



Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258

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DRAFT MINUTES FOR REGULAR SESSION MEETING

Held on October 7, 2009

9535 E. Doubletree Ranch Road • Scottsdale, Arizona

Board Members

Douglas D. Lee, M.D., Chair

Paul M. Petelin Sr., M.D., Vice Chair

Amy J. Schneider, M.D., F.A.C.O.G., Secretary

Patricia R. J. Griffen, Member-at-Large

Andrea E. Ibáñez

Ram R. Krishna, M.D.

Todd A. Lefkowitz, M.D.

Lorraine L. Mackstaller, M.D.

William R. Martin III, M.D.

Dona Pardo, Ph.D., R.N.

Germaine Proulx

CALL TO ORDER

The meeting was called to order at 8:00 a.m.

ROLL CALL

The following Board members were present: Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board members were absent: Ms. Ibáñez and Dr. Martin.

CALL TO THE PUBLIC

Charlene Wood, M.D., addressed the Board regarding the Board's previous denial of her application for licensure. She stated that she has applied to several family medicine residency programs, but has not qualified due to the unresolved issues identified by the Board. Pursuant to A.R.S. §32-1427(H)(1)(2), Dr. Wood requested that the Board change its documentation regarding the license denial to specifically state the following:

"Deny the license as Charlene Wood, M.D., needs to successfully complete a residency or resolve her clinical skills/competency issues. It is understood that she left the University of Arizona, Family Medicine residency in lieu of dismissal and for clinical skills/competency issues. The Arizona Medical Board encourages her to complete a residency. Additionally, if accepted to an Arizona Family Medicine residency, a training license will be issued for use while under the supervision of trainers in a residency training program, and that upon completion of a residency program or at which time that Dr. Wood is identified as competent by her trainers, she would be eligible to apply for a full license."

Dr. Anthony Dekker addressed the Board in support of Dr. Wood. He stated that she has received a scholarship from the Indian Health Services and that the Indian Health Services wants to see Dr. Wood finish her residency in order to serve her community.

All other statements issued during the call to the public appear beneath the case referenced.

EXECUTIVE DIRECTOR'S REPORT

Lisa Wynn, Executive Director, reported that the Agency has been working with the Governor's Office in processing the current budget deficit. She stated the Agency was instructed to submit a budget plan for the current fiscal year implementing a fifteen percent reduction; however, it is anticipated that the Agency will not be mandated to implement the reduction. Ms. Wynn informed the Board that the Agency is currently operating with expenditures less than the Agency's current appropriation. Ms. Wynn reported that the State has launched its State Employee Charitable Campaign (SECC) and that Board staff has donated over \$3,000. She also reported that Marlene Young, Case Manager, continues to work on coordinating a blanket campaign for a youth program in Phoenix.

Ms. Wynn reported that she and Suzann Grabe attended the Administrators in Medicine (AIM) Eastern and Southern Regional Meeting in Charleston, West Virginia on September 24-25, 2009. She stated that Ms. Grabe suggested that it would be beneficial for state licensing boards to utilize a uniform license verification system during the course of the credentialing process. Ms. Wynn

recognized the Agency's Senior Management Team for their hard work, that includes William Wolf, M.D., Chief Medical Consultant, Amanda Diehl, Deputy Executive Director, Pat McSorley, Case Review Manager, Suzann Grabe, Licensing Office Manager, Chris Banys, Board Operations Manager, Kathleen Muller, Physician Health Program, Roger Downey, Media Relations Officer, James Gentile, Chief Information Officer, and Evangeline Webster, Business Office Manager. Ms. Wynn also recognized Lisa McGrane's efforts in helping guide the Agency stating that Lisa has been instrumental in guiding throughout this difficult budget year. She informed the Board that the Agency continues to operate with a lot of strength, and that when areas of the Agency seem to fall short, the Senior Management Team evaluates the situation and determines solutions.

Dr. Lee commended Board staff for its efforts in issuing medical licenses, which is currently averaging 29 days. He noted the number of complaints the Board has received and questioned the nature of the complaints. Ms. McSorley informed the Board that the Agency anticipates more complaints to be filed during the winter time largely due to the fact that there are more people traveling to the valley during that time. Ms. McSorley also stated that there was no pattern in the issues identified in the complaints. Dr. Lee stated that with the Board's proactive stance, he anticipates that Board staff will stay on top of these matters and will advise the Board if concerns develop. Dr. Pardo commended Board staff for coordinating another one day Board meeting. Dr. Pardo noted an increase in the number of physicians who accepted the invitation for a Formal Interview. Ms. Wynn stated that there may be an increased number of physicians who wish to have their case reviewed by the Board during a Formal Interview rather than by signing a Consent Agreement.

CHAIR'S REPORT

Dr. Lee reminded Board members of the Offsite Planning Meeting scheduled for Thursday, October 8, 2009. Board members expressed their condolences to Dr. Martin and his family for their loss of a family member in Chicago. Dr. Lee reported that Dr. Krishna would be leaving the meeting early as he will be representing the Board at the Federation of State Medical Boards (FSMB) meeting in Florida.

LEGAL ADVISOR'S REPORT

Appellate Report

Jennifer Boucek, Assistant Attorney General, reported two appellate decisions that recently occurred. The case of Gaveck v. Arizona Board of Podiatry involved the issue of whether a professional licensing board had the authority to establish the standard of care by employing its own expertise. The ruling of the case reaffirmed the boards' ability to articulate the standard of care by utilizing its own expertise. The second matter, Advanced Cardiac Specialists v. Tri-City, involved complaints made to the Board by a physician. A physician filed a complaint with the Board, and then was sued for defamation by the physicians with whom the complaint had been filed. Ms. Boucek reported that pursuant to A.R.S. §32-1451.A., the Court found that the physician who filed the complaint was entitled to qualified immunity as the plaintiffs did not produce clear and convincing evidence that the physician abused his privilege when filing the complaint with the Board.

BOARD FORMAL INTERVIEW EDUCATIONAL SEMINAR

This item was delayed and will be placed on a future agenda.

APPROVAL OF MINUTES

MOTION: Dr. Petelin moved to approve the August 5, 2009 Regular Session Meeting, including Executive Session.

SECONDED: Ms. Proulx

VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.

MOTION PASSED.

ADVISORY LETTERS

MOTION: Dr. Schneider moved to issue an Advisory Letter in item numbers 1, 3-6, 9-15, 17, and 19.

SECONDED: Dr. Krishna

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

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
1.	MD-09-0561A	TIMOTHY V. BELL, M.D.	36515	Issue an Advisory Letter for action taken by another state. The licensee has demonstrated substantial compliance through remediation that has mitigated the need for disciplinary action.
2.	MD-08-1405A	MARCIA G. KO, M.D.	12181	Issue an Advisory Letter for lack of documentation of an extended family history in a high-risk patient, and for failing to further evaluate developing symptoms of breast pain and newly palpable breast findings. The violation was a one-time occurrence that does not rise to the level of discipline.

Attorney Robert Feinberg and Dr. Ko spoke during the call to the public. Mr. Feinberg deferred his comments to Dr. Ko who summarized that over an eighteen month period, she had seen the patient six times. Dr. Ko stated that the patient's complaints were addressed each time, and that she had a normal mammogram with no symptoms until she presented with cancer. Dr. Ko requested that the Board reconsider the position of the medical consultant and dismiss the case. Dr. Mackstaller stated that she recommended dismissing the case as she believes Dr. Ko met the standard of care in this case.

MOTION: Dr. Mackstaller moved for dismissal.

SECONDED: Ms. Griffen

Dr. Petelin spoke against the motion and noted that the patient's initial mammogram in Dr. Ko's possession was from a very competent radiologist, who deals primarily with breast disease, with a recommendation that the patient's breast be biopsied. However, he stated it was unclear as to whether this same area of the patient's breast ultimately became the infiltrating carcinoma. Dr. Mackstaller stated that she felt it was two different areas of the breast. Dr. Petelin noted that Dr. Ko is a rheumatologist and he questioned her role in functioning as a breast specialist in a breast clinic. He found that there was a delay in diagnosis of breast cancer, and believed that an Advisory Letter would be appropriate. Dr. Mackstaller noted that Dr. Ko has practiced in a breast clinic for twelve years, and stated that she does not have an issue with her change in focus to women's breast issues. Dr. Mackstaller said she believed that the breast clinic did work up that area of the breast, but there were no abnormal findings noted. Dr. Krishna spoke against the motion and stated that when there is a family history of breast cancer and when there is a suspicious lesion with a diagnostic report recommending further work up, the breast should have been biopsied.

VOTE: 3-yay, 6-nay, 0-abstain, 0-recuse, 2-absent.

MOTION FAILED.

MOTION: Dr. Krishna moved to issue an Advisory Letter for lack of documentation of an extended family history in a high-risk patient, and for failing to further evaluate developing symptoms of breast pain and newly palpable breast findings. The violation was a one-time occurrence that does not rise to the level of discipline.

SECONDED: Dr. Petelin

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

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
3.	MD-09-0244A	KAREN A. RAGAINI, M.D.	27459	Issue an Advisory Letter for failing to order discontinuation of the Pitocin and for failing to give orders to have the patient stop pushing when significant decelerations were noted. This matter does not rise to the level of discipline.
4.	MD-09-0525A	WILLIAM T. KO, M.D.	26333	Issue an Advisory Letter for inadequate medical records. This matter does not rise to the level of discipline.

Attorney Kraig Marton spoke during the call to the public. Mr. Marton said that Dr. Ko did not know what else should have been included in the operative report beyond what the laser was set at and that it was performed on a test spot. He further stated that the medical consultant had also expressed concern with the consent form as it did not list which specific laser was used; however, Mr. Marton stated that listing the specific laser would not have affected the risks that were explained to the patient and outlined in the consent form.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
5.	MD-09-0585A	NATASHA N. DEONARAIN, M.D.	24795	Issue an Advisory Letter for failure to order x-rays in a patient with leg pain and bone tenderness, and for inadequate medical records. The violation was a one-time occurrence that does not rise to the level of discipline.
6.	MD-09-0427A	ARTHUR J. BACON, M.D.	27256	Issue an Advisory Letter for failing to evaluate diplopia. The violation was a one-time occurrence that does not rise to the level of discipline.

Drs. Lee and Mackstaller were recused from this case.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
7.	MD-09-0840A	JAMES I. OKOH, M.D.	34467	Advisory Letter for placing a chest tube on the wrong side. The violation was a one-time occurrence that does not rise to the level of discipline.

Dr. Pardo noted that the underlying patient care involving a chest tube that was placed on the wrong side occurred in another state, which ultimately took disciplinary action against Dr. Okoh's medical license. She questioned why the recommended Advisory Letter was for the underlying patient care, rather than the action taken by another state. Dr. Wolf informed the Board that SIRC observed significant mitigating circumstances in this case and found that an Advisory Letter was sufficient to track the incident. Dr. Wolf pointed out that the Pennsylvania and West Virginia Board actions were not available to SIRC during its deliberation; however, he stated that it would not have affected SIRC's recommendation. Dr. Pardo noted that the underlying case involved patient harm and stated that she believed the matter rises to the level of discipline. Dr. Pardo recommended offering Dr. Okoh a Consent Agreement for a Letter of Reprimand. Dr. Krishna agreed with Dr. Pardo's concerns, but commented that Board staff should obtain the medical records from the other state, prior to final adjudication.

MOTION: Dr. Krishna moved to return the case for further investigation to obtain the medical records from the Florida Medical Board regarding the underlying quality of care matter, and return the matter to the Board.

SECONDED: Dr. Pardo

Drs. Petelin and Schneider spoke against the motion. Dr. Petelin pointed out that a tension pneumothorax is a true respiratory emergency that requires immediate intervention. Dr. Petelin found that Dr. Okoh recognized that the chest tube was placed in the wrong side, he corrected it, and that the patient ultimately did well. Dr. Petelin spoke in favor of issuing an Advisory Letter. Dr. Pardo recommended changing the Advisory Letter language to reflect that it was issued for action taken by another state.

VOTE: 3-yay, 6-nay, 0-abstain, 0-recuse, 2-absent.

MOTION FAILED.

MOTION: Dr. Petelin moved to issue an Advisory Letter for placing a chest tube on the wrong side. The violation was a one-time occurrence that does not rise to the level of discipline.

SECONDED: Dr. Mackstaller

VOTE: 6-yay, 3-nay, 0-abstain, 0-recuse, 2-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
8.	MD-08-0079A	EDWARD W. SONG, M.D.	33859	Issue an Advisory Letter for failure to re-operate immediately on a patient who developed cauda equina syndrome following laminectomy. This matter does not rise to the level of discipline.

Dr. Song and Attorney Stephen Myers spoke during the call to the public. Mr. Myers summarized that Dr. Song was first notified of the patient's complications at 12:12 a.m., and that at 2:00 p.m. Dr. Song took the patient to surgery. He stated that irreversible changes had already occurred, and Dr. Song could not justify pushing other patients and surgeons back in the operating room schedule. Dr. Song stated that the window of opportunity to reverse the complication had most likely passed, which is why he did not operate on the patient in the middle of the night.

MOTION: Dr. Lee moved to issue an Advisory Letter for failure to re-operate immediately on a patient who developed cauda equina syndrome following laminectomy. This matter does not rise to the level of discipline.

SECONDED: Dr. Krishna

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

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
9.	MD-09-0046A	AUDREY K. TSAO, M.D.	34748	Issue an Advisory Letter for retention of a foreign body during a total hip arthroplasty. The violation was a one-time occurrence that does not rise to the level of discipline.
10.	MD-07-0951A	ROBERT A. ALFICH, M.D.	19453	Issue an Advisory Letter for failure to order x-rays in a timely manner for an elderly patient who fell while in an assisted living facility. The violation was a onetime occurrence that does not rise to the level of discipline.
11.	MD-09-0499A	ROBERT W. IRWIN, M.D.	28417	Issue an Advisory Letter for delay in addressing overuse of Xanax with frequent early refills and for failure to refer the patient to a psychiatrist as anxiety and panic symptoms progress. There is insufficient evidence to support discipline.
12.	MD-09-0489A	FREEMAN FAVORS, M.D.	23115	Issue an Advisory Letter for inadequate medical records. The violation was a one-time occurrence that does not rise to the level of discipline.
13.	MD-09-0686A	TERENCE J. GIBBONEY, M.D.	31490	Issue an Advisory Letter for injection of glenohumeral joint instead of the acromioclavicular joint. The violation was a one-time occurrence that does not rise to the level of discipline.
14.	MD-09-0344A	MICHAEL A. CHASIN, M.D.	8082	Issue an Advisory Letter for failure to make the diagnosis of intraperitoneal perforation following TURBT, and for inadequate medical records. The violation was a one-time occurrence that does not rise to the level of discipline.

Dr. Chasin spoke during the call to the public and stated that the standard of care articulated in the medical consultant's report was not accurate. With regard to the medical records issue identified, he admitted that he failed to specifically document in the operative report whether the perforation was intraperitoneal versus extraperitoneal.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
15.	MD-08-0288A	PAUL D. MONTANARELLA, M.D.	22111	Issue an Advisory Letter for billing excessive preoperative time and for inadequate medical records. This matter does not rise to the level of discipline.

Dr. Petelin was recused from this case.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
16.	MD-09-0405A	HIMANSHU H. SHUKLA, M.D.	33766	Dismiss.

Dr. Shukla and Attorney Stephen Myers spoke during the call to the public. Dr. Shukla stated that the procedure was performed prior to the guidelines being published, which the medical consultant used in articulating the standard of care pertaining to the transesophageal echocardiogram (TEE). Dr. Shukla stated that both patients involved in this case had very transient complications and were managed appropriately. Mr. Myers stated that with respect to the alleged excess contrast, the particular agents Dr. Shukla used were associated with lower volume overload and renal failure. Mr. Myers found that Dr. Shukla's aggressive approach was reasonable, and stated that had he aborted the case earlier, he would have avoided peer criticism but would not have been acting in the patient's best interest.

Dr. Petelin found Dr. Shukla's statement issued at the call to the public to be very explanatory. Dr. Petelin noted that the patient was in sinus rhythm and that Dr. Shukla did not feel the need for a TEE. Dr. Petelin found that Dr. Shukla explained his rational in comparison of the risks in utilizing the 600cc of contrast, which is over and above the amount typically used, in order to save the patient from having to undergo an open procedure, which would have been a more risky procedure.

MOTION: Dr. Petelin moved for dismissal.
SECONDED: Dr. Mackstaller

Dr. Krishna noted that the patient for whom Dr. Shukla utilized the 600cc of contrast sustained renal failure. Bhupendra Bhatheja, M.D., Medical Consultant, stated that he would have waited for the patient's creatinine to return to normal levels prior to proceeding to surgery. Dr. Krishna spoke against the motion.

VOTE: 7-yay, 2-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
17.	MD-09-0461A	MARK C. FOSTER, M.D.	11793	Issue an Advisory Letter for failure to refer a patient with a dilated aortic root to a cardiologist or cardiovascular surgeon. The licensee has demonstrated substantial compliance through remediation that has mitigated the need for disciplinary action.

Dr. Lee was recused from this case. JB, patient BB's wife, spoke during the call to the public. She stated that following an aortic valve replacement in 1995, echocardiograms were obtained in 2000, 2003, and 2006, which were all done and assessed by Dr. Foster. JB stated that by the time of her husband's last echocardiogram, his aneurysm was the size of his heart. She asked that the Board consider the case and move it beyond an Advisory Letter. BB's son addressed the Board during the call to the public. He stated that BB did everything that was asked of him by his physicians. He stated that his MRIs continued to show steady growth of the aneurysm over the course of six years, but Dr. Foster never notified him of this. BB's niece also addressed the Board and read the initial complaint filed with the Board. She questioned how Dr. Foster was able to let BB go almost seven years without ever informing him of the aneurysm.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
18.	MD-09-0538A	LEE R. GOLDBERG, M.D.	31261	Issue an Advisory Letter for failure to make further efforts to re-open the diagonal coronary artery following occlusion during coronary artery stenting. The violation was a one-time occurrence that does not rise to the level of discipline.

Dr. Mackstaller was recused from this case. Dr. Goldberg and Attorney Ed Gaines spoke during the call to the public. Mr. Gaines stated that when looking at the facts of the case, the real issue is whether he made sufficient attempts to deal with the diagonal artery after cardiac catheterization. Dr. Goldberg ballooned the diagonal branch, two wires were placed in the diagonal, and one was inserted in the lower ascending artery. Mr. Gaines further stated that an Advisory Letter in this case with a 2mm diagonal artery would not be appropriate. He stated that Dr. Goldberg attempted to re-enter and re-open the diagonal branch, but was unsuccessful. Dr. Goldberg stated that he ballooned the diagonal branch three times and then stented across it. However, the diagonal branch shut down and he tried to pass a wire but was unsuccessful. Dr. Goldberg pointed out that an echocardiogram was performed the following day that revealed the heart to be normal and did not show any damage to the diagonal branch.

Dr. Lee questioned whether Dr. Goldberg should have stented the diagonal branch. Dr. Bhatheja pointed out that the operative report identified the diagonal artery as being moderate size. Dr. Bhatheja explained that once the diagonal branch closed off, Dr. Goldberg should have placed a balloon on the two wires that were already inserted and blew them up simultaneously. Dr. Lee questioned whether the standard of care required Dr. Goldberg to perform the procedure. Dr. Bhatheja stated that it would have depended on the patient's symptomatology.

MOTION: Dr. Lee moved to issue an Advisory Letter for failure to make further efforts to re-open the diagonal coronary artery following occlusion during coronary artery stenting. The violation was a one-time occurrence that does not rise to the level of discipline.

SECONDED: Ms. Griffen

VOTE: 8-yay, 0-nay, 0-abstain, 1-recuse, 2-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
19.	MD-09-0541A	ARTHUR B. SCHACHTER, M.D.	11385	Issue an Advisory Letter for failure to consider pulmonary embolus in a patient presenting with shortness of breath and tachycardia. The violation was a one-time occurrence that does not rise to the level of discipline.

REVIEW OF EXECUTIVE DIRECTOR DISMISSALS

MOTION: Dr. Mackstaller moved to uphold the dismissal in item numbers 1-5, 7-12.

SECONDED: Dr. Lefkowitz

VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
1.	MD-08-1046A	RAJESH N. KUKUNOOR, M.D.	33762	Uphold Dismissal.
2.	MD-09-0363A	ERIC B. WHITACRE, M.D.	32120	Uphold Dismissal.

Dr. Mackstaller was recused from this case.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
3.	MD-08-1414H	LUIS A. HASHIMOTO, M.D.	34015	Uphold Dismissal.

Patient CS spoke during the call to the public. She alleged that Dr. Hashimoto failed to consult with her regarding her mother's treatment options as she was in no condition to make her own medical decisions. She asked that the Board take action due to Dr. Hashimoto's negligence in the care of her mother.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
4.	MD-09-0680A	SUMER L. DAIZA, M.D.	24528	Uphold Dismissal.

Dr. Petelin was recused from this case. TN spoke during the call to the public on behalf of her mother, the complainant. She stated that her mother underwent breast augmentation and abdominoplasty performed by Dr. Daiza. TN alleged that Dr. Daiza performed a breast reduction on her mother without her consent.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
5.	MD-09-0509A	PAUL H. RHEE, M.D.	28432	Uphold Dismissal.
6.	MD-09-0801A	BRIAN B. DURSTELER, M.D.	28901	Uphold Dismissal.

BB and JB spoke during the call to the public. BB stated that her son died on March 30, 2009 hours after leaving the emergency room at West Valley Hospital where Dr. Dursteler supervised his care. JB asked that the Board determine whether there was a mistake made in his son's care. He stated that the medical record supports that Dr. Dursteler never examined his son, but signed off on his chart, and billed to the effect that the patient was seen by him. JB stated that his son's records indicated that his son required level three care in the emergency room, which would have obligated the physician to obtain lab tests.

Dr. Petelin suggested that the case return for further investigation to allow SIRC the opportunity to review the case. Dr. Petelin expressed concern with the issues of billing that may have indicated Dr. Dursteler saw the patient. Dr. Bhatheja informed the Board that the matter was reviewed by a medical consultant who found that there was no deviation from the standard of care. Dr. Petelin questioned whether something additional could have been done in the emergency room. Dr. Bhatheja pointed out that the patient was discharged from the emergency room without an emergency medical condition present. Dr. Petelin found that returning the case may not identify any violation and; therefore, he spoke in favor of upholding the dismissal.

MOTION: Dr. Petelin moved to uphold the dismissal.

SECONDED: Dr. Mackstaller

VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
7.	MD-09-0503A	JEFFERY D. SELLERS, M.D.	33321	Uphold Dismissal.
8.	MD-09-0655A	NAVTEJ S. TUNG, M.D.	30264	Uphold Dismissal.
9.	MD-08-1414E	GARY S. KAUFFMAN, M.D.	22774	Uphold Dismissal.

CS spoke during the call to the public on behalf of her mother, the patient. She reported that her mother was started on Lovenox on a Tuesday, and remained on Lovenox until the following Sunday at which time a major bleed occurred. She requested that the Board hold Dr. Kauffman accountable for the inadequate care provided to her mother.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
10.	MD-09-0589A	GERALD L. MUNCY, M.D.	20267	Uphold Dismissal.

SF spoke during the call to the public on behalf of her husband, the patient. She stated that she and her husband were never informed that his Coumadin dose was too high. She informed the Board that her husband was later reported to be brain dead and subsequently died after suffering a hemologic stroke. She requested that the Board look into the matter further.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
11.	MD-09-0581A	KERRY G. SCHLECHT, M.D.	22856	Uphold Dismissal.

Dr. Schlecht spoke during the call to the public. She stated that she dismissed the complainant from her care and referred her to another physician as she felt her dog's aggressive behavior was threatening to her and her office staff. She asked that the Board uphold the dismissal.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
12.	MD-09-0884A	JOSEPH W. NOLAN, M.D.	14186	Uphold Dismissal.

Attorney Michael Troncellito spoke during the call to the public on behalf of the complainant. He stated that the complainant alleged the physician inappropriately touched her and failed to document her prior medical history that includes Hodgkin's Lymphoma. Mr. Troncellito stated that the complainant's medical records remain unchanged despite her several requests.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
13.	MD-09-0607A	KEVAN A. PICKREL, M.D.	30069	Return the case for further investigation.
14.	MD-09-0607B	AAASHISH, N. SAGAR, M.D.	33270	Return the case for further investigation.

BS spoke during the call to the public on behalf of her elderly father, the patient, who was involved in both cases MD-09-0607A and MD-09-0607B. BS briefly summarized that her father underwent a G-tube placement which she stated he did not require. She alleged that he sustained a bowel perforation and was starved for eleven days. BS pointed out that both physicians were provided

with x-ray reports from the radiologist who suggested possible bowel perforation; however, she stated that Drs. Pickrel and Sagar ignored the radiologist's concerns for approximately eleven days.

Dr. Petelin noted that some physicians may have a tendency to not be as aggressive when treating elderly patients. He expressed concern regarding the large area of free air in the peritoneum that was identified on x-ray. Kathleen Coffey, M.D., Medical Consultant, pointed out to the Board that the patient was followed by pulmonary, gastroenterology, and infectious disease specialists during his hospital stay. Dr. Petelin requested that both cases return for further investigation.

MOTION: Dr. Petelin moved to return cases MD-09-0607A and MD-09-0607B for further investigation.

SECONDED: Dr. Mackstaller

VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.

MOTION PASSED.

OTHER BUSINESS

MOTION: Ms. Griffen moved to accept the proposed Consent Agreements in Other Business item numbers 1-5.

SECONDED: Ms. Proulx

Dr. Petelin recalled the physician's statement issued during the call to the public on behalf of item number 4. He stated that the Board does not typically see physicians who sign a consent agreement and then come to the Board meeting and speak during the call to the public to request the Board not follow through with the consent agreement. Ms. Boucek instructed the Board that they could either reject or accept the proposed Consent Agreement. Dr. Mackstaller inquired as to the Board's options if they voted to reject it. Ms. Boucek advised that the Board may return the matter for further investigation, or invite the physician for a formal interview, at which point the physician would also have the option of a formal hearing. Dr. Pardo pointed out that the Board, in the past, has rejected the Consent Agreement, proposed changes to the Agreement, and then re-offered the Agreement to the physician.

ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board members were absent: Ms. Ibáñez, Dr. Krishna, and Dr. Martin.

VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
1.	MD-08-1330A	FLORIN GAIDICI, M.D.	29891	Accept the proposed Consent Agreement for a Letter of Reprimand.
2.	MD-07-0468A	IMAD M. AL-BASHA, M.D.	16896	Accept the proposed Consent Agreement for a Letter of Reprimand.
3.	MD-09-0562A	GARY W. HALL, M.D.	12977	Accept the proposed Consent Agreement for Surrender of license.

Dr. Lefkowitz was recused from this case.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
4.	MD-09-0134A	GEORGE S. SARA, M.D.	15912	Accept the proposed Consent Agreement for a Letter of Reprimand.

Dr. Lee was recused from this case. Dr. Sara spoke during the call to the public. He summarized that the patient had some complaints of an alternative nature that did not occur prior to his performance of cervical epidural injection. He stated that a follow up MRI revealed that he penetrated her spinal cord, and failed to document in the patient's chart his discussion with her in the outpatient surgery center. Dr. Sara stated he has learned from this case, but that it is unclear whether the standard of care requires outpatient centers to document each contact with the patient in their chart. He stated that if this standard has changed, the Board should make a publishing to that affect to clarify the issue.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
5.	MD-09-0246A MD-09-0320A MD-09-0882A	ALBERT SZU YUN YEH, M.D.	32323	Accept the proposed Consent Agreement for Surrender of license.
6.	This matter was pulled from the Agenda prior to the Board meeting.			
7.	MD-02-0216A MD-02-0764A MD-02-0765A MD-03-0504A MD-03-0166A	ABEDON A. SAIZ, M.D.	24387	Grant the request for modification of Board Order as recommended by Board staff.

Celina Shepherd, Case Manager, summarized that on August 17, 2004, Dr. Saiz entered into a Consent Agreement that required him to remain in compliance with his June 15, 2004 Board Order with several terms and conditions. She stated that on July 13, 2009, Dr. Saiz requested termination of his August 2004 Board Order. Board staff recommended that the Board terminate the probationary terms of maintaining a log of operative procedures, chart reviews, notification within five days of pending malpractice or restriction in Dr. Saiz's privileges by any hospital or free standing surgery center, and to modify the requirement for quarterly declarations to require that he submit an annual declaration of compliance. Board staff further recommended that the restrictions from performing bariatric surgery, including gut shortening and excision of omentum for weight loss purposes, and the restriction from performing thoracic surgery without supervision, remain in effect.

MOTION: Dr. Pardo moved to grant the request for modification of Board Order as recommended by Board staff.

SECONDED: Ms. Griffen

VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
8.	MD-07-0700A	MARTIN L. BELL, M.D.	23962	Accept the proposed Consent Agreement for Restitution and Continuing Medical Education (Non-Disciplinary). Dr. Bell shall pay restitution to patient BC in the amount of \$7500 within 10 days of the effective date of this Order. Failure to pay restitution within 10 days of this Order's effective date will constitute unprofessional conduct. Dr. Bell shall obtain 8-10 hours of Board staff pre-approved Category I non-disciplinary CME in ethics. The CME hours shall be in addition to the hours required for the biennial renewal of medical license.

Dr. Coffey summarized that patient BC underwent several plastic surgeries performed by Dr. Bell. Dr. Coffey stated that BC paid upfront for the procedures, but was later informed that her insurance company was also billed for a portion of the procedures. In addition, Dr. Coffey stated that Dr. Bell failed to bill the insurance company for the breast surgery as requested by the patient. BC subsequently requested a refund and received a check in the amount of \$590, but returned it as she believed the refund was inadequate.

MOTION: Dr. Pardo moved to enter into Executive Session to receive legal advice.

SECONDED: Ms. Griffen

Vote: 8-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.

MOTION PASSED.

The Board went into Executive Session for legal advice at 5:18 p.m.

The Board returned to Open Session at 5:26 p.m.

No deliberations or discussions were made during Executive Session.

MOTION: Dr. Pardo moved to accept the proposed Consent Agreement for Restitution and Continuing Medical Education (Non-Disciplinary). Dr. Bell shall pay restitution to patient BC in the amount of \$7500 within 10 days of the effective date of this Order. Failure to pay restitution within 10 day of this Order's effective date will constitute unprofessional conduct. Dr. Bell shall obtain 8-10 hours of Board staff pre-approved Category I non-disciplinary CME in ethics. The CME hours shall be in addition to the hours required for the biennial renewal of medical license.

SECONDED: Ms. Griffen

ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board members were absent: Ms. Ibáñez, Dr Krishna, and Dr. Martin.

VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.

MOTION PASSED.

FORMAL HEARING MATTERS – CONSIDERATION OF ADMINISTRATIVE LAW JUDGE (ALJ) RECOMMENDED DECISION

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
1.	MD-08-1469A MD-09-0522A MD-09-0528A MD-09-0782A	ROBERT C. TEAGUE, M.D.	3925	Adopt and modify the ALJ's recommended Findings of Fact, Conclusions of Law and Order for Revocation.

Dr. Teague was not present during the Board's consideration of the matter. Board members indicated that they received and reviewed the administrative record of the Formal Hearing in this matter. Anne Froedge, Assistant Attorney General, requested that the board accept and modify the ALJ's recommended decision. She requested that Finding of Fact #1 be amended to adequately reflect the Board's title, and that Findings of Fact #s 51 and 55 be replaced with a summary of what the various healthcare providers found in this case rather than include full excerpts of the records.

MOTION: Dr. Krishna moved to adopt and modify the ALJ's recommended Findings of Fact, as amended by Board counsel.

SECONDED: Ms. Griffen

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

MOTION PASSED.

MOTION: Dr. Krishna moved to adopt and modify the ALJ's recommended Order for Revocation.

SECONDED: Dr. Petelin

ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board members were absent: Ms. Ibáñez and Dr. Martin.

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

MOTION PASSED.

LEGAL MATTERS

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
1.	MD-08-0748A	CARLIN G. BARTSCHI, M.D.	9497	Deny the motion for rehearing or review.

Dr. Bartschi was not present during the Board's consideration of this matter. Dr. Krishna stated that he knew Dr. Bartschi, but it would not affect his ability to adjudicate the case. Ms. Froedge presented this matter for the Board and requested that Dr. Bartschi's motion be rejected as there was no legal basis for a rehearing or review.

MOTION: Dr. Krishna moved to deny the motion for rehearing or review.

SECONDED: Ms. Proulx

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

MOTION PASSED.

FORMAL INTERVIEWS

NO.	CASE NO.	PHYSICIAN	LIC.#	RESOLUTION
1.	MD-08-1430A	JANET MOORE, M.D.	28427	Issue an Advisory Letter for failing to admit a patient with pre-eclampsia.

Drs. Lee and Schneider were recused from this case. Dr. Moore was present with legal counsel, Mr. Jeff Campbell. Kathleen Coffey, M.D., Medical Consultant, summarized that Dr. Moore failed to admit the patient for further evaluation and treatment of pre-eclampsia, and failed to obtain a high risk pregnancy specialty consultation. Dr. Moore stated that when the patient began experiencing high blood pressure, she was placed on bed rest and given warning regarding pre-eclamptic symptoms. Dr. Moore stated that had the patient returned for re-evaluation, she would have admitted her to the hospital as she has done in similar situations. Dr. Moore further stated that she takes complete responsibility and that she has learned a lot from the case.

Dr. Petelin noted that the patient was moderately obese, and had a significant history of blood pressure issues with her preceding pregnancies. Dr. Moore stated that she recognized the patient was at high risk of becoming pre-eclamptic. Dr. Petelin also noted that the patient was non-compliant with the recommendations for bed rest. Dr. Moore explained that when the patient presented on January 5, 2004, she was seen by the nurse practitioner who instructed her to return in two days for a blood pressure re-check. On January 7, 2004, the patient returned and was seen by the medical assistant who performed a blood pressure check, but did not consult with the attending physician. Dr. Moore stated that she was in surgery at the time that the patient presented, but saw the chart when she returned and requested that the patient return that day for further evaluation. Dr. Moore stated that her office attempted to reach the patient and left her a voicemail message instructing her to return to the office. Dr. Petelin expressed concern with Dr. Moore's failure to act more aggressively to contact the patient.

Dr. Pardo stated that she was concerned with the nurse practitioner who saw the patient on January 7, 2004. Dr. Moore said she had no issue with the nurse's evaluation of the patient, but stated that it would have been reasonable for the nurse to have consulted the attending. Dr. Pardo questioned what Dr. Moore would have done differently. Dr. Moore stated that she would have considered admitting the patient on January 5, 2004 to place her on a non-stress test monitor to measure the fetal heart tones and uterine activity. In closing, Mr. Campbell asked that the Board consider it mitigating that Dr. Moore collapsed in her office on the afternoon of January 7, 2004, and was admitted to the hospital for an emergency medical condition. He stated that perhaps another phone call may have been made to the patient had Dr. Moore stayed in the office that day. Mr. Campbell pointed out that the Board's medical consultant does not actively practice in the community and he requested that matter be dismissed. Dr. Petelin stated that he did not believe the matter rises to the level of discipline. He opined that earlier intervention may not have changed the outcome of the case.

MOTION: Dr. Petelin moved to issue an Advisory Letter for failing to admit a patient with pre-eclampsia.

SECONDED: Dr. Krishna

ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Griffen, Dr. Krishna, Dr. Lefkowitz, Dr. Mackstaller, Dr. Pardo, Dr. Petelin, and Ms. Proulx. The following Board members were recused: Drs. Lee and Schneider. The following Board members were absent: Ms. Ibáñez and Dr. Martin.

VOTE: 7-yay, 0-nay, 0-abstain, 2-recuse, 2-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC.#	RESOLUTION
2.	MD-08-1196A	JOHN P. CREASMAN, M.D.	5933	Issue an Advisory Letter for failure to adequately supervise technicians and for allowing technicians to act outside of their scope of practice. This matter does not rise to the level of discipline.

Dr. Creasman was present with legal counsel, Mr. Robert Feinberg. Bhupendra Bhatheja, M.D., Medical Consultant, summarized that Dr. Creasman allowed a technician, beyond his training, to examine and diagnose patients from the clinic without physician input. Dr. Creasman stated that the patient presented to the ophthalmology department at the clinic with blurred vision and was offered an appointment to be seen by an ophthalmic technician because there were no ophthalmologists available. He stated that the technician was well qualified and within his appropriate scope of experience when he saw the patient. Dr. Creasman explained that the patient's first symptoms of retinal detachment occurred almost two weeks after he was seen at Mayo. Dr. Creasman

pointed out that the Board's medical consultant opined that there was no basis to believe that different care that day would have changed the outcome of the case. Dr. Creasman informed the Board that had he seen the patient, he would not have acted any differently than the technician.

Dr. Lefkowitz opined that technicians tend to not have the level of experience or sophistication as the ophthalmologists and that making those subtle determinations can be critical in the treatment of the patient's vision problems. Dr. Lefkowitz stated he believed that the patient should have been either dilated or seen by an ophthalmologist. Dr. Petelin questioned whether delay in diagnosis of a retinal detachment increases the chances of a bleeding complication, which occurred in this patient. Dr. Creasman stated that delay in diagnosis of a retinal detachment may increase the size of the detachment, but it would not increase the chances of bleeding. Dr. Lefkowitz explained that subretinal hemorrhage is rare during retinal detachment.

In closing, Mr. Feinberg pointed out that the Board's medical consultant opined that many ophthalmologists, given the circumstances of this case, may not have dilated the patient, which he stated speaks to the issue of the standard of care. Mr. Feinberg further stated that the medical consultant was clear in finding that there was no basis to believe that different care on that date would have changed the outcome of the case. Dr. Lefkowitz found that Dr. Creasman's actions did not rise to the level of discipline and Dr Lefkowitz opined that systemic issues at the clinic's ophthalmology department at the time that this case occurred were grossly deficient. However, Dr. Lefkowitz noted that Dr. Creasman supervised the department, and found that it was his responsibility to establish firm guidelines to govern the acts of the technician staff. Dr. Lefkowitz recommended issuing an Advisory Letter and opined that the violation was a one-time occurrence.

MOTION: Dr. Lefkowitz moved to issue an Advisory Letter for failure to adequately supervise technicians and for allowing technicians to act outside of their scope of practice. This matter does not rise to the level of discipline.
SECONDED: Dr. Petelin

Dr. Schneider spoke against the motion, and noted that the issue in the ophthalmology department occurred over a period of several years. Dr. Lee stated that he was disturbed by the fact that there are technicians practicing in the medical community without adequate physician supervision. Dr. Petelin noted that the Board disagreed with Board staff's recommendation for discipline, and recommended that the Advisory Letter reflect that, having been appropriately reviewed by the Board, the case rises only to the level of an Advisory Letter.

ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Dr. Lefkowitz, Dr. Mackstaller, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board members voted against the motion: Ms. Griffen, Dr. Lee, and Dr. Pardo. The following Board members were absent: Ms. Ibáñez, Dr. Krishna, and Dr. Martin.
VOTE: 5-yay, 3-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC.#	RESOLUTION
3.	MD-09-0433A	DOUGLAS W. HALLIDAY, M.D.	36606	Decree of Censure and Three Years Probation to run concurrently with the New York Board Order. Dr. Halliday shall remain in compliance with his New York Board Order. Dr. Halliday shall submit to the Arizona Medical Board the certificate of completion of the New York ordered CME in ethics and clinical practice within one year. The Probation shall include the requirement that Dr. Halliday notify the Arizona Medical Board's Executive Director 30 days prior to practicing medicine in Arizona.

Dr. Halliday was present without legal counsel. Ms. Anita Shepherd, Case Manager, summarized that Dr. Halliday was disciplined by the New York Medical Board for deviating from the standard of care by using non-FDA approved botulinum neurotoxin and for failure to maintain adequate medical records. The New York Medical Board also found that Dr. Halliday failed to conform to minimal standards of acceptable medical practice. Dr. Halliday briefly summarized that in 2004, he received flyers regarding a new type of botulinum neurotoxin. He stated that his head nurse ordered two vials that they used on twelve patients. He stated that later that Fall, an investigator from the FDA informed his office that the neurotoxin was not a new type of Botox, and that two physicians in Arkansas fraudulently manufactured the product. Dr. Halliday further stated that he immediately informed the twelve patients and notified the New York Medical Board of the issue.

Dr. Halliday reported that there was no information provided with the product that indicated it was non-FDA approved, nor did it state that it was not for human use. Dr. Lee noted that the New York Medical Board made a very concerted effort in the Order to indicate that Dr. Halliday knew the product was not Botox and that he knew it was not FDA approved. In his response to the Arizona Medical Board's investigation, Dr. Halliday reported that the action taken by the New York Medical Board did not place restrictions on his privileges. However, Dr. Lee noted that the Order required Dr. Halliday to obtain a practice monitor to review twenty of his patients' charts per week, and that he was required to maintain no less than \$2.6 million of malpractice insurance. Dr. Halliday explained that he did not interpret the requirements to be restrictions on his privileges.

Dr. Halliday pointed out that six other physicians in the Albany, New York area also received the product. However, he stated that those physicians continued to use the neurotoxin after informed that it was non-FDA approved, and were subsequently indicted on felony charges. Dr. Petelin questioned whether any patients experienced complications rather than decreasing effectiveness. Dr. Halliday stated that one patient presented with complaints that were subsequently identified as pre-existing. Dr. Halliday

commented that he entered into the settlement agreement with the New York Medical Board, but that he did not find all of the statements in the Order to be true. Dr. Lee noted that the Order was also for quality of care issues and questioned whether the allegations regarding patient care were factual. Dr. Halliday stated that those cases involved legitimate complications. Dr. Halliday thanked the Board for allowing him the opportunity to present his case.

MOTION: Dr. Lee moved to enter into Executive Session to receive legal advice.

SECONDED: Dr. Mackstaller

Vote: 8-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.

MOTION PASSED.

The Board went into Executive Session for legal advice at 1:47 p.m.

The Board returned to Open Session at 1:50 p.m.

No deliberations or discussions were made during Executive Session.

Dr. Lee found that Dr. Halliday engaged in unprofessional conduct based upon action taken by another state.

MOTION: Dr. Lee moved for a finding of unprofessional conduct in violation of A.R.S. §32-1401(27) (o) - Action that is taken against a doctor of medicine by another licensing or regulatory jurisdiction due to that doctor's mental or physical inability to engage safely in the practice of medicine, the doctor's medical incompetence or for unprofessional conduct as defined by that jurisdiction and that corresponds directly or indirectly to an act of unprofessional conduct prescribed by this paragraph. The action taken may include refusing, denying, revoking or suspending a license by that jurisdiction or a surrendering of a license to that jurisdiction, otherwise limiting, restricting or monitoring a licensee by that jurisdiction or placing a licensee on probation by that jurisdiction.

SECONDED: Dr. Pardo

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

MOTION FAILED.

Dr. Lee pointed out that Dr. Halliday entered into the settlement agreement with the New York Medical Board, attesting that the facts listed within that Order were true. Dr. Lee opined that the five patient cases reviewed by that Board were more egregious than the issue of the neurotoxin. Dr. Mackstaller spoke in favor of reconsidering the Board's previous motion of unprofessional conduct. Ms. Boucek clarified that by finding a violation of A.R.S. §32-1401(27)(o), the Board is finding that had the incident occurred in Arizona, it would have been a violation of the Medical Practice Act.

MOTION: Dr. Mackstaller moved to reconsider the motion regarding the finding of unprofessional conduct.

SECONDED: Ms. Proulx

ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board members were absent: Ms. Ibáñez, Dr. Krishna, and Dr. Martin.

VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.

MOTION PASSED.

MOTION: Dr. Lee moved for a finding of unprofessional conduct in violation of A.R.S. §32-1401(27) (o) - Action that is taken against a doctor of medicine by another licensing or regulatory jurisdiction due to that doctor's mental or physical inability to engage safely in the practice of medicine, the doctor's medical incompetence or for unprofessional conduct as defined by that jurisdiction and that corresponds directly or indirectly to an act of unprofessional conduct prescribed by this paragraph. The action taken may include refusing, denying, revoking or suspending a license by that jurisdiction or a surrendering of a license to that jurisdiction, otherwise limiting, restricting or monitoring a licensee by that jurisdiction or placing a licensee on probation by that jurisdiction; based upon New York's statute equivalent to the following Arizona statute: A.R.S. §32-1401(27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public.

SECONDED: Dr. Pardo

Dr. Lee reiterated that the neurotoxin issue was one of several issues, and that he found the five patient cases to be more egregious. Dr. Mackstaller noted that the neurotoxin issue was a national scandal, and stated that spoke in favor of New York's action based upon the fact that it also involved patient care concerns.

ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board members were absent: Ms. Ibáñez, Dr. Krishna, and Dr. Martin.

VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.

MOTION PASSED.

MOTION: Dr. Lee moved for a draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure and Three Years Probation to run concurrently with the New York Board Order. Dr. Halliday shall remain in compliance with his

New York Board Order. Dr. Halliday shall submit to the Arizona Medical Board the certificate of completion of the New York ordered CME in ethics and clinical practice within one year. The Probation shall include the requirement that Dr. Halliday notify the Arizona Medical Board's Executive Director 30 days prior to practicing medicine in Arizona.
SECONDED: Dr. Pardo

Dr. Lee found that the recommendation for a Decree of Censure was appropriate.

ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board members were absent: Ms. Ibáñez, Dr. Krishna, and Dr. Martin.

VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC.#	RESOLUTION
4.	MD-08-1041A	EHAB F. ABDALAH, M.D.	36239	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and One Year Probation. Dr. Abdalah shall within one year of the effective date of this Order obtain 15-20 hours of Board staff pre-approved Category I CME in ethics. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure. The Probation shall terminate upon successful completion of the CME.

Dr. Lefkowitz was recused from this case. Dr. Abdalah was present with legal counsel, Mr. Stephen Myers. Ms. Celina Shepherd, Case Manager, summarized that Dr. Abdalah failed to disclose a prior felony charge, academic probation, and that he failed his board certification exams when applying for privileges at Banner Surgery Centers (Banner). Dr. Pardo noted that the Board received three separate complaints from Banner alleging that Dr. Abdalah made false statements in connection with his application for privileges. Dr. Abdalah stated that he did not fill out the applications personally, but that he did sign each one prior to submitting them to Banner. Dr. Pardo noted that when signing the applications, Dr. Abdalah indicated that he read, reviewed, and answered all questions on the applications and attested to their accuracy.

Dr. Abdalah pointed out that he did disclose the information on his application for licensure to the Board because he personally filled out the paperwork. Dr. Petelin expressed concern regarding Dr. Abdalah's failure to disclose on all three applications that he failed his board exams. Dr. Petelin stated he believed that Dr. Abdalah omitted the information purposefully. In closing, Mr. Myers stated that there was no false statement made as there was no statement made whatsoever. He pointed out that Banner returned the applications to Dr. Abdalah stating that they were incomplete. Upon resubmitting the applications to Banner, Dr. Abdalah disclosed his previous omissions. Mr. Myers stated that the matter does not rise to the level of discipline and requested that the Board issue Dr. Abdalah an Advisory Letter.

MOTION: Dr. Pardo moved to enter into Executive Session to receive legal advice.

SECONDED: Ms. Proulx

Vote: 7-yay, 0-nay, 0-abstain, 1-recuse, 3-absent.

MOTION PASSED.

The Board went into Executive Session for legal advice at 2:56 p.m.

The Board returned to Open Session at 3:03 p.m.

No deliberations or discussions were made during Executive Session.

Dr. Pardo found that Dr. Abdalah engaged in unprofessional conduct and commented that an act of omission does not mean it was not fraudulent.

MOTION: Dr. Pardo 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.

SECONDED: Dr. Petelin

VOTE: 7-yay, 0-nay, 0-abstain, 1-recuse, 3-absent.

MOTION PASSED.

Dr. Pardo commented that the Board views any type of deception or fraud very seriously and recommended Dr. Abdalah obtain CME in ethics.

MOTION: Dr. Pardo moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and One Year Probation. Dr. Abdalah shall within one year of the effective date of this Order obtain 15-20 hours of Board staff pre-approved Category I CME in ethics. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure. The Probation shall terminate upon successful completion of the CME.

SECONDED: Dr. Petelin

ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Griffen, Dr. Lee, Dr. Mackstaller, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board member was recused: Dr. Lefkowitz. The following Board members were absent: Ms. Ibáñez, Dr. Krishna, and Dr. Martin.

VOTE: 7-yay, 0-nay, 0-abstain, 1-recuse, 3-absent.
MOTION PASSED.

Dr. Pardo commended Ms. Shepherd on her investigation report and stated that it was very well organized.

NO.	CASE NO.	PHYSICIAN	LIC.#	RESOLUTION
5.	MD-08-1533A	GEORGE H. WEBB, M.D.	14417	Issue an Advisory Letter for failing to personally evaluate a patient in a timely manner. There is insufficient evidence to support discipline.

Dr. Webb was present with legal counsel, Mr. Dan Cavett. Ingrid Haas, M.D., Medical Consultant, summarized that Dr. Webb failed to evaluate the patient in a timely manner when there was a significant change in her vital signs and a significant drop in her hematocrit and hemoglobin. Dr. Haas pointed out that there was no operative report from the cesarean section (C-section). Dr. Webb summarized that he performed a C-section on the patient, and that the operation went well with the exception of a small vein on the artery that was bleeding. Several hours after the procedure, he was notified by the nurse that the patient's blood pressure had decreased. He was called shortly thereafter for an emergency C-section at another hospital, but he stayed in contact with the nurse and the obstetric anesthesiologist. Dr. Webb further stated that he returned to the hospital, evaluated the patient, and noted that she was stable. Dr. Webb stated that his plan included blood transfusion, and if the blood count did not rise, if it dropped more, or if the patient's status changed, he planned to take her back to the operating room.

Dr. Webb informed the Board that he did dictate an operative report of the C-section, and that he typically dictates the report prior to leaving the operating room. He also stated that he was never informed by the hospital that they did not have a report. He stated that he felt the low blood pressure was due to the pre-eclampsia because there was no increased vaginal bleeding, and that no blood was coming from the incision on exam. Dr. Petelin stated that the burden of proof was on Dr. Webb to prove whether or not the patient was bleeding internally. Dr. Petelin expressed concern with Dr. Webb's failure to respond for six hours after first being notified of the patient's hypotension. Dr. Webb agreed with Dr. Petelin's concern and acknowledged that he was the physician in charge of the patient's care. In closing, Mr. Cavett pointed out that this case was complex. He stated that Dr. Webb dictated an operative report and came to the hospital three hours before the patient crashed. Mr. Cavett also pointed out that Dr. Webb received advice from the perinatologist, who recommended that he not take the patient to surgery as the risks were too great. Dr. Haas informed the Board that during the course of the investigation, Board staff obtained the patient's medical records from two hospitals and Dr. Webb's office. She noted that neither record showed the C-section, but did include the consult report, the discharge summary, and the exploratory laparotomy. Dr. Haas stated that had the operative report been dictated, it would have been included in at least one set of records.

Dr. Schneider noted several mitigating factors, including the complex patient with severe pre-eclampsia and the fact that the patient was in the intensive care unit under the care of other physicians. Dr. Schneider opined that Dr. Webb should have evaluated the patient in a timely fashion, when her hematocrit and hemoglobin dropped and when the blood pressure continued to be low.

MOTION: Dr. Schneider moved for a finding of unprofessional conduct in violation of A.R.S. §32-1401(27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public.

SECONDED: Dr. Petelin

VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.

MOTION PASSED.

Dr. Schneider noted that Board staff recommended a Letter of Reprimand for failure to evaluate the patient in a timely fashion and for no operative report.

MOTION: Dr. Schneider moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand.

Ms. Boucek requested that the Board reconsider its motion for a finding of unprofessional conduct as it did not include the medical records violation.

MOTION: Dr. Mackstaller moved for reconsideration of the Board's previous motion regarding unprofessional conduct.

SECONDED: Ms. Proulx

VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.

MOTION PASSED.

MOTION: Dr. Schneider 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 that is or might be harmful or dangerous to the health of the patient or the public.

SECONDED: Dr. Petelin

VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.

MOTION PASSED.

Dr. Petelin found that a disciplinary action was appropriate and recommended issuing a Letter of Reprimand.

**MOTION: Dr. Petelin moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand.
SECONDED: Dr. Pardo**

Dr. Schneider questioned whether Dr. Petelin found fault with Dr. Webb's failure to evaluate the patient in a timely fashion, or with his failure to take the patient back to the operating room. Dr. Petelin stated that he took issue with Dr. Webb's failure to take an aggressive approach. Dr. Mackstaller spoke against the motion and noted that Dr. Webb had skilled physicians advising him to take a more conservative approach. Dr. Mackstaller spoke in favor of issuing the physician an Advisory Letter. Dr. Schneider also spoke against the motion. Dr. Mackstaller found it possible that Dr. Webb may have dictated the operative report, but it was lost prior to making it part of the electronic medical record.

**ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Drs. Pardo and Petelin. The following Board members voted against the motion: Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Ms. Proulx, and Dr. Schneider. The following Board members were absent: Ms. Ibanez, and Drs. Krishna and Martin.
VOTE: 2-yay, 6-nay, 0-abstain, 0-recuse, 3-absent.
MOTION FAILED.**

**MOTION: Dr. Schneider moved to issue an Advisory Letter for failing to personally evaluate a patient in a timely manner. There is insufficient evidence to support discipline.
SECONDED: Dr. Mackstaller**

Dr. Pardo questioned whether Dr. Webb would benefit from obtaining CME. Dr. Schneider spoke against requiring Dr. Webb to obtain CME in the management of a pre-eclamptic patient. Dr. Mackstaller also spoke against the CME and stated that Dr. Webb was not treating the patient's pre-eclampsia; but rather was treating the consequence of pre-eclampsia.

**ROLL CALL VOTE: Roll call vote was taken and the following Board members voted in favor of the motion: Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board member voted against the motion: Dr. Pardo. The following Board members were absent: Ms. Ibáñez, Dr. Krishna, and Dr. Martin.
VOTE: 7-yay, 1-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.**

The meeting adjourned at 5:41 p.m.



Lisa S. Wynn, Executive Director