BEFORE THE ARIZONA MEDICAL BOARD

IN THE STATE OF ARIZONA

In the Matter of: **Gary W. Hall, M.D.** Holder of License No. 12977 For the Practice of Medicine in the State of Arizona, Respondent.	Case Nos. MD-99-0838; MD-01-0145; MD-01-0456; MD-01-0569; MD-03-0327; MD-03-0920 **CONSENT AGREEMENT AND ORDER FOR PROBATION AND PRACTICE RESTRICTION**

CONSENT AGREEMENT

RECITALS

In the interest of a prompt and judicious settlement of the above-captioned matter before the Arizona State Board of Medical Examiners (Board) and consistent with the public interest, statutory requirements, and responsibilities of the Board and pursuant to A.R.S. § 41-1092.07(F)(5), Gary W. Hall, M.D. (Respondent) and the Board enter into this Consent Agreement and Order as the final disposition of this matter.

1. Respondent acknowledges that he has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order. Respondent acknowledges that he understands he has the right to consult with legal counsel regarding this matter and has done so or chooses not to do so.

2. Respondent understands that he has a right to a public administrative hearing concerning each and every allegation set forth in the above-captioned matter, at which administrative hearing he could present evidence and cross-examine witnesses. By entering into this Consent Agreement, Respondent freely and voluntarily relinquishes all rights to such an administrative hearing, as well as all rights of rehearing, review, reconsideration, appeal, judicial review or any other administrative and/or judicial action,

concerning the matters set forth herein, and waives any other cause of action related thereto or arising from this Order. Respondent affirmatively agrees that this Consent Agreement shall be irrevocable.

3. Respondent agrees that the Board may adopt this Consent Agreement, or any part thereof, pursuant to A.R.S. §§ 32-1401 *et seq.* and 41-1092.07(F)(5). Respondent understands that this Consent Agreement, or any part thereof, may be considered in any future disciplinary action against him.

4. Respondent acknowledges and understands that this Consent Agreement and the Order will not become effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Respondent acknowledges and agrees that, although the Consent Agreement has not yet been accepted by the Board and issued by the Executive Director, upon signing this agreement, and returning this document (or a copy thereof) to the Board's counsel or it's Executive Director, Respondent may not revoke his acceptance or the Consent Agreement and Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

7. Respondent further understands that this Consent Agreement and Order, once approved and signed, shall constitute a public record document that may be publicly disseminated as a formal action of the Board and shall be reported on the Board's website,

to the National Practitioner Data Bank, to the Healthcare Integrity and Protection Databank and as otherwise required by law.

8. If any part of the Consent Agreement and Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

9. Respondent understands that any violation of this Consent Agreement constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(24)(r) (violating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under the provisions of this chapter) and may result in disciplinary action pursuant to A.R.S. § 32-1451.

DATED: 3/9/05

Gary W. Hall, M.D.

Reviewed and Approved as to form:

By

Stephen W. Myers
Attorney for Respondent

FINDINGS OF FACT

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

2. Respondent is the holder of License No. 12977 for the practice of allopathic medicine in the State of Arizona.

3. On January 19, 1996, Respondent entered into a Consent Agreement with the Board of Medical Examiners of the State of Arizona (now the Arizona Medical Board). The Consent Agreement contained Conclusions of Law finding that Respondent violated A.R.S. §§ 32-1401(25)(e) (failing or refusing to maintain adequate records on a patient) and 32-1401(25)(q) (any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public). As discipline for these violations, Respondent was ordered to serve a three-year probationary term. The terms of probation included requirements that Respondent: (1) comply with guidelines governing refractive keratotomy and provide much more thorough and careful consultation and follow-up with his patients; (2) perform eighty hours of community service; (3) practice within Medicare guidelines for cataract surgery and YAG laser capsulotomies; and (4) pay $10,000 as reimbursement to the Board for expenses incurred in performing its investigations.

4. On October 21, 1999, Respondent entered into another Consent Agreement with the Board of Medical Examiners (now the Arizona Medical Board) under which Respondent was censured for unprofessional conduct, permanently prohibited from performing radial keratotomy, including enhancements, and placed on probation for three years. The terms of probation: (1) prohibited Respondent from performing LASIK surgery thirty days after issuance of the Order until Respondent completed a training course; (2) required Respondent to comply with staff's requests for patient charts for review; and (3) required Respondent to pay $15,000 as a civil penalty.

CASE NO. MD-99-0838

5. The Board initiated Case No. MD-99-0838 after receiving a complaint from patient M.P., an 81-year-old female. M.P. asserted that Respondent told her that her vision would improve post-operatively over a three-week period, but it did not.

6. M.P. was referred to Respondent by her optometrist, Dr. Bullington, for a cataract evaluation. Dr. Bullington's notes reflect that M.P.'s cataract and vision were worse in the left eye than the right eye, and recommended left eye surgery first.

7. Respondent first evaluated M.P. on April 5, 1999. At that time, she reported: (a) poor vision that had deteriorated over the past two years; (b) migraines; (c) inability to read the newspaper with fine print; (d) spots in her vision; (e) hazy vision; (f) inability to drive at night; (g) that her glasses were not helping; and (h) that she was bothered by bright lights.

8. Respondent's April 5, 1999 examination revealed significant cataracts and reduction of vision in both eyes, worse in the left and the presence of hyaline dystrophy in the cornea of each eye. The remainder of the examination was described as normal.

9. Respondent saw M.P. on July 12, 1999 to schedule cataract surgery. Respondent scheduled her surgery for the next day, July 13, 1999.

10. M.P.'s records indicated she was on a long-term dosage of ASA plus Fiorinal for migraines, although the records do not indicate the dosage or frequency of the medication. Respondent did not instruct M.P. to discontinue the use of ASA before her surgery. It is the standard of care to discontinue ASA well before any elective surgery to avoid an increased likelihood of bleeding.

11. On July 13, 1999, Respondent performed phacoemulsification cataract surgery under local anesthesia on M.P.

12. Respondent characterized the cortical aspect of M.P.'s cataract as "severe" in the left eye and "moderately severe" in the right eye. Thus, based on Respondent's

records and Dr. Bullington's notes, M.P.'s cataract and vision were worse in the left eye than in the right eye. It is correct and customary to operate upon the worse eye first unless contraindicated. Respondent, however, operated on the right eye-best vision first and failed to indicate in the records any reason justifying this decision.

13. The July 13, 1999 surgery was complicated by a rupture of the posterior lens capsule in the right eye, resulting in the vitreous entering the wound. When Respondent attempted to remove the vitreous, the posterior chamber lens dislocated into the vitreous and he could not retrieve it. A second 19.5 diopter lens was placed into the ciliary sulcus after the vitreous had been removed.

14. Respondent saw M.P. the day after her surgery, on July 14, 1999. M.P. presented with some bleeding in her eye and intraocular pressure in the right eye of 19mm. Respondent told M.P. the bleeding should resolve within the next few days.

15. Respondent saw M.P. again on July 15, 1999. Her intraocular pressure in the right eye had dropped from 19mm to zero mm. Such a pressure drop is evidence of a potential leak, yet Respondent failed to check for leakage, such as performing a Seidel test. Failure to detect and treat a leak can cause: (1) infection; (2) entry of vitreous into the wound, which in turn can cause retinal detachment; and (3) entry of the iris into the wound, which in turn can create synechia, glaucoma and a distorted pupil.

16. M.P. returned on July 16, 1999. Her intraocular pressure in the right eye remained at zero. She reported soreness and seeing light flashes and black floaters. Respondent advised M.P. to continue her post-operative instructions, but failed to perform any leakage check.

17. M.P. returned on July 19, 1999, reporting to Respondent that her eye felt as if it had mayonnaise in it and was very light sensitive. The intraocular pressure in her right eye measured 10mm.

18. On July 23, 1999, M.P. called Respondent's office and reported that she still could not see well from her eye and she had "one large teardrop coming from her eye." She was advised to continue with her eye drops as prescribed.

19. M.P. returned to see Respondent on July 26, 1999. Her vision dropped to 3/600, the stromal edema had become moderately severe and pressure was zero. Respondent placed a tight patch on the right eye to remain until he evaluated her.

20. M.P. returned on July 27, 1999. The pressure in her right eye was zero. Respondent diagnosed possible wound leak, but there is no indication in the records that he conducted any tests for wound leakage or performed any treatment for it.

21. On July 28, 1999, the patch was reapplied. There is no record of a pressure measurement.

22. On July 29, 1999, M.P.'s intraocular pressure in her right eye was 4mm. The cornea was very thin temporally and scleral thinning was also noted. Respondent referred M.P. to a corneal specialist, Robert McCulloch, M.D., for evaluation of corneal thinning and possible wound leak.

23. Although M.P.'s pressure had returned to 4mm on July 29, 1999, this was likely due to the iris presenting into the wound and plugging the opening. The iris in the wound created peripheral synechia (iris adhesions), an irregular pupil and glaucoma potential for the patient.

24. Dr. McCulloch referred M.P. to Peter Aiello, M.D. Dr. Aiello's notes for July 31, 1999 report marked inflammatory miosis with pupils of 2mm on the right and 3mm on the left. A corneal melt was documented, and Dr. Aiello performed a suture tarsorrhaphy to eliminate corneal exposure, resulting in resolution of the corneal melt and re-elevation of intraocular pressure. He noted that in the future M.P. may require tectonic penetrating keratoplasty to support the peripheral cornea.

25. Patient M.P. began seeing Terence Daly, M.D. in approximately November 2000. At that time, M.P. complained of decreasing visual acuity for the last 18 months. Dr. Daly diagnosed chronic retinal detachment and dislocated intraocular lens implant.

26. On December 4, 2000, Dr. Daly performed a pars plana vitrectomy, removal of dislocated posterior chamber intraocular lens, retinotomy, fluid-gas exchange, silicone oil installation and endolaser photocoagulation. His prospective diagnosis included chronic rhegmatogenous retinal detachment with proliferative vitreal retinopathy of the right eye with dislocated posterior chamber lens and with a second posterior chamber lens in the visual axis.

27. On February 20, 2001, M.P. was admitted to the hospital for removal of silicone oil from the right eye. Dr. Daly noted, "Due to the chronic nature of the detachment and some peripheral scarring, the long term prognosis for retention of useful vision in this eye is guarded." Patient M.P. declined to undergo any further surgery, feeling that she could not tolerate it.

28. Respondent's records nowhere reflect that the posterior chamber lens lost in the vitreous during the July 13, 1999 surgery was ever recovered or that Respondent notified the physicians to whom he referred M.P. that the lens was left in the vitreous. A lens left in the vitreous may cause later problems including inflammation, hemorrhage, retinal edema, retinal detachment and a variety of visual symptoms. Records from M.P.'s subsequent treatment with Dr. McCulloch, Dr. Aiello and Dr. Daly reveal complaints of just such problems.

29. Respondent's records are inconsistent with respect to instructing the patient whether she should keep her eye patch applied or remove it and rely on eye drops.

30. Respondent breached the standard of care in providing medical care to M.P. in the following ways: (1) failing to record the frequency and dosage of M.P.'s ASA use and failing to direct M.P. to discontinue the ASA before surgery; (2) planning surgery

incorrectly, *i.e.*, operating on M.P.'s right eye first, which had better vision than the left eye, without providing any explanation for deviation from the customary practice of operating on the eye with the worse vision first; (3) failing to notify subsequent physicians that the lens was left in the vitreous; (4) failing to perform a check for leakage on July 15, 1999 when M.P.'s eye pressure dropped from 19mm to 0mm; and (5) failing to maintain accurate charts and records.

31. Respondent's failure to perform a leak check on January 15, 1999 caused actual harm to M.P. Specifically, had Respondent timely diagnosed the leak, M.P. likely would have avoided adhesions of her iris to her corneal wound and an irregular pupil, which could lead to future glaucoma.

CASE NO. MD-01-0145

32. The Board initiated Case No. MD-01-0145 after receiving a complaint from J.E., a 69-year-old male, that Respondent performed an inadequate LASIK surgery and failed to inform him of the potential for a poor surgical outcome.

33. J.E. first saw Respondent on November 16, 2000 for a LASIK consultation. His chief complaints were difficulty reading and blurring at distances. He expressed a desire to improve the quality of his vision and attain a monovision correction. He was using over-the-counter reading glasses. J.E. had undergone radial keratotomy in both eyes in 1991 to 1992 and had some degree of cataract corrected with a mild distance spectacle to 20/20. J.E.'s uncorrected vision was 20/50 in the right eye and 20/30 in the left eye, correctable to 20/20 in both eyes at a distance.

34. Respondent performed a preoperative examination on November 27, 2000. The following was reported as J.E.'s chief complaint: "has monovision and his near vision have gotten worse over time" and "would like to keep monovision." There is no measure of near vision in the records, therefore making it impossible to determine how well J.E. could read in the left eye without glasses. Respondent recommended LASIK surgery to

correct both eyes for distance vision, which would mean that J.E. would have less clear vision for near without spectacles and would need to continue to wear spectacles for reading post-operatively. Respondent's recommendation was inconsistent with the patient's stated goals. Although Respondent's records indicate that J.E. chose "not to proceed w/monovision correction at this time," this note was generated by the macro programs consistently used by Respondent, which involve simply the push of a button and often generate paragraphs of information unrelated to the case at hand.

35. Respondent performed bilateral LASIK on J.E. on November 30, 2000. J.E. had increasing visual problems post-operatively, which resulted in unexpected hyperopia in both eyes.

36. In light of J.E.'s prior surgical history, present degree of cataract and chief complaints, he was not an appropriate candidate for LASIK surgery. The standard of care dictated that Respondent advise J.E. that LASIK would not meet his expectations; that he should wear glasses, and if his cataract progressed, a change in correction could be achieved with a lens implant. Respondent breached the standard of care by not so advising J.E. and by performing bilateral LASIK surgery on J.E.

37. J.E. suffered actual harm from Respondent's violation of the standard of care in that his vision worsened post-surgery.

CASE NO. MD-01-0456

38. On October 21, 1999, Respondent entered into a Stipulation for Consent Order.

39. Paragraph 3B of that Order requires Respondent to comply with Board staff's request for patient charts for review to evaluate the quality of ophthalmic care and surgery provided to patients by Respondent.

Office Practice Survey of December 7, 2000:

40. Pursuant to ¶ 3B of the Consent Order, Board staff conducted an office practice survey on December 7, 2000, which included review of 12 patient files.

41. In general, Respondent's records and notes do not meet the standard of care because they reflect "boilerplate" statements generated through word processing macros that sometimes include superfluous language not applicable to the clinical situation being documented and reflect no actual consideration by Respondent or meaningful communication with the patients. The records also reflect few follow-up visits with limited examinations.

42. Patient N.L.

a. Patient N.L., an 18-year-old female, presented with moderate bilateral myopia in both eyes and underwent LASIK surgery by Respondent on October 15, 1998.

b. During the surgery, the corneal flap of the left eye was inadvertently severed "at about 75% of the entire diameter," leading to a loss in suction. Respondent performed a laser ablation and replaced the cap.

c. N.L. was last seen by Respondent on September 2, 1999. Testing on that date revealed her best vision in her left eye as 20/25-3, (*i.e.*, 20/30, with ghosting); right eye as 20/20+. The quality of the stromal bed, which was not documented by Respondent, could have caused the ghosting.

d. Respondent's records for N.L. do not meet the standard of care. Specifically, Respondent's operative report does not include any documentation of: (1) the size of the optical zone for the cut; (2) whether the corneal cap was placed with its original orientation; and (3) the quality of the corneal stromal bed after the cut (*i.e.*, whether it was even and smooth or irregular).

e. N.L. eventually sued Respondent in connection with her care and Respondent settled the case. The Board initiated an investigation after the settlement and

found additional breaches of the standard of care. Those breaches are outlined in paragraphs 69 to 72 below.

43. Patient I.V.

a. Patient I.V., an 81-year old male, presented to Respondent for a complete evaluation on August 23, 2000 with a growth on the upper part of the left eye.

b. Respondent's records describe the appearance of the tumor as a "gelatinous conjunctival tumor extending over the cornea on the superior portion of the left globe – extended approximately 6 – 7 millimeters on to the cornea – raised and vascular." Respondent's diagnosis was benign tumor, left eye, upper lid. Respondent's notes do not provide a history of the tumor's evolution, a description of the patient's symptoms, a description of the tumor's interference with ocular function, effect upon cosmetic appearance, or a description of the elevation above the ocular surface or adherence to the globe.

c. On September 12, 2000, Respondent excised the tumor from the conjunctiva and cornea and submitted the specimen for pathological examination.

d. Respondent's notes from the excision procedure do not indicate whether any of the corneal "fibrosis" was included in the excision.

e. The index of suspicion for I.V.'s tumor should have been for possible carcinoma not "benign tumor."

f. I.V. returned on September 13, 2000. Respondent's records reflect that I.V. was instructed to call if he had any questions and to return in two weeks for a follow-up exam.

g. I.V. returned on September 27, 2000. Respondent's records from that date indicate that I.V. was instructed to return in one month for a follow-up exam and that the results of the pathology report would be reviewed at that time.

h. On October 2, 2000 Respondent received the pathology report, which revealed a diagnosis of "full thickness squamous dysplasia" and stated, "given that the lesion has been transected, the possibility of invasive carcinoma cannot be entirely excluded." Respondent called I.V. that day about the pathology report. Respondent's records from that conversation reflect that he told I.V. to return in six months for a cataract evaluation, but not for a follow-up evaluation or referral to a sub-specialist for possible carcinoma.

i. I.V. returned on October 30, 2000. Respondent's records from that date do not reflect any recommendation for a follow-up evaluation or referral to a sub-specialist for possible carcinoma.

j. Respondent breached the standard of care in his treatment of patient I.V. by failing to recognize the possibility of carcinoma and by failing to follow up with the patient to ensure that there was no invasive carcinoma. Additionally, Respondent's records for I.V. do not meet the standard of care for the reasons described above.

44. Patient R.L.

a. Patient R.L., a 53-year old male, presented to Respondent on September 25, 2000 wishing to eliminate the need for reading glasses through refractive surgery. R.L.'s uncorrected vision was 20/25 in the right eye and 20/40 in the left eye. The right eye had minimal hyperopic astigmatism only. There is no measure of near vision uncorrected in the records despite the patient's desire to achieve near vision without glasses.

b. On October 13, 2000, Respondent performed bilateral LASIK with limbal relaxing incisions in each eye.

c. Respondent's preoperative record contains no mention of a trial of monovision with a contact lens or spectacles with the left eye to determine if R.L. could cope with having the right eye for distance and the left eye for near vision. Respondent's

pre-operative report also reflects no other information to determine the appropriateness of a monovision correction, such as the patient's occupation.

d. Respondent's pre-operative plan called for limbal relaxing incisions in the right eye. Respondent's notes do not indicate any explanation for a change in plan from limbal relaxing incisions to LASIK surgery on the right eye.

e. Respondent's January 9, 2001 note shows uncorrected vision in the right eye as 20/30 and 20/40 distance uncorrected and 20/40 near uncorrected in left eye. This examination indicates worse vision post-operatively than pre-operatively.

f. Respondent's records for this patient reflect his consistent use of boilerplate "discussions" generated through word processing macros. Given that R.L. underwent surgery that caused a result contrary to his wishes, the alleged "discussions" documented in Respondent's records are unreliable for purposes of determining what was explained to the patient. In fact, one macro states: "Advised pt. LASIK does not take away the need for reading glasses." This advice is directly contrary to the surgery selected by Respondent to address the patient's complaints.

g. Respondent breached the standard of care in his treatment of R.L. by: (1) performing surgery on R.L.'s right eye given the patient's stated goals; (2) performing surgery on R.L.'s left eye without first trying a contact lens to determine if patient was an appropriate candidate for monovision; and (3) failing to document reasons for changing from limbal relaxing incisions to LASIK surgery on the right eye.

Office Practice Survey of March 14, 2002:

45. Pursuant to ¶ 3B of the October 21, 1999 Consent Order, Board staff conducted a second office practice survey of Respondent's records on March 14, 2002.

46. Respondent's records reflect extensive use of technicians utilizing routines and standard chart entries that were often not closely related to the patients' unique characteristics.

47. Respondent's charts include many formal documents signed by the patients but fail to reflect communications with the patients about their wishes and expectations.

48. Respondent's records also reflect an emphasis on technical result and surgical advocacy rather than a meaningful discussion and decision-making process on the appropriate course of treatment.

49. Patient R.G.

a. Patient R.G., a 68-year old male, presented to Respondent on June 29, 2000 for LASIK evaluation to correct average myopia.

b. Respondent performed bilateral LASIK on R.G. on July 17, 2000. The patient's result was slight bilateral hyperopia.

c. On April 4, 2001, Respondent recommended repeat LASIK in both eyes with the right eye to be made myopic again for reading. Respondent also recommended placing temporary collagen punctal plugs in both eyes to control dry eye. Respondent placed permanent plugs on April 18, 2001.

d. Respondent performed repeat bilateral LASIK surgery on April 18, 2001. On the two-week follow-up visit, R.G. complained of seeing "fireworks" in the right eye at night. Respondent's records do not indicate whether these were light reflections or light flashes that can occur with potentially serious retinal problems. The records also contain no indication that this complaint was addressed.

e. Respondent breached the standard of care in his treatment of R.G. by failing to address R.G.'s post-surgical complaint of seeing "fireworks" in the right eye at night.

50. Patient G.D.

a. Patient G.D., a 77-year-old female, presented to Respondent in May 1997 for papilloma of the right upper eyelid.

b. Respondent diagnosed episcleritis on slim documented evidence plus moderate severe cataract in each eye. Respondent removed the papilloma and recommended cataract surgery about five months later.

c. In January 1998, Respondent performed cataract and implant surgery on each eye. Four months later, in early May 1998, he performed Yag Lasarcapsulotomy on each eye. Respondent improperly documented post-operative intra ocular pressures by measuring the pressure for one eye on one day and the second eye on the following day.

d. In March 2001, on routine exam, G.D. reported blur, and Respondent recommended Limbal Relaxing Incisions in both eyes for astigmatism. On December 27, 2001, Respondent performed two incisions in each eye and determined the length of incision by sensory feedback method.

e. Five weeks post-surgery, G.D.'s right eye was watery, and Respondent noted entropion of the right lower eyelid. Rather than recognizing that the entropion was likely due to spasms from irritation from the surgery and employing the non-surgical remedy of taping down the eyelid for a short period of time, Respondent immediately suggested surgical repair, which he performed two weeks later on February 19, 2002.

f. Respondent breached the standard of care in his treatment of patient G.D. by: (1) failing to document sufficient evidence for a diagnosis of episcleritis; (2) failing to properly document post-operative intra ocular pressures after performing Yag laser treatment; and (3) immediately recommending surgery for the patient's entropion without first trying non-surgical remedies.

CASE NO. MD-01-0569

51. The Board initiated Case No. MD-01-0569 after receiving a complaint from patient L.H., a 61-year-old female, that Respondent failed to diagnose a retinal detachment.

52. L.H. presented to Respondent on April 19, 2000 with a history of having been slammed in the head with great force by a jack handle from a trailer with 2000 pounds of water on it. She complained of black, half-moon shadow and brightness when her eyes were closed. L.H. expressed concern to Respondent that she was suffering from a detached retina. Respondent failed to record any of this background information in his records.

53. Respondent initially told L.H. she did not have a detached retina, but a small cataract.

54. Respondent then admitted he did not know what was wrong with L.H.'s eye and scheduled an appointment for her with a refractionist.

55. On April 24, 2000, L.H. saw a refractionist, who made a report to Respondent. Respondent, however, insisted L.H. was suffering from a cataract and scheduled her for cataract surgery.

56. On May 1, 2000, L.H. consulted another ophthalmologist, Dr. Crowell, for a second opinion. At that time, most of her vision was blocked by a slimy brown shadow.

57. On May 3, 2000, L.H. awoke totally blind in the right eye. Dr. Crowell diagnosed a detached retina and referred her to Dr. Dugel for surgery.

58. L.H. first saw Dr. Dugel on May 3, 2000. He found severe detachment because the macula was involved and permanent damage to L.H.'s central vision. Dr. Dugel told L.H. that if she had presented 24 hours later than she did, he would have had to remove her eye.

59. On May 4, 2000, Dr. Dugel performed surgery. He stitched the retina, put a scleral buckle around the eye (permanent) and inserted a glass bubble to hold the eyeball in place.

60. Respondent breached the standard of care in his treatment of L.H. by: (1) failing to pursue examination for the most likely diagnosis, detached retina, in view of her presenting symptoms; and (2) scheduling patient L.H. for cataract surgery without adequate reason and where the patient's symptoms did not match his diagnosis.

CASE NO. MD-03-0327

61. The Board initiated Case No. MD-03-0327 after receiving a complaint against Respondent from patient R.M., a 67-year-old male.

62. Respondent first saw R.M. on November 15, 2002. R.M. reported that he "would like to see better without his glasses." R.M. had a history of known cataract. Based on the corneal topography, Respondent noted suspected keratoconus. Respondent recommended monovision LASIK surgery and asked R.M. to complete a questionnaire on the surgery, the purpose of which was to confirm R.M.'s understanding of it. Despite R.M. answering two key questions incorrectly, thus demonstrating a misunderstanding of the prospects of success, Respondent never followed up to correct this misunderstanding.

63. The standard of care dictates that prior to performing monovision LASIK surgery, a physician should conduct a monovision trial with the patient with contacts or spectacles to ensure that the patient will tolerate the change in vision. Respondent conducted no such trial with R.M.

64. The presence of keratoconus is a contraindication to monovision LASIK surgery.

65. Despite the patient's apparent misunderstanding of the prospects for correction from the surgery, the failure to conduct a monovision trial and the presence of a

contraindication (keratoconus), Respondent nonetheless performed monovision LASIK surgery on patient R.M. on November 16, 2002.

66. Respondent's preoperative records indicate that the left eye was dominant and the right eye was to be corrected for near vision. However, the surgical record reflects the opposite.

67. Two months after the surgery, Respondent diagnosed keratitis sicca (dry eye), but the records reflect no complaints by R.M. to support this diagnosis. Nonetheless, Respondent placed punctal plugs.

68. Respondent breached the standard of care in his treatment of R.M. by: (1) failing to correct the patient's misunderstanding of the prospects for correction; (2) failing to conduct a monovision trial; (3) performing the surgery when contraindicated by the suspected presence of keratoconus; (4) reversing the procedures to be performed on the left and right eyes; and (5) placing punctal plugs without sufficient findings.

CASE NO. MD-03-0920

69. On July 10, 2003, the Board was notified of a medical malpractice settlement made by Respondent regarding his care of an 18-year-old female patient, N.L.

70. Patient N.L.'s chart was also the subject of the December 7, 2000 office practice survey identified in paragraph 42 above. The allegations related to N.L. set forth in paragraph 42 are hereby incorporated by this reference.

71. After the October 15, 1998 LASIK surgery by Respondent, N.L. followed up with her treating ophthalmologist, Dr. Prendeville. Dr. Prendeville's post-operative notes and the drawing of the location of the corneal flap indicate that the severed edge of the flap is so close to the papillary axis that the area of laser ablation would have had to extend significantly outside of the stromal bed of the flap.

72. In addition to failing to keep accurate and proper records on N.L. as described and alleged in paragraph 42 above, Respondent breached the standard of care by

failing to abort the surgery when the corneal flap was mis-cut. This breach resulted in N.L.'s adverse visual outcome.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(26)(q) ("[a]ny conduct or practice which is or might be harmful or dangerous to the health of the patient or the public.")

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(26)(e) ("[f]ailing or refusing to maintain adequate records on a patient.")

4. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (26)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.")

ORDER

IT IS HEREBY ORDERED that:

1. Respondent Gary W. Hall, M.D., License No. 12977, is permanently prohibited from performing or assisting in surgery of any kind. Respondent must refer any patient who may be a surgical candidate to another qualified surgeon. If Respondent refers a patient to a surgeon over whom he exercises control, with whom he has a contract or in whose practice he has some financial interest, he must disclose this interest to the referred patient and must comply with all state and federal laws regarding such referrals.

2. Respondent is placed on probation for a period of five years. If any investigation involving an alleged violation of the probation is initiated but not resolved prior to the termination of the probation, the Board shall have continuing jurisdiction and

the period of probation shall extend until the matter is final. The terms of probation are as follows:

a. During the first six months of the probation period, Respondent shall obtain the services of a Board staff-approved Office Practice Management Consultant to conduct an evaluation of Respondent's office and record-keeping practices. Respondent shall provide the Consultant with a copy of this Order and shall authorize the Consultant to forward a copy of the evaluation with findings and recommendations to the Board. Based upon the office review, the Board retains jurisdiction to take additional disciplinary or remedial action.

b. Respondent shall be subject to chart reviews to be conducted by Board staff or its agents for the term of the probation period. Based upon the chart reviews, the Board retains jurisdiction to take additional disciplinary or remedial action.

c. Respondent shall pay the costs associated with monitoring his probation as designated by the Board each and every year of probation. Such costs may be adjusted on an annual basis. Costs are payable to the Board no later than 60 days after invoice is sent to Respondent and thereafter on an annual basis. Failure to pay these costs within 30 days of the due date constitutes a violation of probation.

DATED AND EFFECTIVE this 13 day of April, 2005.

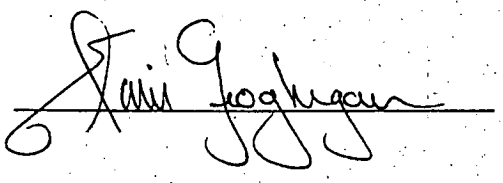
ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER
Executive Director

1594088.1

COPY of the foregoing mailed
by Certified Mail this 13th day
of April, 2005 to:

Gary W. Hall, M.D.
2501 N. 32nd Street
Phoenix, AZ 85008-2104
Respondent

COPY of the foregoing mailed AND FAXED
this 13th day of April, 2005 to:

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Phoenix, AZ 85012-2910
Attorneys for Respondent