BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **M. CECILIA D. DIMAANO, M.D.** Holder of License No. 13509 For the Practice of Allopathic Medicine In the State of Arizona	Case No. MD-07-0245A **CONSENT AGREEMENT FOR LETTER OF REPRIMAND**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and M. Cecilia D. Dimanno, 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.

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.

M. Cecilia Durban Dimaano MD DATED: 10.30.07

M. CECILIA DURBAN DIMAANO, 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 13509 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-07-0245A after receiving notification from a hospital ("Hospital") that Respondent resigned on April 5, 2007 while under investigation for failure to respond to pages and for failure to conduct post-operative rounds. During the investigation, Staff reviewed eight patients' medical records and found deviations in six records.

4. On January 7, 2005, LB was admitted to the Hospital for induction. On January 12, 2005, LB had heavy bleeding and Hospital staff made multiple attempts to reach Respondent at her home, on her cell phone and paged her answering service. By 6:55 a.m., Respondent had not responded to any of the phone calls. Hospital staff then contacted another physician who rendered care to LB. At 8:35 a.m., Respondent arrived at the Hospital to see LB.

5. On June 2, 2005, DW was admitted to the hospital in premature labor. Hospital staff called Respondent at 8:45 p.m. and 9:20 p.m. Respondent did not respond to either call. Hospital Staff contacted another physician who rendered care to DW.

6. On June 12, 2005, EA presented to the Hospital complaining of premature labor, including abdominal pains and contractions. Hospital staff made several attempts to contact Respondent, including leaving messages at her home, on her cell phone and with her office manager. After several attempts to contact Respondent, Hospital staff contacted another physician who rendered care to EA. Respondent eventually responded approximately two hours after the initial call.

7. On April 28, 2006, SF was admitted to the Hospital for an exploratory laparotomy for pelvic pain and with a history of endometriosis. Respondent consulted a urologist and stents were placed prior to the procedure which revealed extensive pelvic adhesions, which were lysed. However, the planned laparotomy was unable to be performed. SF developed numerous post-operative complications for which consultations were obtained, including urology, general surgery, and cardiology and pulmonary. On April 29, 2006, SF asked to see Respondent. Respondent was paged at 9:00 a.m., but she did not respond until 11:00 a.m. on the next day. Respondent documented progress notes on April 30, 2006 through May 3, 2006; May 6, 2006 and May 7, 2006, but failed to examine or evaluate SF's status on a regular basis to maintain on-going care until her discharge on May 15, 2006.

8. On June 16, 2006, MK was admitted to the hospital and underwent a hysterectomy. Respondent did not evaluate MK postoperatively until June 19, 2006 indicating, Respondent did not examine and evaluate DS's status on a regular basis and maintain on-going care.

9. On December 16, 2006, DS was admitted to the hospital in labor. DS progressed in labor to deliver an infant on December 17, 2006. Respondent was DS's primary physician of record, but did not see or evaluate DS's status while she was hospitalized.

10. The standard of care requires a physician providing care for a patient in the hospital to respond to phone calls from Hospital staff in a timely manner.

11. Respondent deviated from the standard of care because she did not respond in a timely manner to Hospital staff's phone calls regarding EA's care and she did not respond at all to staff's phone calls regarding care for LB and DW.

12. The standard of care requires a physician to examine and evaluate the patient's status on a regular basis and maintain on-going care.

13. Respondent deviated from the standard of care because she did not examine and evaluate SF's, MK's and DS's status on a regular basis and she did not maintain on-going care.

14. Due to Respondent's delay in response, LB continued to have bleeding and required three units of red blood cells and, with the significant bleeding, she could have died. Additionally, a delay in DW's and EA's treatment could have lead to premature delivery. There was no harm identified for SF, MK and DS.

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)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.") and A.R.S. § 32-1401 (27)(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 is issued a Letter of Reprimand for failure to respond to hospital staff in a timely manner or at times, not at all and for failure to examine, evaluate and monitor patients on a regular basis.

2. This Order is the final disposition of case number MD-07-0245A.

DATED AND EFFECTIVE this 14th day of December, 2007.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
AMANDA J. DIEHL
Deputy Executive Director

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:

M. Cecilia D. Dimaano, M.D.
Address of Record

_____
Investigational Review