respondent is physically located in Colorado, he cannot prescribe testosterone. He was physically located in Colorado on April 16, 2018 when he instructed Patient D on how she could receive a prescription for testosterone. For these reasons, the court concludes has met its burden of proving Respondent violated a valid Board order in violation of section 12-240-121(1)(n).

Finally, the court concludes the Board met its burden of proving Respondent engaged in unprofessional conduct by falsifying or repeatedly making incorrect essential entries or repeatedly failing to make essential entries on patient records in violation of section 12-240-121(1)(v). It is concerning to the court that Respondent "corrected" a September 22, 2014 SOAP note on January 12, 2017. He did not do so on his own accord; he did so only after receiving the Board's 30-day letter. It is not credible to the court that Respondent's memory was such that he could specifically recall what took place during a September 2014 appointment over two years later. This recreation of a SOAP note is persuasive evidence that Respondent failed to make an essential entry in 2014. Furthermore, Respondent's own expert witness admitted at hearing that Respondent's note taking was lacking, and that he, Dr. Russak, would have done more thorough documentation.

Discipline

Having concluded that Respondent violated the Act, the court must determine the appropriate discipline. Section 12-240-125(5)(c)(III) states:

> If the hearings panel finds the charges proven and orders that discipline be imposed, it shall also determine the extent of the discipline, which must be in the form of a letter of admonition, suspension for a definite or indefinite period, or revocation of license to practice. The hearings panel also may impose a fine of up to five thousand dollars per violation. In determining appropriate disciplinary action, the hearings panel shall first consider sanctions that are necessary to protect the public. Only after the panel has considered sanctions may it consider and order requirements designed to rehabilitate the licensee or applicant. If discipline other than revocation of a license to practice is imposed, the hearings panel may also order that the

> licensee be granted probation and allowed to continue to practice during the period of probation. The hearings panel may also include in any disciplinary order that allows the licensee to continue to practice such conditions as the panel may deem appropriate to assure that the licensee is physically, mentally, morally, and otherwise qualified to practice medicine, practice as a physician assistant, or practice as an anesthesiologist assistant in accordance with generally accepted professional standards of practice, including any or all of the following…

Here, the court concludes that the only form of discipline warranted is revocation of Respondent's license. The reason is that Respondent has had a long history of discipline and has been subject to practice monitoring and Board orders for many years but continues to violate the Act. Given Respondent's lengthy history of Board involvement, practice monitoring, and discipline, it appears to the court that at this time Respondent is not able to be regulated by the Board. When that is the case, unfortunately the only discipline left is revocation. The is charged with balancing a physician's interest in his license against protection of the public. Here, based on all the credible and persuasive evidence in the record, the scale tips in favor of public protection, and for that reason, Respondent's medical license must be revoked.

INITIAL DECISION

It is the Initial Decision of the Administrative Law Judge that Respondent's medical license should be revoked.

Done and signed this 12th day of January 2024.

/s/ Tanya T. Light
TANYA T. LIGHT
Administrative Law Judge