TEXAS COURT OF APPEALS, THIRD DISTRICT, AT AUSTIN

NO. 03-15-00815-CV

Tommy Ernest Swate, M.D., Appellant

v.

Texas Medical Board, Appellee[1]

FROM THE DISTRICT COURT OF TRAVIS COUNTY, 250TH JUDICIAL DISTRICT
NO. D-1-GN-14-002265, HONORABLE ORLINDA NARANJO, JUDGE PRESIDING

M E M O R A N D U M   O P I N I O N

Tommy Ernest Swate, M.D., appeals the district court's judgment affirming the final order issued by appellee, Texas Medical Board[2] (the Board), revoking his license to practice medicine in Texas. The Board revoked Dr. Swate's license after determining that he violated the Texas Medical Practice Act, *see* Tex. Occ. Code §§ 151.001-169.005 (the Act) and certain Board rules, *see* 22 Tex. Admin. Code §§ 160.1-190.16, in his treatment of chronic-pain and addiction patients. Specifically, the Board found that Dr. Swate failed to keep adequate medical records,

[1] Although the parties included Michael Arambula in his official capacity as President of the Texas Medical Board in the styles of their briefs, the record reflects that he was never served and did not appear before the trial court. Therefore, he is not a party to this appeal.

[2] The agency's Final Order in this case was styled, in pertinent part, "Before the Texas Medical Board." The trial court's Final Judgment and the Notice of Appeal referred to the agency as the Texas State Board of Medical Examiners. We refer to the agency as the Texas Medical Board. Acts 2005, 79th Leg., R. S., ch. 269, § 1.01, 2005 Tex. Gen. Laws 720, 720, eff. Sept. 1, 2005 (codified at Tex. Occ. Code § 151.002).

including failing to document history, treatment goals, plans, and progress. In one case, the Board determined Dr. Swate failed to perform and document a proper physical examination. He was further found to have failed to follow through on signs of potential diversion[3] or abuse of medications he prescribed. In seven issues, Dr. Swate contends that the district court erred in affirming the Board's final order. Because we find no error in the Board's final order and conclude that it was supported by substantial evidence, we will affirm the district court's judgment.

BACKGROUND

Dr. Swate practiced medicine in Texas under license number E-3781, which the Board issued to him in 1975. Initially practicing obstetrics and gynecology, in which he was board-certified, Dr. Swate completed additional training in addiction medicine, psychology, interventional pain management, and sports medicine over the course of his career. He earned certification by the American Society of Addiction Medicine. During the time period at issue, 2007 through 2010, Dr. Swate's Houston-area practice focused on treating addiction and chronic pain.

The Board's staff filed its initial complaint against Dr. Swate with the Board and the State Office of Administrative Hearings (SOAH) in October 2011. The complaint alleged that between 2007 and 2010, Dr. Swate prescribed controlled substances to ten patients (Patients A, B, C, D, E, F, G, H, I, and J) for the treatment of chronic pain and anxiety without meeting the standard

[3] "Diversion" is defined to mean "the use of drugs by anyone other than the person for whom the drug was prescribed." 22 Tex. Admin. Code § 170.2(6) (2017) (Tex. Med. Bd., Definitions). This case is governed by the version of the Board's rules in effect at the time of Swate's conduct. Some of the provisions we discuss have been amended since that time. Where there are no differences between the current and applicable versions of a rule that are material to the point in discussion, we cite the current version for convenience.

of care for such treatment or maintaining adequate records. Dr. Swate responded that his treatment of the ten patients at issue complied with the Act and met the standard of care, as did his record-keeping.

After an unsuccessful informal settlement conference, the case proceeded to a contested-case hearing before two SOAH Administrative Law Judges (ALJs). The Board amended its complaint on April 30, 2013, adding allegations that Dr. Swate violated the Act by failing to document any rationale supporting the prescriptions he wrote and failing to document treatment plans and periodic reviews related to the patients' progress. Dr. Swate maintained that he had not violated the Act and that his practices fell within the standard of care. The ALJs conducted a four-day evidentiary hearing, during which the Board offered more than 1600 pages of medical and pharmaceutical records and the expert testimony of Dr. Gregory Powell, a board-certified pain and rehabilitation specialist. Dr. Swate offered his own testimony as well as the report and deposition testimony of Dr. Joseph Cotropia and the deposition testimony of expert Dr. Robert Chabon. The parties also submitted post-hearing briefing.

After the record was closed, the ALJs issued a proposal for decision (PFD) that included 212 findings of fact and 19 conclusions of law. The ALJs concluded that Dr. Swate: (1) failed to keep adequate medical records for Patients A, C, D, E, G, H, I, and J because he failed to obtain records from previous providers or other adequate medical history; (2) failed to document an initial problem-focused physical examination of Patient F that met the standard of care; (3) failed to appropriately document chronic pain treatment goals or objectives or any information detailing progress toward those goals for Patients A, B, C, D, E, F, G, H, I, and J; and (4) failed to use

diligence and safeguard against potential complications from the medications he prescribed to Patients A, E, F, G, and J by not following through on signs of potential diversion or abuse. Based on these findings, the ALJs determined Dr. Swate had violated multiple provisions of the Act, for which the Board was authorized to take disciplinary action. The ALJs also concluded that the Board should consider the fact that Dr. Swate had previously been the subject of disciplinary action to be an aggravating factor and could consider the fact that the ALJs found more than one violation for more than one patient to be an aggravating factor. The ALJs did not make a recommendation as to what, if any, disciplinary action the Board should take.

The Board reviewed the ALJs' proposal and adopted it in full, adding ordering paragraphs that provided that Dr. Swate's license to practice medicine was immediately revoked and permitted Dr. Swate to petition the Board for re-issuance of his license after one year. Dr. Swate sought judicial review of the Board's order in district court. After a hearing on the merits, the district court affirmed the Board's final order. This appeal followed.

ANALYSIS

Dr. Swate raises seven issues on appeal. The first four challenge the ALJs' admission of the testimony of the Board's expert witness, Dr. Powell. Dr. Swate contends that the ALJs abused their discretion in admitting Dr. Powell's testimony because Dr. Powell's methodology had not been shown to be reliable, and because Dr. Powell was allowed to present subjective opinions. In his fifth issue, Dr. Swate challenges the admission of twelve Board exhibits because the authenticating witnesses were not disclosed in discovery. In his sixth issue, Dr. Swate contends that the Board's final order is not supported by substantial evidence. Lastly, in his seventh issue, Dr. Swate contends

that the Board acted in an arbitrary and capricious manner in issuing its final order by disregarding certain findings of fact and conclusions of law.

Admission of Board expert's testimony

In his first and fourth issues, Dr. Swate argues the ALJs erred in admitting the testimony of the Board's expert witness, Dr. Powell, because the expert's methodology was not first shown to be reliable. Administrative rulings on the admission or exclusion of evidence, including expert testimony, are reviewed under the same abuse-of-discretion standard applied to trial courts. *Scally v. Texas State Bd. of Med. Exam'rs*, 351 S.W.3d 434, 450 (Tex. App.—Austin 2011, pet. denied); *Fay–Ray Corp. v. Texas Alcoholic Bev. Comm'n*, 959 S.W.2d 362, 367 (Tex. App.—Austin 1998, no pet). A court abuses its discretion if it acts without reference to guiding rules and principles. *Bennett v. Grant*, No. 15-0338, 2017 WL 1553157, at *7 (Tex. Apr. 28, 2017) (citing *Cire v. Cummings*, 134 S.W.3d 835, 838-39 (Tex. 2004) (quoting *Downer v. Aquamarine Operators, Inc.*, 701 S.W.2d 238, 241-42 (Tex. 1985))). We will reverse the trial court's ruling only if it was arbitrary or unreasonable. *Downer*, 701 S.W.2d at 242.

If expert opinion testimony will help the factfinder understand the evidence or determine a fact at issue, it should be admitted. *See* Tex. R. Evid. 702; *Scally*, 351 S.W.3d at 450; *Fay–Ray Corp.*, 959 S.W.2d at 367. Qualified experts may offer opinion testimony if it is "both relevant and based on a reliable foundation." *Gharda USA, Inc. v. Control Sols., Inc.*, 464 S.W.3d 338, 348 (Tex. 2015); *E.I. du Pont de Nemours & Co. v. Robinson*, 923 S.W.2d 549, 556 (Tex. 1995). When assessing an expert's reliability, the trial court is required to "evaluate the methods, analysis, and principles relied upon in reaching the opinion," and "should ensure that the

opinion comports with applicable professional standards outside the courtroom and that it 'will have a reliable basis in the knowledge and experience of [the] discipline.'" *Watkins v. Telsmith, Inc.*, 121 F.3d 984, 991 (5th Cir. 1997) (quoting *Daubert v. Merrell Dow Pharm.*, 509 U.S. 579, 592 (1993)) (quoted in *Gammill v. Jack Williams Chevrolet, Inc.*, 972 S.W.2d 713, 725-26 (Tex. 1998)). The abuse-of-discretion standard "applies as much to the trial court's decision about how to determine reliability as to its ultimate conclusion." *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 152 (1999).

Dr. Swate based his reliability challenge on the application of *Robinson* to the methodology Dr. Powell used in reviewing Dr. Swate's records. In *Robinson*, the Texas Supreme Court established that an expert's "underlying scientific technique or principle must be reliable." *Robinson*, 923 S.W.2d at 557. It identified six factors that courts may consider when determining whether an expert's scientific testimony is reliable and thus admissible. *See id.* The factors are: (1) the extent to which the theory has been or can be tested; (2) the extent to which the technique relies upon the subjective interpretation of the expert; (3) whether the theory has been subjected to peer review and/or publication; (4) the technique's potential rate of error; (5) whether the underlying theory or technique has been generally accepted as valid by the relevant scientific community; and (6) the non-judicial uses which have been made of the theory or technique. *Id.* Generally, these factors are applied to methodologies used by experts to form, justify, and explain their opinions regarding the facts of a case, rather than the methodology used by experts to gather those facts. *See, e.g.*, *Transcon. Ins. Co. v. Crump*, 330 S.W.3d 211, 217 (Tex. 2010) (assessing expert's use of differential diagnosis to provide opinion on cause of death); *Whirlpool Corp. v. Camacho*,

298 S.W.3d 631, 639 (Tex. 2009) (assessing electrical engineer's analysis of whether defect in dryer design caused fatal fire); *Cooper Tire & Rubber Co. v. Mendez*, 204 S.W.3d 797, 802-03 (Tex. 2006) (assessing witness's theory of wax contamination to explain cause of tire failure); *Constancio v. Shannon Med. Ctr.*, No. 03-10-00134-CV, 2012 WL 1948345, at *3 (Tex. App.—Austin May 22, 2012, no pet.) (mem. op.) (assessing reliability of theories underlying causation opinion rather than methodology of reviewing medical records, deposition testimony, and medical literature).

Subsequent to *Robinson*, the court clarified that its six factors are nonexclusive and "do not fit every scenario." *TXI Transp. Co. v. Hughes*, 306 S.W.3d 230, 235 (Tex. 2010); *see Gammill*, 972 S.W.2d at 726; *Constancio*, 2012 WL 1948345, at *3. Where, as here, experts rely on principles and analysis rather than on a particular methodology to reach their conclusions, we must assess reliability by determining whether there is "'simply too great an analytical gap between the data and the opinion proffered'" for the opinion to be reliable. *Gammill*, 972 S.W.2d at 726 (quoting *General Elec. Co. v. Joiner*, 522 U.S. 136, 146 (1997); *see TXI Transp. Co.*, 306 S.W.3d at 239 ("Reliability may be demonstrated by the connection of the expert's theory to the underlying facts and data in the case."); *Constancio*, 2012 WL 1948345, at *3. In determining whether there is too great an analytical gap, we look to the facts the expert relied on, the facts in the record, and the expert's ultimate opinion. *Gharda USA, Inc.*, 464 S.W.3d at 349. The Texas Supreme Court has elaborated that analytical gaps "may include circumstances in which the expert unreliably applies otherwise sound principles and methodologies, the expert's opinion is based on assumed facts that

vary materially from the facts in the record, or the expert's opinion is based on tests or data that do not support the conclusions reached." *Id*. (internal citations omitted).[4]

Dr. Powell testified that he relied upon his experience and training, as well as Board rules and other professional associations' published guidelines, to formulate his opinion regarding the standard of care for treatment of chronic pain and documentation of that treatment. He applied his expertise to the specific data provided to him, which were Dr. Swate's patient records. Reading Dr. Swate's records to form an opinion about standard of care and documentation was necessarily part of Dr. Powell's methodology used to arrive at his expert opinion. We must review the reasonableness of Dr. Powell's analysis not generally, but "regarding *the particular matter to which the expert testimony was directly relevant*." *Kumho Tire Co.*, 526 U.S. at 154. In this case, the particular matter was whether Dr. Swate met the standard of care for treating chronic pain. The requirements of the standard of care to which Dr. Powell testified, and on which the ALJs identified that they relied, are outlined below, followed by Dr. Powell's stated reasoning.

- **Physician must perform an initial physical examination, the results of which should be documented in the record**. This provides the basis for his rationale for each medication prescribed, which is useful to subsequent practitioners treating the same patient and protects the physician if something goes wrong.

- **Physician must formulate a specific, individualized treatment plan for chronic pain and document it in the records**. This assists the physician in

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[4] In *Gharda*, for instance, the court affirmed the exclusion of expert testimony that attested only to possibilities rather than probabilities, was based on speculation, contained internal inconsistencies without explanation, assumed facts that the experts could not determine, and espoused theories that were undermined by inconsistent facts or were simply unsupported by facts. *Gharda USA, Inc. v. Control Sols., Inc.*, 464 S.W.3d 338, 350-51 (Tex. 2015).

justifying his actions, particularly in prescribing controlled substances, and provides a measure by which the effectiveness of a given treatment might be determined.

- **Physician must document reasons a patient is taking medication prescribed by a different doctor**. This may cause changes to the treatment plan, and the behavior may cause concern as to whether medication was obtained legitimately.

- **Physician must take some action in response to aberrant behavior regarding prescribed medications and document the action**. Evidence of illegal drug use, chronic opioid dependence, non-compliance with prescribed dosing, or other aberrant behavior can be a sign of abuse or diversion, which Board rules direct should be strictly monitored and addressed in chronic pain patients. Actions can include patient counseling, adjusting or stopping prescriptions, referring the patient to a specialist, or termination from the practice.

Dr. Powell's explanations allowed the ALJs to assess whether his testimony was opinion evidence connected to existing data by more than the *ipse dixit* of the expert. *See id.* at 157 (citing *Joiner*, 522 U.S. at 146). We review the relevant facts in the record below in addressing Dr. Swate's substantial evidence challenge. Having reviewed the entire record, we see no indication that Dr. Powell's opinions were based on an unreliable application of otherwise sound principles and methodologies, on assumed facts that varied materially from the facts in the record, or on data that did not support the conclusions reached. *See Gharda USA, Inc.*, 464 S.W.3d at 349.

Additionally, courts have looked to whether experts' methods and conclusions are generally accepted in the relevant professional community as a measure of reliability. *See Kumho Tire Co.*, 526 U.S. at 151. Although Dr. Swate's expert, Dr. Cotropia, generally disagreed with Dr. Powell's conclusion that Dr. Swate did not meet the applicable standards of care, he agreed with Dr. Powell's explanation of the standard of care on many material issues. Dr. Cotropia agreed that

Board Rule 170.3 provides a guideline of the standard of care for treatment of chronic pain. He agreed that the standard of care requires a treatment plan, which provides the physician's rationale and should explain how the physician is treating the source of the patient's pain. Dr. Cotropia testified that a focused physical examination is required by the standard of care, as is keeping accurate medical records. He agreed that the standard of care requires a physician to assess patients' progress toward treatment goals. Lastly, Dr. Cotropia testified that abuse of illicit drugs and non-compliance with a dosing schedule are aberrant behavior that should be addressed with the patient. On this record, the determination that Dr. Powell's ultimate opinion was reliable was not an abuse of discretion.

Lastly, this Court has previously noted that bench trials allow the trial court to act as both gatekeeper and factfinder. *See Scally*, 351 S.W.3d at 451 (citing *Olin Corp. v. Smith*, 990 S.W.2d 789, 796-97 & n.1 (Tex. App.—Austin 1999, pet. denied)). The confluence of these two roles allays certain concerns about potential prejudicial impact of expert testimony because the judges are able to conduct ongoing assessment regarding an expert's reliability, expertise, and the principles on which he relied when reaching his opinions. *See id.* The record indicates that the ALJs conducted such an assessment here.[5] Thus, we conclude the ALJs did not abuse their discretion in assessing the reliability of the methodology underlying Dr. Powell's analysis and admitting his testimony. We overrule Dr. Swate's first and fourth issues.

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[5] For example, where the ALJs found that Dr. Powell did not clearly delineate the standard of care regarding periodic problem-focused medical examinations and the manner in which Dr. Swate failed to meet that standard, they did not rely on Dr. Powell's assessment.

Dr. Swate's experts' testimony

In his second issue, Dr. Swate contends that the ALJs abused their discretion by rejecting Dr. Swate's experts' testimony without explanation. Dr. Swate argues that because Drs. Cotropia and Chabon testified that Dr. Powell's testimony was not reliable, and because their testimony was not impeached or contradicted, the ALJs should not have "rejected" their testimony by admitting Dr. Powell's testimony. The Board points out, however, that the experts' testimony was, in fact, contradicted.

Dr. Swate is correct that "an agency must provide a basis for its rejection of uncontradicted, unimpeached testimony that is neither inherently improbable or conclusory." *CenterPoint Energy Entex v. Railroad Comm'n*, 213 S.W.3d 364, 373 (Tex. App.—Austin 2006, no pet.) (citing *Cities of Port Arthur, Port Neches, Nederland & Groves v. Railroad Comm'n*, 886 S.W.2d 266, 270-72 (Tex. App.—Austin 1994, no writ)). In this case, however, the testimony at issue was directly contradicted and impeached. For instance, Dr. Chabon testified that Dr. Powell improperly based his determination of the standard of care on his subjective opinion. However, on cross-examination, Dr. Chabon agreed that Dr. Powell was qualified by his training and experience to render an opinion as to treatment of chronic pain patients, and that "some opinions hold much more validity[,] even though they may be largely subjective[,] than other opinions." Likewise, Dr. Cotropia testified that Dr. Powell's testimony was unreliable and subjective, but as explained above, he also agreed with Dr. Powell on many material matters.

Although couched in terms of admissibility and reliability, in substance, Dr. Swate attacks the weight that the ALJs afforded each expert's testimony. Dr. Swate's experts'

disagreement with Dr. Powell's conclusions does not render Dr. Powell's methods, analyses, principles, and resulting opinions unreliable or inadmissible. *See Scally*, 351 S.W.3d at 451-52. It is foundational that the agency is the sole judge of the weight to be accorded the testimony of each witness. *Central Power & Light Co. v. Public Util. Comm'n*, 36 S.W.3d 547, 561 (Tex. App.—Austin 2000, pet. denied). When weighing the evidence, the agency may accept or reject the testimony of witnesses or may accept part of a witness's testimony and disregard the remainder. *Id.* There is no requirement that the ALJs explain themselves. We conclude the ALJs did not abuse their discretion in admitting all expert testimony offered and overrule Dr. Swate's second issue.

Subjective opinion regarding standard of care

In his third issue, Dr. Swate alleges that the ALJs abused their discretion by allowing Dr. Powell to testify about subjective standards of care. He claims that Dr. Powell's testimony was entirely subjective, based on his personal opinions, rather than any identifiable objective standard of care. Dr. Swate argues that because the Board did not disclose to him the standard of care on which he was being assessed, he was deprived of procedural due process. Specifically, he contends that because Dr. Powell was allowed to testify as to his subjective opinions based solely on his experience and qualifications, the Board failed to establish the standard of care to which Dr. Swate was being held, and this deprived him of the right to cross-examine and rebut evidence that existed only in Dr. Powell's mind.[6]

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[6] In his reply brief, Dr. Swate emphasizes that the Board violated Board Rule 187.28(b)(1)(C), which required an expert report to set out the standard of care specifically. *See* 22 Tex. Admin. Code § 187.28(b)(1)(C) (2010) (Tex. Med. Bd., Discovery), *repealed by* 39 Tex. Reg. 3959 (2014), *adopted by* 39 Tex. Reg. 5749 (2014). In support of his argument,

We review claims regarding deprivation of constitutional rights de novo because they present questions of law. *Scally*, 351 S.W.3d at 446 (citing *Granek v. Texas State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 771-72 (Tex. App.—Austin 2005, no pet.). This Court has previously concluded that a professional license is a constitutionally-protected property interest that must be afforded due process. *Id.* Due process minimally requires notice and an opportunity to be heard at a meaningful time and in a meaningful manner. *Id.* (citing *Mathews v. Eldridge*, 424 U.S. 319, 333 (1976)).

The Board's Second Amended Complaint, filed 41 days before the hearing, outlined in detail the factual allegations supporting each alleged violation and the provisions of the Act or Board rules that were allegedly violated.[7] In addition, Board Rule 170.3 provides that a "physician's treatment of a patient's pain will be evaluated by considering whether it meets the generally accepted standard of care and whether the following minimum requirements have been met . . . ." 22 Tex. Admin. Code § 170.3(a) (2010) (Tex. Med. Bd., Guidelines), *amended by* 40 Tex. Reg. 4898 (2015) *and* 41 Tex. Reg. 4824 (2016). In these documents, Dr. Swate was provided adequate notice

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Dr. Swate cites a finding by the ALJs that Dr. Powell did not identify a standard of care and apply it to Dr. Swate's practice in violation of Rule 187.28(b)(1)(C). However, this finding was particular to the standard of care regarding periodic problem-focused medical examinations, an allegation for which Dr. Swate was not found to be in violation of the Act. Additionally, this alleged violation by the Board was not raised to the ALJs, and therefore was not preserved for appeal. *See* Tex. R. App. P. 33.1.

[7] Dr. Swate alleges the Board violated section 164.005 of the Act, which requires that a formal complaint allege with reasonable certainty each specific act allegedly constituting a violation of a specific statute or rule. *See* Tex. Occ. Code § 164.005(f). In the proceedings below, the Board was ordered to amend its complaint twice in response to motions by Dr. Swate requesting more specific allegations. However, Dr. Swate raised no objection to the Board's Second Amended Complaint, the live pleading at the time of the hearing. Because this alleged violation was not preserved for appeal, we do not consider it. *See* Tex. R. App. P. 33.1.

regarding the specific rules and statutes the Board alleged he violated, as well as the facts underlying these allegations. Drs. Chabon and Cotropia agreed that Rule 170.3 provides a basis for the applicable standard of care for treatment of chronic pain. Dr. Swate was also afforded a full and fair hearing before ALJs, who, by statute, are neutral administrative magistrates. *See* Tex. Gov't Code §§ 2001.058 (a)-(d), 2003.021(a); *Scally*, 351 S.W.3d at 447-48; *Pierce v. Texas Racing Comm'n*, 212 S.W.3d 745, 755 (Tex. App.—Austin 2006, pet. denied). Furthermore, Dr. Swate took advantage of the opportunity, cross-examining the Board's expert witness as well as presenting his own testimony and that of two expert witnesses. We conclude Dr. Swate was not deprived of procedural due process and accordingly overrule his third issue.

Admission of pharmacy records

In his fifth issue, Dr. Swate contends that the trial court erred in admitting Board Exhibits 3, 6, 12, 15, 18, 21, 25, 26, 29, 30, 31, and 36. Each exhibit consisted of an Affidavit of Pharmacy Records, signed by the respective custodian of pharmacy records at various pharmacies, which attested to the authenticity of attached records, plus the records, which consisted of a list of prescriptions that had been filled for each patient at that pharmacy during the time that Dr. Swate had treated them. The Board did not amend its discovery responses to disclose the custodians of records as persons with knowledge of relevant facts. Dr. Swate objected to admission of the records, arguing that because of the Board's failure to amend its discovery responses, Dr. Swate was surprised and prejudiced and the records authenticated by the undisclosed custodians should not have been admitted. The ALJs overruled Dr. Swate's objection, agreeing that it was error for the Board to not

amend its discovery, but deciding that because it was "not harmful error," it did not require that the exhibits be stricken as inadmissible.

On appeal, Dr. Swate points to Texas Rule of Civil Procedure 193.6(a) to contend that the applicable standard is not "harmful error," but instead that all information not timely disclosed must be excluded. However, as the Board argues, Rule 193.6's prohibition of the introduction of evidence that was not timely disclosed is subject to two exceptions: if the court finds "(1) that there was good cause for the failure to disclose; or (2) that the failure will not unfairly surprise or unfairly prejudice the other parties." Tex. R. Civ. P. 193.6(a). The burden of establishing good cause or the lack of unfair surprise or unfair prejudice is on the party seeking to introduce the evidence. *Id.* R. 193.6(b). In its response to Dr. Swate's objection to these documents, the Board submitted that Dr. Swate had been provided copies of these exhibits in hard copy and electronically at Dr. Powell's deposition on August 8, 2012, ten months prior to the hearing. In addition, the exhibits had been referenced in Dr. Powell's report that Dr. Swate received on May 12, 2012, so Dr. Swate had knowledge of their existence and the Board's reliance on them more than a year before the hearing. Dr. Swate's motion confirmed these assertions. The ALJs determined that because Dr. Swate had notice of the existence of these records, the Board had carried its burden under Rule 193.6(a) to show that the failure to amend discovery did not result in unfair surprise or unfair prejudice to Dr. Swate. We cannot conclude the ALJs failed to refer to guiding rules or principles in making this determination. Therefore, the ALJs did not abuse their discretion in admitting Board exhibits 3, 6, 12, 15, 18, 21, 25, 26, 29, 30, 31, and 36. Dr. Swate's fifth issue is overruled.

Substantial-evidence review of the Board's findings and conclusions

In his sixth issue, Dr. Swate contends that the Board's order is not supported by substantial evidence. We address this challenge under the substantial-evidence standard of the Texas Administrative Procedure Act (APA). *See* Tex. Gov't Code § 2001.174. The APA authorizes reversal or remand of an agency's decision that prejudices the appellant's substantive rights where "the administrative findings, inferences, conclusions, or decisions are . . . not reasonably supported by substantial evidence considering the reliable and probative evidence in the record as a whole." *Id.* § 2001.174(2)(F). We presume an agency order is valid, and if the evidence in its entirety is sufficient to allow reasonable minds to have reached the conclusion the agency must have reached to justify the disputed action, then the order is supported by substantial evidence. *Texas State Bd. of Dental Exam'rs v. Sizemore*, 759 S.W.2d 114, 116 (Tex. 1988); *Texas Gen. Land Office v. Crystal Clear Water Supply Corp.*, 449 S.W.3d 130, 135 (Tex. App.—Austin 2014, pet. denied). Substantial evidence "does not mean a large or considerable amount of evidence, but rather such relevant evidence as a reasonable mind might accept as adequate to support a conclusion of fact." *Slay v. Texas Comm'n on Envtl. Quality*, 351 S.W.3d 532, 549 (Tex. App.—Austin 2011, pet. denied). The party challenging the order has the burden of demonstrating a lack of substantial evidence. *CenterPoint Energy Entex*, 213 S.W.3d at 369 (citing *City of El Paso v. Public Util. Comm'n*, 883 S.W.2d 179, 185 (Tex. 1994)). The burden is significant—evidence in the record may preponderate against the agency's decision but still provide a reasonable basis for the decision and thereby meet the substantial-evidence standard. *Texas Health Facilities Comm'n v. Charter Med.-Dallas, Inc.*, 665 S.W.2d 446, 452 (Tex. 1984).

We may not substitute our judgment for the agency's judgment "on the weight of the evidence on questions committed to agency discretion." Tex. Gov't Code § 2001.174. Resolving factual conflicts and ambiguities is the agency's function, and the substantial-evidence rule protects that function. *Firemen's & Policemen's Civil Serv. Comm'n v. Brinkmeyer*, 662 S.W.2d 953, 956 (Tex. 1984). Our ultimate concern is the reasonableness of the agency's order, not its correctness. *Id.*; *Charter Med.-Dallas, Inc.*, 665 S.W.2d at 452. "We must uphold the Board's order 'if (1) the findings of underlying fact in the order fairly support the [Board's] findings of ultimate fact and conclusions of law, and (2) the evidence presented at the hearing reasonably supports the findings of underlying fact.'" *Scally*, 351 S.W.3d at 452 (quoting *Texas Water Comm'n v. Lakeshore Util. Co.*, 877 S.W.2d 814, 818 (Tex. App.—Austin 1994, writ denied)).

In briefing to this Court, Dr. Swate challenges the substantial evidence supporting five "factual and legal findings cited in the Order as supporting [the Board's] decision to revoke Dr. Swate's medical license."[8] However, the five items listed are not legal or factual findings in the order. Instead, they are categories into which the ALJs separated the Board staff's allegations for purposes of analyzing the evidence. Items 3 and 5 on Dr. Swate's list are actually categories under which the ALJs found the Board staff failed to prove its allegations. Item 1 is a category in which

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[8] (1) Dr. Swate failed to document a problem-focused physical examination of the Patient or any other medical rationale that support prescriptions written; (2) Dr. Swate failed to appropriately document chronic pain treatment goals or objectives or any information detailing how the Patients were progressing toward goals; (3) Dr. Swate failed to consider or offer the Patients options for treatments other than prescriptions for controlled substances; (4) Dr. Swate failed to address signs of possible abuse and/or diversions of controlled substances; (5) Dr. Swate failed to monitor for abuse or diversion of controlled substances.

the ALJs determined that Board staff proved its allegations as to a single patient, but did not present sufficient evidence as to the other nine. We will address Dr. Swate's substantial-evidence challenges to the ultimate findings of fact and conclusions of law in the order that we understand to correspond with Dr. Swate's briefing. *See* Tex. R. App. P. 38.9. Those include the following ultimate findings of fact:

> 60. Dr. Swate failed to document an initial problem-focused physical examination of Patient F that met the standard of care.
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> 87. For Patients A, B, C, D, E, F, G, H, I, and J, Dr. Swate failed to appropriately document chronic pain treatment goals or objectives or any information detailing how these Patients were progressing toward those goals.
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> 146. For Patients A, E, F, G, and J, Dr. Swate failed to use diligence and to safeguard against potential complications from the medications he prescribed to these patients.
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> 199. Dr. Swate failed to follow through on signs of potential diversion or abuse in Patients A, E, F, G, and J.

The corresponding conclusions of law we understand Dr. Swate to challenge are:

> 8. Dr. Swate failed to practice medicine in an acceptable professional manner consistent with public health and welfare for Patients A, B, C, D, E, F, G, H, I, and J. Tex. Occ. Code § 164.051(a)(6).
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> 9. Dr. Swate failed to treat Patients A, B, C, D, E, F, G, H, I, and J according to the generally accepted standards of care of the treatment of chronic pain. 22 TAC § 190.8(1)(A).[9]
>
> 10. Dr. Swate failed to use proper diligence in his treatment of Patients A, B, C, D, E, F, G, H, I, and J. 22 TAC § 190.8(1)(C).

[9] "TAC" is an abbreviation for the Texas Administrative Code.

11. Dr. Swate failed to safeguard against potential complications for Patients A, E, F, G, and J. 22 TAC § 190.8(1)(D).

13. Dr. Swate failed to document treatment plans, treatment objectives, and periodic reviews for Patients A, B, C, D, E, F, G, H, I, and J in violation of Tex. Occ. Code § 164.051(a)(6); 22 TAC § 165.1(a)(1)(C), (a)(4); and 22 TAC § 170.3(a)(2), (5), and (7).

14. Dr. Swate committed a prohibited act connected with his practice of medicine by prescribing a drug or treatment that is nontherapeutic in nature or nontherapeutic in the manner the drug or treatment is prescribed for Patients A, E, F, G, and J. Tex. Occ. Code § 164.053(a)(5).

15. Dr. Swate committed a prohibited act or practice by prescribing controlled substances for Patients A, E, F, G, and J in a manner inconsistent with public health and welfare. Tex. Occ. Code § 164.053(a)(6).

16. Dr. Swate failed to take action in response to warning signs that indicated that Patients A, E, F, G, and J were misusing or diverting medications, and he continued prescribing medications to these patients despite abnormal drug screens and other aberrant behavior in violation of Tex. Occ. Code § 164.052(a)(5).

17. Dr. Swate's actions did not meet the standard of care, and he failed to use diligence in addressing signs of possible abuse or diversion for Patients A, E, F, G, and J in violation of 22 TAC § 170.3(a)(6).

18. Dr. Swate failed to document a problem-focused initial physical examination that supported the prescription of pain medication to Patient F in violation of 22 TAC §§ 165.1(a)(1)(A), 170.3(a)(2)(A), and 190.8(1)(L).

Initial problem-focused physical examination for Patient F

Dr. Swate first challenges Finding of Fact 60, which supports Conclusion of Law 18, regarding the failure to perform an initial problem-focused physical examination for Patient F. Board rules provide that documentation in the medical record must include the reason for the encounter, relevant history, physical examination findings, and prior diagnostic test results for each

encounter. 22 Tex. Admin. Code § 165.1(a)(1)(A) (2017) (Tex. Med. Bd., Medical Records). The "physician is responsible for a written treatment plan that is documented in the medical records," which should include how prescribed medication "relates to the chief presenting complaint of chronic pain." *Id*. § 170.3(a)(2)(A). It is a violation of the Act to prescribe any controlled substance without first establishing a proper professional relationship with the patient, which requires as a threshold element "establishing a diagnosis through the use of acceptable medical practices such as patient history, mental status examination, physical examination, and appropriate diagnostic and laboratory testing." *Id*. § 190.8(1)(L) (2010) (Tex. Med. Bd., Violation Guidelines), *subsection amended by* 40 Tex. Reg. 3159 (2015). Dr. Powell testified that the standard of care required that an initial physical examination be documented in the record to support the prescription of medication.

Dr. Swate's medical records for Patient F's first visit to Dr. Swate on October 24, 2008 consist of four pages of forms completed almost entirely by the patient. The only part not filled out by the patient was at the bottom of a page titled "Progress Note." There, in a section labeled "Office Use Only," handwritten notes indicate the patient's height, weight, blood pressure, heart rate, and chief complaint, which the ALJs referred to as a "mini-physical." No other physical exam form or typewritten supplement (which were found in other patients' charts) was in the record for this first visit. The patient's responses on the forms indicate his complaint was pain in his left hip and ankle. There is no indication that Dr. Swate conducted a physical examination focused on this problem.

Dr. Swate did not contend that he had conducted a problem-focused physical examination at Patient F's initial visit. Instead, he testified that a physician at a Veteran Affairs

(VA) medical facility had given Patient F a complete and sufficient physical examination and taken a medical history, and that Dr. Swate relied on that physician's resulting diagnosis as the rationale for his prescription of controlled substances. Dr. Swate's records included an MRI of the patient's spine, ordered by a different physician in August 2007, which Dr. Swate contended was part of the patient's physical examination. However, the MRI was more than a year old, and Dr. Swate did not document or discuss the imaging results in his record for Patient F's first office visit as a rationale for the prescription of pain medicine. We can find no evidence in the record that Dr. Swate performed an initial physical examination, relied on it to prescribe medicine for Patient F, or documented his resulting rationale for his prescriptions. Instead, the record contains substantial evidence to the contrary. Accordingly, we conclude substantial evidence supports Finding of Fact 60 and Conclusion of Law 18.

Failure to properly document chronic pain treatment goals, objectives, or progress

In Finding of Fact 87, the ALJs determined that Dr. Swate failed to appropriately document chronic pain treatment goals or any information detailing progress with respect to treatment goals for Patients A, B, C, D, E, F, G, H, I, and J. The record shows that generally Dr. Swate utilized two pre-printed forms to document his patients' visits: the Pain Assessment Documentation Tool (PADT) and the Current Opioid Misuse Measure (COMM). For the most part, patients filled out these two forms at each visit. Less regularly, Dr. Swate's patients filled out a Drug Abuse Screening Test (DAST-10), a follow-up progress notes form, or a SOAP-R checklist that screened for patients who were high-risk for misuse or diversion of medication. Dr. Swate also occasionally employed urinalysis drug tests or a neural scan, which Dr. Swate described as "a device

that measures the alpha delta fibers in the preganglionic and [dorsal] root of the spinal [cord]," or "an indices [sic] of whether somebody has chronic pain." Sometimes Dr. Swate filled out a checklist progress-note form or added typewritten progress notes of his own. Beginning in mid-2009, Dr. Swate's progress-note form also contained a section titled Treatment Plan, which indicated it was to be completed by "Practitioner" and contained a list of 16 possible elements of a treatment plan, such as:

> 1. Pain level __ or lower on a scale pf [sic] 1-10 ________________________
>
> . . .
>
> 5. Continue opioid protocol ____
>
> . . .
>
> 11. Obtain liver studies and drug screen at least once per year and more frequent if indicate [sic]____
>
> . . .
>
> 13. Goals obtained reduce pain Y / N Improved disability Y / N Patient is compliant with dosing schedule Y / N. ______________________________

Board staff alleged that the pre-printed forms did not constitute sufficient creation, maintenance, or documentation of individualized and fully explained treatment of chronic pain. The Board agreed, and it now argues that the insufficiency of Dr. Swate's records constituted a violation of section 164.051(a)(6) of the Act and Board Rules 190.8(1)(A) and (C). In addition, the ALJs determined, and the Board maintains, that Dr. Swate's failure to document treatment objectives and periodic reviews of the patients' progress toward those objectives are violations of Board Rules 165.1(a) and 170.3. Dr. Swate responds that the treatment plans included in his patients' charts met the standard of care because they included medication dose, notation of whether the patient was

benefitting from the treatment, the patient's activities of daily living, some level of a physical exam, a history of the patient's chronic pain, certification that patient benefit was clinically significant, questions as to whether the patient was taking medications as prescribed and whether the patient was using illegal drugs, and periodic drug-abuse screening. He further testified that when necessary, patients' charts included items he believed to be goals, such as improvement of disability, compliance with dosing schedule, and a determination that the patient was qualified to continue with opioid treatment.

Generally, an "adequate medical record" should include documentation of the plan for care for each encounter. *Id.* § 165.1(a)(1)(C). The written plan for care should include specific instructions for follow up. *Id.* § 165.1(a)(6)(D). "The patient's progress, including response to treatment, change in diagnosis, and patient's non-compliance should be documented." *Id.* § 165.1(a)(4). More specifically, "treatment of chronic pain requires a reasonably detailed and documented plan to assure that the treatment is monitored." *Id.* § 170.1(8) (2010) (Tex. Med. Bd., Pain Mgmt.) *amended by* 38 Tex. Reg. 6483 (2013), *adopted by* 39 Tex. Reg. 279 (2014) *and* 40 Tex. Reg. 4898 (2015). While Chapter 170 of the Board rules is intended to be used as guidelines for the treatment of pain, the Board expressly used "shall" to "identify those items a physician is required to perform in all such cases." *Id.* § 170.1(9). "The medical record shall document the medical history and physical examination. In the case of chronic pain, the medical record must document . . . (ii) current and past treatments for pain . . . ." *Id.* § 170.3(a)(1)(B). Medical records must document the physician's rationale for any treatment plan and should include treatment objectives. *Id.* § 170.3(a)(7).

Dr. Powell testified that the standard of care required that a physician formulate and document an individualized treatment plan for chronic pain for each patient. He explained that a treatment plan assists the physician in justifying his actions and gives a measure by which the effectiveness of treatment can be determined. To this end, he stated that while a treatment plan can include a number on a pain scale, it should also include other information, such as the physician's goals for the patient. Moreover, Dr. Powell testified that the standard of care requires that the physician periodically review and document any progress toward stated goals, which can be used to explain the need for continued medical therapy or changes in therapy.

The ALJs' proposal for decision detailed the records of each patient to assess their documentation of chronic pain treatment goals, objectives, and progress. We will summarize the facts most pertinent to the Board's ultimate conclusion that Dr. Swate's records inadequately documented treatment plans, goals, and progress. Review of Dr. Swate's records revealed frequent internal inconsistencies. For example, in some cases, one part of a treatment record affirmed that a patient's pain was reduced, while the patient's self-report on the PADT showed no change in pain (Patients A, C, D, E, and G). Similarly, some treatment progress notes stated that a patient was compliant with the prescribed dosing schedule while the patient reported non-compliance (Patients D, E, and G). At times, patients' treatment assessments stated that their disability had improved where there was no other indication in the record of what their disability was or how it was being addressed (Patients G, H, I, and J). One patient's treatment plan noted a prescription adjustment where the actual prescription showed no change (Patient J), and another recommended therapy for smoking cessation six months in a row when the patient was identified as a non-smoker at her first

visit (Patient I). Records for Patient B show no identifiable treatment goals or objectives at all. Dr. Swate's records for Patients D, A, and F include no identifiable treatment goals or objectives on the first visit and for six to eight months after that, despite monthly visits by the patients. For Patients E and G, the only identifiable treatment goal in their records is in the check-box form titled Treatment Plan, with the numbers two or three entered in the blank for pain-level goal on a scale of one to ten. The Treatment Plan check-box form for Patient D was occasionally incomplete. Lastly, though Dr. Swate noted recommending additional treatment or therapy for Patients F, I, and J, no additional information following up on those recommendations is included in documentation of subsequent visits. Patients A and B are missing medical records altogether for periods of multiple months when their prescription records show they were still filling prescriptions.

Having reviewed the entire record, we conclude that evidence provides a reasonable basis for the conclusion that Dr. Swate failed to appropriately document treatment goals, objectives, or progress for the ten patients at issue. Treatment plans were not documented for every visit, and where they are documented, they were regularly incomplete, inconsistent, or lacking information required by Board rules. On the record before us, the ALJs' ultimate finding that "For Patients A, B, C, D, E, F, G, H, I, and J, Dr. Swate failed to appropriately document chronic pain treatment goals or objectives or any information detailing how these Patients were progressing toward those goals" is supported by substantial evidence. Consequently, we overrule Dr. Swate's challenge to Finding of Fact 87 and Conclusions of Law 8, 9, 10, and 13.

Failure to use diligence, to safeguard against potential complications from prescribed medications, and to follow through on potential signs of diversion

The final two ultimate findings of fact that Dr. Swate challenges, findings 146 and 199, are based on the same evidence, so we will address them together. For Patients A, E, F, G, and J, the ALJs determined that Dr. Swate failed to use diligence and to safeguard against potential complications from the medications he prescribed by failing to follow through on signs of potential diversion or abuse. Dr. Swate contends that no evidence was presented that the patients in question showed signs of abuse or diversion that were not timely and properly addressed. The Board responds that the evidence more than proved the charges against Dr. Swate.

Under section 164.051 of the Act, the Board may take disciplinary action against a licensed physician who "fails to practice medicine in an acceptable professional manner consistent with public health and welfare." Tex. Occ. Code § 164.051(a)(6). Board rules define such failure to include: "failure to treat a patient according to the generally accepted standard of care," "failure to use proper diligence in one's professional practice," and "failure to safeguard against potential complications." 22 Tex. Admin. Code § 190.8(1)(A), (C), (D). The Act also prohibits the commission of "unprofessional or dishonorable conduct that is likely to deceive or defraud the public, as provided by Section 164.053, or injure the public." Tex. Occ. Code § 164.052(a)(5). The Act defines such conduct to include prescription or administration of a drug or treatment that is nontherapeutic or in a nontherapeutic manner and prescription of controlled substances in a manner inconsistent with public health and welfare. *Id.* § 164.053(a)(5), (6). Board rules governing the treatment of pain state: "Patients who are at-risk for abuse or addiction require special attention. Patients with chronic pain and histories of substance abuse . . . require even more care. A consult

with or referral to an expert in the management of such patients should be considered in their treatment." 22 Tex. Admin. Code § 170.3(a)(6).

Dr. Powell testified that the standard of care requires a physician to carefully monitor a chronic pain patient who demonstrates aberrant behavior with respect to prescription medications. When a patient does not comply with the prescribed dosing schedule, Dr. Powell testified, the standard of care requires that the physician take some action in response, such as counseling the patient, stopping the medications, modifying the prescriptions, or referring the patient to a specialist. According to Dr. Powell, any abnormal drug screens, at a minimum, should be explained in the patient's record. Dr. Powell further testified that drug screens that show positive results for illicit drugs along with prescriptions for chronic opioid therapy suggests termination of treatment.

The record shows that Patients A, E, F, G, and J demonstrated such aberrant behavior.[10] For example, Patients A, E, F, and G repeatedly self-reported taking more medication than Dr. Swate prescribed. Patients A and F regularly self-reported taking medications that were not prescribed by Dr. Swate. Patient A also self-reported not taking medications that Dr. Swate had prescribed to him at seven visits over the course of 16 months. Dr. Swate testified that he reviewed the patients' self-report PADT and COMM forms at every visit and any inaccuracies were explained elsewhere in the chart. However, Dr. Swate's records do not indicate that Dr. Swate took any action in response to most of these warning signs, and where he did, his follow-up was inconsistent. For instance, the record shows that Dr. Swate counseled Patient F once regarding his self-report of taking

[10] The proposal for decision describes each patient's records in detail; we will summarize pertinent findings.

more medication than prescribed, but there is no information of any other intervention despite the patient reporting on 13 subsequent visits that he continued to take more medication than prescribed. Similarly, there is no evidence that Dr. Swate addressed Patient G's report of taking more medication than prescribed, despite its recurrence at 12 monthly visits. In nearly every case of self-reported aberrations, Dr. Swate continued prescribing the same "opioid protocol," and failed to note the aberration or any explanation in the record.

Dr. Swate's records do not indicate that he made regular use of urinalysis drug screens with Patients A, F, G, and J, despite the patients' self-reports of mis-use of medications. For Patients A, E, F, G, and J, some of the drug screens that were administered showed negative results for medications Dr. Swate had prescribed, positive results for medications Dr. Swate had not prescribed, or positive results for illicit drugs. Most often, Dr. Swate did not note or explain abnormal drug screen results in the record or show that he took action in response. Dr. Swate testified that Patients A, E, F, G, and J were monitored for drug abuse using the Drug Abuse Screening Test, COMM score, SOAP-R questions, and Potential Aberrant Drug Related Behavior, which he asserts are peer-reviewed tools. Nevertheless, there is no evidence that Dr. Swate followed through on signs of potential abuse or diversion that were revealed by these tools. There is no indication that Dr. Swate increased his attention and care for patients showing signs of illicit drug use or referred them to specialists. On the record before us, we conclude that there is substantial evidence supporting the ALJs' finding that Dr. Swate failed to meet the standard of care, failed to use diligence and safeguard against complications, and failed to take action in response to warning signs of abuse or diversion, all in violation of the Act and Board rules, as set out in Findings of Fact 146

and 199 and Conclusions of Law 11, 14, 15, 16, and 17. Accordingly, we overrule Dr. Swate's sixth issue because we conclude that substantial evidence supports the challenged findings of fact underlying the ultimate conclusions in the Board's order.

The Board's order was not arbitrary and capricious

Lastly, in his seventh issue, Dr. Swate contends that the Board acted in an arbitrary and capricious manner when it disregarded certain findings of fact and conclusions of law in adopting its final order. Dr. Swate argues that certain conclusions are contradicted by underlying findings, and that the Board should have provided explanation for disregarding some of the ALJs' findings that were favorable to Dr. Swate. He further contends that Board Rules 170.1(5) and 170.3 protect physicians from disciplinary action if they provide proper pain treatment, and when applied to certain underlying findings, should have protected Dr. Swate from the Board's revocation of his license. The Board responds that it adopted all findings as proposed by the ALJs, which cannot constitute arbitrary and capricious action, and argues that the inclusion of some fact-findings in Dr. Swate's favor does not countermand the findings that demonstrate Dr. Swate's violation of the Act.

"An agency acts arbitrarily and capriciously when it: (1) denies a litigant due process and prejudices its substantial rights; (2) wholly adopts the record from another case involving different parties, fails to make findings of fact, and bases its decision on its findings made in the other case; or (3) improperly bases its decision on non-statutory criteria." *CPS Energy v. Public Util. Comm'n*, No. 03-14-00340-CV, 2017 WL 744694, at *6 (Tex. App.—Austin Feb. 24, 2017, no pet. h.) (citing *Charter Med.-Dallas, Inc.*, 665 S.W.2d at 454). Furthermore, an agency's decision

is arbitrary if it is made without regard for the facts, relies on fact findings that are not supported by any evidence, or lacks a rational relation between the facts and the decision. *Id.* Therefore, we must remand for arbitrariness if we conclude that the agency has not "'genuinely engaged in reasoned decision-making.'" *Id.* (quoting *Starr Cty. v. Starr Indus. Servs., Inc.*, 584 S.W.2d 352, 356 (Tex. Civ. App.—Austin 1979, writ ref'd n.r.e.)).

Dr. Swate claims the Board failed to explain its rejection of some of the ALJs' findings, in violation Section 2001.058 of the Government Code. Section 2001.058 allows an agency to change a finding of fact or conclusion of law made by an ALJ in a contested case hearing before SOAH in certain situations and requires that if the agency does so, it must "state in writing the specific reason and legal basis for a change made under this subsection." Tex. Gov't Code § 2001.058(e). The Board expressly adopted the ALJs' proposal without amendment. Every finding of fact and conclusion of law in the Board's final order is identical to its corollary in the proposal for decision. There is no indication that the Board "disregarded" any of the ALJs' findings, analyses, or conclusions, as Dr. Swate asserts. Accordingly, the Board had no obligation to explain any changes under section 2001.058(e).

Board Rule 170.1 in effect at the time explained the purpose of the rules setting forth the Board's policy for the proper treatment of pain and includes the following statement:

> Physicians should not fear board action if they provide proper pain treatment. The board will not look solely at the quantity or duration of drug therapy. Proper pain treatment is not a matter of how much drug therapy is used, as long as that therapy is based on sound clinical judgment. Sound clinical judgment results from evidence-based medicine and/or the use of generally accepted standards.

22 Tex. Admin. Code § 170.1(5). In addition, Board Rule 170.3 set out the guidelines used to assess a physician's treatment of pain, subject to the following provision:

> It is not the board's policy to take disciplinary action against a physician solely for not adhering strictly to these guidelines if the physician's rationale for the treatment indicates sound clinical judgment documented in the medical records. Each case of prescribing for pain will be evaluated on an individual basis. The physician's conduct will be evaluated by considering: (1) the treatment objectives, including any improvement in functioning, (2) whether the drug used is pharmacologically recognized to be appropriate for the diagnosis as determined by a consensus of medical practitioners in the State or by recognized experts in the field for which the drug is being used, (3) the patient's individual needs, and (4) that some types of pain cannot be completely relieved.

Id. § 170.3(b). Dr. Swate contends that the Board did not adhere to these rules when it revoked his license. Dr. Swate relies on the following statements in the PFD:

> Staff failed to provide sufficient evidence that: (1) Dr. Swate's Patients did not see sufficient improvement in functioning related to their treatment, (2) the drugs prescribed were not appropriate for the treatment of chronic pain, (3) the individual Patients did not need the drugs Dr. Swate prescribed, or (4) the pain which the Patients suffered could have been completely alleviated by a different treatment. Therefore, Staff failed to prove that Dr. Swate's diagnosis and treatment of chronic pain in any individual case was not appropriate.

Dr. Swate argues that because in these statements, the ALJs determined that Dr. Swate treated his patients appropriately, which demonstrates sound clinical judgment, Rules 170.1(8) and 170.3(b) direct that the Board should not have taken disciplinary action against him for not strictly adhering to the Rule 170.3 guidelines.

While we agree that the quoted findings in Dr. Swate's favor tend to encourage consideration of Rules 170.1(5) and 170.3, we do not agree that the favorable findings automatically

absolve Dr. Swate of other violations of Board rules. First, the quoted statements were a part of the ALJs' analysis that resulted in findings that Board staff did not prove certain alleged violations. However, the ALJs also found that Dr. Swate did commit multiple violations of the Act and Board rules, and many of those violations affected multiple patients. For instance, in Conclusion of Law 9, the ALJs determined that Dr. Swate failed to treat all ten patients according to the generally accepted standards of care of the treatment of chronic pain, in violation of Board Rule 190.8(1)(A), which is considered failure to practice in an acceptable professional manner consistent with public health and welfare within the meaning of the Act. *Id.* § 190.8(1). Similarly, in Conclusion of Law 17, the ALJs concluded that Dr. Swate's actions did not meet the standard of care and that he failed to use diligence in addressing signs of possible abuse or diversion for five patients, in violation of Board Rule 170.3(a)(6). The Board also concluded that Dr. Swate prescribed drugs or treatment that were non-therapeutic in nature or non-therapeutic in the manner prescribed for five patients. We have determined these findings are supported by substantial evidence. We further conclude that the Board did not look solely at the quantity or duration of drug therapy, but instead looked at the totality of the evidence, in compliance with Rule 170.1, and found that Dr. Swate did not use generally-accepted standards in his treatment of chronic pain patients. Similarly, the Board did not take disciplinary action based solely on Dr. Swate's failure to strictly adhere to the guidelines, but based instead on his failure to adequately document treatment plans, objectives, and progress, in conformance with Rule 170.3(b). Based on the record before us, we cannot conclude that the Board did not "genuinely engage in reasoned decision-making." *See Starr Cty.*, 584 S.W.2d at 356 (quoted in *CPS Energy*,

2017 WL 744694, at *6). Because we conclude the Board did not act in an arbitrary and capricious manner, we overrule Dr. Swate's seventh issue.

CONCLUSION

Having overruled Dr. Swate's issues on appeal, we affirm the judgment of the trial court.

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Cindy Olson Bourland, Justice

Before Chief Justice Rose, Justices Goodwin and Bourland

Affirmed

Filed: August 31, 2017