BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **ANCA M. MARAS, M.D.** Holder of License No. 13103 For the Practice of Medicine In the State of Arizona.	Case No. MD-04-0567A **CONSENT AGREEMENT FOR DECREE OF CENSURE AND PROBATION**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Anca M. Maras, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

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

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

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement of any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. 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.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. 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.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

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

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

Anca Maras, M.D. Dated: 11. 7. 07

ANCA M. MARAS, M.D.

FINDINGS OF FACT

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

2. Respondent is the holder of license number 13103 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-04-0567A after receiving notification of a malpractice lawsuit involving Respondent's care and treatment of a fifty-seven year-old male patient ("RB").

4. In March 2000, RB sustained a spinal injury as a result of a fall down an elevator shaft during construction. RB subsequently underwent a decompressive laminectomy and an instrumented posterior fusion at an Illinois hospital. RB then returned to Arizona.

5. The screws inserted in RB's spine began to bend and the fusion failed within nine months of the initial surgery. On November 21, 2000, two orthopaedic surgeons recommended RB undergo an anterior corpectomy and strut reconstruction/fusion in order to support the spine and decompress the bone.

6. On December 5, 2000, RB underwent surgery at the hospital under the care of the orthopaedic surgeons and Respondent, an anesthesiologist. The surgery began at 8:24 a.m. RB suffered a large and rapid amount of blood loss at approximately 12:00. By 12:30, RB had been given 11 liters of fluid, which is treatment for hypotension; however, Respondent documented normal blood pressures and pulses.

7. The nursing record shows at 12:55, there was a decrease in RB's blood pressure and an increase in his pulse during the surgery, which is consistent with hypotension. However, Respondent documented normal vital signs, an increase in blood pressure and a decrease in heart rate. By 2:30 p.m., Respondent gave RB 24 liters of

volume replacement to maintain his blood pressure; however, Respondent did not obtain laboratory tests to check RB's blood loss, including hemoglobin and hematocrit levels. By 3:00 p.m., Respondent gave RB 27 liters of volume replacement, but she did not obtain laboratory tests to check RB's blood loss until 4:10 p.m. At approximately 5:00 p.m., RB had bradycardia, suffered cardiac arrest and died.

8. Although in the medical malpractice lawsuit the jury did not find Respondent responsible for the death of patient RB, the Board medical consultant who reviewed the case has opined that Respondent did not meet the standard of care in her treatment of RB.

9. The standard of care requires a physician to timely obtain appropriate laboratory tests.

10. Respondent deviated from the standard of care because she failed to timely obtain appropriate laboratory tests for RB until after RB had received 27 liters of volume replacement.

11. The standard of care requires a physician to adequately monitor, assess and treat the patient's blood loss and hemoglobin and hematocrit levels.

12. Respondent deviated from the standard of care because she failed to adequately monitor and treat RB's blood loss and assess his hemoglobin and hematocrit levels.

13. Respondent's failure to adequately assess RB's blood loss through appropriate laboratory testing could have resulted in RB bleeding to death.

14. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another

practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because she failed to maintain accurate medical records. Although Respondent treated RB with treatment consistent with hypotension, she documented RB had normal interoperative blood pressures and pulses.

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(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient.") and A.R.S. §32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Decree of Censure for failure to timely obtain appropriate laboratory tests, for failure to adequately monitor and treat a patient's blood loss and assess the patient's hemoglobin and hematocrit levels and for failure to maintain adequate medical records.

2. Respondent is placed on Probation for **five years** with the following terms and conditions:

A. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all conditions of probation. The declarations shall be submitted on or before the 15th of March, June, September and December of each year, beginning on or before March, 2008.

B. Respondent shall practice in a group setting that allows effective consultation when needed for patient safety.

C. Respondent shall be subjected to random periodic chart reviews to assure adequate documentation.

D. **Obey All Laws.** Respondent shall obey all state, federal and local laws, and all rules governing the practice of medicine in Arizona.

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

3. This Order is the final disposition of case number MD-04-0567A.

DATED AND EFFECTIVE this 17th day of December 2007.

ARIZONA MEDICAL BOARD

(SEAL)

By: Amanda Diehl

Amanda Diehl
AD ~~Interim~~ Executive Director
Deputy

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

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

EXECUTED COPY of the foregoing mailed
this 14th day of December 2007 to:

Anca M. Maras, M.D.
Address of Record

Investigational Review