

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of
3 **Vazgen Roger Artounian, M.D.**
4 Holder of License No. **31593**
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-09-0811A
**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER**
(Letter of Reprimand and Probation)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on
8 April 14, 2010. Vazgen Roger Artounian, M.D., ("Respondent") appeared with legal
9 counsel before the Board for a Formal Interview pursuant to the authority vested in the
10 Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of
11 Law and Order after due consideration of the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

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

15 2. Respondent is the holder of License No.31593 for the practice of allopathic
16 medicine in the State of Arizona.

17 3. The Board initiated case number MD-09-0811A after receiving a complaint
18 regarding Respondent's care and treatment of a 67 year old patient ("CP") alleging failure
19 to timely diagnose and treat breast cancer.

20 4. On January 29, 2008, CP underwent a diagnostic bilateral mammogram that
21 revealed left axillary adenopathy and a probable complex cyst in the retroareolar region of
22 the left breast. In addition to clinical correlation, a follow up ultrasound was recommended
23 in six months.

24 5. On February 2, 2008, Respondent examined CP and documented normal
25 exam findings even though he had initialed the January 2008 mammogram that noted

1 several left axillary lymph nodes that were enlarged and had lost their normal fatty hila
2 consistent with pathologic left axillary nodes.

3 6. On May 20, 2008, Respondent again saw CP, who complained of left breast
4 pain in addition to other concerns, but did not document a thorough breast exam. He did,
5 however, indicate normal findings for most systems, including the breasts.

6 7. On August 1, 2008, Respondent ordered health care maintenance tests,
7 including a mammogram. On August 29, Valley Radiologists reported that CP did not
8 return for her follow up breast imaging. On September 23, 2008, a follow up mammogram
9 showed a spiculated left breast mass and an abnormal enlarged left axillary lymph node.
10 Respondent ordered STAT left axillary lymph node and stereotactic breast biopsies.

11 8. On September 27, 2008, Respondent saw CP, who was complaining of
12 breast pain. He documented normal findings to most systems, but also noted breast pain
13 and a breast lump. CP underwent breast biopsies in September that showed infiltrating
14 well differentiated ductal carcinoma. The final breast biopsy report dated October 7, 2008,
15 which was initialed by Respondent, showed infiltrating well differentiated ductal carcinoma.

16 9. On March 26, 2009, Respondent ordered a diagnostic mammogram. In
17 March 31, 2009, CP returned with complaints of dizziness and shortness of breath. A CT
18 scan and mammography were ordered, and CP was referred to oncology and radiation
19 oncology for breast cancer.

20 10. A mammogram revealed a 1.0 x 1.0 cm oval density in the left breast with no
21 significant changes,

22 11. On April 7, 2009, the pathologist contacted Respondent regarding a
23 miscommunication at the office and questioned whether a CP had been referred to a
24 surgeon.

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1 12. On April 22, 2009, a PET/CT scan showed a flourodeoxyglucose-avid right
2 lower lobe lung mass, multiple left breast masses, probable adenopathy in the right chest
3 wall node very suspicious for metastatic disease.

4 13. On May 4, 2009, CP was seen by oncology and she was felt to have
5 metastatic disease. She was started on Aromasin and referred for a lung biopsy. The
6 lesion resolved by the time CP was scheduled for the biopsy and the procedure was
7 cancelled. The oncologist felt that CP's lung lesion had responded to treatment; however,
8 infectious etiology could not be ruled out and CP was referred for surgical resection.

9 14. During his formal interview, Respondent testified that he missed the patient's
10 breast cancer because of clerical errors and a lack of appropriate follow-up systems in his
11 office. He stated that he has hired a practice consultant and is implementing some of the
12 consultant's recommendations, including documentation of all findings on the problem list
13 and creation of a critical follow up list for all tests and referrals for patients.

14 15. At the formal interview one board member noted that in a letter to the Board
15 dated March 19, 2010, Respondent stated, "A review of the chart, in fact, does indicate
16 that a final report appears to have been electronically mailed to my office on October 7,
17 2008, and it bears my initials without an indication that it was received on a date other than
18 October 7, 2008. I believe it is only credible to conclude that I did receive the final report
19 and did review it on or shortly after October 7, 2008."

20 16. The standard of care requires a physician, who is the ordering provider, to
21 obtain the results of a biopsy procedure in a timely manner.

22 17. Respondent deviated from the standard of care by failing to promptly follow
23 up on the pathology reports from the breast and lymph node biopsies showing well
24 differentiated ductal carcinoma.

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1 2. Respondent is placed on Probation for one year with the following terms and
2 conditions:

3 a. Respondent shall within 30 days of the effective date of this order,
4 enter a contract with a Board pre-approved monitoring company ("Contractor") to provide
5 all monitoring services. Respondent shall bear all costs of monitoring requirements and
6 services.

7 b. Continuing Medical Education

8 Respondent shall complete the PACE Medical Recordkeeping course within
9 six months. Upon completion of the course, Respondent shall provide the Contractor with
10 satisfactory proof of attendance.

11 c. Chart Review

12 The Contractor shall conduct periodic chart reviews upon completion of the
13 PACE Medical Recordkeeping course. The chart review shall also include review of the
14 billing records.

15 d. Obey All Laws

16 Respondent shall obey all state, federal and local laws, all rules governing
17 the practice of medicine in Arizona, and remain in full compliance with any court ordered
18 criminal probation, payments and other orders.

19 e. Tolling

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

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4 3. The Board retains jurisdiction and may initiate new action based upon any
5 violation of this Order.

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7 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

8 Respondent is hereby notified that he has the right to petition for a rehearing or
9 review. The petition for rehearing or review must be filed with the Board's Executive
10 Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The
11 petition for rehearing or review must set forth legally sufficient reasons for granting a
12 rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after
13 date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed,
14 the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

15 Respondent is further notified that the filing of a motion for rehearing or review is
16 required to preserve any rights of appeal to the Superior Court.

17 DATED AND EFFECTIVE this 22 day of June, 2010.

18
19 ARIZONA MEDICAL BOARD

20 (SEAL)



21 By Amade Rich
22 Lisa S. Wynn
23 Executive Director
24
25

1 ORIGINAL of the foregoing filed this
2 10th day of June, 2010 with:

3 Arizona Medical Board
4 9545 East Doubletree Ranch Road
5 Scottsdale, Arizona 85258

6 Executed copy of the foregoing
7 mailed by U.S. Mail this
8 10th day of June, 2010 to:

9 Stephen Myers
10 Myers & Jenkins
11 One E. Camelback Rd., Ste. 500
12 Phoenix, AZ 85012

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26 Arizona Medical Board Staff