Arizona Medical Board

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FINAL MINUTES FOR REGULAR SESSION MEETING
Held at 9:30 a.m. on October 11, 2006 and 8:00 a.m. on October 12, 2006, 9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members
Robert P. Goldfarb, M.D., F.A.C.S., Chair
William R. Martin III, M.D., Vice Chair
Douglas D. Lee, M.D., Secretary
Patrick N. Connell, M.D.
Patricia Griffen
Tim. B. Hunter, M.D.
Becky Jordan
Ram R. Krishna, M.D.
Lorraine L. Mackstaller, M.D.
Sharon B. Megdal, Ph.D.
Dona Pardo, Ph.D., R.N.
Paul M. Petelin Sr., M.D.

Executive Director's Report

Timothy C. Miller, J.D., Executive Director delivered his report.

Monitoring Office Report
There are currently 104 physicians enrolled in the Monitored Aftercare Program (MAP) and 25 physicians enrolled in the Physician Health Program (PHP). Most of the physicians in PHP have psychological issues. Board Staff is currently looking into interviewing a part-time medical consultant who is a psychiatrist to help with cases involving physicians with psychiatric impairment.

Patrick N. Connell, M.D. asked about the MAP Request for Proposal (RFP) approved in June of 2006. Mr. Miller stated the RFP has been put out for bid and the vendors are currently in the process of bidding.

Investigations Office Report
The Investigative staff is continuing to meet the goal set by the Auditor General's Office to complete investigations within 180 days. The case load has reduced and most of the remaining 2005 cases were in their final stage of investigation.

Licensing Office Report
Staff has improved the timeframes for licensing an applicant. Routine applications with deficiencies are approved in 30 days, not including the time it takes the physician to correct a deficiency in the application. License application cases that require investigation are completed within 60 days.

Legal Advisor Report
Former Board Members Serving as Medical Consultants
Christine Cassetta, Board Legal Counsel said counsel on behalf of a physician on this meeting's agenda objected to Internal Medical Consultant (IMC) Ingrid Haas, M.D. reviewing and presenting the case because she is a former Board Member. Ms. Cassetta noted there was no legal prohibition against Dr. Haas serving as the Board's consultant as long as the Board stated on the record that her prior service on the Board did not bias them in any way. Ms. Cassetta noted an objection had also been raised on whether Dr. Haas was qualified to opine for obstetrical cases since she was not currently practicing obstetrics and deferred to Assistant Attorney General Dean Brekke on this issue.

Mr. Brekke noted the Board's job was to determine if the Medical Consultants had adequately captured the standard of care in each case and the Board should determine individually if a practitioner had been out of practice too long based on the consultant's determination of the standard of care. Mr. Brekke noted Dr. Haas quotes the current American College of Obstetricians and Gynecologists (ACOG) Guidelines and supplies written materials to support the standard of care in the cases she reviews.

William R. Martin, III, M.D. asked each Board Member individually if they felt their opinions in cases presented by Ingrid Haas, M.D., Medical Consultant were influenced by her having served on the Board.

The following Board members said they had either served with Dr. Haas on the Board in the past or they knew she served on the Board and their association/knowledge of her would not impact either affirmatively or negatively their decision of cases: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Paul M. Petelin, Sr., M.D. and Dona Pardo, Ph.D., R.N.

Tim B. Hunter, M.D. stated the Board will decide per case if the Medical Consultants have adequately reflected the standard of care. Ram R. Krishna, M.D. noted he had confidence in the Board's Staff to determine the competency of the medical consultants retained to review cases.

Motion to Reconsider Board Recommendations for PA Supervision

Kari Shmul, P.A.-C, President Elect of the Arizona State Association of Physician Assistants (ASAPA) spoke during the call to the public. Ms. Shmul said the handful of Physician Assistants (PAs) who do not follow the law do not represent all PAs' in practice. Ms. Shmul said that the Board's recommendation that PAs can see only the patients of their supervising physician makes PA practice complicated. PA's function most effectively when the PA can see patients of physicians and agents as well. Ms. Shmul said emergency rooms and urgent care centers would suffer most under the Board's recommendations as they are overcrowded and have long depended on PAs to address the overcrowding.

Richard Bitner, Legislative Counsel for the Arizona State Association of Physician Assistants (ASAPA) and the American College of Emergency Room physicians said he also had concerns regarding the Board's recommendations and asked them to reconsider the statement they issued regarding PA supervision.

Jason Bezozo, Arizona Hospital and Healthcare Association spoke during the call to the public on behalf of hospitals in Arizona represented by the Association and voiced concern regarding the Board's recent press release regarding Physician Assistants. Mr. Bezozo said emergency rooms rely heavily on PA's because of the increased population and critical shortage of nurses and physicians. Mr. Bezozo said under the Board's policy it will take more time to move patients through emergency departments and emergency rooms would be severely handicapped if PA's could not deliver care in such a setting. Mr. Bezozo suggested a group of stakeholders be pulled together to address the Board's concerns with the practice of physician assistants.

MOTION: Lorraine Mackstaller, M.D. moved to suspend the statement the Board issued regarding Physician Assistants and form a subcommittee to look into the matter further.
SECONDED: Tim B. Hunter, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

The Board noted it was not saying its position was incorrect and it was simply suspended the statement until further review and input from stakeholders.

Patrick N. Connell, M.D, Becky Jordan, Ram R. Krishna, M.D. and Paul M. Petelin, Sr., M.D. stated they would like to serve on the subcommittee. The Board asked Mr. Miller to inform the Chairman, Robert P. Goldfarb, M.D., FACS, of their intent and ask him to formalize the subcommittee.

Proposed Sunrise Legislation – Non-Physician Surgical Assistants and Optometrists

There is currently Sunrise Legislation that proposes that surgical assistants need to be regulated by the Arizona Medical Board. This has been brought up in the past and has failed at Legislature, but the Board has not been presented with specific statutory language for this proposal. Additionally, there is a proposal for optometrists to be able to prescribe all medications within certain classes.

Approval of Annual Fees

MOTION: Patrick N. Connell, M.D. moved to accept the fee schedule as proposed by Staff that leaves all fees as currently stated.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

Consideration of Substantive Policy Statement re: Deadline for Submission of Materials

Christine Cassetta, Board Legal Counsel presented the policy requested by the Board that materials for the Board's review must be submitted three weeks prior to the Board Meeting and failure to retain legal counsel will not be an acceptable excuse for failure to submit.
MOTION: Patrick N. Connell, M.D. moved to accept the Substantive Policy Statement regarding Deadline for Submission of Materials.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

Approval of Minutes

MOTION: Ram R. Krishna, M.D. moved to approve the August 9-10, 2006 Regular Session Meeting Minutes, Including Executive Session, August 24, 2006 Teleconference Minutes, Including Executive Session and the September 8, 2006 Offsite Planning Meeting Minutes.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 4-absent
MOTION PASSED.

ADVISORY LETTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-0898A	AMB	MARSHALL R. KENOYER, M.D.	14182	Advisory Letter for failure to timely diagnose and treat pneumonia in a two year old and for inadequate medical records.

Paul M. Petelin, Sr., M.D. recused himself from the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-05-0972A	D.F.	DEIDRE J. SOLBERG-DANIELS, M.D.	16168	Advisory Letter for failure to cooperate with the Board's investigation and for failure to provide medical records upon request to the patient.

Paul M. Petelin, Sr., M.D. said he was concerned Dr. Solberg-Daniels seemed to be receiving an Advisory Letter because he failed to respond to the Board and this usually merits discipline. Victoria Kamm, Senior Medical Investigator noted Dr. Solberg-Daniels did respond. Dr. Petelin noted he had no further objections for issuing an Advisory Letter.

MOTION: Paul M. Petelin, Sr., M.D. moved to issue an Advisory Letter for failure to cooperate with the Board's investigation and for failure to provide medical records upon request to the patient.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-05-0882A	AMB	WALTER H. MAGEN, M.D.	6349	Advisory Letter for failure to appropriately interpret chest x-ray and CT scan.
4.	MD-05-0773A	M.S.	ROBERT H. TAMIS, M.D.	4044	Advisory Letter for failure to retain records for the statutory period of time.
6.	MD-06-0039A	S.B.	THOMAS A. OPECHOWSKI,M.D.	22676	Advisory Letter for inadequate medical records and lack of treatment plan and lack of indication for medications prescribed and 20 hours non-disciplinary CME in medical record keeping to be completed within one year.

Dona Pardo, Ph.D., R.N. said she felt it was appropriate to issue non-disciplinary CME for this case. Douglas D. Lee, M.D. asked that, in cases such as this, Staff recommend this to the Board initially. Timothy Miller, J.D., Executive Director noted the Board specified at their September 8, 2006 Off Site Meeting that if Staff recommends non-disciplinary CME, the recommendation would be brought to the Board for their consideration. At the time the Staff Investigational Review Committee (SIRC) reviewed this case the statute allowing for non-disciplinary CME was not yet in effect.

MOTION: Dona Pardo, Ph.D., R.N. moved to issue an Advisory Letter for inadequate medical records and lack of treatment plan and lack of indication for medications prescribed and 20 hours non-disciplinary CME in medical record keeping to be completed within one year.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-06-0156A	AMB	RICHARD D. COVEY, M.D.	28184	Advisory Letter for failure to appropriately follow up on an abnormal chest x-ray.

Lorraine Mackstaller, M.D. recused herself from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-06-0048A	AMB	AZBER A. ANSAR, M.D.	33994	Advisory Letter for falsely reporting a crime.
9.	MD-06-0012A	AMB	JOSE M. PISCOYA, M.D.	25569	Advisory Letter for allowing a physician not licensed in Arizona to cover his practice.

Ram R. Krishna, M.D. said he knows Dr. Piscoya, but it would not affect his ability to adjudicate the case.

Tim B. Hunter, M.D. said this case appeared to warrant more than an Advisory Letter as Dr. Piscoya allowed an unlicensed physician to cover his practice and Dr. Hunter did not want to send a message to the community that physicians could be casual about who they hire. Patrick N. Connell, M.D. noted the physician who was hired had a license in another state and was working on an Indian Reservation within Arizona, but both the hired physician and Dr. Piscoya did not realize the physician could not practice outside of the Indian reservation. Paul M. Petelin, Sr., M.D. said he could not see what information could be gained by bringing in Dr. Piscoya in for Formal Interview. Douglas D. Lee, M.D. said that issuing an Advisory Letter puts it into the record for tracking should a similar incident occur again and possible disciplinary action could be taken at that time.

MOTION: Tim B. Hunter, M.D. move to issue an Advisory Letter for allowing a physician not licensed in Arizona to cover his practice.
SECONDED: Douglas D. Lee, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-05-0974A	AMB	CLAUDE C. FOSDICK, M.D.	13210	Advisory Letter for failure to follow up on an abnormal chest x-ray.

Tim B. Hunter, M.D. pulled this case for discussion indicating in the past the Board had given discipline in cases that, at first glance, seemed similar to this case.

The Board reviewed the x-rays from the case. William Wolf, M.D., Medical Consultant summarized the case for the Board. It was alleged Dr. Fosdick failed to notify a patient of an abnormal chest x-ray result and failed to order a follow up chest x-ray that led to a delay in the diagnosis of lung cancer and the patient's subsequent death. However, Dr. Wolf noted there was a notation in the record that indicated the office manger discussed the x-ray with the patient and recommended to the patient that follow up views be performed.

MOTION: Tim B. Hunter, M.D. moved to issue an Advisory Letter for failure to follow up on an abnormal chest x-ray.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-06-0058A	R.L.	JOEL A. FALK, M.D.	27031	Invite for a Formal Interview.

Paul M. Petelin, Sr., M.D. noted the injury in this case may have been avoided and there was a problem with the judgment Dr. Falk exercised in proceeding in this case. Dona Pardo, Ph.D., R.N. stated she had an issue with the medical records, including no history and physical.

Ingrid Haas, M.D., Medical Consultant stated the injury seemed to be from the Trochar and not the needle even though Dr. Falk said the Trochar failed. Becky Jordan said there was patient harm and the events in this case could have resulted in death.

MOTION: Paul M. Petelin, Sr., M.D. moved to invite Dr. Falk for Formal Interview.
SECONDED: Dona Pardo, Ph.D., R.N.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
12.	MD-05-0896A	AMB	DWIGHT C. LUNDELL, M.D.	6960	Advisory Letter for failure to maintain adequate medical records and for a technical surgical error.
13.	MD-05-0628A	AMB	MALCOLM G. WILKINSON, M.D.	21001	Advisory Letter for inadequate medical records.
14.	MD-06-0274A	AMB	PATRICK J. DI FONZO, M.D.	29570	Offer a Consent Agreement for a Letter of Reprimand for failure to discontinue a diuretic and for submitting false information to a hospital. One Year Probation to include CME in Ethics. If the physician declines, invite for a Formal Interview.

Dona Pardo, Ph.D., R.N. noted Dr. DiFonzo admitted he altered a copy of the medical record and Dr. Pardo added she felt non-disciplinary CME should be added to the Order. Mark Nanney, M.D., Chief Medical Consultant stated the physician did not actually alter the record, he created a copy of the record and altered the copy for the peer review committee.

Christine Cassetta, Board Legal Counsel noted the issue is whether appearing before peer review is the practice of medicine and Dr. DiFonzo did not alter the record that remained the official record. Tim B. Hunter, M.D., looks at that as practice of medicine.

MOTION: Tim B. Hunter, M.D. moved to Offer a Consent Agreement for a Letter of Reprimand for failure to discontinue a diuretic and for submitting false information to a hospital. One Year Probation to include CME in Ethics. If the physician declines, invite for a Formal Interview.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
15.	MD-05-0903A	AMB	BENTON M. O'NEAL, M.D.	24380	Advisory Letter for failure to follow up on an abnormal urinalysis consistent with diabetes.

MOTION: Tim B. Hunter, M.D. Moved to issue Advisory Letters for items 1,3, 4, 7, 8, 12, 13, 15.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

REVIEW OF ED DISMISSALS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0096A	N.W.	RONALD E. BARNES, M.D.	4544	Uphold Executive Director's Dismissal.

Ram R. Krishna, M.D. recused himself from the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-06-0086A	C.P.	THOMAS P. FOERSTER, M.D.	6887	Uphold Executive Director's Dismissal.
3.	MD-06-0027A	B.T.	ROBERT A. ALFICH, M.D.	19453	Uphold Executive Director's Dismissal.
4.	MD-05-0449A	D.C.	STEPHEN D. GLACY, M.D.	17082	Uphold Executive Director's Dismissal.

Wallace Callahan, the patient's husband, was present and spoke during the call to the public. Mr. Callahan said Dr. Glacy charged for two epidurals because he claimed Medicare would not pay for them. However, Dr. Glacy collected money from Medicare and did not return Mr. Callahan's first payment until a complaint was filed with the Arizona Medical Board and did not return his second payment until Medicare was in the second phase of their fraud investigation.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-05-0947A	M.B.	RAY A. SILAO, M.D.	22582	Uphold Executive Director's Dismissal.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-06-0095A	N.R.	JAMES A. TAMMARO, M.D.	21591	Uphold Executive Director's Dismissal.

MOTION: Sharon B. Megdal, Ph.D. uphold the Executive Director's Dismissal for items1-6.
SECONDED: Douglas D. Lee, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

OTHER BUSINESS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0147A	M.L.	ALAN C. SACKS, M.D.	9475	Consent Agreement for a Decree of Censure for inappropriate sexual conduct with a patient and a five year Probation to include presence of a licensed female medical professional during all interactions with female patients, a Board approved psychotherapist to address boundary violations, professional ethics the power differential between patient and physician. In addition 10 hours CME in a Board approved sexual boundaries course.

JE was present and spoke during the call to the public. JE said she did not realize initially that Dr. Sacks had her return for more follow up visits than normal in order to seduce and violate her. JE said Dr. Sacks played on her insecurities and did not have a chaperone in the room during her visits. JE said Dr. Sacks manipulated her emotionally and seduced her into having an affair with him.

TF, a family member of JE, was present and spoke during the call to the public. TF said she contacted Dr. Sacks upon learning of the affair and Dr. Sacks admitted to having an affair with JE and said his x-wife and former girlfriend were also his patients.

PF read a statement from JE's husband who said he believed Dr. Sacks, a 62-year-old physician, was someone he could trust with his wife's care. However, Dr. Sacks has and will continue to abuse his position to prey on women. PF said the consequences of Dr. Sacks' actions affected more than just the two involved in the affair as JE's children have suffered greatly and a toll has been taken on his family who have dedicated hundreds of hours keeping JE and her husband's marriage together. PF said Dr. Sacks' actions should not be allowed to continue with just a simple warning or Probation. PF said they waited eight months for the Board to take action and he wondered how many other complaints had transpired during that period.

Ram R. Krishna, M.D. said he felt the Board's Order should require Dr. Sacks to have a chaperone present at all times. Patrick N. Connell, M.D. noted Dr. Sacks had undergone a psychosexual evaluation that recommended he use a chaperone. The Consent Agreement included that he abide by the recommendations of the evaluation. Sharon B. Megdal, Ph.D. said she would like to find a way to notify the public

about physicians who are sexual predators and said she was concerned about letting Dr. Sacks continue to practice even when he was under treatment. William R. Martin, III, M.D. noted patients can go to the Board's website to learn the details of a case. Dr. Krishna noted that even if a patient is not aware of details of case, they are protected if a chaperone is present.

MOTION: Ram R. Krishna, M.D. moved to reject consent agreement as offered and offer a revised consent agreement adding a requirement to the original consent that Dr. Sacks to have a licensed female medical professional in the room during all interactions with female patients for the duration of the 5 Year Probation Period. If the physician rejects the Proposed Consent Agreement, the matter shall be returned to Board for consideration of summary action within 24 hours.
SECONDED: Patrick N. Connell, M.D.

Tina Geiser, Senior Medical Investigator said Dr. Sacks notified Staff he had already hired a chaperone who is in the room at all times with his patients. Dona Pardo, Ph.D., R.N. recommended the Order be effective the same day. Dr. Megdal agreed that if Dr. Sacks did not sign the Consent Agreement today, the Board should consider summarily restricting his license.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, and Paul M. Petelin, Sr., M.D. The following members were not present: Robert P. Goldfarb, M.D. and Patricia R.J. Griffen,
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

Board Staff negotiated the proposed amendments to the consent agreement and informed the Board later in the day that Dr. Sacks signed the revised consent agreement.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-04-0521A	P.S.	KENNETH S. BISTRICKY, M.D.	8807	Consent Agreement for a Letter of Reprimand for the general mismanagement of three patients.
4.	MD-05-0788A	AMB	BRIAN E. DEMUTH, M.D.	15614	Consent Agreement for a Letter of Reprimand for failure to recognize fetal distress and failure to deliver infant in a timely manner resulting in the death of the infant.
5.	MD-06-0089A	AMB	WALTER J. JASIN, M.D.	10086	Consent Agreement for a Letter of Reprimand for performing surgery while impaired. Five Year Probation to include participation in the Board's Monitored Aftercare Program.

Dona Pardo, Ph.D., R.N. recused herself from this case.

MOTION: Ram R. Krishna, M.D. moved to accept the Proposed Consent Agreements for items 3, 4 and 5.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following members were not present: Robert P. Goldfarb, M.D. and Patricia R.J. Griffen,
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-05-0184A	AMB	RONALD E. SHERER, M.D.	19367	Accept Findings of Fact, Conclusions of Law and Order for a Decree of Censure for gross negligence in the management of a known diabetic pregnant patient resulting in fetal demise. Probation for 15 years with practice restriction in obstetrics and shall submit quarterly reports to the Board to attest to his compliance.

Ronald Sherer, M.D. was present during the call to the public with counsel, Mr. Kent Turley. Dr. Sherer said he brought in an office assistant to organize his practice and said he is a caring physician who loves his patients and they love him. Dr. Sherer said he realized patient MC's case could have been handled better and in retrospect realizes he should have sent MC to a perinatologist initially.

Bill Ng, office administrator for Dr. Sherer was also present and spoke during the call to the public. Mr. Ng said he had been a pharmacist for 32 years and had known Dr. Sherer for 12 years. Mr. Ng said Dr. Sherer is a compassionate physician and he is working as Dr. Sherer's office manager without pay because he believes in Dr. Sherer and does not want the community to lose such a good physician. Mr. Ng said he was a past director of multiple hospitals and is working to organize Dr. Sherer's practice. Mr. Ng said he believes Dr. Sherer's past problems were associated with his work schedule and he has helped Dr. Sherer to manage his load by not seeing too many patients in a year.

William R. Martin, III, M.D. said it seemed Dr. Sherer got himself into trouble because of being very busy and not being able to say "no" to patients. Dr. Martin noted if the Board restricted Dr. Sherer's practice to a certain number of hours, Dr. Sherer may still be able to help the public. Lorraine Mackstaller, M.D. noted Dr. Sherer seemed to be a caring and competent physician, but erred in the treatment of the patient in this case and needs to be restricted to doing low risk obstetrics. Patrick N. Connell, M.D. noted Dr. Sherer had a long history with the Board including a Decree of Censure in the year 2000 for mismanagement of numerous gynecological cases and a Probationary Order in 2001 for a chemical dependency.

Sharon B. Megdal, Ph.D. asked Christine Cassetta, Board Legal Counsel if procedurally the Board could re-discuss the case at this stage. Ms. Cassetta noted generally the process is to confirm that in drafting the Order she captured the Board's discussion and motion from the interview, not to reconsider the matter at this point. However, Ms. Cassetta reminded the Board of its rehearing and review rule that allows the Board to rehear or review a matter on its own motion within 15 days after the Order is issued. Dr. Connell noted that in February 2006 the Board voted to not issue the Order based on the same type of comments and granted a continuance until Dr. Sherer completed the Physician Assessment and Clinical Evaluation (PACE) and such results were returned to the Board. The results of the PACE evaluation were not favorable to Dr. Sherer. Dr. Martin said that having heard the point raised by Dr. Connell, the Board should move forward on accepting the Order.

MOTION: Douglas D. Lee, M.D. accept the Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for gross negligence in the management of a known diabetic pregnant patient resulting in fetal demise. Probation for 15 years with practice restriction in obstetrics and shall submit quarterly reports to the Board to attest to his compliance.
SECONDED: Ram R. Krishna, M.D.

Dr. Martin noted, although the Probationary period was for 15 years, if Dr. Sherer presented to the Board as early as within three months with a game plan that was acceptable to the Board, the Board could consider issuing a new Order.

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

Sharon B. Megdal, Ph.D. asked Ms. Cassetta to look into the procedural issues for re-discussing a case when the Board considers the Draft Order.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-05-0511A	AMB	JOAN M. WARNER, M.D.	27858	Issue Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for failure to recognize fetal distress and failure to promptly deliver two fetuses resulting in harm to one fetus and fetal death of the other.
NO.	**CASE NO.**	**COMPLAINANT v PHYSICIAN**		**LIC. #**	**RESOLUTION**
8.	MD-05-0503A	AMB	DUANE G. MARTIN, M.D.	30487	Issue Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to recognize signs and symptoms of myocardial origin and for failure to obtain an EKG, depriving the patient of a chance for earlier intervention.
NO.	**CASE NO.**	**COMPLAINANT v PHYSICIAN**		**LIC. #**	**RESOLUTION**
9.	MD-03-0014A	AMB	ZEV FAINSILBER, M.D.	22634	Issue Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to appropriately refer a patient with suspected melanoma, for inappropriate contact with a patient, and for making false statements in the patient's record. Probation for 5 Years with all interactions with female patients to take place in the presence of a female licensed healthcare provider, shall undergo treatment by a Board approved therapist for psychosocial issues for a period of 24 months and shall complete 15 hours of CME in medical records within six months.
NO.	**CASE NO.**	**COMPLAINANT v PHYSICIAN**		**LIC. #**	**RESOLUTION**
10.	MD-04-0187A	AMB	T.S. SOUNDARARAJAN, M.D.	15670	Issue Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for action taken by the California Medical Board for conduct that is unprofessional.

T.S. Soundararajan, M.D. was present and spoke during the call to the public. Dr. Soundararajan responded to the allegations against him by stating he did document the patient's Coumadin dose, but only gave it for a two week period. Secondly, he did perform a neurological examination on the patient and thirdly, the accusation that he had misrepresented himself was dismissed by the California Medical Board.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-05-0460A	AMB	DANIEL J. MARTINIE, M.D.	29155	Issue Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for Article 15 action taken by the Federal Government and for engaging in a sexual relationship with a former patient within six months after the last consultation.
12.	MD-04-0850A	AMB	JAMIE MCREYNOLDS, M.D.	15120	Issue Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to adequately care for a patient with critical carotid artery stenosis. One year Probation with 20 hours of CME in the treatment of cerebral vascular disease.

Paul M. Petelin, Sr., M.D. recused himself from the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
13.	MD-05-0390A	R.T.	JOHN N. GLOVER, M.D.	8971	Issue Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to pursue the etiology of an abnormal chest x-ray with a worsening clinical picture.

RT was present and spoke during the call to the public. RT thanked the Board for their investigation in this case and for subsequently sending a letter to the community to make them more aware of Valley Fever. RT noted the Board gave Dr. Glover the benefit of the doubt that he did not fail to diagnose Valley Fever in her father, however, RT reminded the Board that Dr. Glover allowed and watched her father decline, visit after visit without taking sufficient action. RT also stated she was not able to see the Draft Findings of Fact, Conclusions of Law and Order in this case prior to the Board voting on such.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
14.	MD-05-0770A	AMB	RICHARD C. ROTHMAN, M.D.	29754	Issue Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to verify the correct data was entered into the laser prior to an ophthalmologic procedure and for failing to adequately supervise a technician.
15.	MD-04-0912A	AMB	MAHDI S. AL-BASSAM, M.D.	21073	Deny request for Rehearing or Review.

Legal Counsel Mr. Paul Giancola spoke on behalf of Mahdi S. Al-Bassam, M.D. during the call to the public. Mr. Giancola said disciplinary action was excessive in this case as the patient experienced a sudden and acute bleed and Dr. Al-Bassam did timely diagnose the bleed, but unfortunately the patient died. Mr. Giancola said the Internal Medical Consultant found a history and physical was not required in this case and the experts found nothing could be done to prevent the outcome of the patient and that appropriate monitoring had been given in this case.

Paul M. Petelin, Sr., M.D. noted there were many deviations in this case.

MOTION: Paul M. Petelin, Sr., M.D. moved to deny the request for rehearing or review.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-yay, 0-nay, 1-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
16.	MD-06-0742A	AMB	JOHN F. MICHIELS, M.D.	22251	Consent Agreement for Surrender of Active License for the practice of allopathic medicine.

MOTION: Tim B. Hunter, M.D. moved to accept the Proposed Consent Agreement for Surrender of Active License for the practice of allopathic medicine.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., and Dona Pardo, Ph.D., R.N. The following Board Members abstained from voting: Patrick N. Connell, M.D., Sharon B. Megdal, Ph.D. and Paul M. Petelin, Sr., M.D. The following Board Members were absent: Robert P. Goldfarb, M.D. and Patricia R.J. Griffen
VOTE: 7-yay, 0-nay, 3-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Ram R. Krishna, M.D. accept the Draft Findings of Fact, Conclusions of Law and Order for items 7-14.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

Wednesday, October 11, 2006

CALL TO ORDER

William R. Martin, III, M.D. called the meeting to Order at 9:30 a.m.

ROLL CALL

Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Members were not present: Robert P. Goldfarb, M.D. and Patricia R.J. Griffen

CALL TO PUBLIC

Statements issued during the call to the public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-0794A	AMB	DALLAS E. PETERSON, M.D.	23268	Issue an Advisory Letter for failure to appropriately institute treatment modalities to affect prompt delivery. This was a minor technical violation.

Dallas Peterson, M.D. was present with counsel Mr. Daniel Jantsch.

Ingrid Haas, M.D., Medical Consultant summarized the case for the Board. The Arizona Medical Board received notice of a medical malpractice settlement alleging Dr. Peterson failed to identify fetal distress when interpreting the fetal monitor strip resulting in a delay in delivery and subsequent fetal demise. A pregnant female patient was admitted for elevated blood pressure and was induced. A non-reactive stress test and meconium were identified. Dr. Peterson was not present initially, but came to deliver the patient. A vacuum attempt was unsuccessful and the infant was delivered by forceps. Resuscitative attempts failed and the infant died. No coagulopathy or anomalies were found in the infant.

Douglas D. Lee, M.D. led the questioning. Dr. Peterson said he administered the patient's prostaglandin gel and left the hospital to wait for nursing staff to notify him of the patient's status. Dr. Peterson said his office is 23-25 miles from the hospital and it is his routine to depend on nursing staff to notify him of any complications and when he needs to present for delivery. Dr. Peterson said the nurses did not make him aware of the patient's late decelerations. Dr. Lee noted nursing staff placed a second treatment of induction gel although there were late decelerations. Dr. Lee noted there was also no note in the chart from nursing staff either positive or negative about tracings. Dr. Lee noted the nurses then administered oxygen to the patient and placed her on her side. Nursing notes also indicated they notified Dr. Peterson at the time they started the oxygen. Dr. Lee found the initiation of oxygen was a red flag that should have prompted Dr. Peterson to at least come and examine the patient.

Dr. Lee noted that a nurse then ruptured the membranes and only a midwife would be qualified to rupture the membranes. Dr. Lee noted the nurse was not acting in the position of a midwife at the time of this case. Dr. Peterson said when he arrived for delivery he did not review the fetal tracings that would have alerted him the infant was in distress because he was focused on delivery.

Dr. Lee noted it was Dr. Peterson's testimony that, at the time, it took about an hour to get a surgical team set up for C-section. Dr. Lee noted, in such circumstances, Dr. Peterson should have notified the surgical team to prepare at the time he found the patient required oxygen and had ominous tracings. Dr. Peterson said he was not told the patient had ominous tracings during the day. Dr. Lee found Dr. Peterson did not appropriately monitor the patient's labor progress, failed to timely recognize the signs of fetal distress and failed to appropriately and timely institute treatment modalities to deliver the infant.

Dr. Peterson said in retrospect he wished he would have called the surgical team and if he would have reviewed the late decelerations, the surgical team would have definitely been contacted for C-section. Dr. Peterson said rural medicine places unique demands on physicians and practicing miles from the hospital demands reliance on others to provide adequate notification. Dr. Peterson said he stopped practicing obstetrics six months before litigation in this case was initiated. Dr. Peterson said this experience was emotionally distressing for both the patient and himself and was the roughest experience of his life.

Mr. Jantsch noted the standard of care should not be looked at with a retrospective approach and the standard of care is not always what the optimal level of care is.

Dr. Lee found unprofessional conduct in this case in that Dr. Peterson failed to adequately recognize signs of fetal compromise and failed to appropriately institute treatment modalities for prompt delivery.

MOTION: Douglas D. Lee, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

Dr. Lee did not find any aggravating factors in this case. Dr. Lee found it mitigating that the hospital process was deficient in that Dr. Peterson was not adequately informed of the problems as the case progressed. Dr. Lee had many problems with the nurses in this case

and found a physician has to depend on the hospital to provide him with pertinent information regarding patients. However, Dr. Lee noted there was fetal death in this case.

MOTION: Douglas D. Lee, M.D. moved to Draft Findings of Fact Conclusions of Law and Order for a Letter of Reprimand for failure to appropriately institute treatment modalities to affect prompt delivery.

There was no seconder to the motion.

Ram R. Krishna, M.D. found, although the outcome was unfortunate, in light of the mitigating circumstances, this case did not rise to a level of a discipline.

MOTION: Ram R. Krishna, M.D. moved to issue an Issue an Advisory Letter for failure to appropriately institute treatment modalities to affect prompt delivery. This was a minor technical violation.
SECONDED: Patrick N. Connell, M.D.

Dr. Lee said, even discounting the monitoring issues at the hospital, it should have been clear as a minimum standard that there was an ongoing problem with the fetus. Dr. Lee said, knowing how long it took for surgical team, it was below the standard of care to not begin set up of the team in advance and failure to do so led to the poor outcome of the fetus.

Dr. Pardo said it seemed Dr. Peterson was given a false sense of security by nursing staff. Dr. Pardo expressed concern with the nurse midwife who overstepped her bounds by rupturing the membranes at a time when she was not working as a midwife. Lorraine Mackstaller, M.D. noted Dr. Peterson was a rural physician who was regularly was faced with challenges of a rural setting and should be commended for his service. Dr. Krishna said quality of care is not determined by location of a practice.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D. and Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board members were not present: Robert P. Goldfarb, M.D. and Patricia R.J. Griffen
VOTE: 6-yay, 4-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Douglas D. Lee, M.D. moved to refer this matter to the Arizona State Board of Nursing.
SECONDED: Dona Pardo, Ph.D., R.N.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-05-1119A	M.G.	SUDHIR K. GOEL, M.D.	27103	Draft Findings of Fact, Conclusions of Law & Order for a Letter of Reprimand for failure to perform adequate examinations and for failure to maintain adequate medical records. One Year Probation to include 20 hours CME in patient management in primary care settings and medical record keeping. The Probation would end upon satisfactory completion of the course. The CME is in addition to the CME required for license renewal.

Sudhir Goel, M.D. was present with legal counsel Mr. Paul Giancola.

William R. Martin, III, M.D. said he knows Mr. Giancola, but it would not affect his ability to adjudicate the case. Lorraine Mackstaller, M.D. said she met Dr. Goel when he was doing his nephrology fellowship between 1986 and 1988, but it would not affect her ability to adjudicate the case. Tim B. Hunter, M.D. said he knows the medical consultant in this case, but it would not affect his ability to adjudicate the case.

Patrick N. Connell, M.D. noted Dr. Goel's counsel had asked for his recusal in this case. However, Dr. Connell said he had no prior knowledge of the case and could see no cause for recusal.

The Board went into Executive Session for legal advice at 10:44 a.m.
The Board returned to Open Session at 10:50 a.m.
No deliberations or decisions were made during Executive Session.

Roderic Huber, M.D., Medical Consultant summarized the case for the Board. It was alleged Dr. Goel inadequately evaluated a patient with chronic problems with her back and knee, failed to refer her to an appropriate specialist, and did not obtain an MRI for the patient. Dr. Huber noted the standard of care would require appropriate evaluation of the patient's problems with referrals as needed. Dr. Goel's medical records were found to be inadequate and failed to address the patient's problems. It was also found that Dr. Goel recalled the patient to an appointment every week or two without providing any real treatment and gave the patient small quantities of medication with each visit.

Dr. Goel said the patient presented with a new complaint on every visit and was not consistent on appearing for appointments. Dr. Goel said he did recommend the patient see a specialist and did order an MRI as was documented in the chart.

Ram R. Krishna, M.D. led the questioning and noted the patient had significant back and knee pain as noted in Dr. Goel's medical record. Dr. Krishna noted Dr. Goel should have examined the patient's back, however, there was no documentation of a back exam. Dr. Lee noted the patient presented to Dr. Goel a week later and he did not document an objective finding for the knee or an exam of the knee. Dr. Krishna noted Dr. Goel saw the patient approximately every six days and prescribed various medications including Percocet at each visit. Dr. Krishna noted the patient also presented at one point with the complaint of nausea and diarrhea that Dr. Goel also did not adequately address. Dr. Krishna found Dr. Goel did not adequately treat this patient from the standpoint of an internal medicine physician.

Mr. Giancola stated the patient often did not present for appointments or would come in when not scheduled. Mr. Giancola also noted the patient had various complaints and it was difficult to evaluate each complaint.

MOTION: Ram R. Krishna, M.D. moved to moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient and A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Ram R. Krishna, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to perform adequate examinations and for failure to maintain adequate medical records.
SECONDED: Douglas D. Lee, M.D.

Dr. Megdal questioned if Continuing Medical Education (CME) would be appropriate because Dr. Goel was currently under a Summary Suspension of license. Dr. Lee said he felt a CME requirement would be helpful because if the order of Suspension was lifted, Dr. Goel could return to practice at that point.

MOTION: Ram R. Krishna, M.D. moved to Amend the motion to include Draft Findings of Fact, Conclusions of Law & Order for a Letter of Reprimand for failure to perform adequate examinations and for failure to maintain adequate medical records. One Year Probation to include 20 hours CME in patient management in primary care settings and medical record keeping. The Probation would end upon satisfactory completion of the course. The CME is in addition to the CME required for license renewal.
SECONDED: Douglas D. Lee, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D., The following Board Members were absent: Robert P. Goldfarb, M.D. and Patricia R.J. Griffen
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-05-1182A	J.B.	KAREN B. BARCKLAY-DODSON, M.D.	29446	Draft Findings of Fact, Conclusions of Law & Order for a Letter of Reprimand for failure to appropriately evaluate and refer a patient with a significant head injury.

Karen Barcklay-Dodson, M.D. was present with counsel Ms. Donna McDaniel.

Roderic Huber, M.D., Medical Consultant summarized the case for the Board. The Arizona Medical Board received notification of this case from the Arizona Department of Corrections. It was alleged Dr. Barcklay-Dodson failed to appropriately treat and recommend imaging studies resulting in the patient/inmate's death. Dr. Huber noted the patient/inmate was assaulted and rendered unconscious from blows to the head. The Outside Medical Consultant found Dr. Barcklay-Dodson deviated from the standard of care by failing to order a CT-scan, prescribing sedating medications and ordering neurological checks for only an eight hour period rather than a 24-48 hour period as is recommended for head trauma. The patient subsequently died.

Patrick N. Connell, M.D. led the questioning. Dr. Barcklay-Dodson said, although the nurse's note in the medical record showed the patient/inmate had lost consciousness, both the inmate and security who were present at the time of the incident denied loss of consciousness and she based her treatment on this information. Dr. Connell noted in this setting, an assault could be pretty vicious and it would be best to err on the side of caution in treating the patient. Dr. Connell noted the patient was kicked several times in head and complained to Dr. Barcklay-Dodson of severe headache and vomiting and this should have raised a red flag. Dr. Connell noted Dr. Barcklay-Dodson should have looked at the patient's ear canal for blood that could have indicated a fracture. Dr. Connell noted the patient died from an intracranial bleed and skull fracture. Dr. Connell also noted there should have been some palpation of the patient's head that would have shown swelling. Dr. Connell noted the Autopsy Report showed contusions that were very different from Dr. Barcklay-Dodson's exam. Dr. Connell noted the patient had history of hepatitis C and Cirrhosis that would place him at increased risk of intracranial bleed after blunt injury.

Dr. Connell found Dr. Barcklay-Dodson ordered vital signs and neurological checks for a period of eight hours only. Dr. Barcklay-Dodson said that order was intended to cover the time until the patient was transferred to the observation cell where he would automatically be checked every 30 minutes. Dr. Connell said, years ago, observation would be required for head trauma. However, he noted that in this present day, a CT-scan is necessary first before observation of the patient. Dr. Connell also noted Dr. Barcklay-Dodson did not document that she performed a neck exam. Dr. Connell noted a neurological exam was required and Dr. Barcklay-Dodson conceded it was.

Lorraine Mackstaller, M.D. noted the autopsy report showed a large contusion of 14 centimeters to the head and it would be difficult to believe Dr. Barcklay-Dodson's examination would not have revealed such a large contusion.

William R. Martin, III, M.D. noted Dr. Barcklay-Dodson's records showed the patient/inmate did not remember the assault. Dr. Martin said this finding along with the patient/inmate's severe headache and vomiting would make the nurse's notes more plausible that there was a loss of consciousness.

Dr. Barcklay-Dodson said, retrospectively, she admits she did not meet the standard of care. However, based on the information given to her at the time of the event, she felt she met the standard of care. Dr. Barcklay-Dodson also said if the bruising and contusions were present when she saw the patient, she would have sent the patient to the emergency room. However, Dr. Barcklay-Dodson noted it would take 12 or more hours for the patient to get the scan depending on the amount of people in the emergency department. Dr. Barcklay-Dodson noted, since the patient/inmate was walking, talking and conscious, he would not be considered a priority by the emergency department. Dr. Barcklay-Dodson said she prescribed Phenergan, a potentially sedating medication, because she did not want to give the inmate/patient Tylenol due to his increased potential for bleeding. Dr. Barcklay-Dodson said she has changed since this incident in that she is much less trusting of reports from security and nursing and is more prone to send patients to the emergency room.

Ms. McDaniel said Dr. Barcklay-Dodson tried several times to verify the account of the assault and the nurse's account in the medical record could not be verified. The nurse's account of the assault was taken from other inmates whom Dr. Barcklay-Dodson could not consider as credible. Ms. McDaniel also noted inmates sometimes lose consciousness in order to stop an assault. Ms. McDaniel also noted the patient/inmate may not have been truthful with Dr. Barcklay-Dodson about the assault for various reasons.

Dr. Connell said he takes care of prisoners regularly and understands issues both with security and obtaining an accurate history. Dr. Connell did acknowledge there were mitigating circumstances in this case. However, Dr. Connell noted that, when dealing with potentially life-threatening situation it is best to err on the side of the patient. Dr. Connell found the autopsy report made it difficult to believe that, had careful physical exam been done, red flags would not have been seen. Dr. Connell noted the standard required a thorough history physical and appropriate decision making in the context of blunt head injury. Dr. Connell found actual harm in this case in that the patient died.

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any 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)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Becky Jordan
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

Dr. Martin said he felt strongly that in the past 10 years no patient should die from a subdural hemorrhage with the modern imaging and air transport that is available and that this patient could have been saved. Ram R. Krishna, M.D. noted, regardless of how long it would have taken to get the patient to the hospital and get a CT-scan, Dr. Barcklay-Dodson should have taken action to initiate movement in that direction.

MOTION: Patrick N. Connell, M.D. Draft Findings of Fact, Conclusions of Law & Order for a Letter of Reprimand for failure to appropriately evaluate and refer a patient with a significant head injury.
SECONDED: Paul M. Petelin, Sr., M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Members were not present: Robert P. Goldfarb, M.D. and Patricia R.J. Griffen
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-05-0695A	M.T.	ROBERT L. BROOKS, M.D.	31171	Continue the matter until a future Board meeting.

Robert Brooks, M.D. was present with counsel Mr. Gregory Harris.

Ingrid Haas, M.D., Medical Consultant summarized the case for the Board. The Arizona Medical Board received a complaint alleging Dr. Brooks failed to diagnose an ectopic pregnancy that later ruptured, causing the patient to undergo emergency surgery to remove the ruptured fallopian tube. Dr. Haas said a transvaginal ultrasound showed no intrauterine pregnancy and stated it could not rule out ectopic pregnancy. A Dilation and Curettage (DNC) was performed and no villi were detected. However, Dr. Brooks delayed to carry out a follow up of the transvaginal ultrasound that, if done, may have prevented the rupture.

Timothy B. Hunter, M.D. led the questioning and noted an additional ultrasound would have easily resolved the issue of ectopic pregnancy. Dr. Brooks stated the patient appeared stable and he scheduled a DNC several weeks out due to both technical reasons and because he did not think this case was an emergency. Dr. Brooks said he did not do another ultrasound on the patient because he thought another one had already been done and thought there would unlikely be a change on the ultrasound because the patient was asymptomatic and her blood count remained the same.

Dr. Hunter noted the patient was in danger for ectopic rupture for several weeks while waiting for the DNC to be performed and found it concerning the DNC was not performed in a more timely fashion. Dr. Brooks agreed he failed to schedule the DNC in a timely manner and he has since changed his practice to pay more attention to when the DNC is set.

Mr. Harris stated he did not believe the Board had received one of the Medical Consultant Reports in this case.

The Board went into Executive Session for legal advice at 2:56 p.m.
The Board returned to Open Session at 3:00 p.m.
No deliberations or decisions were made during Executive Session.
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Patrick N. Connell, M.D. noted there was an additional Medical Consultant Report in this case that had been reviewed by Dr. Brooks and his counsel, but had not been provided to the Board or Dr. Haas.

MOTION: Patrick N. Connell, M.D. moved to continue the matter until such time as the additional Medical Consultant Report could be supplied to the Board. Board Staff shall submit a written explanation to the Board regarding why the Board did not have the Medical Consultant Report.
SECONDED: Ram R. Krishna, M.D.
VOTE: 5-yay, 5-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-05-0124B	M.M.	ZULFIQAR FAROOQUI, M.D.	24737	Draft Findings of Fact, Conclusions of Law & Order for a Decree of Censure for knowingly making false or fraudulent statements in connection with the practice of medicine, knowingly making a false or misleading statement to the Board, and for failing to adequately follow up on abnormal lab tests and one year Probation with 10 hours of Board staff approved CME in Ethics.

MM was present with her husband and spoke during the call to the public. MM said a fertility specialist suggested she could use an egg donor. MM presented to Dr. Farooqui to make sure she had a clean bill of health before proceeding. MM said she did not receive her lab results from Dr. Farooqui's office, but was told by his staff that "no news is good news". MM said became deathly ill during pregnancy and had to terminate the pregnancy as part of the effort to preserve her life. MM said it was then she discovered she had a blood disorder that Dr. Farooqui failed to inform her she had.

Zulfiqar Farooqui, M.D. was present with counsel Mr. Edwin Gaines, Jr.

Kelly Sems, M.D., Internal Medical Consultant summarized the case for the Board. The patient had provided the Board with her medical record and it differed from the medical record Dr. Farooqui submitted. The medical record Dr. Farooqui submitted suggested the patient's chart was altered retrospectively to suggest Dr. Farooqui did give appropriate notification of the abnormal CBC lab values. However, even if MM was notified, there was no evidence her other physicians were notified of the abnormalities. Dr. Sems said Staff received four copies of the abnormal lab report, but never received the original report. Each copy of the lab report had a different notation. Dr. Sems noted Dr. Farooqui was less than clear with Staff regarding the discrepancies in the medical record.

Timothy B. Hunter, M.D. led the questioning. Dr. Farooqui said he never cleared the patient for infertility work up. Dr. Farooqui also said he did not have the patient's original medical record in his office when it was requested and he had to create a new record. Dr. Hunter noted there was no documentation that Dr. Farooqui told the patient of her lab result.

Paul M. Petelin, Sr., M.D. noted the patient's medical record showed the patient's sister had a hereditary blood disorder and that should have raised a red flag to Dr. Farooqui. Dr. Sems stated with such a history, at the time Dr. Farooqui received the abnormal blood work, it would have been prudent to refer the patient out.

Mr. Gaines said Dr. Farooqui recognized he made an error in not indicating the entries in his chart that are not contemporaneously made and this will not happen again. It was Dr. Farooqui's practice at the time to call patients only with abnormal results. However, his office now calls patients for both normal and abnormal results. Also, they did not believe there was a correlation with the patient's abnormal lab result as seen by Dr. Farooqui and the patient's low platelet count that later developed in pregnancy.

Dr. Hunter noted the medical records did not appear inadequate as it appeared Dr. Farooqui performed a complete history and physical for the patient. However, Dr. Hunter found Dr. Farooqui ether failed to notice abnormal lab values, notify the patient and refer her out or attempted to cover this up by altering the record. Dr. Hunter found the lab value results were not that outstanding and not recognizing their significance did not constitute not gross negligence. However, Dr. Hunter found it egregious that Dr. Farooqui attempted to cover up his error by altering the medical record.

MOTION: Tim B. Hunter, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(t)- Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution., A.R.S. §32-1401 (27)(q)- Any 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)(jj) - Knowingly making a false or

misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

Dr. Hunter said he could not determine a direct cause and effect relationship in what happened to the patient and the lack of notification of the lab results, however, the fraudulent statements by Dr. Farooqui were a serious matter. Lorraine Mackstaller, M.D. agreed the most egregious finding in this case was the fraudulent records as she was not sure an earlier finding based on the lab result would have changed the outcome for this patient.

MOTION: Tim B. Hunter, M.D. moved to Draft Findings of Fact, Conclusions of Law & Order for a Decree of Censure for knowingly making false or fraudulent statements in connection with the practice of medicine, knowingly making a false or misleading statement to the Board, and for failing to adequately follow up on abnormal lab tests and one year Probation with 10 hours of Board staff approved CME in Ethics.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D., The following Board Members were not present: Robert P. Goldfarb, M.D. and Patricia R.J. Griffen
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-05-0338A	S.M.	NICK RIZOS, M.D.	14298	Dismiss.

SM was present and spoke during the call to the public. She felt abandoned by Dr. Rizos during the week when her hemolysis, elevated liver enzyme levels, and a low platelet count (HELLP) syndrome was most severe. He took her off pain medications when she was in severe pain and did not recognize she had HELLP syndrome. Dr. Rizos did not come in to see her often or keep in contact with her at a time when she needed his treatment most. SM said she finally received adequate help because she was flown to a hospital in another city when she asked for a second opinion.

Nick Rizos, M.D. was present with counsel Mr. Jay Fradkin.

Ingrid Haas, M.D., Medical Consultant summarized the case for the Board. The patient had pre-existing conditions including hypertension in addition to previous premature delivery and advanced maternal age. She was admitted to hospital and laboratory studies revealed 3+protein and 2+ blood in the urine. She also had elevated liver functions. The patient delivered prematurely with the loss of the child. Dr. Rizos did not recognize the patient had HELLP syndrome.

Dr. Rizos said, although he regrets the outcome in this case, he did not believe he contributed to the premature birth and demise of the infant. Dr. Rizos said he could not have changed the outcome through anything he would have done for the patient. Dr. Rizos said he was in contact with nursing staff regularly to receive updates on the patient's lab values and symptoms.

Patrick N. Connell, M.D. led the questioning and said he found Dr. Rizos's records to be very thorough. Dr. Rizos said that for impending HELLP syndrome at 23 weeks there is nothing that can be done other than wait for it to further develop. The only treatment for fully developed HELLP is to deliver the infant and delivering the infant prematurely should be avoided for as long as possible. Dr. Rizos said the patient saw a gastroenterologist who said there was no problem with her liver, pancreas or GI and because of this he did not consider HELLP syndrome.

Douglas D. Lee, M.D. noted the patient was angry at Dr. Rizos's responses to her concerns. Dr. Rizos said he realizes he did not meet her expectations, but yet he attested he did not jeopardize her care. Dr. Rizos said he has since made an effort to solicit what patients expectations are of him.

Mr. Fradkin said the physician who treated the patient after she was moved to a different hospital said he would have treated her in the same way Dr. Rizos had and he would not have been able to make a difference in the patient's outcome even if she was under his care sooner.

Dr. Connell said he recognized there were some communication problems as far as Dr. Rizos being more attentive to the patient, but said he found no quality of care deviations in this case.

MOTION: Patrick N. Connell, M.D. moved to Dismiss the case.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N. The following Board members voted against the motion: Douglas D. Lee, M.D. and Paul M. Petelin, Sr., M.D. The following Board Members were absent: Robert P. Goldfarb, M.D. and Patricia R.J. Griffen
VOTE: 8-yay, 2-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-06-0236A	B.G.	JAMES M. HURLEY, M.D.	3191	Draft Findings of Fact, Conclusions of Law & Order for a Letter of Reprimand for failure to evaluate and appropriately diagnose a patient with acute abdominal pain. One year Probation for 12-15 hours of CME in differential diagnosis and management of the acute abdomen in adults and children. The Probation is to terminate upon completion of the CME.

James Hurley, M.D. was present with counsel Mr. Thomas Bakker.

Kelly Sems, M.D., Internal Medical Consultant summarized the case for the Board. The Arizona Medical Board received a complaint alleging Dr. Hurley failed to diagnose and treat small bowel obstruction resulting in patient death. The patient presented to Dr. Hurley with abdominal pain and history of NSAID use. The standard required Dr. Hurley to perform an adequate examination and to obtain laboratory evaluations and the Staff Investigational Review Committee (SIRC) found Dr. Hurley fell below the standard of care by failing to do so.

Paul M. Petelin, Sr., M.D. led the questioning. Dr. Hurley said he found nothing in the examination that would indicate the patient had a bowel obstruction. Dr. Petelin noted the patient had severe abdominal pain and a paucity of physical findings and such findings should have alerted Dr. Hurley to have performed x-rays, ordered a complete blood count (CBC) and a urinalysis with serum amylase.

Dr. Petelin said he did not find any deficiencies in medical record. However, he found the standard required a more thorough history and physical exam and, if performed, the findings would have alerted Dr. Hurley that the patient needed to be moved immediately to the emergency room. Dr. Petelin found actual harm in that Dr. Hurley's failure to make a diagnosis of bowel obstruction led to the demise of the patient.

MOTION: Paul M. Petelin, Sr., M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any 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)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Ram R. Krishna, M.D.

Tim B. Hunter, M.D. spoke against sustaining A.R.S. §32-1401 (27)(ll) because he was not certain that test results would have definitely shown the severity of the patient's illness and that the lack of such tests definitely led to the patient's demise.

VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

Dr. Petelin said Dr. Hurley's failure was to identify and treat this patient with acute abdominal pain.

MOTION: Paul M. Petelin, Sr., M.D. moved to Draft Finding of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to appropriately diagnose a patient with acute abdominal pain. One year Probation for 12-15 hours of CME in differential diagnosis and management of the acute abdomen in adults and children.
SECONDED: Tim B. Hunter, M.D.

Sharon B. Megdal, Ph.D. suggested the motion state Dr. Hurley failed to evaluate and appropriately diagnose a patient with acute abdominal pain.

AMMENDED MOTION: Paul M. Petelin, Sr., M.D. moved to amend the motion to Draft Findings of Fact, Conclusions of Law & Order for a Letter of Reprimand for failure to evaluate and appropriately diagnose a patient with acute abdominal pain. One year Probation for 12-15 hours of CME in differential diagnosis and management of the acute abdomen in adults and children. The Probation is to terminate upon completion of the CME.
SECONDED: Tim B. Hunter, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N. and Paul M. Petelin, Sr., M.D. The following Board members were absent: Robert P. Goldfarb, M.D., Patricia R.J. Griffen and Becky Jordan
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-05-1189A	R.N.	FRANCISCO RODRIGUEZ, M.D.	21376	Issue an advisory letter for a technical record keeping violation of an intended procedure.

Francisco Rodriguez, M.D. was present with counsel Mr. Stephen Myers.

Paul M. Petelin, Sr., M.D. said he knew Dr. Rodriguez, but it would not affect his ability to adjudicate the case.

William Wolf, M.D., Medical Consultant summarized the case for the Board. The Arizona Medical Board received a complaint alleging Dr. Rodriguez performed an unnecessary surgery, did not perform the surgery as described to the patient, and failed to obtain appropriate

consent prior to surgery. Dr. Wolf noted Dr. Rodriguez obtained consent for and recorded he would be performing bilateral subcutaneous mastectomies that would preserve the patient's nipples and areolae. However, Dr. Rodriguez performed bilateral simple mastectomies on the patient with no apparent information of his indication to do so in the record and without disclosing this to the patient. As a result, the patient's nipples and areolae were not preserved.

Paul M. Petelin, Sr., M.D. led the questioning. Dr. Rodriguez said the consulting physician in this case suggested the patient's nipples be preserved, however, on the day of surgery the consultant agreed with him that a bilateral simple mastectomy should be performed because all of the patient's pain complaints were from the nipple and areola region. Dr. Petelin noted there was operative permit three weeks before the surgery that indicated "bilateral subcutaneous mastectomy" was to be performed. Dr. Petelin noted there was no indication for the reason of Dr. Rodriguez's change of procedure on the day of surgery. Dr. Petelin found Dr. Rodriguez chose the appropriate procedure for the patient, but stated he could see why patient was not aware she would be undergoing a bilateral simple mastectomy because the record reflected that. Dr. Petelin noted the operative permit showing the plan of procedure up to the final hour of surgery and checked in verification by hospital staff showed a bilateral subcutaneous mastectomies would be performed.

Ram R. Krishna, M.D. noted Dr. Rodriguez did not obtain a written consent specifically stating the patient would undergo a bilateral simple mastectomy.

Mr. Myers stated the patient verbally consented and, although it was not documented, it did not mean there was no consent.

Paul M. Petelin, Sr., M.D. found it mitigating that Dr. Rodriguez had no prior Board history. Dr. Petelin said the standard of care is for the operative permit to reflect the actual surgery performed and that was not documented in this case. Dr. Petelin also noted the patient underwent a procedure she did not consent to and there was no written proof that patient understood she was going to have her nipples removed. Dr. Petelin noted actual harm resulting in physical deformity from losing the nipple and areola as well as emotional and psychological trauma to the patient from such.

MOTION: Paul M. Petelin, Sr., M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27) (e)- Failing or refusing to maintain adequate records on a patient and A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Patrick N. Connell, M.D.

Sharon B. Megdal, Ph.D. spoke against the motion stating she was not certain the patient was the one who filed the complaint against Dr. Rodriguez because the complaint form was not signed. Dr. Megdal said she felt this case warranted an Advisory Letter for a minor technical violation. Tim B. Hunter, M.D. spoke against the motion stating it appeared the patient was aware of the procedure to be performed and was probably a dissatisfied patient as evidenced by her past multiple surgeries and would have filed a complaint in this case regardless of the procedure performed.

VOTE: 4-yay, 5-nay, 0-abstain, 0-recuse, 3-absent
MOTION FAILED.

MOTION: Sharon B. Megdal, Ph.D. moved to Issue an advisory letter for a technical record keeping violation of an intended procedure.
SECONDED: Lorraine Mackstaller, M.D.

Douglas D. Lee, M.D. spoke against motion stating there was a consent that came into the operating room for a procedure, an operative report that was verified and then an incorrect procedure was performed.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D. R.N. The following Board Members voted against the motion: Ram R. Krishna, M.D., Douglas D. Lee, M.D., and Paul M. Petelin, Sr., M.D. The following Board members were absent: Robert P. Goldfarb, M.D., Patricia R.J. Griffen and Becky Jordan
VOTE: 6-yay, 3-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

FORMAL HEARING MATTERS – CONSIDERATION OF ALJ RECOMMENDED DECISION

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0126A	AMB	ABDOL R. ARJMANDFARD, M.D.	33227	Adopt ALJ's proposed Findings of Fact and Conclusions of Law, as amended. Stayed Revocation, Suspension until further Order of the Board, physician shall begin a Board approved evaluation treatment program for sexual offenders within 90 days of this Order and remain in that treatment program until successful completion thereof. At the end of 12 months he may petition the Board for reinstatement of his license with any conditions the Board may apply at that time. If he fails to enter a treatment program within 90 days and/or fails to comply with its recommendations the physician's license will be Revoked.

Abdol Arjmandfard, M.D. was present without counsel. William R. Martin, III, M.D. confirmed the Board had received and reviewed the record in this case.

Dean E. Brekke, AAG summarized the case for the Board. A Formal Hearing was conducted in this case. There was an allegation of sexual misconduct and the Board ordered Dr. Arjmandfard to submit for evaluation through Sexual Recovery Institute (SRI). Dr. Arjmandfard presented to SRI, but did not complete the evaluation because he refused to participate in the polygraph test. The evaluator at SRI stated Dr. Arjmandfard's refusal to participate in the polygraph denied the evaluator the information to conclude the evaluation. Mr. Brekke said he believe the Administrative Law Judge (ALJ) missed the point in this case by not finding Dr. Arjmandfard violated the Board order. Mr. Brekke said Dr. Arjmandfard violated the Board's order by not completing the evaluation as instructed. Mr. Brekke requested the Board immediately Revoke Dr. Arjmandfard's license rather than issuing a Stayed Revocation. Mr. Brekke noted the ALJ sustained that Dr. Arjmandfard did commit sexual misconduct, did not complete Board Ordered evaluation and noted he was diagnosed with pharaphelia. Mr. Brekke noted it may be difficult for the Board to appropriately monitor such a physician. Mr. Brekke presented the Board with amendments to the ALJ's Draft Findings of Fact, Conclusions of Law and Order.

Dr. Arjmandfard said the allegations made against him were false and were made by one patient only who was not credible due to her memory issues and hallucinations. Dr. Arjmandfard said the patient's story was not plausible. Dr. Arjmandfard said he was evaluated by two psychologists who both said he did not have a psychological disorder. He said he underwent the SRI evaluation for four days and did not believe he was in non-compliance with the Board Order as it did not specifically state he had to undergo a polygraph test.

Mr. Brekke said the victim‘s testimony was not contradicted and all other professionals that came in contact with her did not attest to her hallucinations.

Tim B. Hunter, M.D. said he found it troubling that Dr. Arjmandfard did not fully comply with the SRI evaluation.

MOTION: Sharon B. Megdal, Ph.D. move to adopt the ALJ's proposed Findings of Fact, with amendments as recommended by counsel. Specifically, in Paragraphs 6 and 7 delete the references to specific SRI personnel; in Paragraph 12 delete the language "the Administrative Law Judge addresses each…in turn;" Paragraph 28, delete "the Administrative Law Judge found;" Paragraph 32 delete all language after the first comma and substitute "however, the Interim Consent Agreement does provide that any violation of the agreement is unprofessional conduct and may result in disciplinary action. The Interim Consent Agreement required Respondent to undergo an evaluation at SRI. A polygraph is a standard component of such evaluation and Respondent did not complete that component. Respondent may not pick and choose those portions of the evaluation he will complete. Respondent was required to undergo evaluation at SRI and he did not complete that evaluation;" and Delete Paragraph 34 and 35.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

MOTION: Sharon B. Megdal, Ph.D. moved to adopt the ALJ's proposed Conclusions of Law, with amendments as recommended by counsel. Specifically, in Paragraph 1 delete all language after "evidence;" in Paragraph 3 delete "the Administrative Law Judge concludes;" Paragraph 5 delete the parenthetical referencing earlier testimony; Paragraph 7 delete "the Board claims that Dr. Arjmandfard violated that consent agreement when he refused to participate in a polygraph test at SRI;" Delete Paragraph 8 and substitute "By refusing to participate in the polygraph test, Respondent deprived SRI of useful data from making its evaluation and violated A.R.S. § 32-1401(27)(r);" Delete Paragraphs 9, 12, 13 and 14.
SECONDED: Tim B. Hunter, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

Sharon B. Megdal, Ph.D. said she was in favor of ALJ's recommended order placing the physician on Probation that would require an evaluation as part of the treatment program. Patrick N. Connell, M.D. said that after reading the transcript from the Formal Hearing and hearing Dr. Arjmandfard's testimony on all occasions when he presented to the Board, he found the license should be Revoked because he felt Dr. Arjmandfard's offenses were not remediable. Dr. Hunter was in favor of Probation with Stayed Revocation and to provide the Board with documentation within one year that he was safe to practice. The Board felt modification of the order would better protect the public health and safety while giving Dr. Arjmandfard an opportunity for rehabilitation.

MOTION: Patrick N. Connell, M.D. moved to issue a Stayed Revocation, Suspension until further Order of the Board, physician shall begin a Board approved evaluation treatment program for sexual offenders within 90 days of this Order and remain in that treatment program until successful completion thereof. At the end of 12 months he may petition the Board for reinstatement of his license with any conditions the Board may apply at that time. If he fails to enter a treatment program within 90 days and/or fails to comply with its recommendations the physician's license will be Revoked.

Ram R. Krishna, M.D. said he was concerned about Dr. Arjmandfard having an unsupervised practice at the end of one year.

SECONDED: Tim B. Hunter, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-06-0445A	AMB	RICHARD CARINO, M.D.	25808	Accept the recommended Findings of Fact and Conclusions of Law as presented by the Administrative Law Judge. Adopt Administrative Law Judge's recommended order for Revocation of an active license, effective immediately.

Richard Carino, M.D. was not present. William R. Martin, III, M.D. confirmed the Board had received and reviewed the record in this case.

Anne Froedge, Assistant Attorney General summarized the case for the Board. The State recommended Dr. Carino's license be Revoked immediately and Ms. Froedge asked the Board to accept the ALJ's Finding of Fact, Conclusions of Law and Order.

MOTION: Tim B. Hunter, M.D. moved to accept the recommended Findings of Fact and Conclusions of Law as presented by the Administrative Law Judge.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

MOTION: Tim B. Hunter, M.D. moved to adopt Administrative Law Judge's recommended order for Revocation of an active license.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N. and Paul M. Petelin, Sr., M.D. The following Board Members were not present: Robert P. Goldfarb, M.D., Patricia R.J. Griffen and Becky Jordan
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

MOTION: Tim B. Hunter, M.D. moved to add a finding of immediate effectiveness because the protection of the public and safety required the Order be effective immediately.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-04-0081A MD-03-0248A	AMB	W. NEIL CHLOUPEK, M.D.	4553	Adopt ALJ's recommended Findings of Fact #1-47. Adopt ALJ's recommended Conclusions of Law #1-3, modify #5 by deleting "not." Modify the Administrative Law Judge recommendation and Revoke the physician's license.

Neil Chloupek, M.D. was present with counsel, Mr. Paul Giancola.

Dean E. Brekke, AAG summarized the case to the Board. Mr. Brekke said the Administrative Law Judge (ALJ) did not find Dr. Chloupek in violation of a Board Order. However, Mr. Brekke said the Board ordered Dr. Chloupek to enter long term in-patient treatment and subsequently enter the Monitored Aftercare Program (MAP) abiding by the treatment center's recommendations. Upon discharge, the treatment center recommended Dr. Chloupek enter MAP and refrain from using his drugs of choice, Ritalin and Hydrocodone. Dr. Chloupek initially refused to enter MAP, but later agreed. However, at that point Dr. Chloupek was back on Ritalin and Hydrocodone which made him ineligible to enter into a MAP agreement.

Mr. Giancola said Dr. Chloupek had a unique circumstance in that Ritalin and Hydrocodone is prescribed to him because his physician has found it is medically necessary for him to function. Mr. Giancola noted Dr. Chloupek has been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and is been treated appropriately with Ritalin. Mr. Giancola said this is not a case of relapse and asked that the Board allow Dr. Chloupek to enter into a MAP agreement.

Mr. Brekke noted the MAP Program is an abstinence based program and it would be impossible to monitor a physician who was allowed to take his drugs of choice. Mr. Brekke also noted this case was not a matter of relapse but rather a matter of violation of a Board order.

MOTION: Patrick N. Connell, M.D. moved to adopt the Administrative Law Judge's recommended Findings of Fact #1-47.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

MOTION: Tim B. Hunter, M.D. moved to adopt the ALJ's recommended Conclusions of Law #1-3, modify #5 to delete "not" from the phrase "do not support a conclusion."
SECONDED: William R. Martin, III, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

Tim B. Hunter, M.D. noted although Dr. Chloupek may need the prescriptions he was taking, he nonetheless violated the Board's order by failing to submit to MAP.

MOTION: Tim B. Hunter, M.D. moved to issue a Decree of Censure for violation of board order, enter Map program and comply with all requirements of MAP.

The motion did not receive a second vote and therefore failed.

Patrick N. Connell, M.D. noted Dr. Chloupek would not be able to be monitored under a MAP agreement while on two substances he has a history of abusing. Dr. Connell said Dr. Chloupek had a 33 year history of multiple relapses and other violations and has proven himself not willing to enter the Board's abstinence based program. Kathleen Muller, Physician Health Program Manager said there was no way to monitor urine drug screens and determine if the substances in his system were at a level of impairment or not. Ms. Muller noted the Board has never placed a physician in the MAP program while continuing to use his drugs of choice.

Douglas D. Lee, M.D. noted it would be difficult to ensure the public was protected and that Dr. Chloupek was not impaired while working.

MOTION: Patrick N. Connell, M.D. moved for to issue a Stayed Revocation with Five year Probation. Within 6 months must successfully abide by the treatment recommendations of Betty Ford and if not, Revocation becomes effective.

The motion did not receive a second vote and therefore failed.

Christine Cassetta, Board Legal Counsel noted Dr. Chloupek had been out of treatment for a long period of time and the MAP program will not admit someone who did not come directly from treatment.

Lorraine Mackstaller, M.D. said she favored the abstinence based program and noted Dr. Chloupek was detoxified without incident while at treatment.

MOTION: Tim B. Hunter, M.D. moved to modify the Administrative Law Judge recommendation and Revoke the physician's license because for the reasons stated by Dr. Connell previously.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

Dr. Connell noted Dr. Chloupek displayed relapse behavior that was consistent with the illness of chemical of dependence. He is in denial and refuses to accept that he has a dependency and fails to recognize the consequences of the dependency.

Tim B. Hunter, M.D. stated he would prefer an alternative to the motion, but he has a duty to protect the public.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board members were absent: Robert P. Goldfarb, M.D., Becky Jordan and Patricia R.J. Griffen
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

MOTION: Patrick N. Connell, M.D. moved to add a finding of immediate effectiveness because a rehearing or review of the Board's decision is impracticable or contrary to the public's interest.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

Thursday, October 12, 2006

CALL TO ORDER
William R. Martin, III, M.D. called the meeting to order at 8:00 a.m.

ROLL CALL
The following Board Members were present: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Members were not present: Robert P. Goldfarb, M.D. and Patricia R.J. Griffen

CALL TO THE PUBLIC
Statements issued during the call to the public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
1.	MD-05-0427A	AMB	GEORGE KAM K. WONG, M.D.	21765	Draft Findings of Fact, Conclusions of Law & Order for a Letter of Reprimand for failure to ask appropriate questions and follow up on a patient who was critically ill.

George Wong was present with counsel Mr. Andrew Rosenzweig.

Kelly Sems, M.D., Internal Medical Consultant summarized the case for the Board. This case was opened as a result of a medical malpractice alleging Dr. Wong failed to properly diagnose a patient, failed to properly perform cardiac catheterization, failed to respond to a nursing call when the patient was critically ill and in an immediate life-threatening situation, and failed to recognize and treat a known complication of cardiac catheterization. The Outside Medical Consultant found Dr. Wong fell below the standard of care by misinterpreting the echogram, failed to obtain adequate angiograms, failed to respond to the nurses when he was notified of a critically ill patient for whom he was the most medically knowledgeable and for refusing to treat a known complication of cardiac catheterization.

Lorraine L. Mackstaller, M.D led the questioning and noted the patient died because of a complication of a cardiac procedure. Dr. Mackstaller noted his INR was 1.8 at time of cardiac catheterization and that made the patient more concerning for watchful follow up. Dr. Mackstaller questioned Dr. Wong's watchful post operative monitoring because 12 hours after surgery the patient developed 10/10 right abdominal pain, his pulse rate went up, and for two to three hours the patient was not treated. Dr. Mackstaller noted it was during that time a nurse called Dr. Wong, but Dr. Wong did not go to the hospital. Instead he referred the nurse to the physician on call, Joseph Caplan, M.D. Dr. Mackstaller noted it appeared from the nurses notes they relayed patient's blood pressure was 56/35. Dr. Wong said he was not given this information and if he would have known severity of the situation, he would have gone in immediately.

Dr. Mackstaller, noted Dr. Wong could have asked the nurses the reason for their call, and Dr. Wong said, in retrospect he wished he would have done so. Dr. Wong said he has since changed his practice by becoming more vigilant by calling the nursing and hospital staff to make sure the patient is doing okay, even if they do not call him.

Dr. Mackstaller noted the patient's INR was 3.6 when the patient was admitted. She also noted the FFP did not have the desired impact and this would increase the risk of developing a complication and should have alerted Dr. Wong. Dr. Mackstaller noted the patient was anti-coagulated before and a catheterization did not obtain hemostasis. No additional lab work was ordered until the primary care physician or the internist ordered work the next morning. He did not even order anticoagulants.

Tim B. Hunter, M.D. said he believed Dr. Wong should have gone in to see the patient because, even in the healthiest patient, cardiac catheter bleeds are a risk.

Dr. Wong said he regretted the patient's outcome in this reversible situation and if he would have had received the information he would have gone to see the patient. Mr. Rosenzweig said Dr. Wong has received no prior Board history and is a caring physician.

Dr. Mackstaller found Dr. Wong deviated from the standard of care by refusing to respond to a patient in crisis resulting in patient death.

MOTION: Lorraine Mackstaller, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any 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)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Ram R. Krishna, M.D.

Douglas D. Lee, M.D. said he did not find Dr. Wong refused to treat the patient and that it was a high standard of care for a physician not on call to be expected to respond to a phone call. The nurse did not appear to show any urgency. Dr. Hunter said he felt Dr. Wong should have had concern over the phone call from the nurse because he had just performed a catheterization and the patient had coagulation issues.

Lorraine Mackstaller, M.D. amended the motion to state “improper evaluation and management of patient’s complications”. Dr. Pardo commented it was not possible to know what the conversation was between the nurse and Dr. Wong, nevertheless, it was Dr. Wong’s responsibility to believe the nurse was calling for a specific reason and to inquire as to the reason.

VOTE: 9-yay, 1-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Lorraine Mackstaller, M.D. moved to issue Draft Findings of Fact, Conclusions of Law & Order for a Letter of Reprimand for failure to ask appropriate questions and follow up on a patient who was critically ill.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Member voted against the motion: Douglas D. Lee, M.D. The following Board Members were not present: Robert P. Goldfarb, M.D. and Patricia R.J. Griffen
VOTE: 9-yay, 1-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
2.	MD-05-0427C	AMB	JOSEPH A. CAPLAN, M.D.	14750	Draft Findings of Fact, Conclusions Of Law and Order for a Letter of Reprimand for failure to obtain a past medical history and for failure to understand the complication of a cardiac catheterization resulting in the death of a patient.

Joseph Caplan, M.D. was present without counsel.

Kelly Sems, M.D., Internal Medical Consultant summarized the case to the Board. This case resulted from a medical malpractice alleging Dr. Caplan failed to advise other personnel regarding the presence of a retroperitoneal hemorrhage in a patient, failed to attend to the patient immediately and failed to recognize and treat complications of cardiac catheterization. The Outside Medical Consultant (OMC) found Dr. Caplan’s failure to attend to the patient in a timely manner may have contributed to the patient’s death. The patient in this case is the same as in the case involving George Wong, M.D.

Lorraine L. Mackstaller, M.D. led the questioning. Dr. Caplan said George Wong, M.D. told him the hemodynamic aspects of the case when it was his turn to be on call. However, Dr. Caplan said Dr. Wong did not tell him of the patient’s atrial fibrillation or that the patient was anticoagulated. Dr. Caplan said when he was called by the nurse at 4:30 a.m. he was told the patient was hypotensive and had just had a catheterization. However, Dr. Caplan said he did not make the connection that this was the same patient Dr. Wong had told him about. Dr. Caplan said he was not told by the nurse that the patient had severe abdominal pain or that the Internist had been called. Dr. Caplan said he was later called back and told the patient was not doing well and so he had the patient sent to Intensive Care Unit (ICU). Dr. Mackstaller noted Dr. Caplan did not go in to see the patient at all in this case. Dr. Caplan said he has regretted he did not go in to see the patient, but noted the patient went on to have a spontaneous severe retroperitoneal hematoma and there was nothing that could be done to save the patient.

William R. Martin, III, M.D. agreed many people cannot be saved from a retroperitoneal bleed. Dr. Martin noted, however, the reason for the bleed was because the patient was anticoagulated and, if given clotting factors, the bleed may have stopped or slowed down to where the patient could have been successfully resuscitated. Dr. Martin noted Dr. Caplan should have been alerted to come in when the patient had to be transferred to the ICU. Dr. Caplan said the communication from the nurse was lacking and he was not told this was a more serious situation. Dr. Martin noted the standard of care is to get the history of the patient and that cannot be done without attending to the patient.

Dr. Caplan said there were many issues in reference to nursing communication in this case and as Chief of Cardiology at the hospital he has used this case to create a nursing protocol for better management in cases such as these and better communication.

Dr. Mackstaller found it disturbing that there was not a complete sign-out from Dr. Wong to Dr. Caplan when the shift changed and noted Dr. Wong did not tell Dr. Caplan the patient was anticoagulated. Dr. Mackstaller noted the treatment for retroperitoneal bleed is aggressive hydration and there was miscommunication between nursing staff and the physician regarding this patient. Dr. Mackstaller found Dr. Caplan had the responsibility to ask more questions of the nursing staff and if he would have known the patient’s past medical history and anticoagulation status, the patient’s outcome would have been changed. Dr. Mackstaller noted unprofessional conduct in that Dr. Caplan failed to obtain a history of the patient and also failed to timely manage a known complication of cardiac catheterization resulting in the patient’s death.

MOTION: Lorraine Mackstaller, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any 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)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Patrick N. Connell, M.D.

Dr. Connell noted better communication of the part of the nurse could not replace Dr. Caplan presenting to the hospital to review the patient’s chart.

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Lorraine Mackstaller, M.D. moved to Draft Finding of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to obtain a past medical history and for underestimating the complication of a cardiac catheterization resulting in the death of a patient.
SECONDED: Patrick N. Connell, M.D.

Dr. Hunter spoke against the motion stating this case was inadequately handed off to Dr. Caplan with no information given of the patient's status. Dr. Hunter noted Dr. Caplan's initial responses were appropriate and there were mitigating circumstances in this case. Paul M. Petelin, Sr., M.D. spoke in favor of the motion stating the standard of care would have required Dr. Caplan to have ordered tests over the phone if he was not going to come in initially to see the patient. Dr. Petelin noted tests results could have been obtained in less than one hour and would have shown that the patient was in trouble.

Dona Pardo, Ph.D., R.N. noted there were many system errors because of the situation and the way it progressed, but found Dr. Caplan was at fault for not asking the nurse for more information. However, Dr. Pardo said she did not feel this case rose to the level of disciplinary action. Dr. Lee said it is the on call physicians' responsibility to gain the necessary knowledge to care for the patient.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., William R. Martin, III, M.D. and Dona Pardo, Ph.D., R.N. The following Board Members were not present: Robert P. Goldfarb, M.D. and Patricia R.J. Griffen
VOTE: 5-yay, 5-nay, 0-abstain, 0-recuse, 2-absent
MOTION FAILED.

MOTION: Tim B. Hunter, M.D. moved to Issue and an Advisory Letter for a technical error for failure to obtain a past medical history and for failure to understand the complication of a cardiac catheterization resulting in the death of a patient.
SECONDED: Ram R. Krishna, M.D.

Dr. Connell spoke against an Advisory Letter stating if Dr. Caplan would have had obtained the entire picture he would have treated the patient differently**.** Ram R. Krishna, M.D. noted the nurses should have been in communication with Dr. Caplan when things were not going well with the patient.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Members voted against the motion: Patrick N. Connell, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D. and Paul M. Petelin, Sr., M.D. The following Board Members were not present: Robert P. Goldfarb, M.D. and Patricia R.J. Griffen
VOTE: 5-yay, 5-nay, 0-abstain, 0-recuse, 2-absent
MOTION FAILED.

MOTION: Tim B. Hunter, M.D. moved to issue Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to obtain a past medical history and for failure to understand the complication of a cardiac catheterization resulting in the death of a patient.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D. and Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Becky Jordan, Ram R. Krishna, M.D. and Dona Pardo, Ph.D., R.N. The following Board Members were not present: Robert P. Goldfarb, M.D. and Patricia R.J. Griffen
VOTE: 7-yay, 3-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Dona Pardo, Ph.D., R.N. moved to refer the nurse in this case to the Arizona State Board of Nursing.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
3.	MD-05-0781A	AMB	STEVE PI-HSIUNG CHOW, M.D.	31428	Draft Findings of Fact, Conclusions of Law & Order for a Letter of Reprimand for failure to appropriately monitor a patient while under anesthesia leading to respiratory arrest and possible cardiac compromise and for failure to maintain adequate medical records.

Steve Chow, M.D. was present with counsel Mr. Paul Giancola.

Carol Peairs, M.D., Medical Consultant summarized the case for the Board. A Medical Malpractice settlement alleged Dr. Chow failed to appropriately monitor a patient while providing anesthesia, failed to administer the proper muscle relaxant, and provided inadequate charting. Dr. Peairs noted Dr. Chow deviated from the standard of care when the patient was left unmonitored for about 23 minutes while awaiting transfer to the recovery room immediately following completion of surgery and while under general anesthesia. The patient subsequently experienced respiratory arrest and died.

Dr. Chow said the patient's monitors were disconnected when he moved the patient from the operating room to the gurney because he was told the nurse that was to be monitoring the patient would be back in minutes. However, during the waiting period the patient went into respiratory arrest. Dr. Chow said he regrets he did not reconnect the monitors upon hearing there would be an unanticipated delay in moving the patient to the recovery room. Dr. Chow said there was a gap in the medical record of the patient's vital signs because he was busy resuscitating the patient.

Douglas D. Lee, M.D. led the questioning. Dr. Lee noted the American Society of Anesthesiologists (ASA) guidelines stated a patient shall be continually evaluated and treated during transport with monitoring and support appropriate to the patient's condition. Dr. Lee noted the patient had a higher level of potassium than normal when he first presented to the emergency room and Dr. Chow administered a drug that had the potential to cause a dangerous rise in the patient's potassium. Dr. Lee also noted the medical record did not show he routinely monitored the patient after administering a muscle relaxant. Dr. Lee said he tended to believe Dr. Chow did monitor the patient, but just failed to document it. Dr. Lee did not find a breach in the standard of care in the type of muscle relaxant used. Dr. Lee also noted Dr. Chow mentioned he had trouble intubating the patient, but he did not document this in the medical record. Dr. Lee noted the patient's vital signs over the surgical time period showed a failing consistent downward trend of a blood pressure and pulse showing the patient was not stable and Dr. Chow should have noticed these changes. Dr. Lee noted Dr. Chow attempted to transport the patient who was non-arousable, intubated, and had unstable vital signs. Dr. Lee noted the medical record showed the patient coded within 23 minutes of being disconnected from monitoring as the last documented vital sign was at 1415 and the code began at 1438. Dr. Lee noted Dr. Chow said the patient was possibly septic and if so, more careful monitoring would be required. Additionally, the patient's high blood pressure should have alerted Dr. Chow that something further may be happening with the patient.

Mr. Giancola said although the peripheral nerve stimulator was not documented, Dr. Chow's custom and practice was to use the peripheral nerve stimulator when administering reversal agents. Mr. Giancola also noted during the time gap Dr. Chow was with the patient the entire time making judgments about patient's condition.

Dr. Lee stated the ASA guidelines require an anesthesiologist to appropriately monitor anesthesiology patients and also require appropriate monitoring during transportation. Dr. Lee found Dr. Chow should have declined to transport a patient who was unexpectedly unarousable, intubated, and had less than stable vital signs. Dr. Lee also noted Dr. Chow's documentation was inadequate because he did not record the difficulty of the intubation, and the routine monitoring. Dr. Lee found Dr. Chow's treatment in part contributed to the outcome of this patient.

MOTION: Douglas D. Lee, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient.
SECONDED: Ram R. Krishna, M.D.

MOTION: Douglas D. Lee, M.D. moved to Draft Findings of Fact, Conclusions of Law & Order for a Letter of Reprimand for failure to appropriately monitor a patient while under anesthesia leading to respiratory arrest and possible cardiac compromise and for failure to maintain adequate medical records.
SECONDED: Paul M. Petelin, Sr., M.D.

Dr. Lee noted the finding of Dr. Chow's inadequate medical record keeping was for the time during the 23 minute period as the monitors were not connected during that period so documentation would have been impossible. Dona Pardo, Ph.D., R.N. suggested Continuing Medical Education (CME) for charting.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Members were not present: Robert P. Goldfarb, M.D. and Patricia R.J. Griffen
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
4.	MD-06-0072A	AMB	STEVEN C. TORRES, M.D.	31282	Draft Findings of Fact, Conclusions of Law & Order for a Letter of Reprimand for failure to recognize Diabetic Ketoacidosis (DKA) in a pregnant patient.

Steven Torres, M.D. was present with counsel Mr. Cal Raup.

Douglas D. Lee, M.D. said he knew Mr. Raup, but it would not affect his ability to adjudicate the case. Patrick N. Connell, M.D. recused himself from the case.

Ingrid Haas, M.D., Medical Consultant summarized the case for the Board. The patient had a history of diabetes and was 33 weeks into pregnancy when she presented to the emergency room complaining of vomiting for one day. The patient's initial Accucheck was 180 and she was treated by Dr. Torres for high blood sugar. Dr. Torres was aware the finding for the patient of positive ketones, positive glucose and positive protein. The patient's vomiting became controlled, but a subsequent Accucheck showed her blood sugar rose to 446. Dr. Torres signed out the case to another physician at end of his shift, but there was no documentation of any discussion or plan between Dr. Torres and the oncoming physician. The oncoming physician discharged the patient. The patient returned to the emergency room the following day and delivered a stillborn infant.

Dr. Torres said he was extremely busy when the patient presented because he was the only physician in the emergency room at the time. Dr. Torres said the patient came to him with hyperemesis orders and he was not informed the patient was a diabetic. Dr. Torres said he realizes, in retrospect, that he should have triaged the patient immediately. Dr. Torres said the patient was barely tachycardic, did not appear toxic and did not appear to have Diabetic Ketoacidosis (DKA). Dr. Torres said he was not aware of the Accucheck of 180 and realizes he should have asked to see the chart. Dr. Torres said he told the oncoming physician the information he had, that the patient had hyperemesis and her vital signs were stable. Dr. Torres said a nurse told him the patient's Accucheck was 446 while the oncoming physician was with him going over the sign out. Dr. Torres said he regretted he did not send the patient immediately to labor and delivery, did not demand to see the patient's chart and did not order labs to rule out DKA prior to signing off to the oncoming physician. Dr. Torres said he has since changed his practice that if he wants something ordered he writes it in the chart and also now carefully reviews the chart and writes who he signs off to. Dr. Torres said he has since taken Continuing Medical Education in high risk obstetrics.

Timothy B. Hunter, M.D. led the questioning and noted Dr. Torres did not ask the patient and she did not volunteer that she was diabetic. Ram R. Krishna, M.D. found Dr. Torres should have checked the patient's blood work because of the one day of vomiting the patient complained of. Paul M. Petelin, Sr., M.D. noted only one day elapsed from the time the patient was discharged from hospital until the patient presented again to emergency room leading to the speculation that the patient had been uncontrolled on the first visit to submit back to the hospital that quickly. Dr. Mackstaller noted when the patient presented to the hospital a second time it was for ruptured membranes and not for the same reason she first presented to the emergency room. However, Dr. Mackstaller noted the patient was acidotic on the second presentation. Dr. Mackstaller also noted the patient was a long-time uncontrolled diabetic and likely could have been a non-compliant diabetic. Dona Pardo, Ph.D., R.N. noted a nurse had told Dr. Torres the patient had hyperemesis. Dr. Torres said, in retrospect he realized the nurse had jumped to a conclusion and was guessing at the diagnosis.

Mr. Raup said Dr. Torres appropriately discussed the patient with the oncoming physician. Mr. Raup also said the patient should have gone to labor and delivery to be evaluated first before coming to Dr. Torres and Dr. Torres has since moved to another hospital where staffing is better and outcomes as in this case are less likely.

Tim B. Hunter, M.D. said he found both Dr. Torres and the oncoming physician were at fault in this case. Dr. Hunter noted Dr. Torres was misguided by the nurses and was in a busy situation but nevertheless was responsible to the patient.

MOTION: Tim B. Hunter, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any 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)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 1-recuse, 2-absent
MOTION PASSED.

Dr. Hunter found Dr. Torres' fund of knowledge was adequate and the errors made in this case were partly because he was hurried. Dr. Pardo noted her concern about the way the nurses handled this case. Dr. Hunter said there were a number of things that could have been handled better in this case such as referring the patient to labor and delivery from the start.

MOTION: Tim B. Hunter, M.D. moved to Draft Findings of Fact, Conclusions of Law & Order for a Letter of Reprimand for failure to recognize Diabetic Ketoacidosis (DKA) in a pregnant patient.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D., Ram R. Krishna, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D. and Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Becky Jordan, Douglas D. Lee, M.D., Lorraine Mackstaller, M.D. and Dona Pardo, Ph.D., R.N. The following Board Member was recused: Patrick N. Connell, M.D. The following Board Members were absent: Robert P. Goldfarb, M.D., and Patricia R.J. Griffen
VOTE: 5-yay, 4-nay, 0-abstain, 1-recuse, 2-absent
MOTION PASSED.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
5.	MD-05-0695B	M.T	WILLIAM H. CASTRO, M.D.	18402	Continue this case to a future Board meeting.

This case was continued to the December 6-7, 2006 Board Meeting.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
6.	MD-05-0196B	AMB	CHARLES LEW, M.D.	18472	Draft Findings of Fact, Conclusions of Law & Order for a Letter of Reprimand for failure to diagnose and treat bowel obstruction in a timely manner and for failure to evaluate a patient presenting with continued emesis. One year Probation to include 20 hours CME in management of acutely ill pediatric patients.

Charles Lew was present without counsel.

William Wolf, M.D., Medical Consultant summarized the case to the Board. A Medical Malpractice lawsuit alleged Dr. Lew failed to promptly diagnose and treat a six-month-old patient with symptoms of bowel obstruction who suffered from prolonged dehydration and shock and as

a result had a cardiac arrest that left the patient with permanent brain damage and a seizure condition. The Outside Medical Consultant (OMC) found Dr. Lew failed to record the patient's pulse, failed to obtain lab or x-ray studies, and failed to order observed rehydration. The OMC found it mitigating that the infant increased in weight between two office visits.

Ram R. Krishna, M.D. led the questioning. Dr. Krishna noted Dr. Lew was doing rounds for walk-in patients and had access to the medical record of the patient's previous emergency room visit that showed the patient was vomiting for two days prior to seeing him. Dr. Krishna noted Dr. Lew did not document the patient was not tachycardic so there was no proof Dr. Lew checked for that. Dr. Krishna found further work up should have been done for such a delicate patient (6-months-old). Dr. Krishna noted a red flag in this case was the patient was not holding down any food or liquids. Dr. Krishna found Dr. Lew should have checked the patient's pulse and should have done a blood culture. Dr. Krishna found both the medical record and examination were incomplete.

Tim B. Hunter, M.D. noted Dr. Lew did not have much experience in the area of bowel obstruction at the time and has since taken Continuing Medical Education in this area and has worked to improve his documentation. Patrick N. Connell, M.D. found Dr. Lew misdiagnosed the child and treated the child with Phenergan for the wrong diagnosis. Dr. Connell also noted it was below the standard of care to prescribe Phenergan to this patient as it was contraindicated in a child less than two years old.

Dr. Krishna noted Dr. Lew's medical records were sparse and found he deviated from the standard of care by failing to record the patient's pulse, failing to obtain lab or x-ray studies, and failing to order observed rehydration.

MOTION: Ram R. Krishna, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Tim B. Hunter, M.D.

Dr. Connell said he was appalled that Dr. Lew fell below the standard of care in this case and noted he should have performed double the work up for a child who presents to the emergency room a second time within a 24 hours period and is not better.

VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

Dr. Krishna also stated he was appalled by this case and felt record keeping was also an issue along with the deviation from the standard of care.

MOTION: Ram R. Krishna, M.D. moved to Draft Findings of Fact, Conclusions of Law & Order for a Letter of Reprimand for failure to diagnose and treat bowel obstruction in a timely manner and for failure to evaluate a patient presenting with continued emesis. One year Probation to include 20 hours CME in management of acutely ill pediatric patients.
SECONDED: Patrick N. Connell, M.D.

Dr. Connell said he believed Dr. Lew needed more experience in the management of acutely ill children. Dr. Hunter expressed concern regarding Dr. Lew's fundamental knowledge base. William R. Martin, III, M.D. found Dr. Lew lacked pharmacological knowledge in the management of acutely ill patients and stated he had no confidence Dr. Lew was capable of caring for patients.

The Board went into Executive Session for legal advice at 3:30 p.m.
The Board returned to Open Session at 3:35 p.m.
No deliberations or decisions were made during Executive Session.

Dr. Hunter stated he would like a Findings of Fact statement to include that Board members were troubled by the answers Dr. Lew gave during the Formal Interview with the Board and believed it would be in the public's best interest for Dr. Lew to undergo an evaluation by the Physician Assessment and Clinical Evaluation (PACE) program. Dr. Hunter explained this requirement could not be included in the final Order because Dr. Lew is not currently licensed in Arizona.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Member abstained: Becky Jordan. The following Board Members were absent: Robert P. Goldfarb, M.D., Patricia R.J. Griffen and Sharon B. Megdal, Ph.D.
VOTE: 8-yay, 0-nay, 1-abstain, 0-recuse, 3-absent
MOTION PASSED.

Dr. Krishna asked the Executive Director to send a letter to the Washington State Board of Medicine, with whom Dr. Lew holds a license, to make them aware of the Board's concerns.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
7.	MD-05-0602A	C.W.	MARGARET R. KHOURI, M.D.	27739	Issue an Advisory Letter for proceeding with an EGD on a critically ill patient instead of postponing the procedure to allow the patient to stabilize. There is insufficient evidence to support discipline.

Margaret Khouri, M.D. was present with counsel, Mr. Cal Raup.

Ram R. Krishna, M.D. knows Dr. Khouri but it would not affect his ability to adjudicate the case. Patrick N. Connell, M.D. and Douglas D. Lee, M.D. said they know Mr. Raup, but it would not affect their ability to adjudicate the case.

William Wolf, M.D., Medical Consultant summarized the case to the Board. The Arizona Medical Board received a complaint alleging Dr. Khouri performed an unnecessary esophagogastroduodenoscopy (EGD) on a patient who had extensive abdominal metastasis. It was alleged the EGD procedure resulted in the patient's premature death. The Outside Medical Consultant (OMC) found the standard of care was that the EGD procedure was contraindicated when the risk to the patient life or health was judged to outweigh the benefits of the procedure. The OMC found Dr. Khouri deviated from the standard of care by performing the EGD prior to stabilization of the patient's clinical course.

Dr. Khouri said the patient was critically ill and her life could be measured in terms of weeks. Dr. Khouri said the patient was informed of the risks of the EGD, but the patient had a desire to proceed because she was in extreme pain and wanted to find the etiology of her pain in order to have it relieved. Dr. Khouri said if she was faced with similar set of circumstances again she would approach it in the same way because of the patient's desire to undergo the procedure.

Paul M. Petelin, Sr., M.D. led the questioning. Dr. Petelin noted when the patient arrived for the EGD, the patient was unstable as her blood pressure was low and she was in a lot of pain. The outpatient endoscopy center made the decision to stabilize the patient first before performing the procedure. Dr. Petelin found Dr. Khouri should have waited 48 to 72 hours rather than 12 hours before performing the EGD. Dr. Petelin noted Dr. Khouri said the patient was septic and Dr. Petelin noted because of that, 12 hours was not an adequate time period to assure the patient was fully resuscitated.

Tim B. Hunter, M.D. stated the sedation compromised her respiratory function. Dr. Khouri had no way to evaluate the severity of her pain without compromising her respiratory status. Dr. Hunter questioned whether Dr. Khouri would approach this differently by possibly intubating the patient electively before doing an endoscopy.

Ram R. Krishna, M.D. noted the patient's vital signs the day before the procedure showed she was a very ill patient and was not medically stable for the EGD and the procedure was contraindicated. Lorraine Mackstaller, M.D. noted nothing was gained from doing the endoscopy because the patient was unable to benefit from the knowledge the gastroenterology brought.

Dr. Petelin found there was no reason for urgency to perform a purely diagnostic study. However, Dr. Petelin found Dr. Khouri's poor judgment did not rise to the level of disciplinary action.

MOTION: Paul M. Petelin, Sr., M.D. moved to issue an Advisory Letter for proceeding with an EGD on a critically ill patient instead of postponing the procedure to allow the patient to stabilize. There is insufficient evidence to support discipline.
SECONDED: Patrick N. Connell, M.D.

Dr. Hunter noted the vast majority of gastroenterologists would not have performed and EGD on this patient.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D,R.N. and Paul M. Petelin, Sr., M.D. The following Board Members were absent: Robert P. Goldfarb, M.D., Patricia R.J. Griffen and Sharon B. Megdal, Ph.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
8.	MD-05-0861A	AMB	MITCHELL ROY HALTER, M.D.	29626	Continuance granted because physician signed an interim consent agreement not to perform implantations or spinal or epidural regional sensory anesthesia.

Lorraine Mackstaller, M.D. recused herself from this case.

JZ was present and spoke during the call to the public on behalf of Dr. Halter. JZ said he suffered with migraine headaches for over 20 years for which no specialists were able to help him. JZ said he had exhausted all treatments and medications to no avail and his quality of life, family and career all were suffering. JZ said after Dr. Halter implanted a neuro-stimulator he has had no a return of the migraines that were destroying his life. JZ said he hoped Dr. Halter will be able to return to the operating room to help other patients as Dr. Halter has helped him.

Dr. Halter said he did not have the opportunity to obtain legal counsel and did not feel comfortable proceeding without it.

MOTION: Tim B. Hunter, M.D. grant request for continuance of this matter
SECONDED: Ram R. Krishna, M.D.

Ram R. Krishna, M.D. noted the Board was not obligated to grant a continuance, but felt that out of fairness to the physician they should continue the matter. Timothy Miller, J.D., Executive Director said the Staff had serious concerns about Dr. Halter's practice and desired to have him present to the Board as soon possible. Mr. Miller said Dr. Halter had received adequate time to obtain an attorney.

The Board went into Executive Session for legal advice at 4:00 p.m.
The Board returned to Open Session at 4:06 p.m.
No deliberations or decisions were made during Executive Session.

Dr. Halter said the Board should not have concern that he was an imminent threat to the public because he voluntarily stopped performing implantations since the incident in this case at least two years prior. Dr. Martin asked Dr. Halter if he would be willing to sign a Consent Agreement that he would not do implantations at this time.

Amended Motion: Tim B. Hunter, M.D. moved to grant request for continuance if the physician voluntarily signed an interim Consent Agreement to not perform implantations or spinal or epidural regional sensory anesthesia.
SECONDED: Ram R. Krishna, M.D.

The matter was tabled until Staff could draft a Consent Agreement. Upon doing so, the Board resumed discussion of the Consent.

Christine Cassetta, Board Legal Counsel said the Consent Agreement was disciplinary and Dr. Halter was aware of this before signing the Agreement.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Members were absent: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Lorraine Mackstaller, M.D. and Sharon B. Megdal, Ph.D.
VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 4-absent
MOTION PASSED.

OTHER BUSINESS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-03-0859A	C.B.	JOHN M. RITLAND, M.D.	17268	Adopt the Findings of Fact as presented and accept the Conclusions of Law as drafted in the original ALJ recommended decision, with amendments recommended by counsel and add a conclusion of law regarding the Board's previous and current knowledge of its ability to reject the ALJ's credibility determination and it is declining to do so. Reject the ALJ recommended Order, and issue the order as originally modified by the Board, with the omission of paragraphs two, three, four and five of the Board's previous Order.

John Ritland, M.D. was present with counsel, Mr. Bob Milligan.

Douglas D. Lee, M.D. said he knew Dr. Ritland, but it would not affect his ability to adjudicate the case. William R. Martin, III, M.D. and Patrick N. Connell, M.D. said they both knew Mr. Milligan, but it would not affect their ability to adjudicate the case.

Dean Brekke, Assistant Attorney General summarized the case for the Board. Mr. Brekke said two witnesses/teenagers submitted allegations of sexual misconduct and quality of care concerns. Mr. Brekke said the witnesses were consistent in the police report and in interviews with Board staff. Mr. Brekke noted that four years prior the Board voted to refer the case to Formal Hearing for Revocation and the decision before the Board at this time was whether or not they would retain their previous recommendation.

Mr. Milligan said the witnesses in this case were not credible because their stories were illogical and their stories had changed. Mr. Milligan said one witness had reason to lie about Dr. Ritland because of her fear he would reveal incriminating evidence against her.

Mr. Brekke noted the ALJ found the witnesses credible in this case.

MOTION: Ram R. Krishna, M.D. moved to adopt the Findings of Fact as presented.
SECONDED: Patrick N. Connell, M.D.
VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 4-absent
MOTION PASSED.

MOTION: Patrick N. Connell, M.D. moved to accept the Conclusions of Law as drafted in the original ALJ recommended decision, add a conclusion that the Board was aware when it previously considered this case and is currently aware it has the authority to reject the ALJ's credibility determination and has declined to do so with amendments recommended by counsel, and amend

Paragraph 8 to reflect Dr. Ritland did violate A.R.S. § 32-1401(27)(d) and amend Paragraph 9 to reflect the conduct and circumstances *do* constitute unprofessional conduct.
SECONDED: Ram R. Krishna, M.D.
VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 4-absent
MOTION PASSED.

MOTION: Patrick N. Connell, M.D. moved to reject the ALJ recommended Order, and issue the order as originally modified by the Board, with the omission of paragraphs two, three, four and five of the Board's previous Order.
SECONDED: Becky Jordan

Dr. Connell noted it would be impossible for Dr. Ritland to practice OBGYN without the ability to conduct appropriate sexuality counseling. Dr. Connell felt the order put Dr. Ritland on enough notice of boundary issues without having to add that restriction.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Member was abstained: Douglas D. Lee, M.D. The following Board Members were absent: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Lorraine Mackstaller, M.D. and Sharon B. Megdal, Ph.D.
VOTE: 7-yay, 0-nay, 1-abstain, 0-recuse, 4-absent
MOTION PASSED.

The Board's original reasons for modifying the recommend Order were that the charges against Dr. Ritland were serious and he needed to understand he had gone to the precipice.

Public Comment on proposed Substantive Policy Statement re: Internet Prescribing
Consideration of Substantive Policy Statement re: Internet Prescribing
The Board continued this matter to a future Board Meeting.

Timothy C. Miller, J.D., Executive Director