BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **PAUL SAIZ, M.D.** Holder of License No **25767** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-05-0514A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 7, 2006. Paul Saiz, M.D., ("Respondent") appeared before the Board with legal counsel Stephen Myers, 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. 25767 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0514A after being notified of a medical malpractice settlement involving Respondent's care and treatment of a fifty-three year-old female patient ("LY"). LY had persistent back pain and a history of anterior spine fusions in 1997. She presented to a physician on September 4, 2001 and, after reviewing LY's symptoms, performing a physical examination and an MRI, this physician recommended a decompression of L3-L4 and posterolateral fusions of L3-L4, L4-L5, and L5-S1. A lumbar spine X-ray performed this same day was reported by another physician as demonstrating anterior interbody fusions at L4-L5 and L5-S1 with degenerative changes at L3-L4. On October 15, 2002 this same physician reported an

MRI as demonstrating interbody fusions of L4-L5 & L5-S1 with a distal disc presumably S1-S2. He also noted a disc herniation at L3-L4 with a bony bar formation at L3-L4 and L2-L3 on the left.

4. Respondent initially evaluated LY on October 21, 2002. LY was five feet five inches tall and weighed 210 pounds. LY complained of persistent back pain and some leg pain. LY gave a history of having a prior anterior spinal fusion in 1997 at L4-L5 and L5-S1 with persistent symptoms. Respondent's consultation notes indicate review of the MRI and comments on LY's stenosis and retrolisthesis of L3-L4. Respondent obtained X-rays that day and on review noted LY's degenerative scoliosis at L3-L4 with eccentric disc wear and no obvious instability of cages at L4-L5 and L5-S1. Respondent recommended a decompression of L3-L4 with fusion L3-S1 posterolaterally with pedicle screw fixation to augment the anterior fusions.

5. LY next saw Respondent on November 19, 2002. Respondent reviewed his surgical plan and the risks and complications of surgery with LY and noted he reviewed LY's X-rays and MRI scan with her and her husband. Respondent performed the surgery on November 21, 2002. The dictated operative report documents a laminotomy and foraminotomy of L3-L4 with fusions of L3-L4, L4-L5 and L5-S1 with pedicle screw instrumentation and bone graft. Respondent noted he confirmed his level at L4 with intraoperative radiograph and used the C-arm fluoroscopy on multiple occasions to confirm the position of the pedicle screws. Respondent's handwritten postoperative note at 14:15 on November 21 documents his surgical procedure of a laminotomy and foraminotomy of L3-L4 and fusion from L3-S1.

6. In a second postoperative note on November 21, 2002 at 20:00 Respondent noted he reviewed the post-surgery X-ray and that the previously numbered L3-L4 retrolistesis was not instrumented or fused and the anterior cages were at L3-L4 and L4-L5. Respondent also noted on review of the MRI and X-rays he noticed a numbering error of the vertebra on the MRI scan. Respondent discussed this with LY and her family and recommended a second surgery in a few days to fuse L2-L3. LY's postoperative course in the hospital was troubled by nausea and she

elected to delay her surgery. Respondent continued to monitor LY in his office post-surgery and on November 29, 2002 the incision was doing well and he advised LY and her husband the surgery was eighty percent complete. Respondent cautioned LY the fusion below the L2-L3 level could be a stress riser and increase symptoms of her degenerative disc and retrolisthesis. Respondent continued to monitor LY and, because of increasing back and leg symptoms, LY was returned to surgery on January 15, 2003 for a laminotomy and foraminotomy of L2-L3 and fusion with re-instrumentation from L2-S1. LY's wounds healed and her fusion progressed and she was walking three miles per day as of June 15, 2003, but remained symptomatic with back pain requiring Oxy-Contin.

7. In his written response to the Board Respondent notes he obtained X-rays on initial consultation and quotes his initial consultation finding of "no instability from her cages at L4-L5 and L5-S1." Respondent also noted he used the C-arm intraoperatively and noted the previous numbering system was in error and decided to continue with the surgery as described in the consent. Respondent asked that the complaint be dismissed because he discovered a numbering system error intraoperatively and only fused the levels for which he had a signed consent.

8. Respondent testified when he first saw LY her main complaint was lumbosacral pain and posterior hamstring discomfort. Respondent noted he obtained X-rays that confirmed L4-5, L5-S1 prior anterior cages and he reviewed the MRI. Respondent identified two main pain generators – the prior fusion at L4-5, L5-S1 that never improved after surgery, and a degenerative change at the level above the fusion at L3-4 with a retrolisthesis and lateral recess stenosis. Based on these two pain generators Respondent decided to do posterior spinal fusion from L3 to S1. Respondent noted intraoperatively where there should have been a sacralia, or where the transverse processes came together, he noticed the transverse process at S1. Respondent manipulated what he thought to be S1-S2 and there was motion so he went ahead

and played with the C-arm and made it parallel to the end plate and the disc, which appeared to be a fairly small disc on MRI, but still bigger than normal, more lumbarized. Because he could elicit motion in that area Respondent diagnosed a transitional segment and then had three pain generators. Respondent noted because of the signed consent, and the fact that LY never got better, the transitional segment, or new pain generator, made more sense to be the source of her discomfort. Respondent acted within the confines of the consent and the new information and stuck with L3 through S1 posterior spinal fusion and made a small laminotomy at L3-4 to see if he could put his probe up into L2-3, the level above, to see if there was any stenosis. Respondent testified that after doing this, LY's pain got better and, although he initially thought about going back in to adjust the fusion to L2-3, her pain got better and she was discharged.

9. Respondent testified his operative report was dictated on the new numbering system. Respondent noted at the time he was dictating he had a big case – a three level neck – that he was in a rush for so he dictated without opinion and his plan was to go ahead and review everything afterward and make sure the numbering system he said was correct and then discuss it with LY's family and document everything. Respondent noted he handwrites his operative reports ahead of time and leaves the EBL, fluids and procedure open so he can come back and quickly fill them in. Respondent testified his pre-op and post-op diagnosis on his handwritten note was written preoperatively and he did not change his post-op diagnosis and this was the one error on this note. Respondent testified his second error is that on his dictated note he did not change the postoperative diagnosis because his post-op template is the same.

10. Respondent addressed the allegation that he did not address the level that had been talked about as being symptomatic, namely the L2-3 on the new numbering system – a retrolisthesis. Respondent testified intraoperatively he identified three pain generators and on a neurosurgeon report it looks to be more L4 nerve root. Respondent noted L2-3 at best would involve L3, potentially L2, nerve root. Respondent testified it just did not make sense, so he

decided to address the most common pain generators within the confines of the consent and not do L2-3. Respondent addressed the second allegation of LY needing a second surgery. Respondent testified if he had performed the surgery as he had planned preoperatively he would have performed an L2 to L5 posterior spinal fusion and not addressed the transitional segment, which in his mind made more sense. Respondent testified regarding the allegation of a wrong site surgery and noted he believed he identified three pain generators and operated on two of the three and there was no erroneous anatomy disturbed.

11. The Board asked Respondent to describe his training. Respondent testified he did a residency in orthopedics and had minimal exposure to spine surgeries during the residency. Respondent then did a fellowship in spine surgery for one year involving pure spine-related training, deformity based such as scoliosis, adult scoliosis, etc., and it was one year of nothing but surgery. Respondent testified his practice since 2004 involves only the spine and musculoskeletal oncology of the spine. The Board noted at the time of LY's surgery Respondent also did general orthopedics. The Board asked what previous records for LY Respondent had when he evaluated her. Respondent testified he had the previous evaluation by the referring neurosurgeon, her prior MRIs dating back as far as 2001, but he did not have the prior operative report. The Board asked if it would have been prudent for Respondent to get LY's previous operative notes to see what was really done on her before he tried to re-do or re-correct what was done. Respondent testified it was necessary in cases of hardware removal and in LY's case she previously had an anterior procedure with subsequent complications of an ileus and in looking at her pathology on initial evaluation it was continued back pain after prior anterior stand-alone cages at L4-5, L5-S1 (the old numbering system) and retrolisthesis at L3-4 all of which could be addressed from the back. Respondent noted the previous operative report as far as what type of instrumentation was used did not seem important to him.

12. The Board noted it was not just concerned about instrumentation, but the indications for the earlier surgery from the other physician. Respondent testified LY had multiple surgeries including multi-level cervical fusions and low back that she attributed to an earthquake in the mid 1980s. Respondent testified he did not think at that time there was valid pathology noted on his evaluation that the surgeon's summary from 1997 would change his decision making in any way. The Board asked Respondent his clinical finding that made him plan on the posterior lateral fusion. Respondent testified anytime there has been a prior fusion and the patient states the symptoms are the same you are always worried the correct pain generator was not addressed or the patient did not fuse. Respondent testified there was no sentinel sign on the X-rays indicating bone healing within the discs at L4-5 and L5-S1 so he did not see any definitive evidence LY had fused. Respondent noted his question at the time was whether LY had a stable non-union, adjacent segment disease at old numbering system L3-4 with a retrolisthesis that was stable in flexion-extension films.

13. The Board asked if the retrolisthesis was present prior to LY's previous surgery. Respondent testified he did not know if it was present ahead of time, but he had to assume, since it was not addressed anteriorly, that it was not present. Respondent also noted if it was there, it was stable, and was a potential pain generator when he initially saw LY. The Board asked if Respondent thought it was a potential pain generator the previous surgeon would have gone to one level higher. Respondent testified he would have imagined so. The Board asked then if it was necessary to get the records to find out if it was there, retrolisthesis. Respondent testified he did not think whether it was there then or now it would have changed his operative plan because LY was still continuing to have symptoms after the surgery and it was still a potential pain source. The Board noted if retrolisthesis was present LY probably would not have gotten better with the anterior cage fusion at that level. Respondent testified that was true if all the pain was coming from that pain generator, but he has a hard time believing that.

14. Respondent testified it was not uncommon after a stand-alone fusion at two levels to see degenerative changes and as far as his decision making, he was going to make his decision based on LY's complaints. Respondent noted the MRI and other investigations he did also showed there was lateral recess stenosis at the area with stable listhesis and his plan was to try to fuse the level of all the previous caged fusions. The Board confirmed what the operating room permit said; the planned procedure plus any other needed procedures. The Board noted Respondent mentioned in his opening remarks that when he went in he took some X-rays and tried to position the C-arm properly and was able to easily recognize the level of the instrumentation anteriorly. The Board asked when Respondent recognized it was from L3-4, L4-5, or L3-L4-S1 what did he think it was. Respondent testified when he identified the transitional segment he immediately thought to himself "is this a transitional S1-2 or is this an L5-S1" and then he repositioned the C-arm. Respondent noted first there was a bigger disc then he anticipated, which on stand-up films may not be directed parallel to the end plates, and second, when he swung around to an AP and counted from the last rib and the L5-S1 numbering for the transitional segment fit better than an S1-2.

15. The Board asked if Respondent's plan was to fuse LY's disc above the previous fusion. Respondent testified it was one of the previous two generators he was going to address. The Board corrected Respondent and noted his plan was to fuse the level above. Respondent noted this was one level. The Board confirmed Respondent's plan was to fuse one level above the previous fusion. The Board then asked why, when he saw in the C-arm that the level was L3, or whatever Respondent thought it was, did he go proximal to the level he had planned on for fusion, posterolaterally. Respondent testified his thinking at the time was he had three potential pain generators and the two that made the most sense within the confines of the consent was that of the prior BAK cage levels, the new system, 3-4, 4-5 as well as the transitional segment at L5-1, the location LY pointed to as painful. Respondent testified his thinking at the time was that

he could not address all three pain generators, but he could address the two most likely and he thought he could get away with doing less surgery rather than more surgery by addressing the L2-3 level, which was not consented.

16. The Board noted LY had consented for the level above the one that had retrolisthesis, for a laminotomy and fusion of that level. Respondent testified this was correct in the purest sense, LY had consented for the level above. The Board noted this was exactly correct and asked why then did Respondent think he did not have consent for that level, particularly since he thought the symptoms were coming from the level above fusion where she had retrolisthesis and he had discussed with her and her husband that he was going to fuse the level above the previous fusion and why he did not do the procedure as he planned. Respondent testified he did not attribute all LY's symptoms to the L3-4 level, the level above her fusion cages. The Board noted maybe Respondent did not believe all of LY's symptoms were coming from that level, but some symptoms were there and he had planned to fuse those levels. Respondent testified he had potentially planned to do that, but with the new findings intraoperatively, the transitional segment made much more sense as being a pain generator than the new system L2-level. The Board confirmed with Respondent the MRI and the scan documented there was prosthesis proximate to the previous fusion. Respondent testified retrolisthesis can be a stable finding. Respondent noted LY had some L4 symptoms when she was visited by the neurosurgeon because she had posterior hamstring pain, the L2-3 level above her prior fusion did not fit. Accordingly, rather than going outside of and above his consent Respondent felt more comfortable just addressing the prior fused level and transitional segment.

17. The Board asked if Respondent was worried about recessed laterally evolving fusion with spinal stenosis. Respondent testified he was, but intraoperatively he made laminotomy to L3-4 and stuck a probe up into L2-3 and he did not feel any significant stenosis. The Board asked if it was the right procedure to do, just to explore, or did he have to see better.

Respondent testified based on his new intraoperative finding and the consent he felt comfortable with sticking a pedicle probe up there and making sure there was no stenosis and thinking he could perform a smaller procedure versus a larger procedure. The Board asked if after Respondent finished the surgery he documented he fused the level above. Respondent testified he did not and said he fused from L3 to S1. The Board asked if Respondent was suspecting a L3-L4 fusion. Respondent testified he maybe changed the numbering system intraoperatively so the dictation is what he performed – an L3 through S1 posterior spinal fusion, new numbering system.

18. The Board noted Respondent made notation prior to the surgery in his postoperative note as to the level he was going to fuse. Respondent disagreed and noted his earlier testimony that he wrote his preoperative diagnosis and his postoperative diagnosis, surgeon's name, and planned disposition after surgery ahead of time and he filled everything in after surgery and it is timed 2:15, therefore the procedure documented in his handwritten note is exactly what he did – an L3 to S1 posterior spinal fusion. Respondent testified he did not write he did foraminotomies and the preoperative plan was to do laminectomies at L3-4 and he did a smaller procedure to check up into the retrolisthesed segment. The Board asked if the immediate postoperative note and the operative note are different. Respondent testified they were not. The Board noted the one written six hours later was different because Respondent had recognized he had not fused the right level. Respondent testified when he spoke with LY's family he had another case to follow and when he finished that case he obtained a postoperative film because he did not save anything intraoperatively and he went and looked at all of his records, felt comfortable with the numbering system, and then went to talk to the family and documented the findings at that time. The Board asked then if Respondent recognized with the X-ray that he had not fused the level above. Respondent disagreed and testified he recognized intraoperatively he did not address all of the potential pain generators and had not addressed the level originally planned,

but it was not until after his second case that he had time to talk to the family and, before he talked to them, he made sure he did not give them erroneous information by going back and looking at all the MRIs in his office and the postoperative film.

19. The Board asked Respondent his protocols – when does he look at the MRIs, the night before the procedure or just before the procedure. Respondent testified he looks at the MRIs on initial evaluation if the patient brings them, he looks at them at the preoperative visit and hand carries all his films to the operating room and puts everything up. Respondent noted he typically brings the most recent films and most recent MRI. The Board noted it still did not understand why Respondent did not fuse the level above when he planned to fuse the level above. The Board asked Respondent for help in understanding his thought process to not fuse the level above and noted it did not believe inserting a probe into the level above was enough to say there is no stenosis. Respondent testified he was not denying there was stenosis or retrolisthesis at that area, but in light of the new operative information, the transitional segment made much more sense with LY's history and he thought he could do a smaller procedure. Respondent noted at the same time, he had consent for an L3 to S1 posterior spinal fusion and if he involved at the other level he would have fused L2 to S1 and he felt it was conservative not to do the extra level. The Board asked what Respondent thought went wrong with LY's case. Respondent testified looking back he can say he did not foresee having a transitional segment and being a little more medically savvy he realizes he could have addressed L2 to S1, but he thought he was being conservative by doing what made the most sense and doing less. Respondent testified he thought he addressed the most logical pain generators and, in retrospect, does not necessarily think he would change what he did, other than perhaps doing a better job in medical record keeping and check what his postoperative diagnosis is. Respondent testified he thinks he went about in a logical fashion and made an intraoperative decision to address where the pain appeared to be coming from and it turned out LY's pain initially got better, but she hurt

herself six weeks later and he ended up addressing the L2-3 area. Respondent noted he did not think he could have done everything in one surgery and gone outside the consent.

20. The Board noted it was not convinced from the radiographs there was a transitional vertebrae. The Board confirmed Respondent felt LY's symptoms above the level of fusion were not causing her major problem (for the sake of discussion the Board called that level L2-3) and that Respondent felt he could not, with the consent he had, do that level. Respondent testified that at LY's preoperative presentation she had lumbosacral pain over her prior fused levels and over the transitional segment and posterior hamstring pain. Respondent noted one of the neurosurgery notes had a decreased patellar reflex, that he did not elicit, and a weakness of dorsiflexion that corresponded to the L4 nerve root. Respondent noted when you readjust the numbering system, L2-3 is not involved in the L4 nerve root. The Board noted the main contention is why Respondent did not do the level above the fusion. The Board confirmed Respondent did not because his opinion at the time was that it was not the main cause of LY's symptoms because her nerve levels were lower than where he thought that was and he found a transition vertebrae at surgery he felt could be the source of pain because her pain seemed to be at that level.

21. The Board noted LY required a subsequent surgery and asked what Respondent found in that second surgery, if the nerve was really compressed. Respondent testified the amount of stenosis was minimal. The Board asked if Respondent knew what happened to LY subsequently. Respondent testified he had some problems with LY's compliance with physical therapy, but the last physical therapy note had LY walking two miles a day and still requiring some narcotics.

22. The Board asked Respondent to state simply his indications for surgery, what was wrong with LY and what he was going to do for her. Respondent testified LY had low back pain associated with activity and posterior hamstring discomfort. Respondent noted this was not

uncommon in persons who have had prior surgery. Respondent testified the immediate thing that went through his mind was the 1997 surgery did not accomplish its goal – there was potential non-union at the cage level 4-5, S-1, which is not uncommon with stand-alone BAKS and the degenerated segment above that at what he thought was L3-4. The Board confirmed with Respondent that LY never got better after the 1997 surgery and asked if it occurred to him that maybe she did not need the 1997 surgery and that was why she did not get better. Respondent agreed this was possible. The Board noted Respondent's diagnosis was stenosis, bilateral foraminal and central at L3-4, foraminal stenosis at L2-3, and congenitally short pedicles that he was going to make better by surgery even though it was not better after the 1997 surgery. The Board asked how Respondent was going to make LY better on the basis of his diagnosis. Respondent testified the chances of a patient getting better after a previous back surgery go down significantly and his goal was to stabilize LY's prior fused area and address the adjacent segment above that. Respondent testified he was hoping to get at least a fifty percent pain decrease and he typically hopes for increased functionality.

23. Respondent agreed that surgeons may never know if they can make a patient better, but there has to be really good findings before surgery is offered because without good findings that do not correlate surgery can be awful. The Board directed Respondent to his notes under "Imaging Studies," specifically, "the MRI scan shows evidence of degenerative disc disease above her prior fusion along with retrolisthesis. The axial T2 cut does show evidence of some stenosis occurring in L3-4 on the left great than right" and noted that was not a very exciting finding. Respondent agreed. The Board then directed Respondent to his "Assessment and Plan" where he said "we had a long discussion today, over an hour, concerning options. She would like something done sooner rather than later, specifically for her back pain. Unfortunately, after MRIs I have not seen a significant amount of stenosis that could cause this. However decompression is definitely one of her priorities. To that end, the plan of surgery will be a posterolateral fusion at

L3-4 along with a laminectomy and bilateral foraminotomies at L3-4 and possibly L2-3." The Board asked if Respondent was fixated, no matter what the levels are with the upper lumbar spine rather than the lower lumbar spine. Respondent agreed.

24. The Board confirmed another neurosurgeon was concerned about L4 and Respondent had these notes, but was more concerned about what was happening above the juxtaposition level where there is a listhesis above the fusion. The Board also confirmed that the numbering system Respondent was looking at before surgery had the cages at L4-5 and L5-S1, and if it was at L4-5 and L5-1 it was above the junctional area where there was the subluxation and 3 was moved forward on 4 posteriorly. The Board confirmed Respondent was interested in L3-4. The Board noted the X-rays reflect the metal devices were at L4-5 and L5-S1 and, therefore, the level where there is listhesis is the level above. The Board confirmed that, no matter what the numbering system, the level of the implants gives direction in the operating room. Respondent noted after being in the operating room he chose to number the levels differently. The Board noted Respondent had the advantage of having a metallic implant in the interspace at two levels and he knew he was concerned about the upper lumbar disc, therefore, all he had to do was go to the level above the metal cage for at least one of the pain generators, which is what Respondent discussed with the family and what his history and physical revealed. The Board noted it appeared Respondent got lost regarding the levels while in the operating room and before he went to surgery he intended to fix the level just above the cages and fuse it. Respondent testified this was one of the portions of the procedure. The Board noted Respondent did not complete that portion. Respondent testified he chose intraoperatively based on intraoperative information that he did not think that location, that potential pain generator, was the source of LY's discomfort and that was his choice. Respondent testified he did not get lost and had the cages to show him exactly where he was.

25. Respondent testified if he had this case again today he would not do anything differently and any time he evaluates spine patients there are multiple potential pain generators and his job is to identify the ones that are most symptomatic. Respondent noted in LY's case, in light of the intraoperative information he made a choice about what he thought was most symptomatic and did not address the other level. Respondent noted there were three potential pain generators and he addressed two. Respondent testified he made the choice to stay within the confines of the consent and get into less trouble than if he had fused a level not consented to. Respondent noted experts he retained to review the records opined he fused L3 to S1 and these were the levels consented to. The Board asked if Respondent had a consent to operate on a herniated disc, but when he conducted the surgery he discovered the disc was not herniated, would he just stick with the consent and remove the disc. Respondent testified he would not.

26. The Board's Medical Consultant noted the surgery was not addressed at the level consented for and LY had to have a second surgery. The Board noted that, irrespective of the numbering systems, the consent was to fuse the space above the previous anterior fusion and Respondent did not fuse this space.

27. The standard of care required Respondent to proceed with the discussed and consented procedure to address LY's problem.

28. Respondent deviated from the standard of care because he did not proceed with the discussed and consented procedure and did not address LY's problem.

29. LY required a second surgery to decompress and fuse the level planned, but not accomplished, and underwent further risks and complications of a second surgical procedure.

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").

ORDER

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

IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for performing a surgery at a site not originally planned and that did not address the patient's problem requiring a second surgery.

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 11th day of August, 2006.

THE ARIZONA MEDICAL BOARD

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

ORIGINAL of the foregoing filed this 11th day of August, 2006 with:

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

Executed copy of the foregoing mailed by U.S. Mail this 11th day of August, 2006, to:

Stephen Myers
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3003 North Central Avenue – Suite 1900
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Paul Saiz, M.D.
Address of Record

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