



Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258

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FINAL MINUTES FOR REGULAR SESSION MEETING Held at 9:00 a.m. on June 8, 2005, and 8:00 a.m. on June 9 and 10, 2005 9535 E. Doubletree Ranch Road - Scottsdale, Arizona

Board Members

Tim B. Hunter, M.D., Chair
William R. Martin III, M.D., Vice Chair
Douglas D. Lee, M.D., Secretary
Patrick N. Connell, M.D.
Ronnie R. Cox, Ph.D.
Robert P. Goldfarb, M.D.
Ingrid E. Haas, M.D.
Becky Jordan
Ram R. Krishna, M.D.
Lorraine L. Mackstaller, M.D.
Sharon B. Megdal, Ph.D.
Dona Pardo, Ph.D., R.N.

WEDNESDAY, JUNE 8, 2005

CALL TO ORDER

Tim B. Hunter, M.D., Chair, called the meeting to order at 9:00 a.m.

ROLL CALL

The following Board Members were present: Tim B. Hunter, M.D., William R. Martin III, M.D., Douglas D. Lee, M.D., Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Becky Jordan, Ram R. Krishna, M.D., Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Members were not present: Ronnie R. Cox, Ph.D., Ingrid E. Haas, M.D. and Lorraine L. Mackstaller, M.D.

CALL TO THE PUBLIC

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

Executive Director's Report

Timothy C. Miller, J.D. provided the Board with an overview of the current investigative caseload. He stated that there has been a reduction of 207 cases from the last meeting, leaving the Board with 933 open cases. He informed the Board that staff has changed its practice to open cases only on physicians who are within the Board's jurisdiction and who have an allegation of unprofessional conduct. He also stated that staff has triaged cases according to age and severity and is currently focusing on its priority cases.

Mr. Miller explained why there was an increase in the average time to complete an investigation, which he attributed to two factors. First, Mr. Miller explained the time to complete an investigation is gathered from a 13-month average. This average is capturing data from two different investigation processes. In the old process, all complaints were opened as investigations and then, if it was determined the Board did not have jurisdiction, (a case against a D.O.) the case would be quickly closed. This had the effect of reducing the average. Under the current process, the Board only opens a complaint for investigation if it meets two criteria. First, the complaint must be against the licensee of the Board, and second, the allegation, if true, must state a violation of the Medical Practice Act. Therefore, under the current system, there are no cases that will be opened and quickly closed to reduce the average. In each successive month the cases quickly opened and closed under the old process have less impact on the overall average, so there will be an increase in that overall average.

Mr. Miller went on to explain that the second factor affecting the overall average is the manner in which cases were initially investigated to reduce the backlog. Mr. Miller pointed out that the Board staff first concentrated on triaging the cases and processing the cases that posed a threat to the public safety. The next step was to complete quickly those investigations that were at or near completion. Now, the Board staff has turned their attention to the older cases that need significant investigation before they can be completed. Mr. Miller

stated that all investigations must be thoroughly and adequately investigated, therefore, it will take some time to complete these investigations.

Mr. Miller concluded that these two factors are driving up the average and will continue to do so for some time.

Mr. Miller then focused on agency personnel issues and addressed staff turnover. He stated that the agency is reviewing software applications for licensing and investigations to improve the area of Information Technology. Outside consultants have been hired to assist in this process.

In the future, Mr. Miller will work to build staff morale, which has taken some bounces lately due to staff turnover. He believes these efforts will result in decreased investigative caseloads and timeframes for adjudication.

Ram R. Krishna, M.D. stated that he feels it is important to convey to physicians and complainants the agency's backlog and the reasons for the case timeframes. Mr. Miller stated that Amanda J. Diehl, Deputy Executive Director is addressing this issue directly and will provide a solution to this problem.

Robert P. Goldfarb, M.D. asked what the average number of cases the agency receives each day. Mr. Miller stated that this data is not available.

Sharon B. Megdal, Ph.D. asked how many investigators are currently with the agency and inquired as to their experience. Ms. Diehl informed the Board that the agency currently has 7 investigators. Many of them are experienced investigators, but will need time to become familiar with the agency's operations. Mr. Miller also stated that the investigators will be sent to CLEAR training in September. He informed the Board that there are still vacancies to fill.

Douglas D. Lee, M.D. inquired if there was a person directly responsible for taking telephone calls from physicians and complainants who have concerns about their cases. Ms. Diehl stated that she is taking those calls directly.

Dr. Lee asked if complaints are categorized by allegation. Mr. Miller stated that under the current system, the agency is unable to categorize cases based on allegation, but that with a new database application, this will be possible. Mr. Miller also informed the Board that staff will be working next week to prioritize the backlog of complaints that have been received, but not opened in the database. Dr. Megdal clarified that the complainant receives notification from the agency that their cases have been received. Mr. Miller also explained that complainants are notified if their cases are sent to another agency for investigation.

The Board discussed the issue of complaints that are received alleging rudeness on the part of the physician. Mr. Miller stated that Board staff will not open a case against a physician for rude behavior; however, the complaints are screened to distinguish between rude physicians and those who are disruptive.

Mr. Miller stated that after communicating his report, he will provide it to the legislature, the Arizona Medical Association and the press.

Legislative Reports (Mar. 25 – May 13, 2005)

The legislative session is over and some items were held over for next year. The budget contained a sweep of the funds for the Medical Board for this year, but the legislature stated that it is not their intent to sweep the funds in the future. The following is a summary of some of the other tracked legislation:

- The Right of Consciousness bill allowing physicians and pharmacists stalled
- The Malpractice Bill passed, including language allowing a physician to apologize without admitting guilt
- The bill for midwife prescription privileges is being held for sunrise next session
- The medical malpractice punitive damages bill has been held

The Board is also posting a form required by the Legislature on the website for individuals to use when seeking a medical excuse to avoid jury duty.

Legal Advisor Report

Christine Cassetta, Assistant Attorney General advised the Board that the Office of Administrative Hearings (OAH) certified the recommended decision in Case #MD-03-0150A based on the fact that a teleconference was held within 30 days of OAH having forwarded the decision. Ms. Cassetta noted the Board's previous difficulties in handling ALJ decisions at teleconference meetings and suggested the Board not set the teleconferences as firm meeting dates, but just "hold" those dates if Staff decides there are matters that need to go on a teleconference agenda. Ms. Cassetta referred the Board to her memorandum where she explained the Board's options in detail. Sharon B. Megdal, Ph.D., supports this action.

MOTION: Robert P. Goldfarb, M.D. moved to remove the teleconferences from the Board's meeting schedule and set them on an as-needed basis.

SECONDED: Ronnie R. Cox, Ph.D.

VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent

MOTION PASSED.

The Board did note its displeasure that OAH changed its certification process without advance notice to the Board. The Board also noted they have been very satisfied with OAH overall.

Off-Site Meeting

Mr. Miller indicated that one of the topics that should be covered in the off-site meeting is next session's legislative proposals. Board members were provided with a copy of a media interview with Tim Miller regarding the dumping of patient records. Rep. Payton is planning to introduce legislation regarding medical records.

Patrick N. Connell, M.D. stated that he brought up the issue of the Disciplinary Rules. He believed the Board intended the rules to be fluid and that the Board could change them without going through the Governor's Regulatory Review Council (GRRC) process. Ms. Cassetta stated that was her understanding as well, however GRRC and the Secretary of State have a different position. She will prepare a memo to that effect for the offsite meeting.

Possible agenda topics for the offsite meeting include:

- Disciplinary Rules
- Refine the definition of doctor-patient relationship
- Guidelines for Chronic Opiate Use in Non-Malignant Pain
- Patient Safety
- Medical Testimony
- Physician Health Program
- Compliance of physicians on probationary orders
- Telephonic medical advice/telemedicine
- Status Reports from last year's offsite
- What to require as CME in the Medical Practices Act
- Issues with regard to MAP
- Media Relations
- Structure of the Board packet
- Format of the SIRC Report
- Development of CME Programming options, including internet offerings

Dr. Connell stated that in addition to discussions regarding ensuring new Residents understand the Medical Practice Act, perhaps there could be an internet CME program covering the statutes that could even result in an hour of credit. It could either be a course or something that becomes part of the application.

Tim B. Hunter, M.D. said they could even obtain their 20 hours of credit by covering CME online. Ram R. Krishna, M.D. stated that the Executive Director and Board Legal Counsel could make presentations to the Medical School staff. Mr. Miller stated that he is working on a curriculum of practical issues, including insurance billing codes, etc.

Special Award Presentations

A special plaque was presented to Dr. Rudolph Kirschner, retired Medical Consultant, for his work for the Board.

Approval of Minutes

MOTION: Douglas D. Lee, M.D. moved to approve the May 11, 2005 Meeting Minutes, including Executive Session Minutes and the May 18, 2005 Teleconference Meeting Minutes.

SECONDED: Ram R. Krishna, M.D.

VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent

MOTION PASSED.

Sub-Committee Meeting – Office-Based Surgery

Christine Cassetta, Board Legal Counsel informed the Board that the Sub-Committee on Office-Based Surgery has made progress. Materials are being prepared for dissemination to the Board. William R. Martin, III, M.D. said that the Board will be receiving a composite of materials resulting from the process begun by Edward Schwager, M.D. and Ram R. Krishna, M.D. along with Douglas D. Lee, M.D., who has been instrumental in putting together the issues of anesthesia. Ms. Cassetta stated that once the Board approved the draft and instructed that a notice of public ruling be filed, the Board would then begin to receive official public comment. Those comments will then be brought to the Board and a final rule package proposed for filing with the Secretary of State.

Agenda Schedule

There was a discussion about when the Call to the Public should be held. Ram R. Krishna, M.D. said he thinks the Call to the Public should be in the afternoon so that when individuals drive far, they can make it. Sharon B. Megdal, Ph.D. felt that the previous agenda format was more favorable and that there were too many time and non-time specific issues on the agenda for the first day. Tim Miller, Executive Director, said that this agenda was extremely full because it was a three-day session. Tim B. Hunter, M.D., Board Chair, felt that the previous format was working and affirmed that the Call to the Public is very valuable. The preference of the Board is for the Call to the Public to remain on the afternoon of the first day. In actuality, there is a Call to the Public at the beginning of every day. Dr. Hunter stated that if an individual were present, they would be heard.

Dr. Megdal stated that it is important for the meeting to start a half-hour later on the first day to allow for travel. Dr. Hunter took a show of hands and five voted in favor of it. Dr. Hunter indicated that, as an experiment, the August meeting would begin at 9:30 on the first day.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-04-0581A	AMB	LEANDRO F. BATERINA, JR., M.D.	26528	Draft Findings of Fact and Conclusions of Law for Probation for ten years with terms mirroring the Order of the North Dakota State Board of Medical Examiners. Dr. Baterina may not practice in Arizona until completion of provisions of North Dakota plan. If the provisions of probation are not completed within eight years the case shall be referred for Formal Hearing.

Dr. Baterina was present for the formal interview. He appeared without counsel. Mark Nanney, M.D., Chief Medical Consultant presented the case to the Board. He stated that Dr. Baterina underwent an evaluation at the University of Wisconsin that showed him to have several deficits in his medical knowledge. As a result of that evaluation, the North Dakota Medical Board offered Dr. Baterina an Order that included intense Continuing Medical Education (CME) for two years with clinical supervision.

Patrick N. Connell, M.D. began the questioning Dr. Baterina about his education. Dr. Baterina explained that he initially had trouble passing the USMLE and ECFMG tests prior to obtaining licensure in Arizona and in North Dakota. Dr. Connell confirmed that Dr. Baterina was not practicing medicine in the United States or in the Philippines between 1977 and 1991. Dr. Baterina worked as a physician extender, not as a physician assistant, following his family practice residency while preparing for his USMLE examination. Dr. Baterina successfully completed his family practice residency, but because of some changes in the law, was not licensed until 1998.

Dr. Connell questioned Dr. Baterina about the supervised setting that the North Dakota Medical Board ordered. Dr. Baterina stated that he has not worked as a physician since September because of the difficulties associated with a clinical supervisor. Dr. Connell asked Dr. Baterina what he has done to comply with the continuing medical education program set up by the University of Wisconsin. Dr. Baterina stated that because of financial difficulties, he has not completed the ordered education. Dr. Baterina stated that he is looking for a similar continuing medical education program to the plan constructed by the University of Wisconsin in Arizona. He is also looking into a residency program that was offered by the University of Wisconsin as an alternative to the continuing medical education program.

Robert P. Goldfarb, M.D. clarified with Board staff that Dr. Baterina has an unrestricted license in Arizona. Dr. Connell stated that Dr. Baterina's willingness to comply with the recommendations from the University of Wisconsin is a mitigating circumstance. He asked Christine Cassetta, Board Legal Counsel, if it is appropriate to place Dr. Baterina on a probationary term similar to the North Dakota Board order. Ms. Cassetta said it was appropriate, but there would need to be a finding of unprofessional conduct. Sharon B. Megdal, Ph.D. stated that she would prefer that if Dr. Baterina did not satisfy the terms of probation by the eighth year, the Board would like to see this case go to formal hearing for revocation.

MOTION: Patrick N. Connell, M.D. moved for Board staff to draft Findings of Fact, Conclusions of Law and Order for Probation for ten years to mirror the plan established by the North Dakota State Board of Medical Examiners. The physician may not practice medicine in Arizona until such time as this plan is completed. If the terms of probation are not complete within eight years the case should be referred to Formal Hearing.

SECONDED: Ram R. Krishna, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N. The following Board Members were absent: Ronnie R. Cox, Ph.D., Ingrid E. Haas, M.D., and Lorraine L. Mackstaller, M.D.

VOTE: 9 yay, 0-nay, 0-abstain/recuse, 3-absent

MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
2.	MD-04-0407A	M.H. CAROL A. HAHN, M.D.	20408	Dismissed.

Patient M.H. was present for Call to Public. She stated that she and her husband were present to observe the formal interview.

Dr. Carol Hahn appeared with counsel, Barry MacBan. Robert P. Goldfarb, M.D. stated that his medical group has a professional relationship with Mr. McBan; however, that will not influence his ability to adjudicate this case.

Philip Scheerer, M.D., Medical Consultant, presented this case to the Board. He informed the Board that there were five allegations regarding Dr. Hahn's management and care of a laboring patient in the delivery of a baby. He also stated that there were three mitigating circumstances.

Dr. Hahn addressed the Board. She stated that the patient needed to be induced, and that at first, M.H. progressed normally. Later, the patient's progress was not as rapid. Nursing notes indicated very slow change; however, her contractions were inadequate. Dr. Hahn stated that the subjective findings of each person who examined the patient are different. This explained the difference between her examination and the examination of the nurses.

Tim B. Hunter, M.D. stated that he wanted to focus the formal interview on how the patient's labor was managed. The patient's membrane spontaneously ruptured at home and presented to the hospital. Dr. Hahn stated that when she arrived at the hospital, M.H. had already been examined and that it would have been inappropriate to examine her again because M.H.'s membranes were already ruptured. Dr. Hahn stated that she was an attending physician at a teaching hospital and it was normal for the attending residents to notify her of any problems with the patient's labor. Dr. Hahn stated that the reports she was receiving appeared normal throughout the day. If they had been abnormal, she would have presented to the hospital. Dr. Hahn stated that she had confidence in the house medical officers and in the nurse.

Dr. Hunter asked Dr. Hahn how long she would allow a labor to proceed before intervening. Dr. Hahn stated that it is subjective, based on the patient's maternal age and how the fetus was tolerating labor. In this case, she evaluated M.H. approximately 24 hours after she was admitted, as she had received no abnormal reports before then. Dr. Hahn stated that the baby's head was molded upon delivery, but no more so than normal. The molding usually resolves within 24-48 hours. Dr. Hahn stated that if she had hindsight, she would have increased the Pitocin to make the patient's contractions more regular. Additionally, if she had known how her examination differed from the nurse's examination, she would have appeared at the hospital sooner.

Ram R. Krishna, M.D. asked for clarification regarding the patient's excessive bleeding. Dr. Hahn stated that the patient's right uterine vessel had ruptured and that she spent a lot of time repairing that vessel and trying to save the patient's uterus. Tying off the vessel required multiple attempts by her and other physicians.

Mr. McBan made closing comments to the Board and provided American College of Obstetrics and Gynecology (ACOG) standards for the appropriate management of this type of laboring patient. Dr. Hahn's approach mimicked the ACOG standards and she was also found to not be at fault by the hospital.

Tim B. Hunter, M.D. stated that this was a difficult case in which the patient suffered, however, there was no professional misconduct.

MOTION: Tim B. Hunter, M.D. moved to dismiss this case.

SECONDED: Patrick N. Connell, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N. The following Board Members were absent: Ronnie R. Cox, Ph.D., Ingrid E. Haas, M.D., and Lorraine L. Mackstaller, M.D.

VOTE: 9-yay, 0-nay, 0-abstain/recuse, 3-absent

MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
3.	MD-04-0279A	AMB JOSE H. ALVAREZ, M.D.	21702	Draft Findings of Fact and Conclusions of Law for a Letter of Reprimand for removing a healthy ovary during laparoscopic assisted vaginal hysterectomy

Dr. Alvarez was present with counsel, Jay Fradkin. Roderic Huber, M.D. presented this case to the Board. The allegation was that that during a laparoscopic hysterectomy, the patient's ovaries were removed unnecessarily.

Dr. Alvarez made a statement to the Board. He stated that the patient had multiple gynecological problems and she agreed to a hysterectomy. He stated that her ovaries were not normal, contrary to the pathology report.

William R. Martin, III, M.D. began the questioning of Dr. Alvarez. Dr. Alvarez stated that another physician who recommended an open hysterectomy initially saw the patient. She saw Dr. Alvarez for a second opinion and he informed her that he could provide the hysterectomy laparoscopically. Dr. Martin asked how a patient could complain of multiple ovarian cysts. Dr. Alvarez stated that the cysts caused pain. Dr. Alvarez stated that his diagnostic finding was of endometriosis. He did not recall if the patient had any scarring on her uterus. Dr. Martin informed Dr. Alvarez that the only information they have is what is in Dr. Alvarez's medical record. The

medical records make no mention of scarring or of the abnormal ovaries. Dr. Alvarez admitted to not documenting any fibrosis or findings of the abnormal ovaries on his dictation following the surgery.

Dr. Martin asked Dr. Alvarez about the pelvic ultrasound performed prior to the surgery. The right ovary had a cyst, but both ovaries were normal in size. Dr. Martin stated that the gross description of the ovaries stated that both ovaries were slightly enlarged. He asked Dr. Alvarez what medical condition would cause enlarged ovaries. Dr. Alvarez stated that there were many conditions, including endometriosis that could cause enlarged ovaries. Dr. Martin asked if there was any evidence of endometriosis on the ultrasound. Dr. Alvarez conceded that there was no evidence of endometriosis on the gross pathology report. Dr. Alvarez stated that based on the pathology report, the left ovary appeared normal. Dr. Martin asked if it was customary to take out a normal ovary. Dr. Alvarez stated that it was not. The record did not substantiate a reason to remove the ovary.

Dr. Martin then directed Dr. Alvarez to the pathology report. He asked if there was anything in the gross or microscopic report that suggested an abnormal left ovary. Dr. Alvarez stated that there was no abnormality of the left ovary as stated in the record. Dr. Martin questioned why the operative report was not dictated immediately after the surgery. While there were system errors in the hospital, Dr. Martin stated that it was unusual for the operative report to not be dictated until six weeks after the surgery. Dr. Alvarez conceded that operative reports are important. Dr. Martin asked if Dr. Alvarez employed an alternative method to dictate the operative report if there were system errors with the hospital. Dr. Alvarez stated that he did not.

Dr. Martin asked what prior authorization Dr. Alvarez received from the patient. Dr. Alvarez stated that he considered a bilateral salpingo oophorectomy prior to surgery. However, this information is not in the prior authorization, nor is it documented in Dr. Alvarez's pre-surgical discussions with the patient.

Dr. Martin asked if there is a difference between a hemorrhagic and a non-hemorrhagic cyst. Dr. Alvarez stated that there are simple, benign cysts and other types of cysts. Dr. Martin asked if there are effects of removing a single ovary. Dr. Alvarez stated that when one ovary is removed, the person's estrogen level decreases. Dr. Martin questioned why, then, were both ovaries removed?

Robert P. Goldfarb, M.D. asked on average, how many major cases like these he performs. Dr. Alvarez stated that he performs about three a week. Dr. Goldfarb questioned Dr. Alvarez's memory when dictating a report six weeks later when he performs three surgeries like this a week. Dr. Goldfarb stated that while the report met Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements, it was essentially worthless because it was dictated from memory many weeks after the event.

Ram R. Krishna, M.D. questioned where Dr. Alvarez learned to perform laparoscopic hysterectomies. Prior to 1999, Dr. Alvarez stated that 90% of his hysterectomies were performed this way.

Tim B. Hunter, M.D. asked if Dr. Alvarez's consent form today outlines the possibility of removing the ovaries. He stated that it does. Dr. Alvarez stated that he has also obtained a medical record keeping course to ensure this information is documented in the record.

Mr. Fradkin made a closing statement to the Board. He stated this case is the result of an admitted dictation problem that Dr. Alvarez has since remedied. He also stated that the issue with the ovaries was not how they looked upon pathology, but how they looked at surgery. It was Dr. Alvarez's clinical judgment to remove the ovaries based on what he saw during surgery. He asked that the Board take an action that is consistent with the evidence presented to the Board.

Dr. Martin asked if there was anything on the pathologist's amended report that suggested an abnormality. Dr. Huber stated that he was not aware of any new information. Dr. Martin stated that based on the evidence before the Board today, that the patient had a normal left ovary. The standard of care is to preserve the functioning of a normal ovary in a young woman and Dr. Alvarez breached this standard. He stated that (27)(q) is applicable.

MOTION: William R. Martin, III, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (q) - Any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public and (II) - Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.

SECONDED: Patrick N. Connell, M.D.

Dr. Connell stated that he found the delay in the dictated operative report to be below the standard of care and for that reason he supports the motion.

**VOTE: 9-aye, 0-nay, 0-abstain/recuse, 3-absent
MOTION PASSED**

MOTION: William R. Martin, III, M.D. moved for Board staff to draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for removing a healthy ovary during a laparoscopic assisted vaginal hysterectomy.

SECONDED: Patrick N. Connell, M.D.

Dr. Goldfarb stated that he could not understand why this physician removed two normal ovaries. Dr. Hunter stated that often, as physicians, there is a reason behind the decision-making, but that reason is not documented in the medical record.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Ram R. Krishna, M.D.; Patrick N. Connell, M.D.; and Dona Pardo, Ph.D., R.N. The following

Board Members abstained from this matter: Robert P. Goldfarb, M.D.; Becky Jordan; Douglas D. Lee, M.D.; and Sharon B. Megdal, Ph.D. The following Board Members were absent: Ronnie R. Cox, Ph.D.; Ingrid E. Haas, M.D.; and Lorraine L. Mackstaller, M.D.

VOTE: 5-yay, 0-nay, 4-abstain/recuse, 3-absent

MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
4.	MD-04-0161A	J.S. ELIZABETH A. SIMONEAU, M.D.	23693	Dismissed.

J.S. was present for Call to Public. She stated that she had excessive menstrual bleeding, but was an otherwise healthy active patient. She stated that Dr. Simoneau punctured her uterus during a procedure and was sent home with bleeding and cramping. As a result, she underwent an emergency complete hysterectomy. Following the hysterectomy, she saw Dr. Simoneau for additional bleeding. Dr. Simoneau recommended additional surgery to remove her appendix, even though there is no record of appendicitis. J.S. stated that her body and life have been severely altered as a result of the complications from this procedure.

Dr. Simoneau was present with legal counsel, Barry MacBan.

Robert P. Goldfarb, M.D. stated that he knows Mr. MacBan professionally, but that will not influence his ability to adjudicate this case.

Ronnie R. Cox, Ph.D. joined the meeting at 11:39 a.m.

William Wolf, M.D., Medical Consultant, presented this case to the Board. He stated there were five allegations regarding Dr. Simoneau's use of a NovaSure device and her subsequent management and care of the patient. He stated that it was a medical consultant's opinion that Dr. Simoneau's use of the NovaSure device fell below the standard of care.

Dr. Simoneau made a presentation to the Board. She stated that her use of the NovaSure device was appropriate according to the training she had received on the use of the device. She admitted that she punctured the patient's uterus during the procedure. She further stated that there was no evidence of bleeding in her abdomen upon ultrasound and therefore, surgical intervention at that time was not appropriate.

Patrick N. Connell, M.D. began the questioning of Dr. Simoneau. He asked Dr. Simoneau to explain what the NovaSure device is supposed to do when used appropriately. She stated that the device is placed on the uterus and the endometrium is ablated through an electrical loop that is conducted through gold mesh. The device ablates the endometrial tissue about two or three millimeters. Prior to placing the device, Dr. Simoneau attempted a hysteroscopy during which she noted a narrow vaginal cavity. Dr. Simoneau stated that a narrow cavity is not a contraindication to using the NovaSure device. Rather, the contraindication is a thin uterine wall. The longitudinal length of the uterine cavity should be at least four cm to use the device. J.S.'s uterine width was three cm. Dr. Simoneau stated that three cm is also a normal length. Dr. Simoneau stated that she can obtain a more accurate sounding of the uterine wall at the time of surgery is more accurate than the measurement she obtains in the office.

Dr. Connell asked if she could have perforated the uterus in the office when she did the sounding. Dr. Simoneau stated that most perforations that occur happen while the patient is in the office.

Dr. Connell then directed the questioning to the operative report when J.S. was admitted for a laparoscopic assisted vaginal hysterectomy. Dr. Simoneau stated that the operation proceeded without any complications. She later learned that the patient was hypotensive and that raised concerns that J.S. could be bleeding postoperatively. Dr. Simoneau admitted that she had ultimate responsibility for the patient, but when the patient is in the recovery room, the anesthesiologist has primary care of the patient. Dr. Connell asked what Dr. Simoneau's response was when she was called from the recovery room. She ordered blood tests. She was concerned that there was bleeding and therefore ordered an ultrasound. She said there are a number of reasons for why there could be bleeding. Dr. Simoneau stated that the patient's appearance and the fact that she did not have tachycardia was reassuring and did not lead her to believe there was fluid in her abdomen. Dr. Connell stated that in his experience a patient could have fluid in the abdomen without having tachycardia. Dr. Connell stated that in retrospect the patient had a significant retroperitoneal bleed and lost multiple units of blood. Dr. Simoneau stated that she felt following the patient serially and observing her was the appropriate thing to do.

Becky Jordan asked what the advantage of NovaSure was over a D&C or another procedure. Dr. Simoneau stated that the NovaSure application is 85% successful, requires a short hospital stay, and has few complications. Typically, a D&C is diagnostic now.

Robert P. Goldfarb, M.D. asked for how long the NovaSure procedure has been done. Dr. Simoneau said that it has been in use for the last 3-4 years and that the applicator device has changed over time. She completed training in ablations and additional training by the NovaSure representative that included supervised ablations using the device.

Douglas D. Lee, M.D. asked what Dr. Simoneau's role was during the postoperative period. Dr. Simoneau stated that unless she hears otherwise, she expects the patient to be moved to the floor within an hour or two, where she follows up with them. J.S. was not moved for at least three hours. Dr. Lee questioned why she did not follow up with the patient in the recovery area when J.S. was not moved within the normal time period. He also asked if it was common to get a retroperitoneal bleed from the procedure. Dr. Simoneau stated that the procedure itself does not usually cause the bleed, but the trocar can. In terms of the hemoglobin being low and the amount of fluids ordered, Dr. Lee asked why she did not suspect internal bleeding. Dr. Simoneau stated that she suspected that abdominal bleeding would show up on the ultrasound. Dr. Simoneau stated that she was confused by the patient's fluid status, but there were no other diagnostic findings that would have suggested the bleeding.

Tim B. Hunter, M.D. asked if Dr. Simoneau continues to use the device. She stated that she does.

Mr. MacBan made a concluding statement to the Board. He pointed out a report provided by Dr. Crawford that stated there was no contraindication to using the NovaSure devices and that Dr. Simoneau's approach to the patient was appropriate.

Dr. Connell stated that this was a difficult case and that procedures like these require a certain amount of physician judgment and that he found Dr. Simoneau's response to the use of the device was appropriate. Also, Dr. Connell stated that Dr. Simoneau's response to the patient's complications was appropriate.

MOTION: Patrick N. Connell, M.D. moved to dismiss this case.
SECONDED: Robert P. Goldfarb, M.D.

Dr. Goldfarb also noted that the peer review committee found Dr. Simoneau's treatment was appropriate.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Patrick N. Connell, M.D.; Robert P. Goldfarb, M.D.; Becky Jordan; and Dona Pardo, Ph.D., R.N. The following Board Members voted against the matter: Ram R. Krishna, M.D. and Sharon B. Megdal, Ph.D. The following Board Member abstained from this matter: Ronnie R. Cox, Ph.D. The following Board Members were absent: Ingrid E. Haas, M.D. and Lorraine L. Mackstaller, M.D.
VOTE: 7-yay, 2-nay, 1-abstain/recuse, 2-absent
MOTION PASSED.

CALL TO THE PUBLIC

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

ADVISORY LETTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-04-0526A	J.P.	JATIN B. DAAS, M.D.	29127	Issue Advisory Letter for failure to cooperate with another healthcare professional in the delivery of care to another patient.
2.	MD-04-0514C	AMB	THOMAS H. ROSS, M.D.	3713	Issue Advisory Letter for failing to monitor obesity surgery and recognize that the procedure was not completed while serving as a surgical assistant.
3.	MD-04-0466A	AMB	JOSEPH P. PROCACCINI, M.D.	8871	Issue Advisory Letter for failing to act on a high blood pressure reading found on a single emergency room encounter.
4.	MD-04-0461A	AMB	RICHARD D. GERKIN, JR., M.D.	11318	Issue Advisory Letter for failure to notify or document notification to a patient of an abnormal chest x-ray.
5.	MD-04-1008B	P.H.	CHARLES L. SCHAFFER, M.D.	22233	Dismissed

Dr. Schaffer was present for Call to Public. He verified with the Board that the materials he previously provided were given to the Board. He addressed the three specific issues regarding his care to an ophthalmic patient that were discussed in the medical consultant's report. Dr. Schaffer corrected a quote from medical literature provided by the medical consultant. He submitted the text of that literature to the Board. He stated that the issue of pain was addressed with the patient and that it was in the patient's best interest to follow up with a pain medicine specialist to help with her pain issues.

MOTION: Sharon B. Megdal, Ph.D. moved to dismiss this case.
SECONDED: Douglas D. Lee, M.D.
VOTE: 10-0

6.	MD-04-0587A	AMB	RICHARD L. BAILEY, M.D.	25327	Issue Advisory Letter for initiating an operative procedure on the wrong ear.
7.	MD-04-0604A	P.B.	PARVIZ SHAHVAR, M.D.	22714	Dismissed

Sharon B. Megdal, Ph.D. expressed concern that some of the SIRC recommendations appear heavy-handed and questioned whether the test/exam was necessary.

MOTION: Ram R. Krishna, M.D. moved to dismiss this case.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-1 (Ronnie R. Cox, Ph.D. opposed)

8.	MD-04-0785A	S.B.	DEBRA R. ROSE, M.D.	19498	Dismissed
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S.B. spoke on behalf of R.B., the patient, his 3-year old son. He believes his two sons (twins) received less than standard of care for circumcisions. S.B. felt misled by Dr. Rose on the day of the circumcisions because they were not told exactly what to expect. S.B. was told that Dr. Rose was doing a full circumcision when a partial circumcision was completed. When they had post-op complaints,

they felt they were not satisfied. They consulted with another physician who recommended a circumcision revision, which went well, even though it added a financial burden to the family. S.B. believes they were not fully informed about the procedure (removing additional foreskin) and thought it would be complete. He does not feel that an Advisory Letter is sufficient.

Dr. Rose spoke at the Call to the Public. She has been practicing pediatrics for 13 years, during which time she performed thousands of circumcisions. Dr. Rose performed the circumcision of R.B., a premature baby, at six weeks. Dr. Rose expressed concern when she received the notice from the Board and disseminated photos of the procedure to both pediatricians and urologists to determine if the circumcision was correct. Dr. Rose provided substantial testimony that the circumcision met the standard of care. Dr. Rose asked for dismissal of the case.

Becky Jordan stated that she believed it should be dismissed because it appeared to be more cosmetic than medical and that the support of her colleagues was valid. Dr. Wolf, Board Medical Consultant, said that Dr. Rose's description of her procedure met the standard of care. Dr. Nanney, Chief Medical Consultant, described the technique and felt that it is better to err on the side of having more foreskin.

MOTION: Becky Jordan moved to dismiss this case.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-0

9.	MD-04-0961B	N.G.	KAREN E. APODACA, M.D.	19568	Issue Advisory Letter for failure to document that she removed a retained sponge.
10.	MD-04-1021A	C.B.	SAUL AMBER, M.D.	10916	Dismissed

C.B. spoke during the Call to the Public and provided an overview of his complaint. The patient wanted medical records from Dr. Amber since they moved to Prescott, AZ. They believe they were given the runaround in Prescott. When they telephoned Dr. Amber's office, they received a recording that Dr. Amber's office was closing. They wrote a letter requesting the patient records and the letter was returned undeliverable. C.B. inquired at the Board and was provided with a complaint form. C.B. stated that he really did not have a complaint and was just seeking his records. He filed the complaint thinking that this was the only way to get the records. They attempted to contact Dr. Amber personally and finally received the records from another medical office. C.B. commented that he never had a problem with Dr. Amber and that it should never have elevated to this level.

Dr. Amber explained that when he decided to shut down private practice, he called the Board to find out what the process was. He sent cards to all the patients, ran ads for two months, notified the Board of the POB address and was assured that his patients would be taken care of. His old office manager is still on his payroll handling this issue. He has no idea why the complaint from C.B. was handled the way it was since Dr. Amber continues to pay to maintain the files for a period of 7 years.

Robert P. Goldfarb, M.D. said that Board staff should have handled this differently and Tim Miller, Executive Director, said that it is not currently the policy of Board staff to open a complaint for an issue like this. It would now have been resolved without opening a complaint.

MOTION: Ram R. Krishna, M.D. moved to dismiss this case.
SECONDED: Ronnie R. Cox, Ph.D.
VOTE: 10-0

11.	MD-04-0967A	G.H.	JOSEPH E. WEST, M.D.	12717	Issue Advisory Letter for failure to review an abnormal pre-operative x-ray.
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Douglas D. Lee, M.D. recused himself.

12.	MD-04-0906B	L.D.	SUSAN H. BAUMANN, M.D.	16836	Issue Advisory Letter for pre-signing blank prescription forms.
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Sharon B. Megdal, Ph.D. is concerned that this is a serious issue. While this is a statutory violation, there seemed to be a viable alternative.

MOTION: Sharon B. Megdal, Ph.D. moved to dismiss this case.
SECONDED: Ronnie R. Cox, Ph.D.
VOTE: 9-1 (Ram R. Krishna, M.D. opposed)

13.	MD-04-0304A	AMB	N. NEIL BROWN, M.D.	23330	Issue Advisory Letter for failure to operate on the right spinal level due to the presence of Klippel-Feil syndrome.
14.	MD-04-0448A	AMB	PATRICK S. CHANG, M.D.	21908	Issue Advisory Letter for allowing uncertified personnel to perform bone density scans.
15.	MD-04-1310A	AMB	ZULFIQAR AHMAD, M.D.	28404	Dismissed

Ram R. Krishna was concerned that a doctor-patient relationship was not established. Dr. Scherer stated that it appeared that this complaint was based on a claim of sexual harassment.

MOTION: Ram R. Krishna, M.D. moved to dismiss this case.

SECONDED: Ronnie R. Cox, Ph.D.

VOTE: 10-0-2 (The following Board members were absent: Ingrid E. Haas, M.D. and Lorraine L. Mackstaller, M.D.)

MOTION PASSED

16.	MD-04-0426A	J.E.	ZELALEM YILMA, M.D.	25431	Return to Investigations for review of additional information by Outside Medical Consultant
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R.E. spoke during the Call to the Public. He feels very strongly that the medical care his wife received was below the standard and that his wife's longevity was compromised. R.E. presented information not previously reviewed by investigators.

Patrick N. Connell questioned the necessity of the procedure and Dr. Scheerer, Board Medical Consultant explained that there is competition between cardiology practices. He believed that further testing should have been conducted before performing this procedure. The Board felt that this case would benefit from review by an Outside Medical Consultant.

MOTION: Patrick N. Connell, M.D. moved that the arteriogram be reviewed by an Outside Medical Consultant

SECONDED: Robert P. Goldfarb, M.D.

VOTE: 10-0-2 (The following Board members were absent: Ingrid E. Haas, M.D. and Lorraine L. Mackstaller, M.D.)

MOTION PASSED

17.	MD-03-1343A	AMB	RICHARD L. SHINDELL, M.D.	18762	Issue Advisory Letter for failing to order an MRI.
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William R. Martin, III, M.D. recused himself.

18.	MD-04-0055A	E.B.	JOHN C. OPIE, M.D.	19784	Issue Advisory Letter for failure to provide medical records upon request.
19.	MD-03-1320A	AMB	JOSEPH C. MIRABILE, M.D.	9070	Issue Advisory Letter for failure to recognize post cervical laminectomy kyphosis.

Robert P. Goldfarb, M.D. recused himself.

20.	MD-04-0778A	R.G.	DUC C. VO, M.D.	31825	Dismissed
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Douglas D. Lee, M.D. recused himself.

R. G. spoke at the Call to the Public. She has a relationship with Dr. Vo and believes the complainant filed the complaint as retaliation for the breakup of her relationship with the complainant.

Dona Pardo, Ph.D., R.N. stated that she thought an advisory letter was appropriate in this case. Sharon B. Megdal, Ph.D. noted that this complaint seemed to come to the Board because of personal issues. Dr. Pardo stated that while the doctor stopped the doctor-patient relationship, he did initially prescribe to someone he was seeing personally. Robert P. Goldfarb, M.D. noted that Dr. Vo only prescribed Bactrim and Maalox (over-the-counter).

MOTION: Patrick N. Connell, M.D. moved to dismiss this case.

SECONDED: William R. Martin, III, M.D. seconded

VOTE: 11-0 (Mackstaller absent)

21.	MD-05-0157A	AMB	JOSHUA K. TRUSSELL, M.D.	68309	Issue Advisory letter for failure to report a DUI arrest to the Board within ten days of the incident.
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Patrick N. Connell, M.D. discussed this case and stated that this doctor missed the 10-day reporting requirement to the Board by only 2 days. He recommended that this case be dismissed.

Robert P. Goldfarb, M.D. stated that this is a relatively new law and it is not widely known among physicians and residents. Additionally, the Board has not decided how it will handle cases like these. Tim B. Hunter, M.D. stated that the Board adjudicates these cases in order to develop a record of any incidents that may be relevant if there are other similar incidents after the physician is licensed. He further stated that a DUI is a serious incident and that he does not feel comfortable dismissing this case. Dr. Goldfarb stated that most physicians in this state are unaware of their reporting requirements to the Board and education is important to convey this message. Ms. Cassetta stated that this is a violation of the law and if the Board dismissed this case and there was another incident, the Board would be unable to consider the first DUI. Ms. Cassetta also noted the law had been in place for approximately two years and the Board had communicated with the physician community when it was enacted. She also noted that the Board has previously issued advisory letters for failure to report. The Board noted that the physician did his best in attempting to comply and had been given erroneous legal advice that he was not required to report the DUI.

MOTION: Robert P. Goldfarb, M.D. moved to issue an advisory letter for failure to report a DUI arrest to the Board within ten days of the incident.

There was further discussion regarding the reason for reporting a DUI to the Board so that the Board can evaluate the doctor to determine if there is a problem with alcohol abuse. Ms. Cassetta stated that while a DUI is not a violation of the medical practice act, failure to report the incident is a violation of law. Dr. Hunter asked if a DUI is a felony. Mr. Brekke stated that there are different levels of a DUI. Dr. Trussell was charged with a misdemeanor.

SECONDED: Sharon B. Megdal, Ph.D.

VOTE: 10-1-1 (Douglas D. Lee, M.D. opposed, Lorraine L. Mackstaller, M.D. absent)

MOTION PASSED

22.	MD-04-0222A	R.S.	RICHARD J. HARDING, M.D.	23337	Issue Advisory Letter for failure to note a leak on a gastrograph/barium study.
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P.S. spoke at the Call to the Public about the patient, her deceased mother-in-law. P.S. felt that Dr. Harding failed to treat this situation correctly. P.S. believes that Dr. Harding removed more during surgery than anticipated and that the surgery was based on the thought that patient had cancer that she did not have.

R.S. spoke at the Call to the Public and thanked the Board for the opportunity to show that people are being held accountable. R.S. spoke about his grandmother's death and believes that the surgery was the cause of her death. R.S. felt that his grandmother was uninformed about and during the surgery and that her feelings following surgery were not addressed. R.S. stated that they were never told to get a second opinion or to question and that they would like to see Dr. Harding disciplined. The patient's son also spoke on behalf of his mother.

This case was pulled for further discussion. William Wolf, M.D., Medical Consultant, made a presentation to the Board. He stated that this case involved allegations regarding Dr. Harding's performance of an unnecessary partial gastric anastomotomy and that he failed to ensure there was no anastomotic leak prior to instituting oral intake. This case was sent to a radiologic consultant. The Board took a break to review the information provided by the radiologist.

Dr. Hunter stated that the radiologic images do show a leak, but that it was very subtle and it is not commonly picked up on x-ray. He stated that not recognizing the leak did not fall below the standard of care. Dr. Wolf provided the radiologist's findings to the Board. The diagnostic finding was that there was a trace amount of free interperitoneal air on the scout view, however this was never reproduced. Dr. Wolf stated that if the surgeon knew there was a leak he might have watched the patient and not fed the patient immediately. Dr. Harding would have expected a phone call from the radiologist. The findings are very subtle and this was a close call for the physician. Dr. Wolf opined that this was a technical error in Dr. Harding's failure to review the film with the radiologist.

MOTION: Robert P. Goldfarb, M.D. moved to issue an advisory letter for failure to note a leak on a gastrograph/barium study.

This was a technical error.

SECONDED: Ram R. Krishna, M.D.

VOTE: 11-0

23.	MD-04-0346A	C.H.	STEVEN L. SHOLEM, M.D.	8885	Issue Advisory Letter for leaving in vaginal packing, which led to infection, and for inaccurate medical record keeping.
24.	MD-05-0137A	AMB	UDAYA KAKARLA, M.D.	67330	Issue Advisory Letter for failure to report a DUI arrest to the Board within ten days of the incident.

Robert P. Goldfarb, M.D. pulled this case for further discussion.

MOTION: Ram R. Krishna, M.D. moved for advisory letter for failure to report a DUI arrest to the Board within ten days of the incident.

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

VOTE: 11-0

25.	MD-04-0766B	C.M.	KIRIT P. GOSALIA, M.D.	11963	Issue Advisory Letter for failure to ensure a physician was immediately available and on the premises during a cardiac treadmill stress test.
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Sharon B. Megdal, Ph.D. pulled this case for further discussion and asked if it was the standard for the physician to be present for the cardiac treadmill stress test. Dr. Nanney quoted the American Academy of Cardiology opinion that there should be direct supervision by a physician in the vicinity in case of emergency situations. Dr. Nanney also stated that the emergency response team arrived before the physician did. Douglas D. Lee, M.D. noted that the physician's response to the Board states that there is always a physician immediately available, however, in this case, a physician was not immediately available. Robert P. Goldfarb, M.D. noted that Dr. Gosalia was involved with emergency unscheduled cardiac catheterization and this stress test should have been cancelled.

MOTION: Patrick N. Connell, M.D. moved for an advisory letter failure to ensure a physician was immediately available and on the premises during a cardiac treadmill stress test.

SECONDED: William R. Martin, III, M.D.

Douglas D. Lee, M.D. asked if this case needed more discussion in the form of a formal interview. Ram R. Krishna, M.D. agreed. Sharon B. Megdal, Ph.D. stated that she felt an advisory letter was appropriate as there was no real patient harm. Dona Pardo, Ph.D., R.N. stated that she felt the potential for harm was there.

**VOTE: 6-5
MOTION PASSED**

26.	MD-04-1316A	J.B.	KENNETH LEUNG, M.D.	10262	Issue Advisory Letter for prescribing Motrin to a patient with aspirin allergies and a history of peptic ulcer disease.
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This case was pulled for further discussion. Patrick N. Connell, M.D. stated that this physician had prescribed Motrin for a patient with multiple medical problems, including an allergy to aspirin. He noted a letter from the physician's attorney regarding the notice Dr. Leung received for the investigational interview and the possibility of a due process issue. Mr. Brekke opined that that the notice was appropriate.

MOTION: Patrick N. Connell, M.D. moved to issue an advisory Letter for prescribing Motrin to a patient with aspirin allergies and a history of peptic ulcer disease.

SECONDED: Ram R. Krishna, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Patrick N. Connell, M.D.; Robert P. Goldfarb, M.D.; Becky Jordan; Dona Pardo, Ph.D., R.N.; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D.; Ronnie R. Cox, Ph.D.; and Ingrid E. Haas, M.D. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent

MOTION PASSED.

27.	MD-05-0174A	AMB	GEOFFREY P. RADOFF, M.D.	9881	Issue Advisory Letter for failure to report a DUI arrest to the Board within ten days of the incident.
28.	MD-04-0985A	AMB	STANLEY C. GRAVES, M.D.	22387	Issue Advisory Letter for initiating surgery on the wrong site.

William R. Martin, III, M.D. recused himself from this case. This case was pulled for further discussion. Robert P. Goldfarb, M.D. stated that this brings up the issue of wrong site surgery and that he would support an advisory letter because there was an incision made, but there was no harm to the patient. Ram R. Krishna, M.D. and Dona Pardo, Ph.D., R.N. concurred.

MOTION: Patrick N. Connell, M.D. moved to issue an Advisory Letter for initiating surgery on the wrong site.

SECONDED: Ram R. Krishna, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Patrick N. Connell, M.D.; Robert P. Goldfarb, M.D.; Becky Jordan; Dona Pardo, Ph.D., R.N.; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D.; Ronnie R. Cox, Ph.D.; and Ingrid E. Haas, M.D. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent

MOTION PASSED.

29.	MD-04-0524A	AMB	STEVEN J. MANOS, M.D.	23823	Issue Advisory Letter for an error in dosing Demerol.
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Dr. Manos was present for Call to Public. Dr. Manos verbally presented the supplemental information he provided to the Board prior to the meeting. He stated that he believed the medical consultant's opinion was contrary to his own and that he had medical literature to support his position. He also corrected the weight of the patient as mentioned in the medical consultant's report to reflect the true patient weight in the medical record, as this was an important factor in his dosing of Demerol to the patient. He also stated that while he wrote the original Demerol PCA prescription, another physician was responsible for the primary care of the patient.

30.	MD-04-1253A	E.E.	JOSHUA D. HOLLAND, M.D.	17551	Dismissed
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Dr. Holland appeared during the Call to the Public. He has been a family practitioner for 17 years in the Phoenix area and has received no disciplinary action during that time. Dr. Holland stated that he saw the patient, discerned that there was no fracture, and gave instructions for care. The patient was seen again after several days when they called again. Dr. Holland believes the patient was seen in a timely manner and that this case was handled appropriately. Dr. Holland shared his own personal story about an orthopedic injury and stated that he believed the mission of the Board is to protect the public on egregious errors. He did not feel that any harm was done and asked that the Board not issue an Advisory Letter in this matter.

The Board discussed this case and felt that the standard of care was met.

William R. Martin, III, M.D. recused himself from this case.

MOTION: Ram R. Krishna, M.D. moved to dismiss.

SECONDED: Patrick N. Connell, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Patrick N. Connell, M.D.; Robert P. Goldfarb, M.D.; Becky Jordan; Dona

Pardo, Ph.D., R.N.; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D.; Ronnie R. Cox, Ph.D.; and Ingrid E. Haas, M.D. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent

MOTION PASSED.

31.	MD-04-1148A	AMB	JANEEN C. ROSS BJORK, M.D.	30081	Issue Advisory Letter for the management of labor and delivery.
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This case was pulled for further discussion. Sharon B. Megdal, Ph.D. asked if the physician fell below the standard of care. Ingrid E. Haas, M.D. stated that she felt an advisory letter was appropriate as the injury is not common, but is a known complication.

MOTION: Patrick N. Connell, M.D. moved to issue an advisory Letter for the management of labor and delivery.

SECONDED: Ram R. Krishna, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Patrick N. Connell, M.D.; Robert P. Goldfarb, M.D.; Becky Jordan; Dona Pardo, Ph.D., R.N.; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D.; Ronnie R. Cox, Ph.D.; and Ingrid E. Haas, M.D. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent

MOTION PASSED.

MOTION: Ram R. Krishna, M.D. moved to issue Advisory Letters for case numbers 1, 2, 3, 4, 6, 9, 11, 13, 14, 17, 18, 19, 23, 27, and 29.

SECONDED: Robert P. Goldfarb, M.D.

VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent

MOTION PASSED

APPEAL OF ED DISMISSALS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
1.	MD-04-1446B	R.H. SAADEH A. SAADEH, M.D.	27517	Uphold the Executive Director's Dismissal.
2.	MD-04-0170A	C.B. JACEK M. HERCHOLD, M.D.	17909	Uphold the Executive Director's Dismissal.

Dr. Herchold has been a pediatrician for over 20 years and does not believe the child was ever placed at risk and that the initial complaint did not adequately reflect the situation. Nurses' notes indicate that the child was doing well, but later in the day, the situation changed. Dr. Herchold was taken off the case and believes that he handled the situation correctly.

3.	MD-04-0528A MD-04-0528E	N.T. WARREN M. BREISBLATT, M.D. ROBERT L. RODRIGUES, M.D.	24667 20171	Uphold the Executive Director's Dismissal.
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N.T. appeared at the Call to the Public. The appeal is based on the complainant's opinion that a less than thorough investigation was performed. Complainant was told that her husband did not have to die. Husband was transported to Phoenix Baptist for treatment and they were told that the only hospital that had a surgeon that would do the surgery was Phoenix Baptist. Surgical team was waiting for him and stated that he did not feel this was an emergent situation. The complainant wanted her husband to be brought to the Arizona Heart Institute, but they were told they only do bypasses. The complainant believes that Dr. Breisblatt pressured the surgeon to bring the surgery to Phoenix Baptist. The complainant is seeking investigational information from the Board and questioned whether all hospital personnel were interviewed by investigators. The complainant stated that the Board is held in high regard and asked that the case be reopened and hospital staff on duty on April 26-27, 2003 questioned. While they do not know if the outcome would have been different, they would like the case investigated further.

4.	MD-04-0748A	T.G. MICHAEL J. BRUWER, M.D.	9113	Uphold the Executive Director's Dismissal.
5.	MD-04-0996A	F.W. GLENN H. BROWN, M.D.	14201	Uphold the Executive Director's Dismissal.
6.	MD-03-1199B	M.D. JOHN W. HOWLEY, M.D.	22390	Uphold the Executive Director's Dismissal.
7.	MD-04-1342A	M.M. LURALIE L. LEONARD, M.D.	27818	Uphold the Executive Director's Dismissal.
8.	MD-04-1186A	R.H. ANDREW L. WRIGHT, M.D.	26083	Uphold the Executive Director's Dismissal.
9.	MD-04-1229A	W.K. BRENDA C. PATTON, M.D.	22231	Uphold the Executive Director's Dismissal.
10.	MD-04-0299A	Y.L. CHARLES P. PLIMPTON, M.D.	20429	Uphold the Executive Director's Dismissal.
11.	MD-04-0926A	G.G. STEVEN L. HOOVER, M.D.	23858	Uphold the Executive Director's Dismissal.

G.G. spoke at the Call to the Public. Her 13-year old son had one single seizure. She saw Dr. Hoover who started her son on Dilantin. Dr. Hoover promised that he would ease the child off Dilantin, but did not. Now her son has other problems, a head rash, dental problems, personality and anger issues, that she believes are caused by the medications from Dr. Hoover. Complainant drove 150 miles to speak before the Board.

12.	MD-04-0841A	J.S. WILLIAM A. CALDERWOOD, M.D.	11658	Uphold the Executive Director's Dismissal.
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J.S. spoke at the call to the public. Faxes that are being sent to physicians are coming to him because he now has Dr. Caldwood's previous fax number. J.S. noted he gets faxes with numbers to have faxes removed and he keeps asking that faxes be stopped., but

he continues getting them. J.S. has concerns with privacy of medical records. J.S. shared Federal law guaranteeing the privacy of a patient and note he's been receiving the faxes for two years. J.S. would like Dr. Calderwood disciplined.

Dr. Calderwood spoke at the Call to the public. Five years ago he changed offices and changed fax numbers. He requested keeping one of his two fax numbers. Instead they are going to some other individual. Only 3 are for medical issues. Charge appears to be that Dr. Calderwood is sending faxes, but he is not responsible for the faxes. They appear to be spam. Every time the gentleman comes in with faxes, Dr. C's office sends them letters telling them to stop. Now the gentleman will not provide them with the faxes. None of the faxes are from him, they are directed to him.

13.	MD-04-1221A MD-04-1221B MD-04-1221D	P.S.	ROBERT W. WELKER, M.D. ANDREI DAMIAN, M.D. DAVID R. SEASE, M.D.	23594 14782 19507	Uphold the Executive Director's Dismissal.
14.	MD-04-1115A	C.S.	INEKE M. AYUBI-MOAK, M.D.	29638	Uphold the Executive Director's Dismissal.
15.	MD-04-1425A	H.B.	HETAL C. SHAH, M.D.	25006	Uphold the Executive Director's Dismissal.

H.B. spoke at the Call to the Public. H.B. said she has a history of gynecological issues in her life and that Dr. Shah told her that she had cancer after only a visual exam. H.B. went to a different physician and demanded a biopsy and found that she has sclerosis – not cancer. H.B. is furious with Dr. Shah's handling of this case. She said that she knows that this is her word against his word. If the Board does not take action, Dr. Shah will continue to call his patients liars. Believes he is unethical.

16.	MD-04-1279B MD-04-1279C	J.A.	KRISTI A. BOLES, M.D. MICHAEL A. YOUNG, M.D.	32338 31476	Uphold the Executive Director's Dismissal.
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Dr. Young spoke at the Call to the Public and noted he was a concerned pediatrician who wants to the Board to know they take these matters seriously.

17.	MD-04-1546A	L.R.	KURT E. HEILAND, M.D.	24997	Uphold the Executive Director's Dismissal.
18.	MD-04-0861A	C.D.	MICHAEL R. PROBSTFELD, M.D.	25850	Uphold the Executive Director's Dismissal.

Hardy Smith, attorney for Dr. Probstfeld appeared on behalf of his client at the Call to the Public. Mr. Smith noted the Patient filed a lawsuit that was dismissed because the claim could not be supported and he believes that the appeal was filed with a retaliatory motive. Also, there was no indication that the Medical Practices Act was violated and the investigation revealed that conditions occurring after the surgery were, in fact, in place prior to the surgery.

19.	MD-04-1061A	S.S.	MICHAEL S. KLEIN, M.D.	18454	Uphold the Executive Director's Dismissal.
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MOTION: Ram R. Krishna, M.D. moved to uphold the Executive Director's dismissal for case numbers 1 through 19.

SECONDED: Patrick N. Connell, M.D.

VOTE: 11-yay, 0-nay,0-abstain/recuse, 1-absent

MOTION PASSED

OTHER BUSINESS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	SUBJECT
1.	MD-04-0040A	P.M. MARY E. MOYER, M.D.	19675	Recommended for Dismissal

MOTION: Sharon B. Megdal, Ph.D. moved to dismiss this case.

SECONDED: William R. Martin, III, M.D.

VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent

MOTION PASSED

2.	MD-03-1273A	AMB	BRYAN A. GUNNOE, M.D.	22817	Accept the Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to confirm the appropriate level section intra-operatively resulting in his performing spinal surgery at the wrong level.
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MOTION: Sharon B. Megdal, Ph.D., moved to accept the Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to confirm the appropriate level section intra-operatively resulting in his performing spinal surgery at the wrong level.

SECONDED: Ram R. Krishna, M.D.

VOTE: 11-0-0-1 (Board Member absent: Lorraine L. Mackstaller, M.D.)

MOTION PASSED

3.	MD-03-0130B	AMB	ROBERT J. GUERRA, M.D.	10189	Draft Findings of Fact, Conclusions of Law and Order Accepted
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Robert P. Goldfarb, M.D. and Tim B. Hunter, M.D. recused themselves from this case.

MOTION: Sharon B. Megdal, Ph.D., moved to accept the Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to confirm location of patient's tumor resulting in unnecessary removal of healthy tissue.

SECONDED: Ram R. Krishna, M.D.

VOTE: 11-0-2-1 (Board Member absent: Lorraine L. Mackstaller, M.D.)

MOTION PASSED

4.	MD-04-0198A	J.D.	LAURA HARRINGTON-ZAUTRA, M.D.	24671	Draft Findings of Fact, Conclusions of Law and Order Accepted
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MOTION: Sharon B. Megdal, Ph.D., moved to accept the Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for violating physician-patient boundaries.

SECONDED: Ram R. Krishna, M.D.

VOTE: 11-0-0-1 (Board Member absent: Lorraine L. Mackstaller, M.D.)

MOTION PASSED

5.	MD-04-0004B	C.B.	SATISH G. NAMJOSHI, M.D.	20827	Reject the Proposed Consent Agreement. Issue Advisory Letter for prescribing medicine to a patient who was allergic to the prescribed medicine.
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Sharon B. Megdal, Ph.D. requested that this case be pulled for further discussion. She stated that she did not know if this case should be adjudicated with a Letter of Reprimand or an advisory letter. Ram R. Krishna, M.D. and Dona Pardo, Ph.D., R.N. agreed.

MOTION: Ram R. Krishna, M.D., moved to reject the proposed consent agreement.

SECONDED: William R. Martin, III, M.D.

VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent

MOTION PASSED

MOTION: Ram R. Krishna, M.D. moved to issue an Advisory Letter for prescribing medicine to a patient who was allergic to the prescribed medicine. This was a minor technical violation.

SECONDED: Robert P. Goldfarb, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Patrick N. Connell, M.D.; Ronnie R. Cox, Ph.D.; Robert P. Goldfarb, M.D.; Ingrid E. Haas, M.D.; Becky Jordan; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D.; and Dona Pardo, Ph.D., R.N. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

VOTE: 11-yay, 0-nay, -abstain/recuse, 1-absent

MOTION PASSED

6.	MD-04-0514A	AMB	ALAN Y. NEWHOFF, M.D.	5841	Proposed Consent Agreement Accepted
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MOTION: Patrick N. Connell, M.D., moved to accept the proposed consent agreement.

SECONDED: Sharon B. Megdal, Ph.D.

VOTE: 11-0-0-1

MOTION PASSED.

7.	MD-04-0159A	AMB	JAQUELINE S. SILKEY, M.D.	26342	Proposed Consent Agreement Accepted
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Patrick N. Connell, M.D. stated that he knows Dr. Silkey, but that will not affect his ability to adjudicate the case.

MOTION: Sharon B. Megdal, Ph.D., moved to accept the proposed consent agreement.

SECONDED: Ram R. Krishna, M.D.

VOTE: 11-0-0-1

MOTION PASSED.

8.	MD-04-0864A MD-04-1005A MD-04-0024A	AMB S.F. N.M.	KEVEN D. BROCKBANK, M.D.	29044	Refer to Formal Hearing
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Tim B. Hunter, M.D. pulled this case for further discussion.

The Board went into executive session at 11:47 a.m.

The Board returned to open session at 11:52 a.m.

MOTION: Sharon B. Megdal, Ph.D., moved to refer these cases to formal hearing.

SECONDED: William R. Martin, III, M.D.

VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent

MOTION PASSED

9.	MD-88-0293	AMB	GEORGE D. KARALIS, M.D.	6654	Termination of Board Order Granted
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Robert P. Goldfarb, M.D. noted that while Dr. Karalis was on probation he had some inappropriate telephone billing.

Christi Banyas, Compliance Officer, presented this case to the Board. She provided the history of Dr. Karalis's actions that prompted his probationary order by the California Medical Board. She stated that Dr. Karalis has completed the terms of his probation and the California Medical Board has since lifted his restriction. Dr. Karalis entered into a Stipulation with the Board in 1991 based on the California action.

MOTION: Ram R. Krishna, M.D., moved to terminate the Board Order.

SECONDED: William R. Martin, III, M.D.

VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent

MOTION PASSED

FORMAL INTERVIEW

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
1.	MD-04-0044A	AMB GUADALUPE H. MANRIQUEZ, M.D.	20005	Issue Advisory Letter for incorrect pathologic diagnoses.

Dr. Manriquez appeared with counsel, Joel Herz. Dr. Scherer presented the case that was referred to the Board by Northwest Hospital. Additional review was provided by an OMC in Pathology.

Douglas D. Lee, M.D. focused his questioning on the misdiagnoses. The licensee admitted fault on two occasions - missed cells that were malignant and in diagnosing cancer when you have a core biopsy. Dr. Manriquez accepted full responsibility for this case. She stated that she had a stack of cases to be reviewed by another physician, but was told that all the cases did not need to be reviewed. Dr. Manriquez estimated that 5 or 6 cases each day are positive.

Dr. Manriquez commented that she was not thinking clearly at the time because she had discontinued her medication, but did not feel that there were any consequences from taking herself off her meds. Dr. Manriquez is currently working in medical research and development.

Mr. Herz addressed the Board, apologizing for Dr. Manriquez's actions. He stated that Dr. Manriquez takes responsibility for the mistakes she made. She has now left the active practice of medicine.

MOTION: Sharon B. Megdal, Ph.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) (q) "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: - Any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public.

SECONDED: William R. Martin, III, M.D.

VOTE: 11-0-0-1

MOTION PASSED

MOTION: Douglas D. Lee, M.D. moved for an Advisory Letter for incorrect pathologic diagnoses.

SECONDED: William R. Martin, III, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Patrick N. Connell, M.D.; Ronnie R. Cox, Ph.D.; Becky Jordan; and Ram R. Krishna, M.D. The following Board Members voted against this matter: Robert P. Goldfarb, M.D.; Sharon B. Megdal, Ph.D.; and Dona Pardo, Ph.D., R.N. The following Board Members were absent: Ingrid E. Haas, M.D. and Lorraine L. Mackstaller, M.D.

VOTE: 7-yay, 3-nay, 0-abstain/recuse, 2-absent

MOTION PASSED

FORMAL HEARING MATTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
1.	MD-03-0150A	AMB RUBEN J. MARCHISANO, M.D.	10495	No Action Taken

See Non Time-Specific Section Above

2.	MD-04-1201A	G.D.	GARY S. BLASS, M.D.	22064	Adopt Order for Revocation of License
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Steve Wolf cites a change on Page 4, changing the reference from heroin to "relapsed in the use of Hydrocodone". Mr. Wolf provided the Board with the citation to the record supporting his suggested change. Dr. Hunter noted that the change would more accurately reflect the record and would be less inflammatory language than that used by the ALJ.

Ms. Cassetta advised the Board that rather than walking through the extensive format changes she recommends to the proposed order, the Board waive the privilege attached to her memo to the Board on this case. The waiver would allow her to share the reasons for the changes with OAH.

MOTION: Tim B. Hunter, M.D. moved to waive privilege to allow changes recommended by Christine Cassetta, Board Counsel. SECONDED: Patrick N. Connell, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Patrick N. Connell, M.D.; Ronnie R. Cox, Ph.D.; Robert P. Goldfarb, M.D.; Becky Jordan; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Members were absent: Ingrid E. Haas, M.D. and Lorraine L. Mackstaller, M.D.

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

MOTION: Patrick N. Connell, M.D. moved to accept Findings of Fact with the changes recommended by Mr. Wolf and outlined by Ms. Cassetta in her memo.

SECONDED: Robert P. Goldfarb, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Patrick N. Connell, M.D.; Ronnie R. Cox, Ph.D.; Robert P. Goldfarb, M.D.; Becky Jordan; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Members were absent: Ingrid E. Haas, M.D. and Lorraine L. Mackstaller, M.D.

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

MOTION: Ram R. Krishna, M.D. moved to adopt the recommended order to revoke Dr. Blass's license

SECONDED: Patrick N. Connell, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Patrick N. Connell, M.D.; Ronnie R. Cox, Ph.D.; Robert P. Goldfarb, M.D.; Becky Jordan; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Members were absent: Ingrid E. Haas, M.D. and Lorraine L. Mackstaller, M.D.

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

OTHER BUSINESS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
1.	MD-05-0150A	AMB RICHELIE P. BAST, M.D.	14854	Amend terms of Board Order

Dr. Bast appeared with Dr. Hamblin, his Supervising Physician from Springerville, AZ. Dr. Hamblin spoke at the Call to the Public, explaining that they are from rural southern Apache County. Dr. Bast came from St. Johns, which had no doctors, and was recruited to work with Dr. Hamblin at the two clinics in St. Johns and Springerville. The practices built up so that Dr. Bast was ultimately just practicing in St. Johns and Dr. Hamblin in Springerville. The two physicians established a working relationship to share medical care between the two locations.

Kathleen Muller presented provisions of MAP and stated that Dr. Bast practices alone in violation of group practice restriction as currently written in his Order. Dr. Bast considers the sharing of responsibilities as a group practice. Board staff recommends termination of the Order and revocation of license. Dr. Sucher stated that Dr. Bast approached the Board to lift the restrictions of his Order; however, it appeared that he was already in violation of his order. Dr. Sucher stated that Dr. Bast did not approach the Board with regard to changes and that he took it upon himself to change the Order.

Sharon B. Megdal, Ph.D., moved to go into Executive Session at 4:26 p.m.

The Board returned to open session at 4:31 p.m.

Dr. Bast addressed the Board. He stated that he has been required to practice in a group setting since 1997. He petitioned the Board with the question to have the restrictions removed to assist him in getting insurance (paid \$110,000 for the past three years). Dr. Bast read an excerpt from a letter dated 10-9-2002 clarifying that group setting requirement, stating that he can "practice in a medical emergency setting as long as there is a supervising physician". Robert P. Goldfarb, M.D. asked Ms. Muller about quarterly reports that were to have been written by the supervising physician and Ms. Muller confirmed that quarterly information has been provided.

Douglas D. Lee, M.D. reviewed the definition of group versus solo practice and stated that he believes that Dr. Bast has been practicing in a solo setting. William R. Martin, III, M.D. stated that he believes that Dr. Bast was following the intent of the Order. Drs. Megdal and Ronnie R. Cox concurred that there needs to be greater clarity on both sides. Becky Jordan believes that if Dr. Hamblin agrees to serve as his supervising physician, then the Board should amend the Order. Robert P. Goldfarb, M.D. said he thought we needed to see why there was the group stipulation and what the supervising physician's responsibility is. Tim B. Hunter, M.D. asked Dr. Sucher if Dr. Bast is in compliance with the MAP program and Dr. Sucher stated that he has been in compliance. Historically, in 2001, Dr. Bast

took Ultram, a prescription pain killer. As a result of this action, Dr. Bast's license was suspended. He went to Betty Ford Clinic and they recommended that he practice in a group setting, in effect through 2008.

MOTION: Ram R. Krishna, M.D. moved to amend the Board Order to reflect that Dr. Bast is in compliance with the terms of his Order, defining group practice and the supervising role, including overview of some cases in the form of chart review.

SECONDED: Robert P. Goldfarb, M.D.

Dr. Martin was concerned that precedence may be developed but wants to assure that this case is specific only to this individual. Dr. Martin also questioned what would happen in two years and was told by Christine Cassetta, Board Legal Counsel, that when the Order expires, Dr. Bast may return to full practice. Dr. Lee stated that the Board should clearly indicate what group practice means and indicate that it applies only to this case.

MOTION: Sharon B. Megdal, Ph.D. moved to modify the Board Order to allow Dr. Bast to practice in a solo setting as long as he is affiliated with another physician, requiring Dr. Bast to notify the Board of any changes in his practice setting.

SECONDED: Patrick N. Connell, M.D.

MOTION: Robert P. Goldfarb, M.D. moved to define supervision as twice monthly review of Dr. Bast's cases and reporting on a quarterly basis.

SECONDED: Douglas D. Lee, M.D.

VOTE: 4-yay, 5-nay, 1-abstain/recuse, 2-absent

MOTION FAILED

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
1.	MD-03-1119A	AMB	SHEL-DON J. LEGARRETA, M.D.	25100	Proposed Consent Agreement accepted for a Letter of Reprimand for prescribing prescription-only medications without establishing a doctor/patient relationship. Probation for five years with MAP terms.

MOTION: Patrick N. Connell, M.D. moved to accept the signed Consent Agreement

SECONDED: Becky Jordan

VOTE: 10-0-0-2

MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	BOARD RESOLUTION
2.	MD-04-0480A	AMB	SIMON OLSTEIN, M.D.	8589	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for possession of heroin, a felony, 5-year probation with MAP terms, alternative 12-Step meetings as approved by the MAP Director and psychiatric treatment with a Board approved psychiatrist.

Ann Tyrell was present on behalf of Dr. Olstein at Call to Public. She stated that her presence at the Board was voluntary and that in the time she has known Dr. Olstein and served as a first assistant, she has never seen him impaired. Ms. Tyrell stated that Dr. Olstein has sought appropriate treatment and that he deserves the Board's support to continue in the practice of medicine.

Patrick N. Connell, M.D. and William R. Martin, III, M.D. both stated that they have referred patients to Dr. Olstein but it will not interfere with their adjudication of this matter. Robert P. Goldfarb, M.D. said that he has worked with Mr. Milligan's law firm, but it will not interfere with his adjudication of this matter.

Dr. Olstein appeared with counsel, Mr. Robert Milligan. Cathy Riggs reported that the Board was informed by the Phoenix Police Department that they found marijuana and a balloon of heroin in Dr. Olstein's luggage at Sky Harbor Airport. According to the Police report, Dr. Olstein stated that he did smoke marijuana, but that he did not use heroin. Dr. Olstein's alcohol intake consists of occasional beer and wine. He stated that he has depression and was treated for a time with Prozac. Dr. Olstein was treated at Sierra Tucson in 2004. Dr. Olstein went to Life Healing Center in New Mexico (not a Board approved treatment facility) for depression issues. In August, 2004, Dr. Olstein began participation in the Maricopa County TASC treatment program.

Dr. Sucher met with Dr. Olstein in April 2004 and determined that Dr. Olstein was addicted to drugs. Dr. Sucher believes that Dr. Olstein needs to participate in the MAP program prior to returning to the practice of medicine. He does not believe that the SIRC report is an accurate reflection of the situation. He said Dr. Olstein was described as not being forthcoming, even though he made himself available for Board interviews. He was described as not being in treatment and yet, his treatment was just outlined. He has also been in treatment on a weekly basis with Dr. Schulte for the past year. The original report described Dr. Olstein as having no monitoring, but he was in New Jersey taking care of the affairs of his deceased father. He is currently participating in the TASC program and has even increased the frequency of testing.

Dr. Olstein stated that the most difficult part of the evaluation is accepting the poly-substance abuse. The SIRC report recommends a Decree of Censure; however, Dr. Olstein stated that he is not the person described in that report. Dr. Connell asked if Dr. Olstein would be willing to accept a Consent Agreement for MAP participation for five years and in response, Dr. Olstein has asked that the probationary period be set at 4 years allowing for the one year that he has clean. He stated that he does not believe he has a problem with chemical dependency.

Dr. Sucher felt that it would be appropriate and acceptable for Dr. Olstein to participate in the MAP program and that it would be necessary for Dr. Olstein to continue psychiatric counseling with Dr. Schulte.

Dr. Megdal was concerned about the length of time it took for the file to be brought to the Board. Mr. Miller stated that this case was one of the first brought to his attention when he came on board in December, 2004 and that several months have elapsed in trying to produce a Consent Agreement. Under normal circumstances, a substance abuse issue such as this would have been brought before the Board as a summary suspension. However, since Dr. Olstein was already in the TASC program, it was determined that the Board would attempt to establish a Consent Agreement with the licensee. Dr. Krishna stated that they do not feel that Dr. Olstein's practice needs to be restricted as long as he participates in the TASC and MAP programs.

Board went into executive session at 5:54 p.m.

Board returned from executive session at 6:01 p.m.

Board took a break at 6:01 p.m.

Board returned at 6:15 p.m.

MOTION: Patrick N. Connell, M.D. moved accept a consent agreement for a Letter of Reprimand for possession of heroin, a felony, 5-year probation with MAP terms, alternative 12-Step meetings as approved by Dr. Sucher, and psychiatric treatment with a Board approved psychiatrist.

SECONDED: Robert P. Goldfarb, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Patrick N. Connell, M.D.; Ronnie R. Cox, Ph.D.; Robert P. Goldfarb, M.D.; Becky Jordan; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Members were absent: Ingrid E. Haas, M.D. and Lorraine L. Mackstaller, M.D.

VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent

MOTION PASSED

THURSDAY, JUNE 9, 2005

CALL TO ORDER

Tim B. Hunter, M.D., Chair, called the meeting to order at 8:01 a.m.

ROLL CALL

The following Board Members were present: Tim B. Hunter, M.D., William R. Martin III, M.D., Douglas D. Lee, M.D., Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

CALL TO THE PUBLIC

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

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
1.	MD-04-1374A	D.F. LUIS A. COPPELLI, M.D.	9535	Continued. Returned to Investigations

D.F. was present for Call to Public. He informed the Board of the events surrounding his surgery, including a resulting staph infection and surgery to repair a vein graph. He is currently unable to do physical activities as he did in the past.

Luis Coppelli, M.D. was present with counsel, Paul Giancola. William Wolf, M.D., Medical Consultant, presented this case to the Board. The allegations in this case involved a negligent popliteal graft and failure to provide appropriate care and treatment postoperatively.

Dr. Coppelli made an opening presentation to the Board. He addressed the allegations and provided a history of his treatment of these types of grafts in the past. He stated that these infections could be cleared the majority of the time. In this case, patient D.F. required additional work up in the hospital and was treated with antibiotics. D.F. required further care including a return to surgery to debride the wound, however, the graft was not compromised. After a month of antibiotic treatment, the wounds were healing and there was no inflammation. D.F. did not return to Dr. Coppelli after his last visit.

Robert P. Goldfarb, M.D. began questioning Dr. Coppelli. He asked Dr. Coppelli about his practice and for how long he has been performing vascular surgery, including popliteal bypass grafts. Dr. Coppelli stated that he performs about 1 popliteal bypass graft per year. Dr. Goldfarb asked Dr. Coppelli how he would handle a graft that was infected. Dr. Coppelli stated that pus could be a signal to do

a resection. Additionally, he would debride the wound and pack it. However, in this case, he did not see signs of an infection. Dr. Goldfarb questioned Dr. Coppelli if he would use other diagnostic modalities such as a CT scan. Dr. Goldfarb noted that he did not see any evidence of contracture of the knee in Dr. Coppelli's medical record. Dr. Coppelli stated that there was no notation made regarding the knee contracture. Dr. Goldfarb expressed concern that there was not a complete examination. Dr. Coppelli stated that if he discovered an infection, he would have ordered more tests and would have counseled the patient about the possibility of removing the graft.

Ram R. Krishna, M.D. asked Dr. Coppelli about his opinion regarding the use of antibiotics for an infected graft. Dr. Coppelli stated that it was his opinion that the graft was not infected, but rather than the area around the graft was. Dr. Krishna questioned whether there was an error made in the length of time for the use of antibiotics in order to prevent the infection from spreading to the groin or to the graft itself.

Mr. Giancola made a closing statement to the Board that Dr. Coppelli only saw the patient three times following the initial graft. Dr. Munoz and the physician assistant also saw D.F. during the postoperative period. Mr. Giancola stated that in retrospect it is easier to determine when the graft should have been removed; however, at the time, Dr. Coppelli used his best judgment to determine the care for this patient. He asked that the Board find Dr. Coppelli has met the standard of care and should not be disciplined.

Dr. Goldfarb asked Dr. Wolf what the standard is for when to remove a graft that has a surrounding infection. He asked if Dr. Coppelli followed the standard of care from that point of view. Dr. Wolf stated that this is a recognized hazard in vascular surgery and that there are clear indications for when the graft should be removed. However, in this case, there was no clear-cut way to determine when the graft should have been removed. Dr. Goldfarb stated that this result could be attributed to "team care" in which several people are caring for the patient. While this was a technical violation, he did fault Dr. Coppelli for not prescribing antibiotics for more than 10 days.

MOTION: Robert P. Goldfarb, M.D. moved for an Advisory Letter for failure to adequately prescribe antibiotics for a graft site infection.

SECONDED: Ram R. Krishna, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Patrick N. Connell, M.D.; Ronnie R. Cox, Ph.D.; Robert P. Goldfarb, M.D.; Ingrid E. Haas, M.D.; Becky Jordan; Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Member abstained from this matter: Ram R. Krishna, M.D. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

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

MOTION PASSED

After review of related Case MD-04-1374B, D.F. v L. Alfonso Munoz, M.D., the Board voted to reopen this matter. After reopening this matter, the Board voted to continue the investigation on this case, MD-04-1374A.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
2.	MD-04-0406A	AMB KENNETH L. SANDOCK, M.D.	14232	Advisory letter for failure to recognize a lytic lesion on an x-ray. This was a technical violation.

Dr. Sandock appeared with counsel, David Hill. Tim B. Hunter, M.D. recused himself from this case. Robert P. Goldfarb, M.D. stated that he has a professional relationship with Mr. Hill, but that will not affect his ability to adjudicate this case.

Philip Scheerer, M.D., Medical Consultant, presented this case to the Board. The allegation was that Dr. Sandock failed to diagnose a lateral femoral condyle lesion on x-ray. The standard of care is to correctly describe and interpret the findings on the x-ray and Dr. Sandock deviated from the standard by failing to diagnose the lesion. A mitigating factor is that Dr. Sandock readily admitted to missing the lesion.

Dr. Sandock informed the Board that he regretted missing the lesion and that he has made changes in his practice to prevent this error from occurring again. He described his new office protocol that includes conferring with other physicians, taking breaks when he is fatigued, looking for additional information on the Internet, and obtaining continuing medical education.

William R. Martin, III, M.D. began the questioning Dr. Sandock. He questioned the system from which Dr. Sandock worked when the incident occurred and asked how that system has changed. Dr. Sandock stated that due to changes in contracts the amount of work in his practice increased greatly and due to physical problems with one of his partners, he was taking on more work than usual. Dr. Sandock stated that they have adjusted to this amount of work. In the future, Dr. Sandock stated that if this situation would occur again, that he would decrease the number of cases he takes on.

Dr. Martin then focused the questioning specific to this case. He asked Dr. Sandock to review the report he wrote on December 18, 2000. Dr. Martin stated that this was a giant cell tumor and he asked Dr. Sandock how the patient would be affected by a delay in diagnosis. Dr. Sandock stated that this type of tumor grows slowly and there would have been little change in the tumor or in the bone during the delay. He also stated that a tumor like this could be present for several months without the patient knowing that it was there.

Ram R. Krishna, M.D. asked Dr. Sandock if he was comfortable reading the two-view x-ray he received. Dr. Sandock replied that he prefers a four-view study, however, it was customary in his practice at the time to receive two-view x-rays from the x-ray center that sent the views to him.

Dr. Sandock stated that he regrets that this event happened and that he had made improvements to his practice to prevent this error from happening again. Mr. Hill stated that Dr. Sandock is a well-educated radiologist and he has candidly admitted his error. He stated that an advisory letter is an appropriate resolution to this situation. Mr. Hill also provided the Board with an example of another case similar to this in which the Board gave an advisory letter. He also stated that the delay did not cause any true harm to the patient.

MOTION: William R. Martin, III, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (q) - Any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public.

SECONDED: Patrick N. Connell, M.D.

VOTE: 10-0-0-2

MOTION: William R. Martin, III, M.D. moved for an Advisory Letter for failure to recognize a lytic lesion on an x-ray. This was a technical violation.

SECONDED: Patrick N. Connell, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Patrick N. Connell, M.D.; Ronnie R. Cox, Ph.D.; Robert P. Goldfarb, M.D.; Ingrid E. Haas, M.D.; Becky Jordan; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D. ; and Dona Pardo, Ph.D., R.N. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent

MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
3.	MD-04-1026A	L.D. THOMAS F. GRIFFIN, JR., M.D.	7460	Dismissed
4.	MD-04-1026B	L.D. KATHERINE M. BROMAN, M.D.	20547	Dismissed

Dr. Griffin and Dr. Broman each appeared without counsel. The Board elected to hear both cases at the same time. Mark Nanney, M.D., Chief Medical Consultant recused himself from this case. Robert P. Goldfarb, M.D. stated that he has seen some of Dr. Griffin's patients in consultation, but that will not affect his ability to adjudicate this case.

Philip Scheerer, M.D., Medical Consultant presented the cases to the Board. Patrick N. Connell, M.D. began the questioning Dr. Griffin. He clarified that Dr. Griffin was doing obstetrics at the time of the incident, but that he no longer practices in this field. The patient presented to Dr. Griffin in active labor at 36 weeks gestation. He was present about four hours prior to delivery. The patient had diabetes, but had no signs, such as abnormal sugars, at the time of delivery. Dr. Griffin stated that there was muconium stain at the time of delivery. He also informed the Board that he had the opportunity to take the mother for a C-Section if there was abnormal fetal monitoring. Dr. Connell asked if there was anything worrisome about the baby, who was born at 9 lbs, 13 ounces. Dr. Griffin stated that they monitored the baby for its blood sugars. The blood sugar was 36, but it looked good. The baby was formula fed, the nurses kept track of the blood sugars and the baby did not appear to have any abnormalities.

Dr. Griffin stated that he had never seen the mother before the delivery and that he followed up with her a day or two later. He did not recall that the mother had postpartum preeclampsia. She had mild proteinuria, but it came down quickly. Magnesium sulfate was not used, although Dr. Griffin stated that it was used regularly in his practice at the time. After he saw the mother, Dr. Broman resumed care of the mother.

Dr. Connell then began questioning Dr. Broman. The exam showed that the baby was normal, but had some intermittent tachypnea. She stated that it was her practice to monitor babies who showed tachypnea. Dr. Connell clarified that there was no discharge summary on the mother. Dr. Broman stated that it was common to discharge the baby at 24 hours, but they held this baby for 48 hours for examination. Dr. Broman informed the Board that for the most part, the nurses who monitored the baby were a core group of nurses whom she relied upon. Dr. Connell asked how this baby was sent home with a fever and without a discharge order. Dr. Broman could not explain how that happened and stated that this was an abnormality from her regular practice. Dr. Connell asked if she was aware if the baby was sent home without a discharge order. Dr. Broman could not tell from the record. She stated that the baby became more ill after it was sent home and returned to the emergency room later that day. Dr. Broman no longer works in Arizona. Dr. Griffin informed the Board that although the hospital still exists, the OB service it once provided is now closed. He stated that people in this area are now forced to travel 1 –2 hours to Sierra Vista or Tucson to receive prenatal and obstetrical services.

Sharon B. Megdal, Ph.D. asked staff to clarify that this case resulted from a malpractice settlement and not from the patient. Christine Cassetta, Board Counsel, informed the Board that it was a malpractice case.

Dr. Broman stated that this was an unfortunate situation, but that her care in this case was not typical. Dr. Griffin stated that, as far as public health is concerned, they received a good amount of help from the University of Arizona neonatology group.

Dr. Connell stated that this case is a testament to the value of prenatal care and to the challenges of care in rural areas; therefore he recommended dismissal of both cases.

MOTION: Patrick N. Connell, M.D. moved to dismiss the cases against Dr. Broman and Dr. Griffin.

SECONDED: Douglas D. Lee, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Patrick N. Connell, M.D.; Ronnie R. Cox, Ph.D.; Robert P. Goldfarb, M.D.; Ingrid E. Haas, M.D.; Becky Jordan; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D.; and Dona Pardo, Ph.D., R.N. The following Board Member was absent: Lorraine L. Mackstaller, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
5.	MD-04-0882A	AMB DAVID C. CHAPMAN, M.D.	24720	Dismissed.

Dr. Chapman appeared without counsel. Dr. Huber presented two allegations that are related. One is one of excessive prescribing of analgesics and the other relates to Dr. Chapman renting space from a chiropractor whose wife worked as the "office manager". The wife began to self-prescribe, in his name, using his DEA number and without his knowledge. Dr. Chapman notified the Board that the excessive prescribing of Ultram was justified.

Dr. Megdal began questioning about how the investigation started. Dr. Chapman contacted the Scottsdale Police Department and American Medical Security regarding this individual's fraud. American Medical Security notified the Board. Dr. Megdal asked how many prescriptions Dr. Chapman wrote for narcotics. The prescription was actually a three-month supply of Ultram and not Vicodin. He also prescribed a third medication, Pamlor. The third prescription was primarily for dental work and chronic headaches. She told Dr. Chapman that her dentist would have prescribed Vicodin and she was also embarrassed to ask the dentist since she had a problem with the Vicodin in the past. One of the issues is the lack of a doctor-patient relationship. Reports indicate that D.S. and M.S. were not available to the Board. These files were found to be missing.

Dr. Chapman stated that when they contacted American Medical Security to report the vicodin fraud. This individual is now working in another medical practice. The investigation was opened as a result of the inquiry to the American Medical Security Company. Dr. Megdal stated that this whole process began because he filed a police report. Board investigators could not find fault with the physician and without records, there is no verification.

MOTION: Sharon B. Megdal, Ph.D. moved to dismiss the case.
SECONDED: Douglas D. Lee, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Patrick N. Connell, M.D.; Ronnie R. Cox, Ph.D.; Robert P. Goldfarb, M.D.; Ingrid E. Haas, M.D.; Becky Jordan; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Member was absent: Lorraine L. Mackstaller, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
6.	MD-03-0854A	T.S. LEWIS E. MEHL-MADRONA, M.D.	30688	Issue Advisory Letter for boundary violations.

Dr. Mehl-Madrona appeared with counsel, Bruce Heurlin. Dr. Nanney presented for the Board. The complaint was that Dr. Mehl-Madrona took a patient outside of the Mirasol facility for a two-day retreat. Mirasol was aware that the patient was at the home of Dr. Mehl-Madrona. The patient gave conflicting accounts of the two-day period of time. Dr. Mehl-Madrona stated that he continued to treat the patient and would serve as the patient's "spiritual advisor" rather than her psychiatrist. The Board's OMC felt that there were violations of doctor-patient boundaries.

Dr. Mehl-Madrona apologized for the inappropriateness of having a patient stay at his home. He has never had another complaint. His patient, then 21, was invited to stay at his home by his 18-year old daughter who was unaware that J.C. was a patient of Dr. Mehl-Madrona. She was supposed to be staying at a psychologist's B&B, but did not want to stay alone.

Becky Jordan questioned Dr. Mehl-Madrona. Dr. Mehl-Madrona worked at Mirasol from 2002 until 2004. J.C. was Dr. Mehl-Madrona's patient beginning in 2003. She also consulted with Dr. Mehl-Madrona in October 2004. Ronnie R. Cox, Ph.D. questioned Dr. Mehl-Madrona regarding the treatment at Mirasol. There was a negative relationship with his supervisor at Mirasol. Dr. Mehl-Madrona even drove the patient to an appointment that he now feels was inappropriate. He did not feel that this was a problem at the time. Patrick N. Connell, M.D. asked if J.C. was fragile since she had issues with sexual abuse, sexual assault and anorexia, but Dr. Mehl-Madrona did not feel that she was. Dr. Connell questioned Dr. Mehl-Madrona regarding his knowledge of boundary issues. He stated that he certainly understood boundary issues and had reservations about driving J.C. to an appointment. Ingrid E. Haas, M.D. questioned the staffing of Mirasol. Dr. Hunter questioned what Dr. Mehl-Madrona is doing now and Dr. Mehl-Madrona stated that he is currently a professor at the University of Arizona.

Mr. Heurlin stated that there were issues in the treatment at Mirasol. He said that Dr. Mehl-Madrona never denied that there were boundary violations, but understands fully that this is wrong. He felt that what he did was in the best interest of his patient. Sharon B. Megdal, Ph.D. asked Dr. Mehl-Madrona if he explained to his daughter that it was wrong to have J.C. stay at the home and he said that he could not do so without revealing confidential information.

Dr. Nanney stated that he has concerns about the activities at Mirasol and may need to be referred to DHS. The Board agreed.

MOTION: Becky Jordan moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (q) - Any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public.

SECONDED: Patrick N. Connell, M.D.

Dr. Connell felt that he is probably the only Board member who has dealings with psychiatric patients and feels strongly that this is a dangerous violation of boundary issues. He believes that this discipline is appropriate. Tim B. Hunter, M.D. felt that this does not rise to the level of this discipline. Ram R. Krishna, M.D. agreed with the Letter of Reprimand. Dr. Megdal agreed with Dr. Hunter for an Advisory Letter.

MOTION: Becky Jordan moved for Board staff to draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for allowing the patient to spend two nights in his home, and probation for one year to obtain 20 hours of CME on ethics and boundary issues in addition to the hours required for the biennial renewal of medical license. The probationary period shall be terminated upon successful completion of the CME.

SECONDED: Patrick N. Connell, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D.; Ram R. Krishna, M.D., Douglas D. Lee, M.D. and Becky Jordan. The following Board Members voted against this matter: Robert P. Goldfarb, M.D.; Ingrid E. Haas, M.D.; Tim B. Hunter, M.D.; and Sharon B. Megdal, Ph.D. The following Board Member abstained from this matter; Ronnie R. Cox, Ph.D.; William R. Martin, III, M.D.; and Dona Pardo, Ph.D., R.N. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

VOTE: 4-yay, 4-nay, 3-abstain/recuse, 1-absent

MOTION PASSED

MOTION: Sharon B. Megdal, Ph.D. moved to issue an Advisory Letter for boundary violations.

SECONDED: Ingrid E. Haas, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; Douglas D. Lee, M.D.; Ph.D.; Robert P. Goldfarb, M.D.; Ingrid E. Haas, M.D.; Becky Jordan; and Sharon B. Megdal, Ph.D. The following Board Members voted against this matter: Patrick N. Connell, M.D. and Ram R. Krishna, M.D. The following Board Member abstained from this matter; Ronnie R. Cox, Ph.D.; William R. Martin, III, M.D.; and Dona Pardo, Ph.D., R.N. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

VOTE: 6-yay, 2-nay, 3-abstain/recuse, 1-absent

MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
7.	MD-04-0417A	AMB NESTOR N. NAZARENO, M.D.	23491	Advisory Letter for prescribing an excessive dose of Ketorolac.

Dr. Nazareno appeared with counsel, Bruce Crawford. Dr. Scherer presented. The complaint came to the Board via a medical malpractice settlement. The allegation is that Dr. Nazareno prescribed Toradol for a period of two months, even though the indications for this medicine are for a period of five days. The patient had kidney failure, but it is not known if the medication was the reason for the failure.

Dr. Nazareno gave her a shot of Toradol that produced good results in the 36-year old patient. The patient was not consistent with her treatment plans and had a myriad of other medical issues. Dr. Nazareno felt that he did the best he could to treat her medical problems.

Dr. Lee asked if Dr. Nazareno is trained in internal medicine. He began treating the patient in 1998 and he put her on Toradol and an A.C.E. inhibitor. Dr. Lee asked if Dr. Nazareno documented that this use of an off-label drug. He asked if the pharmacist called regarding the two-month use. Dr. Nazareno received a call from another physician's office regarding refills of the Toradol. He asked if Dr. Nazareno knew what other medications she is on. After a period of several months, she was beginning to experience leg swelling. Dr. Nazareno conducted some tests in 2000 to measure kidney levels. Dr. Lee asked if Dr. Nazareno knew the effects of the medication on the kidney and he detailed the treatment of his patient's health. Dr. Haas asked why the patient continued to take oral contraceptives, in spite of her smoking and other health issues. Dr. Martin asked what the patient's chief complaint was and Dr. Nazareno stated that it was her hip and knee joints. He asked if there were any alternative treatments at this time and Dr. Nazareno stated that he could have prescribed steroids. Dr. Martin wanted to know if there was nothing else to prescribe at that time. Dr. Nazareno only treated the patient for a brief time.

Mr. Crawford spoke on behalf of his client, stating that the patient had a number of complaints and a history of not following up on medical situations.

MOTION: Douglas D. Lee, M.D. moved for an Advisory Letter for prescribing an excessive dose of Ketorolac. This was a minor technical violation.

SECONDED: Patrick N. Connell, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Patrick N. Connell, M.D.; Ronnie R. Cox, Ph.D.; Robert P. Goldfarb,

M.D.; Ingrid E. Haas, M.D.; Becky Jordan; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

VOTE: 11-yay, -nay, -abstain/recuse, 1-absent

MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
8.	MD-04-0514B	AMB JAMES D. WALKER, M.D.	20635	Issue an Advisory Letter for failure to order further testing in this patient.

Dr. Walker appeared with his attorney, Sandra Rogers. Dr. Wolf presented on behalf of the Board. The case was referred as the result of a medical malpractice settlement. Allegations are that Dr. Walker failed to order additional testing. A mitigating factor is that the patient had frequent visits to the Emergency Room for similar complaints.

Dr. Walker stated that he was presented with a patient in the ER that had been the same as on a number of other occasions. She was wheelchair bound and chronically ill. He asked if she had obstructions in the past and she answered affirmatively. He completed a workup and did not indicate any leakage. He treated her with pain medication and fluids. She asked to be discharged and was released by the physician. She went home and once there, had a cardiac arrest and was returned to the Emergency Room. If he had known that this would have been the outcome, he would have changed the course of treatment. Patient had a history of previous procedures, operations and hospital stays. Patient did not reveal anything further.

Patrick N. Connell, M.D. questioned the action of another physician who handed off the case and why Dr. Walker did not dispute the transfer of the case. In fact, this physician was involved in a lawsuit with the same patient. Dr. Connell asked if Dr. Walker knew that she was previously obese. Dr. Connell asked Dr. Walker to read the ER notes. Her white count was elevated which Dr. Walker stated could have been an indication of an infection. Reviewed x-ray summaries indicating air pockets in the ileus (bowel), but did not indicate a string of pearl sign (classic sign of obstruction). Dr. Connell stated that the patient had abdominal pain and with her history, this should have been a red flag warranting additional testing.

Robert P. Goldfarb, M.D. asked how Dr. Walker could put in diagnoses that were not appropriate. He asked if he routinely sent home a patient with ileus and how he monitors these patients.

Ms. Rogers pointed out that Dr. Walker did not have sufficient information at the time the patient presented. The patient was chronically ill and Dr. Walker felt the situation that she presented with was under control. Dr. Phillip Keen, Maricopa County Medical Examiner, performed an autopsy and did not indicate a cause of death. An independent consultant in Tucson also reviewed this case. Ms. Rogers asked for dismissal or an advisory letter.

Dr. Connell stated the, while it is difficult to discern the one ER case like this that could be elevated to a critical state, there were a number of red flags. This patient had sudden and severe pain, previous surgeries, and an abnormal x-ray. Dr. Connell believed that this warranted further studies or surgical consult.

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (q) - Any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public.

SECONDED: Ram R. Krishna, M.D.

VOTE: 4-yay, 5-nay, 2-abstain/recuse, 1-absent

MOTION FAILED.

Tim B. Hunter opposed the motion based on thorough exam of documentation and believes that there was nothing Dr. Walker could have done to change the outcome of the case.

MOTION: Ingrid E. Haas, M.D. moved for an Advisory Letter for failing to order further testing in this patient. This was a technical violation and does not rise to the level of discipline.

SECONDED: Douglas D. Lee, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; Douglas D. Lee, M.D.; Robert P. Goldfarb, M.D.; Ingrid E. Haas, M.D.; Becky Jordan; and Dona Pardo, Ph.D., R.N. The following Board Members voted against: Patrick N. Connell, M.D.; Ram R. Krishna, M.D.; and William R. Martin, III, M.D. The following Board Members recused or abstained from the vote: Ronnie R. Cox, Ph.D. and Sharon B. Megdal, Ph.D. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

VOTE: 6-yay, 3-nay, 2-abstain/recuse, 1-absent

MOTION PASSED

The meeting adjourned at 4:31 p.m.

FRIDAY, JUNE 10, 2005

CALL TO ORDER

Tim B. Hunter, M.D., Chair, called the meeting to order at 8:00 a.m.

ROLL CALL

The following Board Members were present: Tim B. Hunter, M.D., Douglas D. Lee, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Members were absent: Patrick N. Connell, M.D., Lorraine L. Mackstaller, M.D. and William R. Martin III, M.D.

CALL TO THE PUBLIC

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

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
1.	MD-04-0772A	G.W. EDWARD D. CAMPBELL, JR., M.D.	9515	Dismissed

Dr. Campbell appeared with counsel, Bryan Murphy. Roderic Huber, M.D., Medical Consultant presented this case. He stated that the allegations were that Dr. Campbell failed to adequately evaluate the patient's knee injury, that he failed to review the MRI of the knee and that he failed to reimburse the patient an overpayment of \$30. Dr. Campbell assessed a possible medial meniscus tear and released the patient with a conservative treatment plan.

Ram R. Krishna, M.D. began the questioning in this case. He asked Dr. Campbell to explain his process for evaluating a new patient with an injury. Dr. Campbell explained that he asks patients to bring in any previous x-rays, MRIs or other studies. If the patient does not provide Dr. Campbell with these studies, he gives the patient the option of postponing the appointment for another day, or if the patient does not want to wait, then he relies on his clinical examination and x-rays conducted during the examination. In this case, Dr. Campbell was unaware that the patient had any previous studies or that any studies were provided to his office. He also stated that he did not know any additional studies were available until after he received a complaint from the Board.

Dr. Campbell stated that his practice mostly involves knee injuries and shoulder injuries. The postgraduate fellow in Dr. Campbell's practice initially saw the patient in this case. It is Dr. Campbell's practice to have the postgraduate fellow provide him with the patient's history. He then sees the patient himself and takes another history. In this patient, Dr. Campbell did not see any ligament dislaxity. The Lockman test was negative and there was no pivot shift. For these reasons, he did not see evidence of an anterior cruciate injury or instability as a result of an injury. Dr. Campbell's finding was that there was not a significantly acutely injured knee. Dr. Krishna asked if there were any pathology tests that would give a positive McMurray test for meniscual injuries.

X-rays were conducted in the office and Dr. Campbell reviewed them himself. He diagnosed the x-rays as being negative. He opted for a conservative plan of treatment that included an anti-inflammatory. He stated that it was his policy to not prescribe narcotics to patients unless it was necessary. In this case, Dr. Campbell did not feel that pain medication was needed. The patient did not present to him on crutches and did not have an obvious antalgic gait. Dr. Campbell stated that generally, he brings patients back for a follow up appointment in four weeks. There was nothing on the patient's x-rays that suggested he should come in sooner.

Dr. Krishna then directed the questioning back to the patient's statement that he brought his MRI to Dr. Campbell's office. Dr. Campbell again stated that he could find no evidence that the MRI was received in his office. If he had the MRI, he would have reviewed it as part of his examination of the patient. However, he stated that his treatment would have been the same. If the patient can tolerate weight bearing, it is a good form of treatment. Dr. Campbell stated that the patient expressed dissatisfaction to Dr. Campbell's office staff when he left his appointment and stated that he would not return to the office and that he would not pay his co-payment. The patient later returned to the office and asked the office staff that if he paid his co-payment, then could he have pain medication. The patient was informed that Dr. Campbell did not prescribe hydrocodone or other pain medication for his knee injury. Dr. Campbell stated that he was unaware if the patient received any follow-up care or reconstructive surgery from another physician.

Tim B. Hunter, M.D. asked Dr. Campbell if he had seen the patient's MRI, would he have altered his course of treatment. Dr. Campbell stated that his treatment would have remained the same. Surgery or pain medication was not clinically necessary. Dr. Campbell stated that he has reorganized his office processes since this event to ensure that there is no possibility that any received records could be lost in his office. This was an unusual occurrence.

Dr. Campbell made a closing statement to the Board. He stated that the patient was orthopedically treated appropriately and that he found Board staff's recommendations to be too severe. Mr. Murphy also addressed the Board. He stated that Dr. Campbell has a long and distinguished career and this was the first time he was subject to discipline by the Board. Both Dr. Campbell and his postgraduate fellow made the same diagnosis that did not include any evidence of fracture or ACL tear. He also stated that because there was no harm to the patient that there can be no finding of a violation of A.R.S. 32-1401(27)(q) or (l). He also quoted the Board's disciplinary rule that recommends an advisory letter for a one-time occurrence. Mr. Murphy stated that a dismissal or advisory letter would be appropriate in this case.

Dr. Krishna stated that Dr. Campbell's clinical examination was appropriate. He also stated that his approach to a case like this would have been similar to Dr. Campbell's.

MOTION: Ram R. Krishna, M.D. moved to dismiss this case.
SECONDED: Douglas D. Lee, M.D.

Robert P. Goldfarb, M.D. spoke in favor of the motion. There was no harm to the patient. Additionally, physicians do not operate on the basis of MRI findings.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; Douglas D. Lee, M.D.; Robert P. Goldfarb, M.D.; Ingrid E. Haas, M.D.; Becky Jordan; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Member voted against this matter: Ronnie R. Cox, Ph.D. The following Board Member abstained from this matter: Patrick N. Connell, M.D. The following Board Members were absent: William R. Martin, III, M.D. and Lorraine L. Mackstaller, M.D.
VOTE: 8-yay, 1-nay, 1-abstain/recuse, 2-absent
MOTION PASSED

Dr. Martin joined the meeting at 8:40 a.m.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
2.	MD-03-0897A	M.H. RANDI M. GERMAINE, M.D.	21309	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for excessive prescribing and a one-year probation to include 20 hours of CME in prescribing controlled substances.

Dr. Germaine appeared without counsel.

Mark Nanney, M.D., Chief Medical Consultant, presented this case to the Board. He stated that the allegations were that Dr. Germaine over prescribed various medications that led to the death of patient S.B. Dr. Nanney stated that he was unable to determine the exact drug count, however, as a whole, the amount of drugs prescribed was excessive. Dr. Nanney also stated that it was concerning that Dr. Germaine did not have a drug contract with the patient. This case was reviewed by an outside medical consultant who found that there was an excessive amount of Dioxitan in the patient upon autopsy. Dr. Germaine presented for an investigational interview. His answers during that interview were found to be unsatisfactory.

Dr. Germaine made an opening statement to the Board. He explained the history of Morenci Health Care at the time of this event. Morenci had a severe narcotic problem with its patients and there were many high-risk patients who were opiod users and abusers. He was left in charge of 150-200 patients who were on opiod narcotics. Patient S.B. was one of Dr. Germaine's most difficult patients to treat. Dr. Germaine consulted David Greenberg, M.D. for pain management recommendations. Dr. Germaine stated that he followed Dr. Greenberg's recommendations to discuss this case with a pharmacy consultant and to refer the patient to an integrated pain clinic. S.B. was taking Darvon, which was prescribed to her by a previous treating physician, and Dr. Germaine researched the side effects of this drug. He also consulted the patient about drug addiction and he stated that she did not have any drug addiction symptoms. Darvon was the only drug that worked for patient S.B. and she stated that she would rather commit suicide than live with her pain.

Douglas D. Lee, M.D. began the questioning of Dr. Germaine. He asked Dr. Germaine about his education and work history. Dr. Germaine stated that before he went to Morenci, he worked in emergency medicine in rural Arizona, followed by five years in occupational medicine and another year in primary care. Dr. Lee questioned Dr. Germaine about his knowledge of prescription narcotics. Dr. Germaine stated that he was familiar with narcotics, but not with the use of Darvon. Dr. Germaine clarified the issue with the difficulty he experienced with the Morenci Health Care pharmacy. Dr. Germaine stated that he saw S.B. frequently and she often complained that she was out of Darvon. Dr. Germaine asked the pharmacy to check if it had a record of a refill. When he found that they didn't, he wrote another prescription. Unbeknownst to Dr. Germaine, S.B. was taking the medication to a pharmacy in another city. Dr. Lee asked why Dr. Germaine didn't ask the Morenci Health Care pharmacist if he had received the primary prescription that would have listed the number of refills he authorized. Dr. Germaine stated that he did not think to ask the Morenci Health Care pharmacist that question. Dr. Lee questioned why Dr. Germaine did not consider the possibility that S.B. was hoarding or diverting narcotics. Dr. Germaine stated that he was concerned with this possibility and he counseled S.B. about it.

Dr. Lee questioned Dr. Germaine's knowledge of propoxefine and what schedule of drug it was. Dr. Lee stated that it was a class II drug. He then pointed to Dr. Germaine's response to the Board in which he expressed comfort in the fact that S.B. was not on any class II or III drugs. Dr. Lee also stated his concern over the length of time during which S.B. was taking these medications. Dr. Germaine stated that he felt the length of time to be a problem, however, because of the lack of resources and his frustrations with this case, he did not refuse to stop prescribing to S.B. Dr. Germaine then stated that he diagnosed S.B. as a pseudo addict because she did not meet the mold of an addict. He also stated that S.B.'s husband admitted to taking some of S.B.'s Darvon.

Tim B. Hunter, M.D. asked Dr. Germaine to describe S.B.'s underlying diagnosis for the pain problem. Dr. Germaine provided a list of diagnoses including degenerative disc disease, lumbar radiculitis, hypothyroidism and migraine headaches. Dr. Germaine stated that he is currently working in Casa Grande as a primary care physician.

William R. Martin, III, M.D. asked what referrals Dr. Germaine made to specialists to deal with S.B.'s actual pathology. She was referred to an orthopedic surgeon and to a physical therapist.

Ronnie R. Cox, Ph.D. asked Dr. Germaine to describe S.B.'s interactions with Dr. Germaine. He stated that S.B. would often appear in his office with her husband in great pain. They discussed her physical problems, religion, and spirituality as it related to addiction and the use of narcotics and opioid addiction.

William R. Martin, III, M.D. asked Dr. Germaine to explain his course of action when he found S.B. was diverting medication to her husband. Dr. Germaine stated that S.B.'s husband was also prescribed Darvon, however, he cautioned S.B. to not divert to her husband. Dr. Germaine stated that he continued to prescribe Darvon to S.B. for two or three months after she admitted to diverting the drugs to her husband. He also stated that it was his plan to refer her to the integrated pain management center to control her narcotic use.

Dr. Hunter asked Dr. Germaine to explain his current measures to ensure this does not happen again. Dr. Germaine stated that he now refers many of his patients to other physicians. He said that in his current practice, he has 10-15 patients on chronic opioid medications. He monitors them on a month-by-month basis, he employs drug screens, and each patient is on a pain contract. Dr. Germaine took an 18-hour pain management symposium in 2003.

Dr. Germaine provided a closing statement to the Board. He realizes now that S.B. was a serial addict who needed psychiatric care. She had been a pain patient since 1986 and any physician who inherited her as a patient would have had difficulty treating her. He informed the Board that he was fired from Morenci Health Care approximately 8 weeks prior to S.B.'s death. The physician who treated S.B. after he left Morenci also continued to prescribe Darvon.

Dr. Nanney stated that he is unaware of any pain contract Dr. Germaine had with S.B. Dr. Nanney also noted multiple steroid injections in S.B.'s chart. Dr. Germaine stated that he never injected S.B. with steroids.

Dr. Lee stated that he did not believe S.B.'s death was directly related to Dr. Germaine's prescribing. He suggested that the Board also look at the other physicians involved with S.B.'s care as well as the health clinic. It is a mitigating factor that other patients in the clinic were treated in a similar manner. However, excessive prescribing did occur. Dr. Germaine's compassion for the patient may have played a role in his objectivity.

MOTION: Douglas D. Lee, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (q) - Any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public.

SECONDED: Ram R. Krishna, M.D.

VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent

MOTION PASSED.

MOTION: Douglas D. Lee, M.D. moved for Board staff to draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for excessive prescribing and a one-year probation to include 20 hours of CME in prescribing controlled substances.

SECONDED: Ram R. Krishna, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; Douglas D. Lee, M.D.; Robert P. Goldfarb, M.D.; Ingrid E. Haas, M.D.; Becky Jordan; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N., Ronnie R. Cox, Ph.D., Patrick N. Connell, M.D. The following Board Members were absent: William R. Martin, III, M.D. and Lorraine L. Mackstaller, M.D.

VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent

MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
3.	MD-04-0373A	AMB DARREN P. HEE, M.D.	20800	Dismissed

Dr. Hee appeared with counsel, Peter Akmajian. Robert P. Goldfarb, M.D. recused himself from this case. Philip Scheerer, M.D., Medical Consultant presented the case to the Board. The allegation was that Dr. Hee inappropriately treated gastric reflux disease resulting in tardive dyskinesia.

Dr. Hee made an opening statement. The patient in this case suffered an unfortunate side effect from Reglan. He stated that he has become more knowledgeable about neuroleptic drugs and has changed his health record system to more accurately store drug information. He deferred the treatment of this patient to Dr. Davis and Dr. Davis never notified him of the continued prescribing of Reglan. This case has changed the way he practices and has resulted in increased communication with his patients.

Dr. Lee began the questioning of Dr. Hee. He asked Dr. Hee to discuss when the patient was first started on Reglan. Dr. Lee noted that Dr. Hee's office notes were quite extensive and included the entire list of drugs the patient was taking. Dr. Hee regularly reviews the drugs the patient is taking at the beginning of the appointment for changes. His practice has since changed so that his computer system accurately reflects what information he has reviewed during each office visit. Dr. Hee stated that he knew of the patient's use of Reglan soon after another physician placed him on it. His notes reflect that he was aware of the patient's neurologic changes. Dr. Lee asked if Dr. Hee considered Reglan to be the source of the patient's symptoms. Dr. Hee stated that the patient had been on Reglan for a long time without side effects and therefore, he did not consider Reglan to be the source of the patient's presenting symptoms. Typically, Dr. Hee runs a patient's medications through a hand-held program called Hippocrates. Tremors were not shown to be associated with Reglan. Rather, he found that the drug Paxil, that the patient was on, could cause Parkinson's. Dr. Hee stated that he does not

regularly use Reglan in his practice. He was unaware of what follow up the patient received because he never received correspondence from the following treating physician.

Tim B. Hunter, M.D. confirmed that Dr. Hee did not prescribe Reglan to the patient, nor did he provide refill prescriptions. The patient was on Reglan before he presented to Dr. Hee. Rather, Dr. Hee did not consider Reglan to be the cause of the patient's problems when the patient presented to him.

Dr. Lee questioned what the patient's prognosis was after he stopped taking Reglan. Dr. Hee explained that the nerve endings become hypersensitized. Dr. Hee stated that the patient's Parkinsonian symptoms improved. It was at that time that his tardive dyskinesia was diagnosed.

Mr. Akmajian addressed the Board and provided a list of continuing medical education Dr. Hee has completed since this incident. He also clarified that the patient had a problem with GERD, for which he was prescribed Reglan by another physician. It was unclear from Dr. Davis's medical records that the patient was notified of the consequences of Reglan. The PDR recommends a prescription of Reglan for no more than three months; however, Dr. Hee relied on Dr. Davis's expertise regarding the prescription timeframe. The symptoms the patient was having were not classic movement disorders that could be associated with Reglan. The patient had a history of restless leg syndrome and his tremors could have been associated with Paxil. He concluded that Dr. Hee has a lot of honesty and integrity who treated his patient with respect throughout the process. Mr. Akmajian noted that for the first time in his years of practice the plaintiff in a malpractice case commended the defendant, Dr. Hee, for his honesty and even wrote a letter praising Dr. Hee that is included in the Board's materials.

Dr. Lee stated that there are several mitigating circumstances in this case. The average family practitioner does not see slowly emerging tardive dyskinesic symptoms. Additionally, he was not the primary prescribing physician. The symptomatology the patient presented with was very nonspecific. However, he felt Dr. Hee should have addressed the symptoms the patient did present with. Dr. Lee also stated that Dr. Hee has provided good explanations for how he has since changed his practice.

MOTION: Sharon B. Megdal, Ph.D. moved to issue an advisory letter for failing to monitor the prescription medications prescribed by a specialist as well as recognizing the emerging symptoms of a drug reaction.

SECONDED: Ram R. Krishna, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Douglas D. Lee, M.D.; Ronnie R. Cox, Ph.D.; Becky Jordan; and Sharon B. Megdal, Ph.D. The following Board Members voted against this matter: Tim B. Hunter, M.D.; Ram R. Krishna, M.D.; William R. Martin, III, M.D.; Ingrid E. Haas, M.D. and Dona Pardo, Ph.D., R.N. The following Board Member recused/abstained from this matter: Patrick N. Connell, M.D. and Robert P. Goldfarb, M.D. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

VOTE: 4-yay, 5-nay, 2-abstain/recuse, 1-absent

MOTION FAILED

Tim B. Hunter, M.D. spoke against the motion. He stated that this is not a common side effect and, therefore, this case should be dismissed. William R. Martin, III, M.D. concurred with Dr. Hunter, stating that this does not appear to be an issue of incompetence and the physician was very forthcoming. Additionally, this was not a drug that Dr. Hee prescribed.

Dr. Lee stated that because Dr. Hee was the primary care physician he was responsible for coordinating the patient's issues and spoke in favor of the motion. Dr. Megdal also spoke in favor of the motion.

MOTION: William R. Martin, III, M.D. moved to dismiss this case.

SECONDED: Ingrid E. Haas, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Ronnie R. Cox, Ph.D.; Ingrid E. Haas, M.D.; Becky Jordan; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Member voted against this matter: Douglas D. Lee, M.D. The following Board Members recused/abstained from this matter: Patrick N. Connell, M.D. and Robert P. Goldfarb, M.D. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

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

MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
4.	MD-04-1374B	D.F. L. ALFONSO MUNOZ, M.D.	9794	Continue the investigation.

Patient D.F. was present for Call to Public. He informed the Board that he spoke yesterday and asked if the Board received the records he provided today. The Board confirmed that they did have the records. D.F. stated that he still has continuous pain and that he is scheduled for an ultrasound on Monday.

Dr. Munoz was present with counsel, Paul Giancola.

William Wolf, M.D., Medical Consultant presented this case to the Board. The allegations were that Dr. Munoz failed to diagnose a treat a femoral popliteal bypass graft in a timely manner. He clarified that the failure to treat the infected graft in a timely manner does not specifically increase the risk of amputation. The literature demonstrates that significant infection of prosthetic grafts can be salvaged with antibiotics and local treatment in selected cases.

Dr. Munoz made an opening statement to the Board. He stated that he was not the original surgeon, but was covering for his partner, Dr. Coppelli. The patient became ill while Dr. Coppelli was out of the office and he needed to proceed with some interventions. Dr. Munoz clarified that critical ischemia is a potential side effect. When he saw D.F. in the office there was no evidence of anastomotic disruption. The graft did not appear to be infected. Therefore, Dr. Munoz proceeded with a conservative approach. When D.F. presented with a recurrence of the infection, he chose to proceed with removing the graft. D.F. then chose to return to Phoenix to see his original vascular surgeon. While waiting for D.F. to decide what he wanted to do, he continued D.F. on Vancomycin.

Robert P. Goldfarb, M.D. began the questioning of Dr. Munoz. He asked what association Dr. Munoz had with Dr. Coppelli. Dr. Munoz stated that they were both salaried physicians by Banner Health and that they shared an office. Both physicians supervised P.A. Scott. Dr. Goldfarb asked how Dr. Munoz supervised Ms. Scott. Dr. Munoz stated that every time Ms. Scott examined the patient, Dr. Munoz or Dr. Coppelli also saw the patient. Dr. Goldfarb pointed out that some charts contain a dual signature and others are only signed by Ms. Scott. Dr. Munoz stated that it was his common practice for both the PA and a physician to see the patient.

Dr. Munoz has been in practice for 25 years. He is a general vascular surgeon and he performs aortic grafts as well as femoral popliteal grafts. At the time of this case, he performed about 10 femoral popliteal grafts per year. Dr. Goldfarb asked Dr. Munoz to explain when he felt an infected graft should come out. Dr. Munoz stated that when antibiotics have been used appropriately and infection recurs, one should consider removing the graft. The literature has some marginal documentation that you should treat the patient for 4-6 weeks with Vancomycin. Dr. Goldfarb questioned Dr. Munoz about the dates on which the patient was on Vancomycin. Dr. Munoz stated that his notes indicated that the patient continue on Vancomycin for another 10 days after he was hospitalized even though they do not specifically state this. Dr. Munoz then later stopped Vancomycin and started the patient on Cipro. He stated his reason for this was to obtain a culture and test it for sensitivity. Dr. Munoz then changed the antibiotic to Vampin. He stated that he was buying time for the patient while he decided to go to Phoenix. Dr. Goldfarb questioned whether this was a good use of antibiotics for a methicillin resistant staph aureus infection (MRSA).

Dr. Goldfarb then questioned why Dr. Munoz did not remove the graft when he drained the infection. Dr. Munoz believed the graft could have been saved. Dr. Goldfarb questioned if there were any diagnostic tests Dr. Munoz could have performed. Dr. Munoz stated the only possibility was to remove the graft.

Dr. Goldfarb stated that when the patient was seen in Phoenix contracture of the knee was noted. He questioned why Dr. Munoz made no note of the contracture when he saw the patient a few days earlier. Dr. Munoz stated that he did not recall seeing the contracture.

Ram R. Krishna, M.D. then questioned whether Dr. Munoz reviewed this case with an infectious disease specialist. Dr. Munoz stated that the hospital does not have an infectious disease specialist, but they had a pulmonologist who could help them on occasion. Dr. Munoz reflected that he has seen instances when the graft has been able to be saved. He stated that the patient was doing well on his antibiotic treatment. Dr. Krishna confirmed that the wound was left open and packing was used.

Mr. Giancola addressed the Board. He noted the differing conclusions between Dr. Kennell and Dr. Wolf. Mr. Giancola asked another physician to also review the records. His consultant determined that Dr. Munoz met the standard of care. He also pointed out that the standard for the use of antibiotics is from 4-8 weeks.

Sharon B. Megdal, Ph.D. questioned whether Mr. Giancola's was testifying and whether the Board should consider his remarks. Ms. Cassetta noted that Mr. Giancola was advocating for his client and that the Board was free to the give the information whatever weight it chose.

Dr. Wolf stated that in a patient with an infected graft, six weeks of antibiotic treatment would be appropriate. Dr. Goldfarb questioned whether the three forms of antibiotics were appropriate. Dr. Wolf stated that to treat the patient aggressively, the patient should have remained on Vancomycin.

MOTION: Robert P. Goldfarb, M.D. voted to go into executive session.

SECONDED: Ram R. Krishna, M.D.

VOTE: 10-0

MOTION PASSED.

The Board went into executive session at 11:12 a.m.

The Board returned to open session at 11:16 a.m.

William R. Martin, III, M.D. asked Dr. Wolf to explain if there is another course of treatment, other than removing the graft or antibiotic treatment, that could be used to save the graft. Dr. Wolf explained that aggressive antibiotics and debridement is the only course of treatment that could be used to save the graft. In this case, he did not see that debridement was necessary.

Dr. Goldfarb stated that during the course of today's formal interview, he was made aware of medical records that were not in the Board's possession. He requested that this case be continued and those records be obtained and reviewed with a focus on developing a timeline of when and who prescribed the antibiotics throughout the care of the patient.

MOTION: Robert P. Goldfarb, M.D. voted to continue the investigation and obtain all the records in this case, including those from the hospital and home health agencies.

SECONDED: Ram R. Krishna, M.D.

VOTE: 10-0

MOTION PASSED.

MOTION: Robert P. Goldfarb, M.D. moved to reopen the case against Dr. Coppelli.

SECONDED: William R. Martin, III, M.D.

VOTE: 10-0

MOTION PASSED.

MOTION: Robert P. Goldfarb, M.D. moved to rescind the advisory letter against Dr. Coppelli and continue the investigation.

SECONDED: William R. Martin, III, M.D.

VOTE: 10-0

MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
5.	MD-03-0488A	AMB ARNOLD B. CALICA, M.D.	12548	Issue Advisory Letter for incomplete surgery, failure to decompress L4-L5 level.

Dr. Calica appeared with counsel, Paul Giancola. Dr. Wolf presented on behalf of the Board. This case was formerly on the March agenda for a possible Advisory Letter, but the Board requested that Dr. Calica appear for the formal interview. Dr. Calica is appearing for improperly performing a lumbar laminectomy. The OMC recommended dismissal of this case as the resultant outcome is expected in cases like this.

Dr. Calica stated that this case involved a 76 year old woman who had difficulty walking any distance and requested surgery to correct stenosis. Surgery was technically difficult, but carried out without significant complications. Eight months after the surgery, the patient experienced foot numbness. Dr. Calica ordered an MRI and found that the spinal stenosis was not the result of the previous surgery. Obesity offered a complication not allowing a sufficient opening to perform the surgery. As the procedure began, Dr. Calica felt that he would cause harm to the patient because of the difficult anatomy. Dr. Calica has completed about 2000 cases prior and 500 afterward and has not met the same situation. Dr. Calica has changed procedures to avoid this in the future.

William R. Martin, III, M.D. questioned Dr. Calica regarding the patient's chief complaints. Dr. Calica stated that the patient had a 6-8 month history of lower back pain, but no lower extremity problems. Dr. Calica determined that the most likely problem was Lumbar neurogenic claudication. Dr. Calica's surgical plan was to decompress her at L3-4 and L4-5. Diagnosis is clear in the notes, but coded differently and Dr. Calica confirmed that the coding was inaccurate. Dr. Calica attempted to unblock the section, but because of the patient's obesity, needed to re-evaluate the situation. Dr. Calica believes that it is within the standard level of care.

MOTION: William R. Martin, III, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (q) - Any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public.

SECONDED: Ram R. Krishna, M.D.

MOTION PASSED

MOTION: William R. Martin, III, M.D. moved for an Advisory Letter for incomplete surgery, failure to decompress L4-L5 level. This is a one-time only event that does rise to the level of discipline.

SECONDED: Ronnie R. Cox, Ph.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Ronnie R. Cox, Ph.D.; Robert P. Goldfarb, M.D.; Ingrid E. Haas, M.D.; Becky Jordan; and Ram R. Krishna, M.D. The following Board Member voted against this matter: Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Member abstained from this matter: Patrick N. Connell, M.D. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

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

MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
6.	MD-04-0270A	AMB GEORGE A. DAVIDSON, M.D.	13477	Draft Findings of Fact and Conclusions of Law for a Letter of Reprimand for failure to manage labor and delivery in a timely manner resulting in the death of an infant

Dr. Nanney presented on behalf of the Board. The case occurred in 1998 and involved an obese patient who had a previous c-section and elevated blood pressure. Dr. Davidson was not the regular physician and was informed at 3:30 p.m. that the patient had a uterine rupture. He informed the nursing staff that he would come in at 5:00 p.m. and instructed them to contact a physician in closer proximity to the hospital. The infant died two days later. The OMC was concerned that internal monitors were not placed in a timely manner and that the physician was not available within the 30 minutes required. Mitigating factors include the fact that this physician was called in late on a very complicated case and that the patient was obese.

Becky Jordan questioned Dr. Davidson to establish a timeline for induction of labor through delivery. At the time that Dr. Davidson was asked to place the internal fetal monitors on the patient, she had only been in labor for two hours. Dr. Davidson gave instructions until he could arrive. The next call he received informed him of the rupture.

Ingrid E. Haas, M.D. asked what Dr. Davidson's recollection is of the calls with the nurses and Dr. Davidson did not feel a sense of urgency. Dr. Haas asked if Dr. Davidson if he was concerned with the risk of complications and Dr. Davidson stated that, in retrospect, he would have changed his response time and handled the entire case differently. He also stated that he would have used Pitocyn to induce labor in an obese patient.

MOTION: Becky Jordan moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (q) - Any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public.

SECONDED: Ram R. Krishna, M.D.

MOTION PASSED

Douglas D. Lee, M.D. asked Dr. Haas what the standard of care would have been in 1998 and Dr. Haas stated that Dr. Davidson should have responded more quickly. Dr. Davidson cited practice bulletins to support his actions.

MOTION: Tim B. Martin, M.D. moved for Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to manage labor and delivery in a timely manner resulting in the death of an infant.

SECONDED: Ingrid E. Haas, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Ronnie R. Cox, Ph.D.; Robert P. Goldfarb, M.D.; Ingrid E. Haas, M.D.; Becky Jordan; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Member abstained from this matter: Patrick N. Connell, M.D. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

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

MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	BOARD RESOLUTION
7.	MD-04-0666A	R.S. JOHN W. MCGETTIGAN, JR., M.D.	12606	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand, two years Probation with 20 hours of CME in Ethics. Probation will terminate upon provision of proof satisfactory to Board Staff of completion of CME hours.

Dr. McGettigan appeared without counsel. Dr. Huber presented the case. The Board received the complaint from a 47 year old man who said that he was a victim of false advertising at Dr. McGettigan's clinic and that he was dispensed Viagra without an exam. Dr. Kirschner felt that a physician should not provide medication until after an appropriate evaluation.

Dr. Goldfarb questioned the path Dr. McGettigan's medical career has taken. Dr. McGettigan stated that in 2000 he opened a clinic specifically for the treatment of erectile dysfunction. This was after some time spent in emergency medicine. Dr. McGettigan stated that he is trained in a variety of courses on the subject of erectile dysfunction and that he believes he is accruing Category 1 CME. Robert P. Goldfarb, M.D. questioned the handling of the complainant. Dr. McGettigan stated that he reviewed the form the patient completed without feeling that a GU exam was necessary. Dr. McGettigan stated that he was not aware that a GU exam was required, but would institute this procedure if required.

Dr. Goldfarb asked Dr. McGettigan if he was aware of the source of this patient and Dr. McGettigan stated that he believed he responded to a television ad for a free Cialis study. When he came to the office, he was told that the Cialis study was filled and that there would be another study for Levitra. He coded the visit as a 99204 indicating that a comprehensive physical exam had been completed. Dr. Goldfarb asked Dr. McGettigan why the patient did not discuss the erectile dysfunction with his surgeon, since he had prostate cancer surgery performed earlier. Dr. Goldfarb asked if he thought Dr. McGettigan's advertising had misled the patient.

Dr. Megdal asked if Dr. McGettigan had any current clinical trials and if he received a fee from the pharmaceutical companies. Dr. McGettigan stated that he did. Dr. Megdal asked if there were forms to track the outcome of the trials and Dr. McGettigan stated that there were.

MOTION: Robert P. Goldfarb, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27)(c) Misleading advertisement and also under (u) for charging a fee for a service not rendered.

SECONDED: Ronnie R. Cox, Ph.D.

Aggravating factors include two previous Advisory Letters. Drs. Megdal and Cox expressed concern with the practices of this physician.

MOTION: Robert P. Goldfarb, M.D. moved for Board staff to draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand, two years Probation with 20 hours of CME in Ethics. Probation will terminate upon provision of proof satisfactory to Board Staff of the completion of CME hours.

SECONDED: Ronnie R. Cox, Ph.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; William R. Martin, III, M.D.; Douglas D. Lee, M.D.; Ronnie R. Cox, Ph.D.; Robert P. Goldfarb, M.D.; Ingrid E. Haas, M.D.; Becky Jordan; Ram R. Krishna, M.D.; Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Member abstained from this matter: Patrick N. Connell, M.D. The following Board Member was absent: Lorraine L. Mackstaller, M.D.

VOTE: 10-yay, 0-nay, 1-abstain/recuse, 1-absent
MOTION PASSED

8.	MD-04-0901A	AMB	RENEE A.C. MCCOY, M.D.	26362	Issue an Advisory Letter for failure to perform a eye dilation.
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Dr. McCoy appeared with counsel, Michael Ryan. Dr. Scherer presented this case that was brought to the attention of the Board through a malpractice settlement. Dr. McCoy failed to recognize retinal detachment. Dr. McCoy stated the patient appeared on two occasions complaining of "floaters" and diminished vision. Following the second visit, the patient returned within two hours and was examined by another physician in the practice. At that time, the patient was diagnosed with a retinal detachment. Dr. McCoy stated that she admits failing to diagnose the retinal detachment. Since this occurrence, Dr. McCoy has instituted several practices that further investigate symptoms.

Ingrid E. Haas, M.D. questioned Dr. McCoy regarding optical issues. She asked if floaters were an indication of retinal detachment and Dr. McCoy stated that they are, but could also be an indication of glaucoma. Dr. Haas asked why there was a delay of three weeks for a return visit. Dr. McCoy stated that this delay was not unusual. The patient returned and received a visual field test. In this case, the patient returned after two hours and was referred to a specialist who noted a significant change in the patient's vision, causing blindness in the eye. A posterior vitreous detachment is a common occurrence, causing floaters without further damage. Other more common problems are breaks and tears. Breaks are more common and tears are more serious and can lead to the retinal detachment. Standard of care for individuals over 40 would be a 90 diopter exam. If there are problems or if the individual is older, a dilated exam is recommended. Dr. McCoy stated that without macular involvement, the prognosis is good.

Mr. Ryan stated that Dr. McCoy is a good doctor and has never had a complaint. She has admitted that she missed the diagnosis on the patient's second visit. Had Dr. McCoy dilated on the second visit, she may have detected the problem. Dr. McCoy has instituted a system where this is unlikely to happen.

MOTION: Ingrid E. Haas, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. § 32-1401(27) "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere: (q) - Any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public.

SECONDED: Ram R. Krishna, M.D.
MOTION PASSED.

MOTION: Ingrid E. Haas, M.D. moved for an Advisory Letter for failing to perform an eye dilation.
SECONDED: Ram R. Krishna, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D.; Douglas D. Lee, M.D.; Ronnie R. Cox, Ph.D.; Robert P. Goldfarb, M.D.; Ingrid E. Haas, M.D.; Becky Jordan; Ram R. Krishna, M.D.; and Dona Pardo, Ph.D., R.N. The following Board Members were absent: Patrick N. Connell, M.D.; William R. Martin, III, M.D.; Sharon B. Megdal, Ph.D.; and Lorraine L. Mackstaller, M.D.

VOTE: 8-yay, 0-nay, 0-abstain/recuse, 4-absent
MOTION PASSED

[Seal]

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