BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **Stephen Flynn, M.D.** Holder of License No. **3351** For the Practice of Medicine In the State of Arizona.	Case No. MD-05-0653A **CONSENT AGREEMENT FOR SURRENDER OF ACTIVE LICENSE**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Stephen Flynn, 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 he 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.

Stephen Flynn MD Dated: 3-10 08

Stephen Flynn, M.D.

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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 3351 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0653A after receiving a complaint from a patient (MH) regarding Respondent's care and treatment of patients. MH stated that Respondent's office was unclean and unsanitary; he did not wear gloves when taking blood samples; he did not use an alcohol swab to disinfect the skin before giving injections; and he administers injections to patients in the waiting room.

4. On January 26, 2006, Board staff conducted a site visit at Respondent's office. The site visit revealed MH had accurately described the conditions in Respondent's office. Respondent's office is located in a converted home and has two examination rooms, Respondent's office, two restrooms, a kitchen and an area for a receptionist. While waiting to be introduced to Respondent, Board Staff observed two men (one elderly, one young) approach the reception desk. The elderly man was later identified as SP. After some conversation between the receptionist and SP, the receptionist called out that "he needs a tetanus and MMR." Respondent came from the back, leaned over the reception counter and administered the immunization directly into SP's upper arm without prepping the injection site with alcohol or by any other method. Board Staff did not observe Respondent conduct any examination of SP. The younger man paid cash for SP's injection and asked for a receipt. The receptionist told him a receipt was not necessary. The receptionist also told them to return in two weeks, or earlier, if the site where Respondent administered SB's TB test became bigger than a quarter.

5. Immediately after injecting SP, Respondent met another man in the examination room located just off the reception area. The man sat in a chair and Respondent sat next to him. Board Staff was able to observe the man's body and Respondent's arms. Respondent applied a tourniquet to the man's right arm and proceeded to draw blood from the arm. Respondent used a vacutainer with what appeared to be a new needle. Respondent did use a pre-packaged alcohol pad to prep the area. Board Staff introduced themselves to Respondent after this blood draw and presented him with a notice of inspection. Respondent took Board Staff on a tour of his office.

6. During the tour, Board Staff observed the following:

a. the examination table in the room used for blood draws was covered with paper and scrub towels;

b. there were a few boxes of sterile syringes in the room and one sharps container on the sink;

c. the sink counter was covered with papers, containers and a cold sterile tray;

d. although Respondent reported he uses Cidex (a clear, pale pink liquid) as a cold sterile solution and changes it approximately every three months, the solution in the cold sterile tray was a slightly viscous, dark orange liquid;

e. the restrooms were generally clean, but had trash overflowing from the waste baskets (the public restroom had a re-purposed dish soap bottle labeled for hand washing and was nearly empty):

f. the kitchen area was used for food preparation and pharmacy;

g. the dining area of the kitchen was cluttered with boxes, papers and old office equipment;

h. bottles of Amoxicillin, Metronidazole, Zinc, and silver nitrate sticks were observed on the shelves, the medications were not expired, but the silver nitrate sticks appeared to be decades old;

i. one side of the sink counter held dishes that appeared set out to dry and the other side held a centrifuge and a haphazard stack of laboratory requisition form copies;

j. patient files, a fax machine, and the financial transaction area were located in the receptionist's area behind the front counter;

k. there was no appointment book or log and Respondent reported they were not necessary because he always remembered when his patients were coming in; and

l. there was no obvious financial tracking system and the patients were not given receipts. During the tour Respondent reported to Board Staff he did not keep any records on the patient he immunized, he just remembered what they needed.

7. The patients observed by Board Staff were immigrants obtaining the necessary medical documentation for residency requirements. Board Staff asked for the medical records of SP and pulled five other charts at random. The medical record for SP consisted of two pages stapled together. The first page was the United States Department of Justice Form I-693 titled "Medical Examination of Aliens Seeking Adjustment of Status." The second page was a supplemental for to the I-693 – the immunization record. A manila folder labeled "RA and TF" contained medical records for RA, and FA and a JTA and an operative report for a CMA dated October 23, 1986. The surname of CMA is not the same as that for RA, FA, and JTA. A manila folder labeled "MM" contained one radiology report for MM and a photocopy of an insurance card for a DM. A manila folder labeled "T, M-S" contained chemistry results for MT dated September 28, 1998 and

January 12, 2002 and an x-ray requisition form for ST dated September 23, 1998. A manila folder labeled "WP" contained a laboratory report dated December 18, 2004. A manila folder labeled "W, M/T" contained insurance forms and mammogram reports for TW and TLS (presumably the same patient). The most recent documentation was dated March 28, 1999.

8. Respondent is required to maintain adequate medical records. Specifically, he must maintain 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).

9. The standard of care requires Respondent to maintain sanitary condition and comply with hygienic procedures and standards in his treatment of patients, including prepping the patient's skin with an alcohol wipe prior to administering immunizations or conducting TB tests.

10. Respondent failed to maintain sanitary conditions and comply with hygienic procedures and standards in his treatment of patients.

11. Respondent's failure to meet the standard of care subjected the patients to potential harm including increased injection site reactions or skin infections.

12. Respondent agreed to attend an evaluation at the University of California, San Diego Medical Center to assess his medical competency. The Physician Assessment and Clinical Education (PACE) program is a two-day evaluation of a physician's abilities through various testing techniques. Results from the PACE program lead to a conclusion of grave concerns over Respondent's ability to safely practice medicine.

13. Respondent admits to the acts described above and that they constitute 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 or the public.

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).

3. 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).

ORDER

IT IS HEREBY ORDERED THAT License Number 3351, issued to Stephen Flynn, M.D. for the practice of allopathic medicine in the State of Arizona, is surrendered and that Stephen Flynn, M.D. immediately return his wallet card and certificate of licensure to the Board.

DATED and effective this 3rd day of Apr. 1, 2008.

ARIZONA MEDICAL BOARD

(SEAL) ARIZONA MEDICAL BOARD 1913 STATE OF ARIZONA

By: _____
LISA WYNN
Executive Director

ORIGINAL of the foregoing filed this 3RD day of April, 2008 with:

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

EXECUTED COPY of the foregoing mailed this 3RD day of April, 2008 to:

Stephen Flynn, M.D.
Address of Record

Chris Bamp
Investigational Review
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