BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **SYED TAHIR, M.D.** Holder of License No. **19801** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-06-0959A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on December 14, 2007. Syed Tahir, M.D., ("Respondent") appeared before the Board with legal counsel Steve Yost for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue 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. 19801 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-0959A after being notified of a malpractice settlement involving Respondent's care and treatment of a thirty-nine year-old male patient ("DM") alleging Respondent failed to remove sponges during an open cholecystectomy leading to subsequent infection and surgery to remove the sponges.

4. On September 12, 2005, Respondent performed abdominal surgery on DM. Respondent initiated a laparoscopic cholecystectomy but converted to an open cholecystectomy during which he ultimately removed a stone from the common bile duct and placed a T-tube. Upon completion of the surgery, an x-ray was taken because, according to the radiology report, the needle count was off. Although Respondent acknowledges dropping a needle that was not

found, Respondent's operative report did not document that the needle count was incorrect. Respondent states he saw the needle go down to the floor. Respondent states that it was communicated to him through a nurse or a technician that the radiology report did not reflect a retained needle. Unbeknownst to Respondent, the radiology report did reflect that there were "probably some sponges" present. Respondent did not personally review the x-ray or the radiology report. Respondent relied on the nurse who told him that the sponge count was correct when, in fact, two sponges remained in the abdomen of DM. In fact, the x-ray report itself was inadequate to determine the location of a missing needle, if any, because it did not adequately show the left side of the abdomen.

5. During DM's hospitalization, on September 15, 2005, a T-tube cholangiogram was performed which reflected an opaque tape of unknown etiology overlying the right abdomen. DM was discharged on September 16, 2005, and no mention was made in the discharge summary of the opaque tape described in the report of the cholangiogram. Respondent described the cholangiogram as "fairly normal".

6. DM was seen by Respondent on September 27, 2005, complaining of weakness, nausea and upper abdominal pain. At that visit, Respondent reviewed all of the records from the surgery and, for the first time, discovered that the cholangiogram report reflected opaque tape of unknown etiology. At that point, Respondent immediately sent DM to the hospital and ordered an abdominal CT scan which reflected the sponges. Respondent performed a second surgery on DM to remove the sponges.

7. The standard of care requires the physician to review an x-ray that he orders and, if he can not review it, to have an immediate report to him. If the x-ray is inadequate, then it should be repeated and adequate KUB obtained.

8. Respondent deviated from the standard of care by failing to know the results of an x-ray that he ordered before he left the attendance of the patient. He further deviated from the

standard of care by failing to make himself aware of the findings of the intraoperative x-ray and the subsequent T-tube cholangiogram prior to discharging the patient from the hospital.

9. The patient was harmed by the failure to discover the loss of a chance for discovery of the retained sponges at a critical time when they could have been removed and avoided the subsequent complications.

10. Respondent's failure to make himself aware of the findings of the x-ray report and the cholangiogram could have resulted in further harm to the patient from the retained sponges including abscess formation, fistula, sepsis and death.

11. It was mitigating that Respondent relied upon the operating personnel who told him that the sponge count was correct.

12. At the time of DM's surgery, it was not Respondent's practice to personally review the x-ray with an incorrect sponge or needle count, although Respondent states that he has since changed his practice.

13. A physician is required to maintain adequate medical records. An adequate medical record means a legible record 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 he failed to document in the operative report an abnormal needle count and how this issue was resolved.

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)(e) ("[f]ailing or refusing to maintain adequate records on a patient;") 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 of the public;") and A.R.S. § 32-1401(27)(ll) ("[c]onduct that the board determines is gross 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:

Respondent is issued a Letter of Reprimand for failing to know the results of an intraoperative x-ray taken due to an abnormal needle count prior to leaving that attendance of the patient; for failing to make himself aware of the findings of the intraoperative x-ray and subsequent T-tube cholangiogram reflecting sponges retained in the abdomen prior to discharging the patient, resulting in the patient becoming ill and requiring a second surgery; and for failure to document the abnormal needle count and its resolution.

RIGHT TO APPEAL TO SUPERIOR COURT

Respondent is hereby notified that this Order is the final administrative decision of the Board and that Respondent has exhausted her 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 7TH day of February, 2008.

THE ARIZONA MEDICAL BOARD

By_____
LISA WYNN
Executive Director

ORIGINAL of the foregoing filed this
7th day of February, 2008 with:

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

Executed copy of the foregoing
mailed by U.S. Mail this
7th day of February, 2008, to:

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Syed Tahir, M.D.
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