



Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258
Home Page: <http://www.azmd.gov>

Telephone (480) 551-2700 • Fax (480) 551-2705 • In-State Toll Free (877) 255-2212

DRAFT MINUTES FOR REGULAR SESSION MEETING Held on December 2, 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, Ms. Ibáñez, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board member was absent: Dr. Pardo.

CALL TO THE PUBLIC

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

EXECUTIVE DIRECTOR'S REPORT

Lisa Wynn, Executive Director, welcomed Mitch James to the Agency as the new Network Administrator. She stated that Mr. James has done a great job during the several months he has worked for the Agency on a contractual basis. Ms. Wynn reported that she, William Wolf, M.D., Chief Medical Consultant, and Dr. Mackstaller, met with the Pima Medical Society on November 10, 2009. She stated that it was an opportunity to describe Board staff's processes for opening and following through with a complaint and she informed them of the Board's role in adjudicating cases. Ms. Wynn thanked Carol Peairs, M.D, Medical Consultant, for her participation in the development of an orientation for the medical students at the University of Arizona that provides a different perspective regarding the components involved in the medical profession. She informed the Board that an intersession will be held on December 13-18, 2009 in Phoenix and that Dr. Mackstaller will be presenting to the students on December 16, 2009. Dr. Krishna suggested informing the Federation of State Medical Boards of the Board's progress as they are interested in the Board's proactive work.

Ms. Wynn thanked Jennifer Boucek, Assistant Attorney General, and stated that a lot of the Board's great outcomes in many of the cases are due to the efforts of Ms. Boucek as well as Anne Froedge, Assistant Attorney General, and their partnership with Pat McSorley, Case Review Manager. Dr. Martin noted an incredible amount of cooperation from the Attorney General's Office and stated that Ms. Wynn, Ms. Boucek, Ms. Froedge, and Dr. Lee should be applauded for all their hard work in doing a great job in helping cases reach a resolution in a fair and timely manner. Ms. Wynn stated that she is grateful for the Board's leadership and the staff's support. She also stated that the Agency's management team has done an extraordinary job in streamlining the processes under the Board's direction and leadership. In addition, Ms. Wynn reported that the Agency will hold its annual holiday party on December 10, 2009, and welcomed Board members to participate in the festivities.

CHAIR'S REPORT

Dr. Lee commended Board staff for the quality of work being performed. He noted that the amount of days to approve a license has been significantly reduced. Ms. Wynn stated that the Agency has streamlined its online renewal process, which has helped speed up the overall approval process. Dr. Lee commended Ms. Boucek and Ms. Froedge for their hard work in moving cases through the legal process. Dr. Lee pointed out that the Attorney General's Office has asked to utilize Ms. Boucek's services in

another division, taking her away from the Board, which reflects how talented and valuable she is to the Board as well as the Attorney General's Office. Ms. Wynn stated that the Attorney General's Office was informed the Board that the assignment is to be temporary. Ms. Boucek stated it is likely that she will be gone for a few months, and that she most likely would not be attending the Board's February 2010 meeting. She stated that she had been asked to assist during the legislative session with policy initiatives the Attorney General is trying to move forward.

Dr. Martin questioned whether the Board will be impacted by the State's budget issues. Ms. Wynn stated that it is projected that the 2010 deficit is still a moving target and that the deficit will be tremendous. She stated that it is anticipated that the 2011 budget deficit will be even worse and that it is hard to imagine how all of the agencies would not be impacted. Ms. Wynn stated that in November, the Agency was asked to submit a 15% reduction plan, but there was no clear understanding of whether or not the Agency would be required to implement the plan. Ms. Wynn stated that current speculation indicates that regulatory boards will be mandated to implement the 15% reduction in their operating budgets. She reported that the Agency has been proactive and has been extremely fiscally responsible. Dr. Martin asked whether the public safety would be jeopardized by the implementation of the reduction. Ms. Wynn stated there is that potential if the Agency's fund balance is swept again. She stated that it would be reasonable to assume that public welfare could be jeopardized throughout the State. Dr. Lee questioned how the Board would be affected since the Board is a 90/10 agency and does not receive revenues through the general fund. Ms. Wynn stated that the Governor has publicly opposed conducting another fund sweep of the 90/10 agencies' reserves to balance the State's budget. Ms. Wynn also pointed out that the quality of the renewal process, the complaint, and adjudication process could be compromised if that were to occur.

Dr. Lee stated that for the past two years, the Board held a social gathering to celebrate the holidays. He stated that this year, in lieu of hosting a holiday party, Board members would be offered the opportunity to make a charitable contribution. Ms. Wynn reported that the Agency raised over \$4,000 for the annual Employee Charitable Campaign (SECC) campaign through various fund raising efforts. She stated that this holiday season, the Agency has adopted a family to donate needed items to, and that staff will hold various fundraising events to raise money for the Fistula Foundation.

CONSIDERATION OF INTERNAL POLICY REGARDING A.R.S. §36-2153(D)

Ms. Boucek presented this matter to the Board. She informed Board members that the internal policy was drafted after the Board held its special meeting on October 20, 2009, when the Board met to consider a proposed stipulation that arose from a lawsuit against the Board. The plaintiffs sought an injunction that would prohibit the Board from enforcing A.R.S. §36-2153(D). At that meeting, the Board rejected the proposed stipulation and instructed Board staff to draft a declaration regarding this matter to address the concerns of the plaintiffs. Ms. Boucek stated that a substantive policy statement was considered; however, she stated that in order to provide direction to Board staff and alert the community as to how the Board will be approaching the enforcement of this provision, Board staff determined that an internal policy memo would be appropriate. She informed the Board that the memo had been reviewed by the Solicitor General's Office, and that it was circulated to the parties involved in the litigation. Ms. Boucek stated that the internal policy memo indicates how the Board will proceed when a complaint is received under the statute regarding payment for services by a patient who inquires about an abortion prior to the recently mandated 24-hour window. She further stated that the policy will help provide guidance and assures that the Board will not be pursuing any case that is filed alleging violation of the statute without facts to support the alleged violation. Dr. Martin thanked Board staff for drafting the policy. Dr. Lee questioned how the Board's regulated community will become aware of the policy. Ms. Wynn reported that the document will be posted on the Board's website and will be available to the medical associations and societies for distribution to their members.

APPROVAL OF MINUTES

MOTION: Dr. Krishna moved to approve the October 7, 2009 Regular Session Meeting, including Executive Session; the October 8, 2009 Offsite Planning Meeting, including Executive Session; and the October 20, 2009 Special Teleconference Meeting, including Executive Session.

SECONDED: Dr. Schneider

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

ADVISORY LETTERS

MOTION: Dr. Krishna moved to issue an Advisory Letter in item numbers 1-5, 7-8, 10-13, 15-17, 20-24, and 26-28.

SECONDED: Dr. Petelin

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
1.	MD-09-0646A	SCOTT S. BERMAN, M.D.	20643	Issue an Advisory Letter for failing to evaluate a patient with syncope and thoracic aneurysm for abdominal aortic aneurysm, and for inadequate medical records. The violation was a one-time occurrence that does not rise to the level of discipline.
2.	MD-09-0411A	ROBIN K. BLITZ-WETTERLAND, M.D.	23820	Issue an Advisory Letter for failing to adequately document and obtain data to support treating diagnoses prior to initiating and changing

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
				psychotropic medications. This matter does not rise to the level of discipline.
3.	MD-09-0555A	WILLIAM M. COCHRAN, M.D.	15469	Issue an Advisory Letter for failure to obtain or recommend liver function tests in a patient with a history of Vicodin abuse. This matter does not rise to the level of discipline.
4.	MD-08-1257A	THOMAS J. WALL, M.D.	24251	Issue an Advisory Letter for inadequate medical records. The physician has demonstrated substantial compliance through remediation that mitigates the need for discipline.
5.	MD-09-0939A	RICHARD K. COCHRAN, M.D.	28181	Issue an Advisory Letter for action taken by another state. This matter does not rise to the level of discipline.
6.	MD-09-0300A	CHING C. WANG, M.D.	30864	Dismiss.

Dr. Wang addressed the Board during the call to the public and stated that the MC's accusations were false in alleging that she failed to document a discussion with the patient regarding informed consent for the performance of colonoscopy. She provided the Board with a copy of her consultation letter to the patient's primary care physician, in which she documented that she discussed the indications, benefits, and potential complications of colonoscopy with the patient. She requested that the Board dismiss the case.

Dr. Krishna expressed concern regarding the patient's complaint of shoulder pain in the recovery room following colonoscopy. Dr. Wolf stated that this is a common complaint following colonoscopy that may result from abdominal distention. Dr. Wolf informed the Board that the MC initially criticized Dr. Wang's failure to see the patient postoperatively; however, after review of Dr. Wang's supplemental response, the MC determined that seeing the patient in the recovery room after colonoscopy is considered best practice, but not a required standard of care. Dr. Krishna questioned whether Dr. Wang was informed by the nursing staff that the patient complained of shoulder pain in the recovery room. Dr. Petelin questioned whether Dr. Wang documented her discussion with the patient anywhere in the record regarding informed consent, other than the letter to the patient's primary care physician. He also questioned the accepted rate of perforations that occur during routine colonoscopy. Dr. Wolf reported that one in 18,000 has been reported and that perforation is relatively rare. Dr. Lee questioned what the minimum standard required as to documentation of the informed consent discussion, and whether the letter to the primary care physician was sufficient in that regard. Board members noted that the letter was included in Dr. Wang's response to the complaint; however, the MC did not address this in the report and summary. Drs. Lee and Krishna suggested tabling the matter to allow Board staff the opportunity to ascertain whether Dr. Wang was informed of the patient's postoperative complaint of shoulder pain.

MOTION: Dr. Krishna moved to table the matter.
SECONDED: Ms. Proulx
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The Board returned to this matter later in the day. Dr. Wolf reported that the patient's medical records do not indicate that Dr. Wang was made aware of the postoperative complaint by the nursing staff; however, he stated that Dr. Wang acknowledged in her response to the complaint that she was aware of the patient's complaint of shoulder pain. Dr. Krishna expressed concern regarding Dr. Wang's failure to identify the etiology of the patient's complaint of shoulder pain while in the recovery room. Dr. Mackstaller pointed out that in the primary care setting, she sees many patients who have undergone colonoscopy and have sustained bowel perforation and stated that the frequency is more common than one out of 18,000.

MOTION: Dr. Krishna moved to issue an Advisory Letter for failing to document a discussion regarding informed consent for the performance of colonoscopy. The violation was a one-time occurrence that does not rise to the level of discipline.
SECONDED: Dr. Martin

Dr. Lee questioned whether the physician should have documented the informed consent discussion in another area of the patient's medical record. He suggested returning the case for further investigation to allow the MC the opportunity to specifically address this question. Dr. Schneider opined that Dr. Wang's letter to the primary care physician demonstrated the informed consent process. Board members noted that the letter to the patient's primary care physician was dictated the same day of the consultation and discussion. Dr. Krishna withdrew his previous motion and spoke in favor of dismissal.

MOTION: Dr. Krishna moved for dismissal.
SECONDED: Dr. Schneider
VOTE: 10 -yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
7.	MD-09-0621A	BARRY R. WEISS, M.D.	25465	Issue an Advisory Letter for failure to follow a patient postoperatively. The violation was a one-time occurrence that does not rise to the level of discipline.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
8.	MD-08-0945A	MARTIN W. YEE, M.D.	33319	Issue an Advisory Letter for inadequate medical records. The violation was a one-time occurrence that does not rise to the level of discipline.
9.	MD-09-0545A	RICHARD A. CARDONE, M.D.	26223	Dismiss.

Ms. Ibáñez stated that she understood Dr. Cardone's hesitancy to transfer the patient out of state while her condition was unstable. She believed that Dr. Cardone was acting in the best interest of the patient and spoke in favor of dismissing the case. Dr. Petelin agreed and stated that this was certainly a difficult decision for Dr. Cardone. He noted that the patient expired shortly thereafter.

MOTION: Ms. Ibáñez moved for dismissal.

SECONDED: Dr. Krishna

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
10.	MD-09-0539A	CATHERINE P. CHEN-TSAI, M.D.	35121	Issue an Advisory Letter for inadequate medical records. The violation was a one-time occurrence that does not rise to the level of discipline.
11.	MD-09-0483A	JOHN E. LASSETTER, M.D.	40796	Issue an Advisory Letter for failure to complete the necessary documentation to obtain EECF in a timely manner, and for failure to maintain adequate medical records. This matter does not rise to the level of discipline.
12.	MD-09-0309A	CHARLES A. CALKINS, M.D.	9848	Issue an Advisory Letter for inadequate postoperative DVT/PE prophylaxis. The violation was a one-time occurrence that does not rise to the level of discipline.
13.	MD-08-1010A	MARK D. CAMPBELL, M.D.	25777	Issue an Advisory Letter for inadequate documentation. The violation was a one-time occurrence that does not rise to the level of discipline.

Dr. Martin stated that he knows Dr. Campbell professionally, but it would not affect his ability to adjudicate the case.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
14.	MD-08-1195A	HERMAN PANG, M.D.	24944	Issue an Advisory Letter for delay in performance of thoracotomy to control exsanguinating hemorrhage. The violation was a one-time occurrence that does not rise to the level of discipline.

Dr. Pang and attorney Stephen Myers spoke during the call to the public. Dr. Pang stated that the MC criticized him for an alleged delay in performing a thoracotomy and noted that Board staff recommended the issuance of an Advisory Letter. He informed the Board that during the course of the procedure, a surgical pause was undertaken in which confirmation was received that there was a fully assembled and functioning saw available in the operating room. He further stated that he believed the patient's best chance of survival was to wait for a functioning saw. Mr. Myers stated that Dr. Pang did not anticipate the long delay to obtain the saw as he never had the issue occur before in the operating room. He pointed out that Dr. Pang's expert witness agreed with the decision to not perform the thoracotomy and opined that sternotomy would have provided the best access to the artery.

Dr. Lee recalled Dr. Pang and Mr. Myers' statements issued during the call to public. He believed that Dr. Pang did what he believed was the best for the patient at the time by waiting for a fully functional saw. Dr. Lee noted that there were a lot of issues at the hospital level in which they failed to provide Dr. Pang with the adequate instrument for the procedure. Dr. Petelin stated that it was a judgment call on part of the surgeon. He noted that the first saw was unable to be assembled, the second saw was also unable to be assembled, and that by the time the third saw was assembled, the window of opportunity had ran out. Dr. Petelin also stated that Dr. Pang should have attempted to obtain access to the artery due to the patient's significant blood loss.

MOTION: Dr. Krishna moved to issue an Advisory Letter for delay in performance of thoracotomy to control exsanguinating hemorrhage. The violation was a one-time occurrence that does not rise to the level of discipline.

SECONDED: Dr. Petelin

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
15.	MD-09-0601A	PAUL D. DLUGIE, M.D.	28012	Issue an Advisory Letter for inappropriate opioid prescribing. This matter does not rise to the level of discipline.
16.	MD-09-0790A	MARK D. GOLDBERG, M.D.	18592	Issue an Advisory Letter for inadequate medical records. There is insufficient evidence to support discipline.
17.	MD-08-1465A	GORDON D. DAVIS, M.D.	12102	Issue an Advisory Letter for failure to adequately evaluate and follow a patient with a postoperative complication. The violation was a one-time occurrence that does not rise to the level of discipline.
18.	MD-09-0632A	DILLIAN LASALLE, M.D.	25273	Issue an Advisory Letter for insufficient monitoring of PT/INR in a patient transitioning from Lovenox to Coumadin. This matter does not rise to the level of discipline.

Attorney Curtis Bergen spoke during the call to the public on behalf of Dr. Lasalle. He pointed out that the MC articulated a standard of care that requires a physician to check the patient's INR every 24 hours; however, he stated that Dr. Lasalle has not heard of this guideline nor could he find it in medical literature. He stated that the literature provides that the INR should be monitored every 48 hours. He informed the Board that Dr. Lasalle scheduled the INR to be checked twice during the week; however, he reported that the patient checked herself out against medical advice before the testing could be done.

Dr. Lee pulled this case for discussion and recalled the issue regarding the articulated standard of care that was mentioned during the call to the public. Dr. Mackstaller agreed that the INR should be checked every 48 hours, and opined that Dr. Lasalle met the standard of care in this case that involved a difficult patient. Dr. Lee questioned whether there is any written standard that states what the measurement should be. Dr. Mackstaller stated that she was unaware whether one existed that determines the frequency. Dr. Coffey presented this matter for the Board and stated that she was concerned by the fact that the patient's INR went from 1.4 to 2.0 at the time she was transferred to the hospital. She noted that the INR was 2.9 the following day, but was not checked for the next four to five days. Dr. Coffey also stated that there were no standing orders for the INR to be checked. Dr. Mackstaller stated that if she were initiating Coumadin on a patient, she would check the INR at least every three to four days. She opined that a follow up should be ordered after the initiation of Coumadin, which Dr. Lasalle failed to do.

MOTION: Dr. Lee moved to issue an Advisory Letter for insufficient monitoring of PT/INR in a patient transitioning from Lovenox to Coumadin. This matter does not rise to the level of discipline.

SECONDED: Dr. Mackstaller

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
19.	MD-09-0434A	VLADIMIR TROCHE, M.D.	20010	Issue an Advisory Letter for failing to either abort the cycle by not giving HCG, or converting the cycle to an IVF situation in a patient with multiple follicles following ovarian stimulation. There is insufficient evidence to support discipline.

Dr. Troche and attorney Gordon Lewis spoke during the call to the public. Dr. Troche spoke against the recommended Advisory Letter and stated that there were other options available to him instead of cycle cancellation or IVF. He further stated that he counseled the patient, who elected to proceed and continue the cycle. Dr. Troche believed he met the standard of care in this case by selecting one of the approved courses of action. Mr. Lewis added that the physician should not suffer the specter of an Advisory Letter in a case where he selected an option for treatment that had been approved by the most respected peer review journal available for his specialty. Mr. Lewis stated that Dr. Troche acted appropriately in this case and within the standard of care. Ingrid Haas, M.D., Medical Consultant, presented this matter to the Board and stated that when the gonadotropin stimulation was performed, numerous sacs were identified and the patient elected to proceed with the HCG. She also stated that the patient was aware of the known risks associated with the procedure. Dr. Lee referred Board members to the MC's report and pointed out that the MC opined that the case represented some deviation from the standard of care along with a good deal of bad luck. Dr. Lee stated that the MC seemed ambivalent and questioned whether there was a breach in the standard of care. Dr. Schneider spoke in favor of issuing the recommended Advisory Letter as she found that Dr. Troche deviated from the standard of care. She opined that Dr. Troche should have waited for the next cycle.

MOTION: Dr. Schneider moved to issue an Advisory Letter for failing to either abort the cycle by not giving HCG, or converting the cycle to an IVF situation in a patient with multiple follicles following ovarian stimulation. There is insufficient evidence to support discipline.

SECONDED: Dr. Krishna

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
20.	MD-09-0815A	EDGARDO D. ZAVALA-ALARCON, M.D.	27016	Issue an Advisory Letter for failure to perform a pre-procedure Artefill skin test to verify that a patient was not allergic and for failure to discuss alternatives to a proposed procedure. There is insufficient evidence to support discipline.
21.	MD-09-0905A	MICHAEL S. WENG, M.D.	18604	Issue an Advisory Letter for prescribing Celebrex and providing Celebrex samples to a patient allergic to sulfa. The violation was a one-time occurrence that does not rise to the level of discipline.

Dr. Martin stated that he knows Dr. Weng professionally, but it would not affect his ability to adjudicate the case.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
22.	MD-09-0631A	SHAILAJA GUNNALA, M.D.	27607	Issue an Advisory Letter for failing to develop a differential diagnosis for post traumatic shoulder pain and for inadequate medical records. There is insufficient evidence to support discipline.
23.	MD-09-0374A	JOHN C. MEDLEN, M.D.	12924	Issue an Advisory Letter for improper performance of a procedure and for inadequate medical records. There is insufficient evidence to support discipline.
24.	MD-09-0768D	MARY GLAS GASPERS, M.D.	41167	Issue an Advisory Letter for inadequate documentation. The violation was a one-time occurrence that does not rise to the level of discipline.

KS, MW, and TS spoke during the call to the public on behalf of the patient. KS stated that her son suffered prolonged and unnecessary pain under the care of Dr. Gaspers. She alleged that Dr. Gaspers' attempts at placing a catheter were hurried and dangerous as well as negligent. TS stated that the day his son's catheter was to be placed by Dr. Gaspers, the family was informed that she could not give him a lot of pain medication and that the procedure would not take very long. TS said the procedure lasted a very long time and finally after requesting another provider for assistance, placement was achieved in a very short period of time. MW also addressed the Board. She stated that a procedure that should have taken minutes took a lot longer. She stated that the patient's family has the paid the price of losing their son, and that Dr. Gaspers must pay a price for causing him undue pain.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
25.	MD-09-0660A	GREGORY D. LAYTON, M.D.	23687	Issue an Advisory Letter for inadequate follow up of a patient in labor. The violation was a one-time occurrence that does not rise to the level of discipline.

Dr. Layton and attorney Stephen Myers spoke during the call to the public. Dr. Layton stated that he is confident that the Board will see that he met and exceeded the standard of care. He stated that he arrived in time to safely deliver the patient and that the on-call physician was aware of the situation and available if he were to have been needed. He pointed out that no harm occurred to the patient or the baby from the medically appropriate plan that was chosen. Mr. Myers stated that there were no maternal or fetal problems that required a more urgent assessment, as pointed out in the initial evaluation letter. Mr. Myers pointed out that the nursing staff was well aware that the on-call physician was available had issues presented.

Dr. Haas presented this matter to the Board. She expressed concern regarding the lack of continuity of care once Dr. Layton notified the nursing staff that he would manage the patient's delivery and found that he was not immediately available to the patient for the delivery. She noted that Dr. Layton started the patient on Pitocin, which can have a very rapid process and may require immediate delivery. Dr. Petelin stated that he knows one of Dr. Layton's expert witnesses and that he was influenced by his opinion stating that this is common practice in the obstetrical community. Dr. Schneider opined that Dr. Layton should have contacted the on call physician personally once he was made aware that the patient was complete to inform him that he was unavailable for delivery. She spoke in favor of issuing the recommended Advisory Letter. Dr. Lee agreed and noted an issue of communication.

MOTION: Dr. Lee moved to issue an Advisory Letter for inadequate follow up of a patient in labor. The violation was a one-time occurrence that does not rise to the level of discipline.

SECONDED: Dr. Schneider

Dr. Krishna noted that the patient and infant did well and spoke against the motion. He agreed that there were communication errors, but pointed out that the outcome was good. Dr. Petelin also spoke against the motion and noted that Dr. Layton knew that the patient's labor was progressing and that he had time before the delivery. Dr. Martin requested that Dr. Petelin clarify whether his reasoning is due to his review of the records or the fact that he knows one of the consultants. Dr. Petelin stated that he was influenced by the consultant, and that in review of the medical record it seemed as though Dr. Layton always felt to be in control of the situation.

MOTION: Dr. Martin moved to enter into Executive Session to obtain legal advice.

SECONDED: Dr. Schneider

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

The Board entered into Executive Session at 10:05 a.m.

The Board returned to Open Session at 10:09 a.m.

No deliberations or discussions were made during Executive Session.

Dr. Schneider questioned whether the potential harm in this case involved patient discomfort, pain, and pelvic organ damage. Dr. Haas stated that it is difficult to determine potential harm in child bearing and child delivery as there is the potential for pelvic organ problems due to long term pressure. Dr. Petelin clarified that he knows the consultant professionally as they practice in the same area, but that he does not know the other individuals who submitted letters in support of Dr. Layton. He further clarified that those consultants had the same degree of influence on him in his review of the case.

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

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
26.	MD-09-0645A	GERALD C. MOCZYNSKI, M.D.	9173	Issue an Advisory Letter for performing wrong-site ankle surgery in 1999. The violation was a one-time occurrence that does not rise to the level of discipline.

Board members indicated that they know Dr. Moczynski, but that it would not affect their ability to adjudicate the case.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
27.	MD-09-0624A	SCOTT R. PARTRIDGE, M.D.	12251	Issue an Advisory Letter for inadequate medical records. This matter does not rise to the level of discipline.
28.	MD-09-0974A	PADMAVATHY TUMMALA, M.D.	21393	Issue an Advisory Letter for making an error in dosing instructions for a prescription for Depo-Estradiol. The violation was a one-time occurrence that does not rise to the level of discipline.

NON-DISCIPLINARY CONTINUING MEDICAL EDUCATION (CME) ORDER

MOTION: Dr. Krishna moved to issue a non-disciplinary CME Order in item numbers 1 and 2.

SECONDED: Dr. Martin

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
1.	MD-09-0510A	PATRICK J. DI FONZO, M.D.	29570	Issue a non-disciplinary CME Order for the inappropriate prescribing of opiates, failing to perform adequate diagnostic evaluations, and for failing to update his board certification status on his stationery and prescription pads. Within six months complete 15-20 hours of Board staff pre-approved Category I non-disciplinary CME in prescribing. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure. This matter does not rise to the level of discipline.
2.	MD-09-0733A	ROGELIO D. NARANJA, M.D.	13156	Issue a non-disciplinary CME Order for inadequate medical records. Within six months complete 15-20 hours of Board staff pre-approved Category I non-disciplinary CME in medical recordkeeping. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure. This matter does not rise to the level of discipline.

REVIEW OF EXECUTIVE DIRECTOR DISMISSALS

MOTION: Dr. Krishna moved to uphold the dismissal in item numbers 1, 2, and 5.

SECONDED: Dr. Petelin

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
1.	MD-09-0998A	ROBERT S. BRIDGE, M.D.	18610	Uphold the dismissal.
2.	MD-09-1046A	JASJEET KAUR, M.D.	36320	Uphold the dismissal.
3.	MD-09-0950A	RICHARD K. PEAIRS, M.D.	15437	Uphold the dismissal.

Dr. Martin stated that he knows Dr. Peairs professionally, but it would not affect his ability to adjudicate the case. JG and CG spoke during the call to the public. JG alleged several inconsistencies and misrepresentations in his medical record. JG reported that he required two additional surgeries, several aspirations, and three weeks of IV therapy due to Dr. Peairs' actions. CG stated that JG should have been seen immediately as a post surgical patient with signs and symptoms of infection. CG further stated that she believes strongly that Dr. Peairs' actions were negligent and that had JG received prompt attention, he would have experienced a better outcome.

Dr. Petelin questioned whether the pseudomonas should have been treated more aggressively and in more of a timely manner once it was recognized. Dr. Bhatheja stated that the MC was satisfied with Dr. Peairs' care of JG and found that he met the standard of care in this case. Dr. Martin stated that while he believes the standard of care was met, he still would have placed a drain in the patient's knee. Drs. Krishna and Martin spoke in favor of upholding the dismissal.

MOTION: Dr. Petelin moved to uphold the dismissal.

SECONDED: Dr. Krishna

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
4.	MD-09-0644A	ANDREW W. MAYBERRY, M.D.	28086	Uphold the dismissal.

Dr. Mackstaller was recused from the case. NS spoke during the call to the public and stated that had Dr. Mayberry taken the time to listen to her complaints during her hospitalization, he would have known immediately that there was a serious problem. She

reported that she required multiple surgeries, had to deal with numerous infections, and lives with the fear of losing her leg. NS's husband also addressed the Board and requested an extension as he believes the upcoming interviews of the nurse practitioners will show that Dr. Mayberry coerced and coached the nurses to make false statements. He stated that Dr. Mayberry should have recognized that his wife was over-hydrated in the hospital.

Dr. Petelin pulled this case for discussion and noted that the patient's complaint of leg pain was treated only by medication. Dr. Petelin questioned whether the leg pain should have been further addressed by Dr. Mayberry. Dr. Bhatheja explained that the leg pain was believed to have been attributed to the electrolyte imbalance. Following the leg pain reported by patient leg/foot pulses were documented in nursing report to be present and symmetric. Dr. Bhatheja reported that Dr. Mayberry signed off on the patient's discharge after discussion with the nurse and finding that the patient was stable and asymptomatic.

MOTION: Dr. Petelin moved to uphold the dismissal.

SECONDED: Dr. Krishna

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

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
5.	MD-09-0849A	STEVEN CHEN, M.D.	25627	Uphold the dismissal.

Attorney Mike Ryan spoke during the call to the public and stated that dismissal is appropriate and should be upheld by the Board.

OTHER BUSINESS

MOTION: Dr. Krishna moved to accept the proposed Consent Agreement in item numbers 1-10.

SECONDED: Ms. Proulx

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

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
1.	MD-09-0424A	ROBERT H. JOCHIM, M.D.	7074	Accept the proposed Consent Agreement for a Letter of Reprimand.

Dr. Lee stated that he knows Dr. Jochim professionally, but it would not affect his ability to adjudicate the case.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
2.	MD-09-0571A	PADMAVATHY TUMMALA, M.D.	21393	Accept the proposed Consent Agreement for a Letter of Reprimand.
3.	MD-09-0047A	MARK D. CAMPBELL, M.D.	25777	Accept the proposed Consent Agreement for a Letter of Reprimand and Five Year Probation to participate in MAP. Dr. Campbell shall receive credit for participation in MAP under his July 8, 2009 Interim Order.

Dr. Martin stated that he knows Dr. Campbell professionally, but it would not affect his ability to adjudicate the case.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
4.	MD-09-0420A	GERALD S. ASIN, M.D.	20348	Accept the proposed Consent Agreement for a Letter of Reprimand and One Year Probation to obtain 15-20 hours of Board staff pre-approved Category I CME in a comprehensive prescribing course and shall undergo the PACE program in medical recordkeeping. The CME hours shall be in addition to the hours required for the biennial renewal of medical license. The Probation shall include periodic chart reviews.

Dr. Asin was present with attorney Amy Cotton who spoke during the call to the public. Ms. Cotton stated that Dr. Asin signed the proposed Consent Agreement as he admits that errors were made in this case, and because he agreed with the recommended discipline. However, Ms. Cotton stated that the Findings of Fact in the proposed Consent Agreement do not accurately reflect what occurred. She requested that the Board return the matter to allow the opportunity for negotiations to correct the errors in the document.

SD and LT also spoke during the call to the public. SD summarized that the patient overdosed twice in the same week and stated that no physician should be allowed to prescribe this large amount of drugs to one patient. LT also addressed the Board and stated that this experience has been devastating to their family. LT stated that she found it appalling that Dr. Asin would call in a prescription upon the patient's request and asked that the Board consider the family's side of the story prior to making a final decision on the matter.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
5.	MD-09-0269A	WARREN M. ZEITLIN, M.D.	20208	Accept the proposed Consent Agreement for a Letter of Reprimand.

Ms. Griffen was recused from this case.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
6.	MD-09-0472A	FERNANDO CRUZADO, M.D.	30961	Accept the proposed Consent Agreement for a Decree of Censure and Ten Year Probation and Practice Restriction prohibiting Dr. Cruzado from supervising physician assistants pursuant to A.R.S. §32-2522(E). After five years, Dr. Cruzado may petition the Board to terminate the Probation.
7.	MD-09-0602A	SAM HOCHANE, M.D.	32092	Accept the proposed Consent Agreement for a Decree of Censure and Five Year Probation. Dr. Hochane's practice shall be restricted in that he shall not see male patients for a minimum of six months. Dr. Hochane shall enter a contract with a Board pre-approved monitoring company to provide all monitoring services, at his expense. Dr. Hochane shall obtain a psychotherapist, and establish and participate in the Professional Enhancement Program (PEP) at Pine Grove care monitoring in the workplace. Within six months, Dr. Hochane shall present to PEP for a re-evaluation and determination of future workplace recommendations, including, but not limited to, an assessment to determine whether he can see female patients and whether he needs a chaperone. Dr. Hochane shall submit to polygraph testing every six months. Within six months obtain 100-15 hours of Board staff pre-approved Category I CME in boundaries and 10-15 hours in prescribing. The CME hours shall be in addition to the hours required for the biennial renewal of medical license.

DM spoke during the call to the public and read a letter from the complainant in which she stated that her family has been affected by this experience and that the acts of Dr. Hochane should lead to intense rehabilitative training and close monitoring.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
8.	MD-07-0746A	GLENN G. ROBERTSON, M.D.	33045	Accept the proposed Consent Agreement for a Letter of Reprimand and Two Year Probation. The Practice Restriction on Dr. Robertson's license is lifted. Dr. Robertson shall obtain a psychiatrist experienced in the treatment of Attention Deficit Disorder. After twelve months, Dr. Robertson may request termination of the requirement that he remain in treatment with a psychiatrist. If Dr. Robertson fails to comply with the terms of the Probation, he shall promptly enter into an Interim Consent Agreement for Practice Limitation that requires, among other things, that Dr. Robertson not practice medicine until such time that he is evaluated, deemed fit to return to practice, and obtains affirmative approval from the Executive Director to return to the practice of medicine. Within six months, Dr. Robertson shall enroll in and complete a Board approved comprehensive boundaries course. He shall enter a contract with a Board pre-approved monitoring company to provide all monitoring services for compliance with the terms of this Order, at his own expense.

Dr. Mackstaller was recused from this case.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
9.	MD-09-0232A	MILES W. HOWARD, M.D.	21113	Accept the proposed Consent Agreement for a Letter of Reprimand. Within six months obtain 15-20 hours of Board staff pre-approved non-disciplinary Category I CME in medical recordkeeping at the PACE program. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure.
10.	MD-09-0516A	DAVID L. CHILD, M.D.	6275	Accept the proposed Consent Agreement for a Letter of Reprimand. Within six months obtain 15-20 hours of Board staff pre-approved non-disciplinary Category I CME in doctor-patient communication. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure.
11.	MD-09-0433A	DOUGLAS W. HALLIDAY, M.D.	36606	Approve the draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure and Three Year Probation, to run concurrently with the New York Medical Board Consent Agreement Probation. Within One Year, Dr. Halliday shall submit to the Board the certificate of completion of the CME in ethics and clinical practice ordered by the New York Medical Board. If Dr. Halliday decides to practice medicine in Arizona, he shall notify the Executive Director in writing 30 days prior to commencing medical practice in this State.

MOTION: Dr. Krishna moved to approve the draft Findings of Fact and Conclusions of Law

SECONDED: Ms. Ibáñez

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

MOTION: Dr. Krishna moved to approve the Board Order for a Decree of Censure and Three Year Probation, to run concurrently with the New York Medical Board Consent Agreement Probation. Within One Year, Dr. Halliday shall submit to the Board the certificate of completion of the CME in ethics and clinical practice ordered by the New York Medical Board. If Dr. Halliday decides to practice medicine in Arizona, he shall notify the Executive Director in writing 30 days prior to commencing medical practice in this State.

SECONDED: Dr. Petelin

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

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
12.	MD-08-1041A	EHAB F. ABDALAH, M.D.	36239	Approve the draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and One Year Probation to 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.

Ms. Boucek referred Board members to Findings of Fact numbers 12 and 13 that she believed reflected the Board's conclusion at the Formal Interview. She stated that the two Findings were based on the Board's deliberations and the final motion for discipline.

MOTION: Dr. Krishna moved to approve the draft Findings of Fact and Conclusions of Law.

SECONDED: Dr. Schneider

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

MOTION: Dr. Krishna moved to approve the Board Order for a Letter of Reprimand and One Year Probation to 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. Schneider

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

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
13.	MD-07-0193A	WILLIAM K. KVIEN, M.D.	15772	Grant the request for termination of Board Order.

Erinn Downey, Case Manager, presented the matter for the Board. She summarized that in October 2007 Dr. Kvien entered into a Consent Agreement for a Letter of Reprimand and Probation with a Practice Restriction prohibiting Dr. Kvien from performing examinations or treating female patients without the presence of a female chaperone, and required him to obtain a psychotherapist. Ms. Downey stated that Dr. Kvien requested termination of the chaperone requirement. She stated that Dr. Kvien

underwent a psychosexual evaluation in June 2009, and that his evaluators supported his request to relieve him of the chaperone requirement, but opined that he should still have one present when he conducts sensitive or invasive exams of female patients. Ms. Downey reported that Dr. Kvien is currently in compliance with his Probation and that his urine drug screen requirement was terminated in October 2009.

MOTION: Dr. Krishna moved to grant the request for termination of Board Order.

SECONDED: Dr. Petelin

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
14.	MD-09-0591A	JAMES H. MYER, M.D.	29398	Dismiss.

Dr. Myer spoke during the call to the public. He stated that dismissing the case would be the most appropriate course of action by the Board. Dr. Petelin questioned whether there was an infarct that led to complete dysfunction of the valve. Dr. Bhatheja stated that there are three major causes that include infarct, endocarditis, or trauma. Dr. Krishna questioned whether the transesophageal echocardiogram would have identified the problem. Dr. Bhatheja stated that it would and noted that one was ordered and obtained. Dr. Krishna spoke in favor of dismissal.

MOTION: Dr. Krishna moved for dismissal.

SECONDED: Dr. Petelin

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC. #	RESOLUTION
15.	MD-02-0749A	HARA P. MISRA, M.D.	14933	Accept the proposed Consent Agreement for Two Year Probation to include quarterly chart reviews, and Dr. Misra shall obtain 20 hours of Board staff pre-approved Category I CME for the indications of placement of vena cava filters. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure. Dr. Misra shall receive credit for his compliance with the terms of Probation pursuant to the previous Order that was remanded in this case. Board staff received evidence that Dr. Misra has completed the CME and complied with the conditions of said Probation.

Dr. Krishna was recused from the case. Ms. Froedge presented this matter for the Board. She summarized that this case involved a surgery performed in 2000, and that Dr. Misra was issued a Decree of Censure and Probation. Dr. Misra appealed the Board action and the Court of Appeals found that there was no substantial evidence to support the finding of actual harm, but that there may be potential harm; therefore, the Court remanded the case to the Board for determination of potential harm. In April 2008, the Board issued Dr. Misra a Letter of Reprimand after finding that there was potential for harm resulting from the quality of care violation. Dr. Misra appealed the Board's decision and the Superior Court found that there should have been a full evidentiary hearing undertaken to determine the issue of potential harm. Ms. Froedge reported that in the mean time, Dr. Misra completed the terms of the original Probation that included chart reviews and CME. She stated that the proposed Consent Agreement is a reasonable resolution of this case.

MOTION: Dr. Schneider moved to accept the proposed Consent Agreement for Two Year Probation to include quarterly chart reviews, and Dr. Misra shall obtain 20 hours of Board staff pre-approved Category I CME for the indications of placement of vena cava filters. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure. Dr. Misra shall receive credit for his compliance with the terms of Probation pursuant to the previous Order that was remanded in this case. Board staff received evidence that Dr. Misra has completed the CME and complied with the conditions of said Probation.

SECONDED: Dr. Petelin

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

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

MOTION PASSED.

FORMAL INTERVIEWS

NO.	CASE NO.	PHYSICIAN	LIC.#	RESOLUTION
1.	MD-09-0456A	PAYAM ZAMANI, M.D.	34305	Issue an Advisory Letter for failing to have an adequate system in place to follow up on critical lab values. The physician has demonstrated substantial compliance through remediation that mitigates the need for discipline.

Dr. Zamani was present with legal counsel, Mr. Stephen Myers. William Wolf, M.D., Chief Medical Consultant, summarized that Dr. Zamani failed to have an adequate system in place to follow abnormal lab values and failed to adequately supervise a PA. Dr. Wolf pointed out that Dr. Zamani indicated in his responses to the Board that he has instituted changes in his practice to prevent a future occurrence. Dr. Zamani stated that he was familiar with Arizona statutes that govern the practice of PAs, and acknowledged that PAs cannot work as independent providers. Dr. Martin commended Dr. Zamani for his meeting logs regarding his weekly meetings with his PA. Dr. Martin found that with the mother reporting a limp and fever, and the possibility of septic arthritis on the

list of differential diagnoses, Dr. Zamani should have personally evaluated the patient. Dr. Martin noted that Dr. Zamani did not report the patient's lab values until two weeks after the office visit in which they were ordered. Dr. Zamani stated that his practice experienced system errors that involved their communicator that allowed the labs to be placed directly into the patients' charts had stopped working. He stated that he was not aware of the severity of the situation. Dr. Martin questioned Dr. Zamani as to the standard of care regarding when a patient should be informed of critical lab values. Dr. Zamani stated that he patient should be informed immediately, and admitted that he did not meet the standard of care in this case.

In addition, Dr. Martin stated that Dr. Zamani should have had a system in place at the time that allowed timely follow up on critical lab values. However, Dr. Martin stated that he found it mitigating that Dr. Zamani indicated that he has changed his practice and currently has a system in place to prevent a similar incident. Dr. Martin noted that the patient's mother contacted Dr. Zamani's office on several occasions to obtain the lab results, but did not receive a timely response from the physician. Dr. Krishna noted that there was potential for harm to the patient, had he not approached another provider to receive medical intervention. In closing, Dr. Zamani stated that he is truly remorseful of the events that occurred. He reiterated that the clinic has modified its policies in order to prevent a future occurrence, and that none of his actions were due to malicious intent or lack of empathy. Mr. Myers stated that he did not believe that there was a violation with regard to Dr. Zamani's supervision of the PA. He asked that the Board consider the system errors and stated that Dr. Zamani has learned a great deal from this experience. Dr. Martin noted that there were system errors involved in the case, but that there were a number of opportunities for Dr. Zamani to work his way out of those system errors. Dr. Martin did not find Dr. Zamani in violation of A.R.S. §32-1401(27)(ii) and stated that Dr. Zamani has demonstrated that he provides adequate supervision of his PA. However, Dr. Martin found that Dr. Zamani deviated from the standard of care as he failed to have a system in place to timely follow up on critical lab values. Dr. Martin opined that there was potential for a missed septic joint or abscess, which may have potential life threatening consequences.

MOTION: Dr. Martin 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. Krishna

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

MOTION PASSED.

Dr. Martin opined that Dr. Zamani has demonstrated substantial compliance through remediation by instituting changes in his practice to prevent a future occurrence. Dr. Martin found that this matter does not rise to the level of discipline and moved for the issuance of an Advisory Letter.

MOTION: Dr. Martin moved to issue an Advisory Letter for failing to have an adequate system in place to follow up on critical lab values. The physician has demonstrated substantial compliance through remediation that mitigates the need for discipline.

SECONDED: Dr. Krishna

Dr. Schneider stated that she was concerned regarding the possibility that Dr. Zamani may have attempted to cover up what occurred by avoiding the mother's attempts at communicating with him, rather than addressing the problem; Dr. Lee agreed. Dr. Krishna believed that Dr. Zamani had learned a lot from this experience and pointed out that he has remediated the issue by making changes to his practice.

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

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

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC.#	RESOLUTION
2.	This item was pulled from the Agenda.			
3.	MD-09-0416A	DEBORAH A. COPUS, M.D.	34460	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and One Year Probation to obtain 10 hours of Board staff pre-approved Category I CME in ethics and 10 hours of CME in medical recordkeeping, to be completed within six months. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure. The Probation shall complete upon successful completion of the CME.

Dr. Copus was present without legal counsel. Dr. Coffey summarized that Dr. Copus prescribed controlled substances to members of her immediate family, failed to obtain prior medical records on patient JT, and failed to maintain adequate medical records. Dr. Copus reported that she offered to provide treatment for JT's insomnia in exchange for the work he performed in her home. She admitted that she did not perform a thorough physical examination prior to prescribing him medication, nor did she perform a urine drug screen or obtain prior treating records. Dr. Copus told the Board that she did not divert any of JT's prescribed medication for her personal use. Dr. Copus informed the Board that JT failed to uphold his end of the verbal barter agreement and; therefore, she cancelled his prescription at the pharmacy and referred him back to the Veteran's Affairs Hospital. Dr. Copus admitted that she prescribed controlled substances to members of her immediate family, but stated that she was unaware that it was against

Arizona statute to do so. In addition, Dr. Copus stated that she performed periodic examinations on her family members with whom she prescribed the medications. Dr. Krishna questioned at what point Dr. Copus realized that she was violating statute by prescribing narcotics to her immediate family. Dr. Copus stated that she was unaware of the violation until she received the Board's notification regarding the investigation, and reported that she then immediately stopped prescribing to her immediately family. Dr. Copus admitted that her medical records pertaining to her family and JT were not sufficient to allow another provider to assume care of the patients. Dr. Petelin believed that Dr. Copus seemed nonchalant about the seriousness of the issues identified in this case. Dr. Copus stated that she is grateful to have a better understanding of the statutes, and assured the Board that a similar occurrence will be avoided in the future. Ms. Ibáñez expressed serious concern regarding the manner in which Dr. Copus terminated JT's care. Dr. Mackstaller questioned whether Dr. Copus had any concern for abruptly discontinuing JT's medications in such a manner. Dr. Copus stated that she had only provided JT with a one month supply of the medication.

MOTION: Ms. Ibáñez 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; A.R.S. §32-1401(27)(h) - Prescribing or dispensing controlled substances to members of the physician's immediate family; 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: Ms. Griffen

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

Ms. Ibáñez found that CME in medical recordkeeping and ethics was warranted; Ms. Griffen agreed. Dr. Petelin spoke against the motion as he believed that Dr. Copus prescribed medication for legitimate medical issues. He stated that her failure to obtain prior records is certainly disturbing; however, he did not believe that the matter rises to the level of discipline. Dr. Martin spoke in favor of the motion and found that a Letter of Reprimand is appropriate.

MOTION: Ms. Ibáñez moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and One Year Probation to obtain 10 hours of Board staff pre-approved Category I CME in ethics and 10 hours of CME in medical recordkeeping, to be completed within six months. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure. The Probation shall complete upon successful completion of the CME.

SECONDED: Ms. Griffen

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

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

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC.#	RESOLUTION
4.	MD-07-0818A	MARGARET R. KHOURI, M.D.	27739	Postpone the Formal Interview.

Dr. Krishna was recused from this case. Dr. Lee stated that the Board received correspondence indicating that Dr. Khouri was unable to appear for the Formal Interview due to an automobile accident.

MOTION: Dr. Mackstaller moved to postpone the Formal Interview.

SECONDED: Dr. Krishna

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

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC.#	RESOLUTION
5.	MD-09-0307A	CHANDANA MISHRA, M.D.	24452	Dismiss.

Dr. Petelin was recused from this case. Complainant IP spoke during the call to the public. He alleged that Dr. Mishra misread an ultrasound of his neck, failed on more than one occasion to forward his medical records to the primary care physician, and broke the law by providing him with test results telephonically rather than in person. Dr. Mishra was present with attorney Mary Pryor. Kathleen Coffey, M.D., Medical Consultant, summarized that Dr. Mishra deviated from the standard of care by failing to perform a thyroid ultrasound, and repeated delays in follow up were noted as well. Dr. Mishra provided a brief overview of the care she provided to IP. She disagreed with the MC's opinion that a thyroid ultrasound is indicated in a patient with Hashimoto's disease. Dr. Mishra stated that she believed that she met the standard of care in this case and pointed out that the patient's prognosis is currently excellent. She further stated that she learned from this case and is more compelled to perform more ultrasounds to prevent a future occurrence. Dr. Mishra explained that the reporting of left sided adenopathy instead of the right sided adenopathy was due to a transcription error, and that did not have any significant impact on the outcome of the case. Dr. Mishra pointed out that the radiological films identify the sight of malignancy correctly. Dr. Mishra was questioned as to whether she was aware of the patient's test results of cancer prior to her leaving on vacation for two weeks. Dr. Mishra stated that she was aware of the cancer, but did not want to give the patient bad news just before the Christmas holiday as it did not change the patient's prognosis. In closing, Ms. Pryor pointed out that there were communication issues involved in this patient's case. She stated that Dr. Mishra was within national guidelines with regard to the diagnosis and treatment of Hashimoto's disease, and for examining and screening for thyroid nodules. Ms. Pryor requested that the consider dismissal. Dr. Mackstaller found that a thyroid ultrasound was not indicated, and spoke in favor of dismissal.

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

Dr. Schneider expressed concern with Dr. Mishra's failure to immediately inform the patient of the cancer once the results were obtained. Dr. Martin opined that Dr. Mishra was extremely knowledgeable in her responses to the Board, and noted that the delay did not change the patient's outcome. Dr. Krishna spoke in favor of the motion and stated that Dr. Mishra seemed to be a very competent physician.

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

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

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC.#	RESOLUTION
6.	MD-08-1263A	HELEN E. WATT, M.D.	22016	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand.

Dr. Watt was present with legal counsel, Mr. Peter Fisher. Dr. Coffey summarized that Dr. Watt failed to obtain vital signs for a child within the context of a sick visit, failed to perform rapid strep assay or obtain a throat culture to validate her assessment of strep throat, prescribed half of the recommended dose of Amoxicillin for strep pharyngitis, failed to maintain adequate medical records, and failed to report her suspicion of child abuse to the appropriate authorities in a timely manner. Mr. Fisher pointed out that Board staff found that the initial allegation of making a false report of child abuse was not substantiated. He noted that a pediatrician who practices as a primary care physician reviewed the case for quality of care issues. Mr. Fisher also noted that Dr. Watt is an otolaryngologist, and informed the Board that the board certified otolaryngologist found that Dr. Watt acted appropriately in the care provided to the patient. Dr. Lefkowitz noted that Dr. Watt failed to obtain the patient's weight during the first visit in which she prescribed Amoxicillin 125mg for ten days. Dr. Watt admitted that she did not obtain a weight on the patient, and stated that his approximate weight and severity of the disease did not merit a 250mg dose suggested by the MC. Dr. Watt pointed out that otolaryngologists typically do not weigh patients. She agreed that the standard of care in prescribing antibiotics in a pediatric patient is based upon a kg/mg per day basis.

Board members questioned whether Dr. Watt believed she should have reported the allegation of child abuse to the proper authorities in a timelier manner. Dr. Watt stated that she knew the patient's grandmother had reported the issue in the past, and that the grandmother told her that she had gone through the appropriate channels, but the investigations found no validity to the allegations. Dr. Lefkowitz stated that Dr. Watt had the responsibility to personally report the matter immediately to the proper authorities. Dr. Watt informed the Board that she had spoken with an Ombudsman who told her that there was no other recourse for them to pursue. Dr. Petelin questioned Dr. Watt with regard to the lawsuit filed against her by the patient's mother, in which she settled. Dr. Watt stated that the patient's mother and her boyfriend alleged that Dr. Watt and the grandmother conspired to defame the mother and boyfriend by falsifying sexual child abuse. Dr. Watt pointed out that she was selectively sued with the grandmother when there were several other individuals involved who also heard the patient's claims of sexual child abuse. In closing, Dr. Watt stated that her case should have been reviewed by her peer who would have found that she acted appropriately in this case with regard to the patient's care.

Dr. Martin recused himself from the Board's deliberation and vote, as he was not present for a portion of the Formal Interview.

MOTION: Dr. Lefkowitz moved for a finding of unprofessional conduct in violation of A.R.S. §32-1401(27)(a) - Violating any federal or state laws or rules and regulations applicable to the practice of medicine, with corresponding A.R.S. §13-3620(A)(1); 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. Lee

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

MOTION PASSED.

Dr. Lefkowitz noted Dr. Watt's significant and extensive prior Board history, and stated that he believed the matter rose to the level of a Decree of Censure.

MOTION: Dr. Lefkowitz moved for a draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure.
SECONDED: Ms. Ibáñez

Dr. Krishna spoke against the motion and stated that the issuance of a Letter of Reprimand would be appropriate. Dr. Schneider questioned why the matter rises to the level of a severe disciplinary action. Dr. Lefkowitz stated that the whole constellation of issues involved in this case warrant a Decree of Censure. Dr. Mackstaller agreed with Dr. Krishna and stated that it was unclear as to whether the dose of Amoxicillin prescribed was inappropriate. Dr. Petelin also spoke against the motion and stated that the issues in the case do not rise to the level of Decree of Censure. Dr. Lee spoke in favor of the motion and noted Dr. Watt's prior Board history, which involved similar issues identified in this case. Ms. Ibáñez also spoke in favor of the motion and stated that

she found it egregious that Dr. Watt alleged malnutrition without supporting documentation in the patient's chart. Ms. Ibáñez also expressed concern with Dr. Watt's failure to follow through with the second report of child abuse and stated that if Dr. Watt believed the child's claims, she should have acted more strongly on the child's behalf.

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

VOTE: 4-yay, 5-nay, 0-abstain, 1-recuse, 1-absent.

MOTION FAILED.

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

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. Mackstaller, Dr. Petelin, and Dr. Schneider. The following Board members voted against the motion: Ms. Ibáñez, Dr. Lee, Dr. Lefkowitz, and Ms. Proulx. The following Board member was recused: Dr. Martin. The following Board member was absent: Dr. Pardo.

VOTE: 5-yay, 4-nay, 0-abstain, 1-recuse, 1-absent.

MOTION PASSED.

NO.	CASE NO.	PHYSICIAN	LIC.#	RESOLUTION
7.	MD-09-0399A	NATIVIDAD VERDEJO-PEREZ, M.D.	22684	Issue an Advisory Letter for failing to follow up on presenting symptoms of chest tightness that increased with strenuous exercise. The violation is a one-time occurrence that does not rise to the level of discipline.

Dr. Verdejo-Perez was present with legal counsel, Ms. Kimberly Kent. Dr. Bhatheja summarized that Dr. Verdejo-Perez accepted a past diagnosis rather than re-evaluating the patient for other possible causes of chest pain, fixated on the initial diagnosis conclusion as the only cause of the chest pain, failed to obtain a cardiac stress test, and failed to obtain a timely consultation to assist in diagnosing the problem. Dr. Bhatheja pointed out that Dr. Verdejo-Perez's handout provided to the Board included information suggesting that the patient had symptomatology two years prior to being seen by her, and that the patient was very noncompliant. Dr. Verdejo-Perez provided the Board with a brief summary of the care she provided to the patient and pointed out that the patient had a very low risk level for cardiovascular disease. Dr. Mackstaller noted that when the patient initially presented to Dr. Verdejo-Perez, he acknowledged heartburn, gas, and bloating on the intake form. Dr. Mackstaller questioned whether the physician asked the patient about any descriptive factors regarding these complaints. Dr. Verdejo-Perez stated that she asked the appropriate questions, and admitted that she did not document that discussion in the patient's chart. Dr. Mackstaller noted that in her opening comments, the physician stated that she performed a complete physical exam; however, she noted that a brief exam was documented in the medical record. Dr. Verdejo-Perez assured the Board that she has changed her recordkeeping in that she elaborates more in the chart.

Dr. Verdejo-Perez stated that she personally evaluated the patient at his initial presentation, and that her physician assistant (PA) saw the patient at the second visit. Dr. Mackstaller noted that the PA documented that the patient's pain increased with strenuous work, and ordered an electrocardiogram. The physician stated that this information was not communicated to her at that time, but that she did see the patient two days later when he presented to undergo the study. Dr. Verdejo-Perez reiterated that the patient had no known cardiovascular risks at that time. Dr. Mackstaller opined that there is no documentation in the patient's medical record to support that Dr. Verdejo-Perez considered a cardiac diagnosis during the patient's work up. Dr. Petelin noted several red flags that included a self-check history of shortness of breath and chest pain, as well as significantly elevated lipids. Dr. Petelin stated that the physician should have considered the problem to be of cardiac origin. Dr. Verdejo-Perez was questioned as to whether she considered having the patient undergo a stress test. The physician stated that she had begun the process of evaluation, as she had only seen the patient at his initial presentation, but that a stress test was certainly considered to be included in the process. In closing, Ms. Kent pointed out that the patient's prior treating physicians' care of the patient was far lacking in comparison to Dr. Verdejo-Perez's care and treatment of him. She informed the Board that their expert witness stated that they would not have considered ischemic heart disease in the differential diagnosis. Ms. Kent also pointed out that the patient was very noncompliant, and asked that the Board dismiss the case or issue the physician an Advisory Letter. Dr. Mackstaller found it somewhat mitigating that the patient was noncompliant, and stated that she found that the physician engaged in unprofessional conduct.

MOTION: Dr. Mackstaller 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. Krishna

Dr. Lee found that the physician failed to have a high index of suspicion in this case. Dr. Mackstaller stated that the physician should have found out more about the patient's pain, and opined that she should have performed a more detailed work up prior to pursuing a diagnosis.

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

MOTION PASSED.

Dr. Mackstaller found it egregious that Dr. Verdejo-Perez failed to ask the appropriate questions during the patient's initial presentation.

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

Dr. Petelin spoke against the motion and noted that Dr. Verdejo-Perez did not have a lot of time to conduct further work up of the patient. Dr. Petelin agreed that the appropriate questions should have been more specifically elaborated on regarding the patient's chest pain.

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

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

MOTION FAILED.

MOTION: Dr. Mackstaller moved to issue an Advisory Letter for failing to follow up on presenting symptoms of chest tightness that increased with strenuous exercise. The violation is a one-time occurrence that does not rise to the level of discipline.

SECONDED: Ms. Griffen

Board members discussed requiring the physician to obtain CME in medical recordkeeping, but noted that Dr. Verdejo-Perez has changed her recordkeeping, mitigating the need for CME.

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

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

MOTION PASSED.

The meeting adjourned at 6:08 p.m.



Lisa S. Wynn, Executive Director