BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of Venu G. Menon, M.D., Holder of License No. 12360 For the Practice of Medicine In the State of Arizona	**Docket No. 07A-070693-MDX** **Case No. MD-07-0693A** **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR REVOCATION OF LICENSE.**

On December 13, 2007 this matter came before the Arizona Medical Board ("Board") for oral argument and consideration of the Administrative Law Judge ("ALJ") Diane Mihalsky's proposed Findings of Fact and Conclusions of Law and Recommended Order involving Venu G. Menon, M.D. ("Respondent"). Respondent was notified of the Board's intent to consider this matter at the Board's public meeting. Respondent did not appear. The State was represented by Emma Mamaluy, Esq. Christopher Munns, Assistant Attorney General with the Solicitor General's Section of the Attorney General's Office provided independent legal advice to the Board.

The Board having considered the ALJ's recommended decision and the entire record in this matter hereby issues the following Findings of Fact, Conclusion of Law and Order.

FINDINGS OF FACT

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

2. Dr. Menon graduated from All India Institute of Medical Science in Ansari Nagar, New Delhi, India in 1963. Although Dr. Menon speaks English fluently, he speaks English with a heavy accent.

3. On October 17, 1980, the Board issued to Respondent Dr. Menon License No. 12360 for the practice of allopathic medicine in the State of Arizona. Dr. Menon practices anesthesiology.

4. Dr. Menon was also licensed as an allopathic physician by the state medical licensing agencies of Ohio, Oklahoma, Iowa, Nebraska, and Florida.

EVENTS LEADING TO THE BOARD'S 2005 LETTER OF REPRIMAND

5. On October 26, 1994, Dr. Menon's application for reappointment for clinical privileges at Stouder Memorial Hospital in Ohio was denied due to alleged concerns about quality of care and availability issues.

6. On June 25, 1997, Dr. Menon's clinical privileges at Piqua Memorial Hospital in Ohio were restricted and were placed on probationary status due to alleged legibility issues. He was required to have a scribe for all pre-operative and intra-operative reports until he established that the alleged problem had been resolved.

7. On September 24, 1997, Piqua Memorial Hospital lifted Dr. Menon's probationary status.

8. On November 24, 1998, Dr. Menon's clinical privileges at Upper Valley Medical Center in Ohio were terminated due to alleged concerns about quality of care. The specific concerns are not included in the record.

9. In 2002, Dr. Menon applied for reinstatement of his Oklahoma medical license. He did not disclose on the application form that his staff privileges had been denied or terminated by Stouder Memorial Hospital and Upper Valley Medical Center in Ohio.

10. In 2002, as a result of Dr. Menon's failure to disclose of the Ohio hospitals' actions denying or terminating his staff privileges, the Oklahoma medical agency denied Dr. Menon's application for reinstatement.

11. In 2003, based on the Oklahoma agency's action, the Ohio agency placed Dr. Menon's license on probation for three years.

12. In 2004, based on the Oklahoma agency's action, the Iowa agency suspended Dr. Menon's license indefinitely.

13. In February 2005, based on the actions of the Ohio and Oklahoma agencies, the Arizona Board issued to Dr. Menon a Letter or Reprimand in Case No. MD-03-0684A.

EVENTS LEADING TO THE BOARD'S 2007 SUMMARY SUSPENSION

14. In early 2005, the Nebraska agency issued a Petition for Disciplinary Action against Dr. Menon's license. The Nebraska agency alleged that Dr. Menon had committed the following acts during the time he was employed by Community Hospital in McCook, NE, during his employment between April 2000 and February 2002:

14.1 On or about June 6, 2001, Dr. Menon had attempted to intubate patient G.R. for the administration of general anesthesia eight to twelve times without success. During these numerous attempts, Dr. Menon instructed the nurse to administer succinylcholine, a paralytic agent. G.R.'s oxygen saturation levels had dropped to between 30% and 40%. Dr. Menon had failed to chart the orders to the nurse to administer succinylcholine and had failed to chart all oxygen saturation levels.

14.2 Between April 2000 and February 2002, Dr. Menon had prescribed antibiotic medication for a patient without documenting in the patient's chart the medications prescribed or the purpose of the medications. Dr. Menon had admitted in September 2003 that he had provided his girlfriend with antibiotics by using hospital prescription pads and that he had not kept records of this medical care.

14.3 Between September 10 and 15, 2003, Dr. Menon had reused the same syringe to provide anesthesia services to four or five patients undergoing cataract procedures. Dr. Menon had admitted reusing syringes until a nurse told him to stop.

14.4 Between April 2000 and February 2002, Dr. Menon failed to label each syringe used to administer different medications. On September 10 and 15, 2003, Dr. Menon had admitted this failure.

14.5 Between April 2000 and February 2002, Dr. Menon had left anesthesized patients under his care to go outside the operating room to speak to students or to drink coffee. On September 10 and 15, 2003, Dr. Menon had admitted to being 20 feet away from patients under his care.

14.6 Between April 2000 and February 2002, Dr. Menon failed to use filtered needles to draw medication from glass ampules.

14.7 Between June 1, 2000 and March 13, 2002, Dr. Menon had written himself 26 prescriptions for Viagra.

14.8 Dr. Menon had written three prescriptions for Tylox (oxycodone with APAP 5/500) to patient J.B., which were filled by a pharmacy. On September 10, 2003, Dr. Menon had lied to Nebraska investigators about having prescribed controlled substances to patients outside the hospital.

14.9 Dr. Menon had failed to report the loss of his privileges in Ohio within 30 days.[1]

15. On February 22, 2005, Dr. Menon signed an Agreed Settlement with the Nebraska agency, in which he admitted "the allegations of the Petition for Disciplinary Action" and agreed voluntarily to surrender his Nebraska license for a minimum of two years in lieu of disciplinary proceedings.[2]

16. On October 18, 2006, the Arizona Board opened an investigation after receiving Dr. Menon's 2006 biennial license renewal. In response to a question on that renewal form, Dr. Menon had disclosed that he had voluntarily surrendered his Nebraska license.

17. On November 27, 2006, the Arizona Board received Dr. Menon's response to its investigation and explained the incidents alleged in the Nebraska complaint as follows:

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[1] *See* the Board's Ex. 1.

[2] *See* the Board's Ex. 16.

1. -Pt was 400+ lbs heavy, thickset with short neck. I had difficulty in intubating; after a few attempts I did a spinal anesthesia and the case went very well and no bad effects to the patient
   -O2 saturation monitor is a trend monitor, a steady decline in the saturation is pathognomic rather than two or three reading in between
   -I was the only Anesthesiologist present and while intubating it was rather impossible to chart at the same time.

   -A letter from the Surgeon is enclosed.

2. My apartment cleaning person had flu like symptoms and I had Rx antibiotic to prevent secondary infection; no medical records were available, I had assured no allergy to Amoxcillin.

3. For eye cataract the surgeon takes about 10 minuets to do it; for IV sedation I used about 3 to 4 cc of Diprivan, which was rather expensive then. I used to fill up the syringe with 20 cc of Diprivan and inject about 3 cc n the injection port of the IV set which is 20 inches from the IV site, changing needle on every patient.

4. I was the only Anesthesiologist; I mostly use three drugs, Diprivan, Rocuronium, and Fentanyl (occasionally Midazolam). I used 20cc for Diprivan, 5 cc for Rocuronium and 3 cc for Fentanyl or Midazolam. There were no labels that were available in the cart at that time.

5. -Only during Local Anesthesia procedures, Epidural or Spinal anes. I used to be away from the head end of the patient, but constantly watching the pt in the OR. The pharmacy tech wanted me to use a big plastic gadget to draw drug from 1 or 2 cc glass vial which was cumbersome, I used metal needle with filter to draw drugs.
   -I wrote prescriptions for antibiotics and sildinafil for myself during the period I was there. Being an Anesthesiologist I do use controlled drugs in the OR but never prescribed controlled substance outside the OR or outside the hospital. If I recollect, I must have signed a script for Tylox as the ENT surgeon had left the hospital. I did not know what Tylox was then, but I do not Rx as it contain Acetaminophen as it might induce high blood pressure esp in females and also contain 30 mg Codeine; this happened once only.

6. -I did not inform the AMB till October 05, it was a mistake and I sincerely apologize for that.

-Community Hospital in McCook is a 42 bed facility with one Surgeon and an Orthopedic surgeon, who has left the hospital for California about three years ago and his whereabouts, is unknown. I was the only foreign born in the facility including Nursing, Ancilliary, Maintenance, and Janitorial staff.

[handwritten] Being colored has created some problem for [me] often.

I did not contest the alleged finding from Nebraska since I had passed the "flex" exam for Nebraska. I did not want to displease them in any way. The attorney general asst. assured me to surrender my license for two years and that is it. Looking back I realize that was a great mistake. Nothing I can do about it. Two years will be up in May 2007.

As it stands now, I am licensed in Arizona, Florida, and Ohio. Although they are investigating.

P.S.: It is very difficult to obtain pt's records from the hospital [without] pt's permission.[3]

18. Dr. Menon attached to his response a letter from Jane M. Eskildsen, MD, dated March 12, 2002 and addressed "To Whom It May Concern," in relevant part as follows:

I am writing at the request of Dr. Menon for a testimonial regarding my experience of working with him as my anesthesia provider. In the time that Dr. Menon has been in McCook, we have worked together extensively and he has handled the majority of anesthetics for my cases. Some of my patients have been high risk elderly (greater than 90 year old) and severe oxygen dependent COPD and critically ill patients. Dr. Menon demonstrated his knowledge and expertise in getting these sick patients safely through their operations.

Dr. Menon provided epidural anesthesia for patients who could not tolerate general anesthesia and provided post-op epidural pain control for my colon

[3] The Board's Ex. 12.

> resection patients who, with very few exceptions, had excellent pain control results.
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> Although there was some conflicting opinions with the nursing staff about the last post-op epidural patient we had, Dr. Menon had appropriate and reasonable explanations for the dosing interval not being shortened in that case. Although I have no reason to doubt the veracity of those who did, I did not witness any breaches of sterile techniques and did not have any episodes in which I would question his medical judgment. Communication between staff members has been a problem and, although Dr. Menon speaks and understands perfectly good English, sometimes people have difficulty with his accent and sometimes people have criticized him rather than discuss his reasons for approaching things a certain way.

19. Dr. Menon also provided another letter from Dr. Eskildsen dated April 22, 2006 addressed to Sonya Longfellow, who apparently was an investigator with the Florida agency, in relevant part as follows:

> Dr. Venu Menon has asked me to write to you regarding the allegations made in the petition for disciplinary action with the Department of Health and Human Services for regulation and licensure of the State of Nebraska. Apparently Dr. Menon did not contest the allegations in Nebraska without understanding that this would affect his licensure and ability to practice in other states, specifically the State of Florida.
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> Dr. Menon provided anesthesia services at Community Hospital in McCook, Nebraska from April 2000 to February 2002. He initially came to McCook as a locum tenens physician and then was hired by the hospital. I am a general surgeon at Community Hospital.
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> The patient in allegation #6 was my patient and I was present during the attempted intubation efforts on this patient. This patient was super morbidly obese and suffered from sleep apnea. There was concerns about his developing respiratory depression so sedatives and long acting neuromuscular blocking agents were avoided. He had a very short thick neck and due to his body habitus was unable to be intubated despite multiple efforts. The patient was pre-oxygenated with

> bag mask ventilation prior to each attempt at intubation and at no time was he allowed to become dangerously hypoxic. The patient had a strangulated hernia and this emergent surgery was necessary. If this had been an elective case, attempts at intubation would have been stopped and surgery canceled, but because his condition required emergent surgery, anesthesia was converted to spinal anesthesia which was no easy feat in this very large person. Dr. Menon was able to get the spinal in and the procedure was able to be completed. The patient did not show any signs of having had hypoxia. If the oximeter measurement was as low as what is alleged, I think it was artifactual. Sometimes, the finger or ear probes used do not make good contact so that occasionally readings will not reflect the true oxygen saturation. Inability to intubate a patient with a difficult airway is something that can occasionally happen to any anesthesia provider. Because of this case, Dr. Menon had the hospital create a difficult intubation tray and ordered a fiber optic laryngoscope to be used for future patients with difficult airways.
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> As to allegation #10, some anesthesia providers do on occasion step away from the head of the bed and go to the hallway just outside the door of the operating room because they can have a cup of coffee or talk to the nurses from there while watching the overhead monitors in the room from the door. This is not unique to Dr. Menon and other providers have done the same thing without anyone accusing them of being substandard for doing it. Usually this is when a patient has a regional or local anesthetic and is not needing medication to be administered during the case. They are close enough to quickly get back to the head of the bed if needed. It does bother me that they do this, but none of the other providers that do the same thing have been sanctioned for it.
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> The remainder of the allegations are for things I was not witness to and thus I cannot comment on them.

20. Dr. Menon also provided copies of letters from Richard W. Slovek, MD, of the McCook Community Hospital Orthopedic Clinic dated February 25, 2002, attesting to Dr. Menon's general competence and professionalism; C. Gill Hoang, MD, an OB/GYN from Sidney, Ohio dated January 28, 1999, attesting to Dr. Menon's skill in epidural anesthesia; Lawrence A. Gould, MD of

Sidney, Ohio, attesting to Dr. Menon's competence in administering anesthesia during their 15-year association; and a letter from Gerald A. Dysert, MD, the President of the Medical Executive Committee of Trover in Madisonville, Kentucky, dated March 6, 2003, praising the competence and professionalism of Dr. Menon, whom Dr. Dysert has known since 1987. In Dr. Dysert's opinion, the loss of staff privileges in Ohio resulted from political motivation and racism in that, "[a]lthough Dr. Menon is a native of India and, therefore, Caucasian, his very dark skin and his very heavy accent did create, what I felt to be, racially motivated bias."[4]

21. As a result of Dr. Menon's voluntary surrender of his Nebraska license, on December 15, 2005, the Ohio agency revoked his Ohio license.

22. Dr. Menon appealed the Ohio agency's revocation of his Ohio license and, on August 11, 2006, Ohio court of appeals upheld his appeal and remanded the matter to the Ohio agency for hearing.

23. On May 30, 2007, the Arizona Board issued an Interim Order for Respondent to undergo a Physician Assessment and Clinical Evaluation ("PACE") within 60 days of the date of the order under A.R.S. § 32-1451(C).

24. On June 13, 2007, the Ohio agency permanently revoked Dr. Menon's Ohio license.

25. On June 27, 2007, Dr. Menon contacted Arizona Board employee Kathleen Muller and informed her that the PACE course was not offered until October. Ms. Muller clarified that the Board had not ordered Dr. Menon to take the PACE course but, instead, had ordered him to undergo an evaluation and provided Dr. Menon with the name of a contact person.

26. Dr. Menon did not schedule a PACE evaluation before the deadline set in the Board's May 30, 2007 order. Ms. Muller attempted to call him at his address of record in Ohio, but

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[4] The Board's Ex. 14.

his home number had been disconnected. Ms. Muller finally was able to contact Dr. Menon at a cellular number he previously had provided and he assured her that he would be sending the $350.00 application fee for the PACE evaluation within a week. Ms. Muller asked him to explain his delay in attending the PACE evaluation and to advise the Board of his new address.

27. On July 28, 2007, Ms. Muller received via facsimile a six-page handwritten letter from Dr. Menon. Dr. Menon explained that he had had difficulty raising $350 for the PACE application, but had borrowed $500 from a friend and would be sending the application fee. The letter is mostly illegible but Dr. Menon requested an extension of time to complete the PACE program. He also informed Ms. Muller that "now I stay at rm. 130 Sands, 2040 Mesquite Ave., Lake Havasu City, AZ 86903."[5]

28. Ms. Muller testified at the hearing that she left several messages on Dr. Menon's cellular phone and called PACE to see if the $350 application fee had been received and was informed that it had not been. But she did not hear from Dr. Menon.

29. Dr. Menon testified that, about this time, he learned that his brother in India had suffered a heart attack. He immediately flew back to India, using a buddy airline pass. His brother got 3 stents and is "not doing well at all." Dr. Menon remained in India six weeks.

30. On August 8, 2007, Board sent a letter to Dr. Menon at the Sands address in Lake Havasu City and at his address of record in Ohio, informing him that the Board would consider summary action against his license under A.R.S. § 32-1451(D) at a meeting at 12:00 p.m. on August 9, 2007.

31. On August 9, 2007, PACE informed Board staff that it had received Dr. Menon's application and a check for $350.

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[5] Board Ex. 6.

32. At the August 9, 2007 meeting, members of the Board determined that Dr. Menon was still in violation of the May 30, 2007 order, which had required him to complete the PACE evaluation, not merely to register for it.

33. On August 13, 2007, the Board issued Interim Findings of Fact, Conclusions of Law, finding cause to sanction Dr. Menon's license based on his failure to comply with the Board's May 30, 2007 order under A.R.S. § 32-1401(27)(r) and medical incompetency under A.R.S. § 32-1451(A). Because the Board concluded that the public health, safety or welfare imperatively required emergency action under A.R.S. § 32-1451(D), it summarily suspended Dr. Menon's license.

34. A hearing was held on September 26, 2007. The Board presented the testimony of its employees Marlene Young and Ms. Muller and had admitted into evidence 20 exhibits. Dr. Menon testified on his own behalf.

35. In addition to the matters set forth above, Dr. Menon testified that he has not worked in medicine since 2006. His DEA license expired on January 30, 2006. Presently, he his earning $8/hour as a telemarketer.

36. Dr. Menon testified that the PACE evaluation costs $6,800. He does not have that kind of money. He must be able to work in medicine to come up with that kind of money.

37. Dr. Menon testified that he has worked at Parker, Lake Havasu, and Flagstaff in Arizona. There were no issues regarding the quality of his care.

38. Dr. Menon testified that he only agreed to surrender his Nebraska license because the attorney general representing the Nebraska agency assured him it would only be for two years, and then he could get his license back. He never would have surrendered his Nebraska license if he had known that the surrender would adversely affect his licenses in other states, including Arizona.

39. Dr. Menon admitted that the Nebraska assistant attorney general had not given him any guarantees that he would get his Nebraska license back after surrendering it.

40. Dr. Menon testified that the Nebraska complaints were primarily political. No patient had complained about his care and family members of patients always requested that he provide anesthesia services.

41. Dr. Menon testified that the administrator at McCook Community Hospital had directed him to cut waste. He therefore used the same IV syringe, but changed the needle for each patient. With respect to labeling syringes, Dr. Menon testified he was the only anesthesiologist at McCook Community Hospital.

42. Dr. Menon testified that he left for India on August 2 or 3 and returned to Arizona on September 12, 2007. Dr. Menon admitted that he did not inform the Board that he would be leaving. He also admitted that he has never filed a change of address form.

43. Dr. Menon admitted that Board staff informed him that he would be in violation of the Board's order if he did not obtain an evaluation by July 28, 2007. He did not know whether the Board had extended the time for his to complete the evaluation.

CONCLUSIONS OF LAW

1. The Board bears the burden of proof and must establish that cause to sanction Dr. Menon's license by a preponderance of the evidence.[6] "A preponderance of the evidence is such proof as convinces the trier of fact that the contention is more probably true than not."[7] A preponderance of the evidence is "[t]he greater weight of the evidence, not necessarily established by the greater number of witnesses testifying to a fact but by evidence that has the most convincing

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[6] *See* A.R.S. § 41-1092.07(G)(2); A.A.C. R2-19-119; *see also Vazanno v. Superior Court*, 74 Ariz. 369, 372, 249 P.2d 837 (1952).

[7] Morris K. Udall, ARIZONA LAW OF EVIDENCE § 5 (1960).

force; superior evidentiary weight that, though not sufficient to free the mind wholly from all reasonable doubt, is still sufficient to incline a fair and impartial mind to one side of the issue rather than the other."[8]

2. When Dr. Menon agreed to surrender his Nebraska license, he admitted the complaint allegations, which raise serious issues about Dr. Menon's competency to practice allopathic medicine. When the Board summarily suspended Dr. Menon's Arizona license, he had failed to comply with the Board's May 30, 2007 order and had left the country, without informing the Board.

3. At a minimum, Dr. Menon committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(o)[9] and (r).[10] Under the circumstances, the Board has borne its burden to establish that the public health, safety or welfare imperatively required it to summarily suspend his license under A.R.S. § 32-1451(D).

4. This record does not contain sufficient evidence to overcome the evidence that required the Board to summarily suspend Dr. Menon's license.

5. The record does contain conclusive evidence that Dr. Menon's care of his patients at McCook Community Hospital in Nebraska was substandard or endangered those patients. And, given Dr. Menon's admissions in the Nebraska settlement, the Board properly required an in-depth PACE evaluation.

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[8] BLACK'S LAW DICTIONARY at page 1220 (8th ed. 1999).

[9] This statute defines "unprofessional conduct" to include the following:

> Action that is taken against a doctor of medicine by another licensing or regulatory jurisdiction due to the doctor's mental or physical inability to engage safely in the practice of medicine, the doctor's medical incompetence or for unprofessional conduct as defined by that jurisdiction and that corresponds directly or indirectly to an act of unprofessional conduct prescribed by this paragraph. . . .

[10] The statute defines "unprofessional conduct" to include "[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter."

ORDER

Based upon the Findings of Fact and Conclusions of Law as adopted, the Board hereby enters the following Order:

1. Respondent's License No. 12360 is revoked on the effective date of this Order and Respondent shall return his wallet card and certificate of licensure to the Board.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review by filing a petition with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09. The petition must set forth legally sufficient reasons for granting a rehearing. A.C.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

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

Dated this 14th day of December, 2007.

ARIZONA MEDICAL BOARD

(SEAL)

By: Amanda Diehl
Amanda J. Diehl
Deputy Executive Director

Original of the foregoing filed this
14th day of December, 2007, with:

Arizona Medical Board
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Scottsdale, AZ 85258

Copy of the foregoing filed this
14th day of December, 2007, with:

Cliff J. Vanell, Director
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1400 W. Washington, Ste. 101
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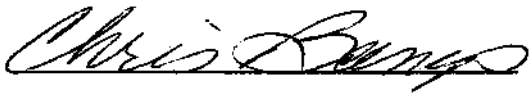
Executed copy of the foregoing mailed
by US Mail this 14th day of December, 2007, to:

Venu G. Menon, M.D.
(Address of record)

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