BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **RONALD S. SHERER, M.D.** Holder of License No. **19367** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-05-0184A **FINDINGS OF FACT,** **CONCLUSIONS OF LAW AND ORDER** (Decree of Censure and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 8, 2006. Ronald S. Sherer, M.D., ("Respondent") appeared before the Board with legal counsel Kent E. Turley for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

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. 19367 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0184A after receiving a complaint regarding Respondent's care and treatment of a twenty-seven year old female patient ("MC"). MC presented in her first trimester of pregnancy with a past medical history of hypertension and diabetes. At the time of this visit MC's medications were noted to be Captopril and Glucotrol. An Accu-Chek revealed her blood sugar was 142. MC's medications were changed to Aldomet and Glucotrol. MC was seen on a regular basis by Respondent and Accu-Cheks were the only evaluations of her blood sugar. Approximately three months into her pregnancy MC requested the Aldomet be discontinued even though she had a history of hypertension. Respondent

honored MC's request. MC's diabetes continued to be elevated with her blood sugar ranging from 116 to 273, but she was maintained only on oral medications. MC had one ultrasound at sixteen weeks and no follow-up ultrasound was done.

4. Respondent did not change MC to insulin until late in her second trimester and after that there was no follow-up of her Accu-Cheks. Respondent referred MC to a perinatologist. MC did not follow through on the referral and the clinic did not follow through to see that MC actually did see the perinatologist. Respondent did not institute fetal monitoring until thirty-four weeks gestation. At thirty-seven weeks MC presented to Respondent with no fetal movements. MC was admitted to the hospital with an intrauterine fetal demise.

5. Respondent testified MC was initially referred to him by her family physician who informed him MC had high blood pressure and Class II diabetes and was on Glucotrol, ten milligrams, twice per day. Respondent testified he told the family physician MC probably should be seen by a perinatologist because she sounded like a high-risk patient who needed higher care. Respondent testified the family physician told him MC could not afford a perinatologist and he thought MC would be a good candidate for control on home monitoring. Respondent testified the family physician also told him he was going to put MC on Accu-Cheks for her diabetes and that she was on Captopril. Respondent testified he told the family physician ace inhibitors could cause teratogenic effects, especially at seven weeks of pregnancy, so they changed her from Captopril to Aldomet. Respondent treated MC at the clinic owned by the family physician.

6. Respondent testified he initially saw MC at thirteen weeks and placed her on Glyburide, 2.5 milligrams BID. Respondent testified he spoke with a perinatologist who told him he could go up to twenty milligrams per day of Glyburide, but he should make sure the sugars were under control before he did so. Respondent testified he asked MC to bring her home Accu-Chek or her home glucose monitoring on the next visit and she said she would. Respondent testified on MC's next visit at fifteen weeks he noted she did not bring her home monitoring and

he ordered a two-hour postprandial to see what type of control she might be under, but for some reason it did not get done. Respondent testified he spoke with MC about her diet. Respondent testified he saw MC two weeks later and a random Accu-Chek had a result of 216. Respondent testified he ordered another two-hour postprandial and the result was 139. Respondent testified he felt MC's two-hour postprandial was within normal limits and he again asked her to bring her home monitoring in. Respondent testified he told MC to do two-hour postprandials and a fasting blood sugar daily. Respondent testified another two-hour postprandial at twenty-three weeks was 188 and a random Accu-Chek of 114 was somewhat elevated. Respondent testified shortly after that time he increased MC's dose to Glyburide TID. Respondent testified he did another two-hour postprandial at twenty-six weeks that came back at 183 and he increased MC's Glyburide to five milligrams TID. Respondent testified at thirty weeks he did another two-hour postprandial and it came back at 273 and he realized MC could not be controlled on Glyburide so he placed her on insulin, 30 NPH and 15 regular and 15 NPH and 10 regular. Respondent testified he ordered MC to definitely watch her Accu-Cheks at home and follow them closely because she was now on insulin and that he wanted to see them in one week.

7. Respondent testified MC returned in one week and he saw there were still a few elevated numbers – one two-hour postprandial was 164 and another was 183 – and he told MC she needed to see a perinatologist immediately because she was on insulin control and he was unable to control the numbers the way he would like to. Respondent testified he also told MC that at her current stage of thirty-one weeks she needed to be monitored by a perinatologist, possibly NST's and biophysical profiles or whatever monitoring they needed to do for fetal surveillance. Respondent testified he told MC he was no longer able to take care of her and she definitely needed to go to the perinatologist. Respondent testified MC returned two weeks later saying she could not afford the perinatologist and Respondent told her he had done the best he could in that regard and MC needed to make arrangements with the perinatologist. Respondent

testified he ordered a NST, but it never got done. Respondent testified he was at Maryvale when MC presented and he asked what was going on and he was told they did not feel any fetal movement and were not getting any heart tones. Respondent testified he told her to go to the nearest emergency center. Respondent testified at twenty-six weeks he usually tells his patients to do fetal kick counts and, for a diabetic, he usually starts doing NSTs or biophysical profiles at thirty or thirty-two weeks and he thought this was going to be done by the perinatologist after he referred MC. Respondent testified it was probably incumbent on him to make sure MC actually got to the perinatologist and he feels very bad it did not happen.

8. The Board asked Respondent to describe the clinic MC originally presented to. Respondent testified it belongs to a family physician and Respondent goes there to do the family physician's obstetric patients. The Board asked Respondent if the family physician was co-managing MC because the family physician made entries in MC's record. Respondent testified he would not exactly say that, but if Respondent was doing a delivery or was otherwise unavailable the family physician may have seen MC on his own. Respondent noted the usual practice is he sees the patients on his own accord after the family physician refers them to him. The Board noted the family physician was clearly treating MC and making notes such as "must adhere to a low sugar diet, recheck in two weeks" – a care plan. Respondent agreed. The Board noted this would be somewhat of a management of a patient.

9. The Board asked Respondent how many obstetric patients he saw on an annual basis. Respondent testified there are a lot of patients that come in and he sees as "drop-in deliveries" at the hospital and he has somewhere in the neighborhood of two-hundred office patients. The Board asked how many of his patients fell within what the American College of Obstetrics and Gynecology ("ACOG") considered high-risk. Respondent testified he had about four or five percent high risk patients. Respondent was asked if this was a high percentage in terms of the community. Respondent testified he should probably rephrase what he said and

noted as far as in the ACOG sense of gestational diabetes it is probably in the range of twenty-five percent, but most of those types of patients he would be able to handle. Respondent testified the amount of patients he needs to refer to a higher source, like a perinatologist, is three or four percent. The Board asked if Respondent would classify MC, a woman with prenatal diabetes, prenatal hypertension, and a previous spontaneous miscarriage, as higher risk than his normal high-risk patient. Respondent testified he would.

10. The Board asked Respondent why there are incidences of fetal demise and why must an obstetrician be careful in the management of a diabetic patient. Respondent testified if the blood sugar is extremely high or erratic the patient can go from hypoglycemia to hyperglycemia and it could affect the development of the fetal neurological system. Respondent testified in the case of gestational diabetes it is a source of macrosomia – the baby would have a large abdomen to head ratio or shoulder to head ratio – and it would make for a difficult delivery. Respondent testified the patient could also develop preeclampsia, especially a patient who had high blood pressure from the beginning or could have unmasked preeclampsia in the later stages. Respondent testified the patient could also have things associated with preeclampsia, which are abruption. Respondent also noted an uncontrolled diabetic has a higher incidence of having teratogenic malformations or miscarriages if they are not managed preconceptually.

11. The Board asked Respondent, in the absence of abruption in this case, what he surmised was the cause of the fetal demise. Respondent testified that according to the records from the hospital MC had preeclampsia, but managing her throughout the pregnancy he never recorded a blood pressure greater than 120 over 90 or 130 over 80 and she never spilled any protein during the entire course of her management. Respondent testified the hospital made it seem that MC was preeclampic, but from his management point of view he never noticed that she had developed preeclampsia. Respondent testified patients have high blood sugars a lot of times

that would just become macrosomic if they are traditionally gestational diabetes and their main enemy in that case would be just the high blood sugar itself.

12. The Board asked Respondent to articulate what he believed was the proposed standard of care in the management of a prenatal, now natal, diabetic hypertensive patient. The Board asked Respondent to focus, for example, on how tight the patient should be controlled in her glucose. Respondent testified MC in her initial workup was determined to have a history of hypertension and diabetes, presumed to be Class II. Respondent testified this automatically put MC at risk for being a high-risk patient in the future and at that point in time he should have referred her to a perinatologist to be monitored. Respondent testified a hemoglobin A-1-c should have been done immediately on his first contact with MC to see what the previous four to eight weeks of blood sugar control had been like. Respondent testified in reviewing the chart he sees immediately that was probably the first priority that should have taken place and organogenesis takes place in the first seven to twelve weeks and that is the most important time to monitor blood sugars. The Board asked how tightly Respondent should have controlled that. Respondent testified people follow the one-hour glucose or the two-hour postprandial or the one-hour postprandial. Respondent testified the one-hour postprandial should be less than 120 and the two-hour should be less than 140 and the fasting blood sugars should all be under 90 or whatever the standard is of the laboratory you are using.

13. The Board asked Respondent if MC was well managed in that sense. Respondent testified in speaking with the primary care physician he understood that MC was well controlled and maintained those parameters and MC was a patient Respondent should be able to follow at least for a while, or if something happened, he could always transfer her to a higher source. The Board asked Respondent if he felt the oral hypoglycemic – Glyburide – was appropriate management and the standard of care for MC. Respondent testified it was in the early stages. The Board asked Respondent what made him consider insulin fairly late in MC's pregnancy.

Respondent testified when he found the two-hour postprandial was in the 280s he thought MC was totally out of control, that the Glyburide had failed, and she needed strong insulin control and probably needed to get to a perinatologist.

14. The Board asked Respondent if, when MC's Accu-Chek was 256 and she was spilling glucose in her urine and her two-hour glucose was 183, he did what he testified was his normal practice of NST or biophysical profiles to look at fetal well-being. Respondent testified the reason it was not done, or one reason it was not done was because when he switched MC to a perinatologist he thought it was something the perinatologist would be doing once they received her and they would take care of her NSTs and her biophysical profiles and monitor her from that point of view as well as monitor her insulin regimen. The Board asked Respondent if he felt by co-managing MC he had control over her management. Respondent testified in the past he has had one or two patients similar to MC and when he transferred them to a perinatologist they managed the patient from there on and he did not realized the ball was dropped in MC's case. The Board noted MC was not a macrosomic patient.

15. The Board asked Respondent if there was any way or mechanism by which he could have helped MC obtain the perinatology consultation and necessary treatment. Respondent testified the first thing he does is tries to get the patient on Arizona Health Care Cost Containment System ("AHCCCS") and he was not aware that she had not achieved the AHCCCS plan until she came back at thirty-three weeks and told him she had not. The Board asked if Respondent or his staff directs and helps patients with AHCCCS coverage. Respondent testified they do. The Board asked Respondent how far along in her pregnancy MC was before he recommended strongly that she obtain a perinatology consultation. Respondent testified MC was at thirty-one weeks.

16. The Board referred Respondent to his earlier testimony that based on the information relayed to him before he even met MC he knew she was a high-risk patient. The

Board asked Respondent why then he accepted MC's care. Respondent testified at the time the referring physician told him MC did not have the proper means to get into a perinatologist, but the package he would give her was one she could afford and that MC was under good diabetic control and her blood pressure was not very elevated and she was on medication and was a nice person who would be easy to maintain and work with. Respondent testified he had second thoughts about it at the time, but the family physician presented it in such a way that he agreed, thinking that if he had to transfer her at a later date, he would. The Board asked why, during the period of time between MC's thirteenth week of pregnancy and her thirty-first week, Respondent, then aware MC was not compliant, did not make a stronger push for a perinatology consultation. Respondent testified MC's very first blood pressure was 130 over 90 and he took her off Captopril and put her on Aldomet and her blood pressure the following visit was 120 over 90. Respondent testified he later took MC off the Aldomet altogether. The Board noted its issue was why Respondent did not make an earlier referral to a perinatologist. Respondent testified he guessed he waited until he thought things had gotten to the point where MC really needed to go, which was at thirty or thirty-one weeks. The Board asked if thirty or thirty-one weeks was the normal time a patient would be referred to a specialist. Respondent testified "the earlier the better" probably would have been better in hindsight and he probably should have referred MC from the very first moment the family physician told him about her.

17. The Board asked whether the standard of care for referral of a patient with hypertension, diabetes, and a previous miscarriage is to refer early or to refer late. Respondent testified it was to refer early. The Board asked if Respondent was familiar with Federal Emergency Services Health Care Coverage (FESHCC), and if he was, to explain it. Respondent testified he was familiar and when he first got involved FESHCC would cover prenatal care for the patient as well as pay for medications and care for the patient locally. Respondent testified after 1996 FESHCC no longer paid for a lot of things such as medications, prenatal care and consults.

Respondent testified it is a hardship for a lot of physicians who deal with emergency AHCCCS patients to get them where they need to be or to get the specialists or subspecialists they need to be taken care of.

18. The Board asked Respondent if the majority of the people covered by FESHCC are foreign nationals in this country without proper documentation and the purpose of the plan is to provide obstetrical care to these patients specifically to avoid the kind of disaster that happened with MC. Respondent testified it seemed to him it was the reverse, that FESHCC only provides for immediate deliveries of patients in the hospital or just the delivery itself – not prenatal care or referrals to other specialists. The Board noted MC was covered by FESHCC when she checked into the hospital and asked Respondent if it was his testimony that she was not covered when she was under his care. Respondent testified MC was probably covered, but they do not cover the prenatal portion of care and, as far as he knew, the patient had to pay out-of-pocket for that. Respondent was asked if he knew any perinatologists in Maricopa County who he could call and tell he has a patient with an impending disaster who has no funds and is living on the streets and ask if the perinatologist would see the patient. Respondent testified he did and he has done it before. The Board asked why Respondent did not do that in this case. Respondent testified MC lived in South Phoenix and the perinatologist he could have contacted was in the far West Valley and he thought he would refer her to a closer location and he had used the closer location in the past without any problem.

19. The Board asked if Respondent's summary of the control of MC's diabetes, looking at his office records about her glycemic control and his response to the Board, would be that she was adequately controlled while she was under his care – whether he met the standard of care. Respondent testified at times MC appeared to be under control and at times she was out of control. Respondent testified when MC was out of control he tried to raise the oral hypoglycemics to a point he thought they might cover those points and when he found he could

no longer cover her, he switched to insulin. Respondent testified he eventually increased her Glyburide to five milligrams three times per day, but that still did not keep MC from having a two-hour blood sugar of 273 and that is when he started her on the insulin and tried to get her to a perinatologist.

20. The Board asked Respondent about fetal monitoring in MC, a high-risk patient, and whether it should have been started prior to thirty-four weeks. Respondent testified MC was supposed to be on home monitoring, but she did not bring her results to him. The Board asked if Respondent himself saw any home monitoring. Respondent testified he did see strips, but not on a consistent basis because MC did not bring them on a consistent basis. The Board asked Respondent where in his notes it was documented that he recommended home monitoring. Respondent testified that was part of his office paper mismanagement and it was not included in his records. Respondent testified he only occasionally said he noticed the monitoring had appeared to be somewhat within normal limits, but he did not actually have the flow sheet available for the numbers that were done. Respondent noted a part of his change in strategy for the future is to have all those things written in the chart.

21. The Board asked Respondent what he would do differently today. Respondent testified he probably would make sure the patient went to a perinatologist immediately and he would not have commenced care. Respondent testified if he were stuck with a patient like MC, and it just happened to land in his hands, he would probably start out by getting a hemoglobin A–1–c on her to see what her previous sugar control had been. Respondent testified the other thing is that MC should have been bringing in her home monitoring on each and every visit with two-hour blood sugars less than forty and with fasting blood sugars of less than ninety to show that she is in control and the medications were sufficiently controlling her. Respondent testified the only thing he had in his chart unfortunately was some random Accu-Cheks, a lot of which were very, very high, and some of them were within normal limits. Respondent testified he guessed

the other thing he would have done was just have her come back weekly throughout the whole process or hospitalize her for a week.

22. The standard of care requires accurate frequent monitoring of blood glucose, strict blood sugar management, frequent fetal monitoring, and timely and appropriate referral of a high-risk obstetric patient.

23. Respondent deviated from the standard of care because he relied on infrequent Accu-Cheks, used oral hypoglycemics until the third trimester, entered a single order for fetal monitoring at thirty-four weeks, but did not actually monitor, and did not timely and appropriately refer a high-risk obstetric patient.

24. A fetal demise resulted from the deviations from the standard of care.

25. There was potential harm in not monitoring the mother and the fetus of an increased risk of preeclampsia, macrosomia, and newborn hypoglycemia.

26. Systems errors at the clinic are a mitigating factor.

27. Respondent's history with the Board, including an Advisory Letter in 1995, a Decree of Censure in 2000 for mismanagement of numerous obstetrical cases, and a Probation in 2001, is an aggravating factor.

CONCLUSIONS OF LAW

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

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes 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 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

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

1. Respondent is issued a Decree of Censure for gross negligence in the management of a known diabetic pregnant patient resulting in fetal demise.

2. Respondent is placed on probation for fifteen years with the following terms and conditions:

a. Respondent's practice is restricted in that he shall not practice obstetrics. The Board may require any combination of Staff approved physical examination, psychiatric and/or psychological evaluations; or successful passage of the Special Purpose Licensing Examination or other competency examination/evaluation or interview it finds necessary to assist it in determining Respondent's ability to safely and competently return to the practice of obstetrics.

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

c. In the event Respondent should leave Arizona to reside or practice 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.

d. Respondent shall obey all federal, state, and local laws and all rules governing the practice of medicine in Arizona.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review 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 or review is required to preserve any rights of appeal to the Superior Court.

DATED this 16th day of October, 2006.

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 17th day of October, 2006 with:

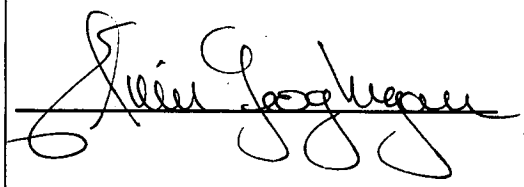
Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 17th day of October, 2006, to:

Kent E. Turley
Turley, Swan & Childers, PC
3101 North Central Avenue – Suite 1300
Phoenix, Arizona 85012-2643

Executed copy of the foregoing
mailed by U.S. Mail this
17th day of October, 2006, to:

Ronald S. Sherer, M.D.
Address of Record



BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **RONALD E. SHERER, M.D.** Holder of License No. **19367** For the Practice of Allopathic Medicine In the State of Arizona.	**Case No. MD-05-0184A** **ORDER DENYING REHEARING OR REVIEW**

At its public meeting on December 7, 2006 the Arizona Medical Board ("Board") considered a Petition for Rehearing or Review filed by Ronald E. Sherer, M.D. ("Respondent"). Respondent requested the Board conduct a rehearing regarding its October 16, 2006 Findings of Fact, Conclusions of Law and Order for a Decree of Censure and Probation. The Board voted to deny the Respondent's Petition for Rehearing or Review upon due consideration of the facts and law applicable to this matter.

ORDER

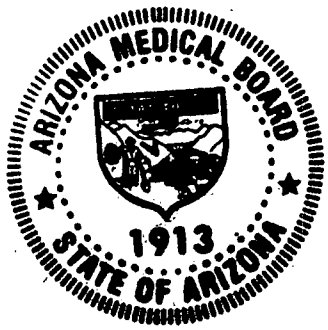
IT IS HEREBY ORDERED that:

Respondent's Petition for Rehearing or Review is denied. The Board's October 16, 2006 Findings of Fact, Conclusions of Law and Order for a Decree of Censure and Probation is effective and constitutes the Board's final administrative order.

RIGHT TO APPEAL TO SUPERIOR COURT

Respondent is hereby notified that he has exhausted his administrative remedies. Respondent is advised that an appeal to Superior Court in Maricopa County may be taken from this decision pursuant to title 12, chapter 7, article 6.

DATED this 12th day of December, 2006.



ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 13th day of December, 2006 with:

The Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 13th day of December, 2006, to:

Kent E. Turley
Turley Swan Childers Righi & Torrens, PC
3101 N. Central Avenue, Suite 1300
Phoenix, Arizona 85012

Ronald E. Sherer, M.D.
Address of Record