BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

GABRIELLE J. GOODRICK, M.D.

Holder of License No. 22811
For the Practice of Allopathic Medicine
In the State of Arizona

Case No. MD-12-1333A

ORDER FOR LETTER OF REPRIMAND AND CONSENT TO THE SAME

Gabrielle J. Goodrick, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for Letter of Reprimand; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

FINDINGS OF FACT

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

2. Respondent is the holder of license number 22811 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-12-1333A after receiving a report from the Arizona Department of Health Services ("DHS") that a survey was conducted at Respondent's office and indicated that there were multiple violations related to her medical practice, including inappropriate prescribing and failure to properly safeguard controlled substances dispensed by her office.

4. DHS reported that Respondent had four pre-written and pre-signed scripts for Percocet 5/325 located in a drawer. Respondent admitted that she did pre-draft prescriptions for 10 tablets of Percocet. She stated that the scripts were drafted each day based on the number of expected patients receiving Percocet, and destroyed if not used

on that day. The full name and address of the patient was not completed until Respondent explicitly directed the nurses to issue the prescription.

5. In its report to the Board, DHS also indicated that Respondent improperly maintained controlled substances in unsecured cabinets and drawers. Specifically, an open bottle of Oxycodone with Tylenol 5/325mg was kept in a cabinet in the lab area. During an investigational interview with Board staff, Respondent admitted that the office process was to remove a bottle of controlled substances from the safe for "short-term" usage. The bottle was left in a cabinet in the lab area during clinic hours for easy access by staff for dispensing to patients seen that day. According to Respondent, access to the lab area was through sliding doors without a lock or key, but patients were not permitted to enter the lab area and were escorted from the lab immediately if they entered inadvertently. Respondent stated that the unused "short-term" bottle was left in the lab overnight, but that the office was secured by double locks and a monitoring system.

6. The DHS report also identified a discrepancy from the medication log and the pills on hand. DHS concluded that 51 pills were missing. Respondent stated later that ten pills were missing, that DHS's count was erroneous and the discrepancy in the log was caused by a one-time failure to report the dispensing of ten pills to a patient.

7. In addition, DHS reported that Respondent disclosed and self-reported to DHS staff during the site inspection that there was another unopened bottle of Oxycodone temporarily being stored at the home of the office manager. She indicated that for some unknown reason, a new sealed bottle of Percocet was received, but not placed into the safe because one of the two staff members who knew the two part code combination was not present in the office. Therefore, the safe could not be opened and she directed the office manager to take it home for security purposes. The office manager was a trusted

1 employee who lived alone. Respondent reported that the bottle was returned the next day
2 sealed and was not tampered with.
3 8. Board staff observed that based upon the problems identified by DHS,
4 Respondent has instituted new policies and written procedures to address the issues
5 regarding dispensing reported by DHS after the inspection. According to Respondent,
6 DHS has accepted and approved the new policies and procedures.
7 9. According to Respondent shortcomings identified by DHS were entirely
8 related to lapses in administrative policies and procedures. Although these shortcomings
9 may have increased the risk of drug diversion or loss, there is nothing to suggest that any
10 diversion, loss, or other improper use actually took place. Also, according to Respondent,
11 administrative lapses at no time endangered the health of any patients or diminished the
12 quality of care. Respondent stated she did not act dishonestly or with any selfish motive
13 and has in good faith fully cooperated with the investigation of the Board, and has rectified
14 the above shortcomings in a timely fashion.
15 **CONCLUSIONS OF LAW**
16 1. The Board possesses jurisdiction over the subject matter hereof and over
17 Respondent.
18 2. The conduct and circumstances described above constitute unprofessional
19 conduct pursuant to A.R.S. § 32-1401(27)(k) ("[s]igning a blank, undated or predated
20 prescription form.").
21 3. The conduct and circumstances described above constitute unprofessional
22 conduct pursuant to A.R.S. § 32-1401(27)(s) ("[v]iolating or attempting to violate, directly or
23 indirectly, or assisting in or abetting the violation of or conspiring to violate any provision of
24 this chapter."), namely, A.R.S.§32-1491(A)(3) ("A doctor of medicine may dispense drugs
25 and devices kept by the doctor if: (3) the dispensing doctor keeps all drugs in a locked

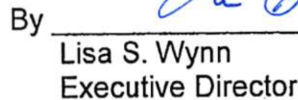
cabinet or room, controls access to the cabinet or room by a written procedure and maintains an ongoing inventory of its contents.")

ORDER

IT IS HEREBY ORDERED THAT Respondent is issued a Letter of Reprimand.

DATED AND EFFECTIVE this 10th day of June, 2013.

ARIZONA MEDICAL BOARD



By ______________________
Lisa S. Wynn
Executive Director

CONSENT TO ENTRY OF ORDER

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

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

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

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

1 5. All admissions made by Respondent are solely for final disposition of this
2 matter and any subsequent related administrative proceedings or civil litigation involving
3 the Board and Respondent. Therefore, said admissions by Respondent are not intended
4 or made for any other use, such as in the context of another state or federal government
5 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or
6 any other state or federal court.
7 6. Upon signing this agreement, and returning this document (or a copy thereof)
8 to the Board's Executive Director, Respondent may not revoke the consent to the entry of
9 the Order. Respondent may not make any modifications to the document. Any
10 modifications to this original document are ineffective and void unless mutually approved
11 by the parties.
12 7. This Order is a public record that will be publicly disseminated as a formal
13 disciplinary action of the Board and will be reported to the National Practitioner's Data
14 Bank and on the Board's web site as a disciplinary action.
15 8. If any part of the Order is later declared void or otherwise unenforceable, the
16 remainder of the Order in its entirety shall remain in force and effect.
17 9. If the Board does not adopt this Order, Respondent will not assert as a
18 defense that the Board's consideration of the Order constitutes bias, prejudice,
19 prejudgment or other similar defense.
20 10. Any violation of this Order constitutes unprofessional conduct and may result
21 in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation,
22 consent agreement or stipulation issued or entered into by the board or its executive
23 director under this chapter") and 32-1451.
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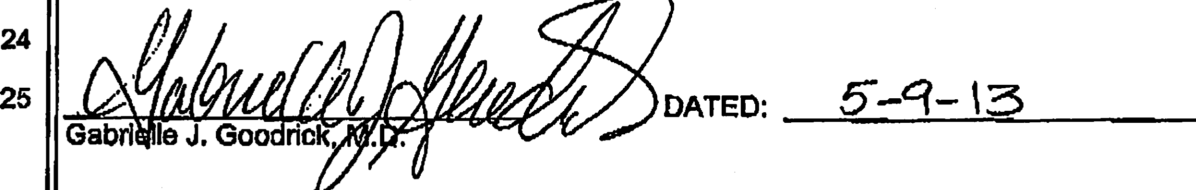

DATED: 5-9-13

Gabrielle J. Goodrick, M.D.

EXECUTED COPY of the foregoing mailed
this 10th day of June, 2013 to:

Jean-Jacques Cabou
Perkins Coie
2901 N Central, Suite 2000
Phoenix AZ 85012-2788
Attorney for Respondent

ORIGINAL of the foregoing filed
this 10th day of June, 2013 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Mary Bober
Arizona Medical Board Staff