Governor
Douglas Ducey

ARIZONA BOARD OF OSTEOPATHIC EXAMINERS IN MEDICINE AND SURGERY
1740 WEST ADAMS SUITE 2410
PHOENIX, ARIZONA 85007
PH (480) 657-7703 | FX (480) 657-7715
www.azdo.gov | questions@azdo.gov

Board Members
Gary A. Erbstoesser, D.O., Pres.
Jonathan Maitem, D.O., V.P.
Jeffrey H. Burg, AIF
Dawn K. Walker, D.O.
Ken S. Ota, D.O.
Samara Shipon, D.O.
Michael Goodman

Executive Director
Justin Bohall

DRAFT MINUTES FOR VIRTUAL MEETING OF THE ARIZONA BOARD OFOSTEOPATHIC EXAMINERS IN MEDICINE AND SURGERY

Held on Saturday, September 11, 2021

1. CALL TO ORDER

Board President Erbstoesser called the meeting to order at 8:36 a.m.

President Erbstoesser thanked the Board members and staff for facilitating today's proceedings, and read aloud the Board's Mission Statement: "The mission of the Board is to protect the public by setting educational and training standards for licensure, and by reviewing complaints made against osteopathic physicians, interns, and residents to ensure that their conduct meets the standards of the profession, as defined in law (A.R.S. § 32-1854)."

2. ROLL CALL AND REVIEW OF AGENDA

	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Present:	X	X		X	X		X
Absent:			X			X	

3. CALL TO THE PUBLIC

President Erbstoesser read aloud the Board's mission statement: "The mission of the Board is to protect the public by setting educational and training standards for licensure, and by reviewing complaints made against osteopathic physicians, interns, and residents to ensure that their conduct meets the standards of the profession, as defined in law (A.R.S. § 32- 1854)."

A. President Erbstoesser welcomed the medical students from Arizona College of Osteopathic Medicine at Midwestern University, A.T. Still University Kirksville College of Osteopathic Medicine and A.T. Still University School of Osteopathic Medicine in Arizona.

B. No individuals addressed the Board during the Call to the Public portion of the meeting.

4. REVIEW, CONSIDERATION AND APPROVAL OF MINUTES

A. June 19, 2021 Open Session

MOTION: Vice-President Maitem moved for the Board to approve the June 19, 2021 Open Session.
SECOND: Mr. Burg
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.

MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

B. June 19, 2021 Executive Session

MOTION: Vice-President Maitem moved for the Board to approve the June 19, 2021 Executive Session.
SECOND: Dr. Ota
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

5. REVIEW, DISCUSSION AND ACTION ON CASE REVIEWS OF ALLEGATIONS OF UNPROFESSIONAL CONDUCT A.R.S. § 32-1855 (D)

A. DO-20-0057A, Tamerut Anna Adams, DO, LIC. #006740

Dr. Adams participated in the virtual meeting during the Board's consideration of this matter.

Board staff summarized that this matter stemmed from a malpractice case that involved a 63-year-old female patient treated by Dr. Adams over a period of time with multiple medical problems. The patient died in May of 2018 after cardiac arrest. The case was reviewed by two board certified internists and both found that the physician me the standard of care noting that this was a complex case and that the patient's multiple medical issues masked the presence of serious cardiac disease.

Dr. Adams stated that this was a very complex patient who had been seen by other providers prior to presenting to their practice. She stated that in hindsight, she would have obtained an EKG at the beginning due to one of the patient's presenting complaints of hypertension. President Erbstoesser recognized the physician was diligently attending to this patient. Vice-President Maitem stated that his review of the file demonstrated that Dr. Adams cared about her patient and was continuously interactive in the chart. President Erbstoesser encouraged the physician to be mindful that specialists have a narrower focus as opposed to a generalist such as herself.

MOTION: President Erbstoesser moved for dismissal.
SECOND: Dr. Ota
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.

MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

B. DO-20-0167A, Scott Patrick Markham, DO, LIC. #4498

Dr. Markham and Attorney Cynthia Patane participated in the virtual meeting during the Board's consideration of this matter. Complainant JJ also participated in the virtual meeting.

Board staff reported that this matter stemmed from a complaint filed by the patient alleging that she underwent failed cataract surgeries performed by Dr. Markham in December of 2019. The case was reviewed by a board-certified ophthalmologist who recognized that the patient developed a condition that can occur after uncomplicated surgery. The Board's reviewer found that Dr. Markham was without fault and that the postoperative care was technically proper, but did find that the communication was lacking.

Dr. Markham stated that the surgery itself was uncomplicated, that the patient's postoperative condition was common and would resolve over time, and that JJ was seen by his colleague when he was on vacation. He stated that he could not think of anything else he could have done in this situation. Dr. Ota questioned whether the patient's condition occurred frequently enough after this type of surgery that it is covered during the preoperative consenting process. Dr. Markham stated that the degree to which the patient the patient has experienced her symptoms was rare and that it is not part of his typical consent discussion. Vice-President Maitem commented that there appeared to an opportunity for better communication with the patient who ultimately sought care elsewhere.

JJ stated that Dr. Markham never diagnosed her current condition despite having classic symptoms and that she was only provided eye drops at each visit for six months. JJ described for the Board how her condition and symptoms have affected her daily life and what occurred during her last encounter with Dr. Markham at which time she presented to his office to obtain her records to seek a second opinion. JJ stated that Dr. Markham did not tell her to obtain a second opinion and reiterated that he never diagnosed her condition.

MOTION: Vice-President Maitem moved for the Board to proceed to investigative hearing in this matter.
SECOND: Mr. Burg
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							

Absent:	2			X			X	

C. DO-20-0208A, Lee Peter Laris, DO, LIC. #2459

Dr. Laris participated in the virtual meeting during the Board's consideration of this matter and the Complainant was not present.

Board staff reported that the case stemmed from the patient's husband with multiple complaints regarding the patient's postoperative pain medications including limited information about the medications prescribed, difficulty obtaining it after hours and difficulty with the pharmacy. The medical consultant found that Dr. Laris met the standard of care in this case, noting that there is no standard amount or type of pain medications given for any procedure and that there is no standard for how quickly medications must be filled. Board staff further reported that in his response to the investigation, Dr. Laris stated that the patient's postoperative pain medication issue was complicated by the pharmacy's nationwide computer outage.

Dr. Laris stated that he never met the complainant, that he had been treating the patient since 2012, and that he performed previous cosmetic surgery for her. He stated that the patient returned eight years later for the same procedure and knew what was involved, that the surgery was performed one week after the consultation and without complication, and the patient returned 18 hours after surgery with no complaints of extreme postoperative pain or any issues the night before. He stated that the patient complained of pain later that evening and called the office stating that she did not receive enough pain medications. Dr. Laris described for the Board the challenges he and his staff encountered with the initial script that was called in to the pharmacy and that the husband was upset the patient would not be able to obtain her pain medication until the next morning and claimed that they were shorted 11 pills initially. Dr. Laris stated that the patient returned five days later for suture removal with no complaints and that she was happy with the results.

President Erbstoesser stated that Dr. Laris did a great job distributing pain medications and documenting the information. Dr. Laris stated that as a result of this complaint, he no longer dispenses narcotics from the office. Dr. Ota recognized the burden and responsibility on staff for dispensing the medications from the office and stated that he was glad to hear the physician has discontinued such practice. Dr. Laris clarified that he did not charge patients for the narcotics sent home with the patient after surgery.

MOTION: Dr. Ota moved for dismissal.
SECOND: Vice-President Maitem
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

6. REVIEW, DISCUSSION AND ACTION ON INVESTIGATIVE HEARINGS PURSUANT TO A.R.S. § 32-1855(E).

A. DO-20-0097A, Scott Patrick Markham, DO, LIC. #4498

Dr. Markham and Attorney Cynthia Patane participated in the virtual meeting during the Board's consideration of this matter. Complainant AF also participated in the virtual meeting.

Board staff reported that the complainant alleged the physician allowed a non-licensed employee to use his prescription pad to write for controlled substances over the course of two years. Board staff also reported that the physician and his counsel filed a motion to dismiss the matter pursuant to A.R.S. § 32-3224.

MOTION: Vice-President Maitem moved for the Board to enter into Executive Session to obtain legal advice pursuant to A.R.S. § 38-431.03(A)(3).
SECOND: Mr. Burg
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

The Board entered into Executive Session at 9:42 a.m.
The Board returned to Open Session at 10:03 a.m.
No legal action was taken by the Board during Executive Session.

AAG Galvin advised the Board to address counsel's motion for dismissal due to lack of jurisdiction as a matter of priority.

MOTION: Vice-President Maitem moved for dismissal due to lack of jurisdiction.
SECOND: Dr. Ota
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

Board staff asked the Board to consider whether to initiate an investigation regarding Dr. Markham's prescribing practices in light of the serious concerns raised regarding his prescribing habits.

MOTION: Mr. Burg moved for the Board to initiate an investigation regarding Dr. Markham's prescribing practices for the past three years.
SECOND: Vice-President Maitem
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

Complainant AF requested an opportunity to speak. She was informed that the Board lacked jurisdiction in the underlying complaint she filed and that the matter was administratively closed. She was also informed that the Board voted to initiate an investigation to review the physician's more recent prescribing habits and that it would be considered at a future meeting. AAG Galvin instructed the complainant to contact the Executive Director for further information.

B. DO-19-0040A, David John Bennett, DO, LIC. #3809

Dr. Bennett and Attorney Scott Holden participated in the virtual meeting during the Board's consideration of this matter.

Board staff reported that this matter stemmed from the Arizona Medical Board's notification that their medical consultant found there may have been failure to timely obtain a surgical consult in a 36-year-old female brought to the emergency room by EMS in April 2015 after being found by her husband with altered level of consciousness and vomiting three days post laparoscopic uterine myomectomy. The case was reviewed by a board-certified emergency room physician who found that Dr. Bennett met the standard of care with regard to the patient's sepsis, respiratory depression and aspiration. However, question was raised as to the physician's judgment when he did not contact a general surgeon or the on-call surgeon when caring for a critically ill postoperative patient especially when the radiologist noted that bowel perforation should be considered.

Dr. Bennett stated that the radiologist's report indicated there was fluid consistent with water density and not bowel content, that he did not feel the patient had a surgical abdomen when he saw her, and that she was intubated and admitted to the ICU for further care. Vice-President Maitem stated that the physician's initial care, evaluation and choice of antibiotics were appropriate, recognized that the physician discussed with the family whether the patient's abdomen seemed normal, and that he reasonably addressed the hypoxia. Vice-President Maitem noted that it is common to see free air in the abdomen after laparoscopic surgery and stated that the physician should have obtained a consultation earlier on in this patient's care. Vice-President Maitem stated he did not find that this matter rises to the level of discipline and noted that the other providers involved in this patient's care were of the same thought process as the licensee.

MOTION: Vice-President Maitem moved for the Board to issue a non-disciplinary Letter of Concern for failure to use early consultation.
SECOND: Dr. Ota
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							

Abstain/ Recuse:	0							
Absent:	2			X			X	

C. DO-19-0124A, Gary Jay Newman, DO, LIC. #3131

This matter was continued.

D. DO-19-0211A, Anne-Marie Reed, DO, LIC. #3885

Dr. Reed participated in the virtual meeting during the Board's consideration of this matter. Complainant KO was not present.

Board staff reported that KO filed a complaint regarding his son who was a patient of Dr. Reed's until the recent closing of her office. KO alleged experiencing difficulty obtaining records for his son's new provider. In her response to the investigation, Dr. Reed indicated that she maintained contact with all patients throughout the process of closing her office, and that she has since forwarded a copy of the records to KO.

Dr. Reed stated that she never received an email regarding KO's request for records and that she sent out numerous medical records since her practice closed in 2019. Vice-President Maitem questioned the physician regarding her process for helping patients obtain their records for transition of care due to her office closure. Dr. Reed explained that notices were sent out, that she secured employed to get patients over to see her again and that an additional email notification went out to patients. She stated that a notice was placed on the office door, but it was not known if the building manager kept it up. Mr. Burg questioned the physician regarding the storage of the patient files during the transition. Dr. Reed reported that the files were stored on a secured private server in her home, and that she received several requests from patients for their records and sent them in a timely fashion.

In response to further questioning by the Board's President, Dr. Reed stated that she was employed as a family practice physician at Bayliss Healthcare. Mr. Burg noted that a quick google search of the licensee provided information for her new employment. Vice-President Maitem commented that physicians are responsible for making the patient's records available. President Erbstoesser stated that physicians must do their due diligence when closing a practice to make sure patients are aware and have access to their records.

MOTION: Vice-President Maitem moved for dismissal.
SECOND: Dr. Ota
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

E. DO-19-0228A, Daniel John Aschenbrener, DO, LIC. #4378

This matter was continued.

F. DO-20-0005A, James Alan Sielski, DO, LIC. #3318

Dr. Sielski participated in the virtual meeting during the Board's consideration of this matter.

Board staff reported that this matter stemmed from a malpractice case alleging failure to supervise a Physician Assistant ("PA") who administered shoulder injections that resulted in septic arthritis of both shoulders in an 83-year-old male patient. Several concerns were raised in the case regarding the PA's treatment including failure to perform thorough physical and shoulder exams, failure to document a history specific to the complaint of shoulder pain, failure to obtain vitals at any visit, failure to order an MRI prior to treatment to rule out rotator cuff injury, and failure to establish a complete differential diagnosis or perform complete work up when the patient returned with shoulder pain. Additionally, it was found that the PA failed to refer the patient to a specialist. After development of complications from injections. Board staff stated that Dr. Sielski did not appear to be aware that the PA was performing injections and failed to perform review of patient records while serving as the PA's Supervising Physician ("SP").

Dr. Sielski stated that he was a PA for twenty years before attending medical school and that he recognized the PA's actions are a reflection of their SP. Dr. Ota questioned the physician as to his understanding of what the PA would be doing in the chiropractor's office. Dr. Sielski explained that he knew the PA would be performing trigger point injections, history and physicals, and a complete line of what would typically take place in a small family practice setting. Dr. Sielski explained that he went to the office several times to watch the PA and have him demonstrate his competence. He stated that he typically reviewed more than 15% of the patients' charts and was primarily supervising the PA remotely. He said he initially had difficulty accessing the office's electronic health records and that after transitioning to a new system, it became more difficult to access.

President Erbstoesser observed that the PA treated the patient with a number of injections resulting in a septic joint. He stated concerns regarding the patient's care and treatment as well as documentation relating to physical exams. Vice-President Maitem stated that there needed to be more regular supervision and noted that the evaluations over an extended period of time were substandard. Dr. Prah stated her concerns regarding the physician's comments relating to the charts he reviewed. She stated that there were no vital signs taken on this patient at any visit and that the PA appeared to be working independently out of the chiropractor's office. Dr. Sielski stated that when he observed the PA onsite, he performed good patient evaluations and that he did not have any specific concerns about the care he was providing.

MOTION: Vice-President Maitem moved for the Board to enter into Executive Session to obtain legal advice pursuant to A.R.S. § 38-431.03(A)(3).
SECOND: Mr. Burg
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

The Board entered into Executive Session at 10:53 a.m.
The Board returned to Open Session at 11:02 a.m.
No legal action was taken by the Board during Executive Session.

Vice-President Maitem stated that Dr. Sielski should have been more aware given his twenty years of practicing as a PA. He stated that the physician appeared to have learned from this experience and was well aware that the supervision was improper.

MOTION: Vice-President Maitem moved for the Board to issue a non-disciplinary Letter of Concern for lack of adequate supervision of a PA in violation of A.R.S. § 32-1854.34 and a

non-disciplinary Order for CME to complete 6 hours in supervision of advanced practice providers within six months. The CME hours shall be in addition to the hours required for license renewal.
SECOND: Dr. Ota
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

G. DO-20-0069A, Vinus Kanti Patel, DO, LIC. #3731

Dr. Patel participated in the virtual meeting during the Board's consideration of this matter. The complainant was not present.

Board staff reported that this matter involved a 71-year-old female diagnosed with early onset Alzheimer's in November of 2019 after a very brief mental evaluation performed by her Medical Assistant ("MA"). The Board's consultant found that Dr. Patel deviated from the standard of care noting that the diagnosis of Alzheimer's should not be based on a single visit, especially given the patient's normal mini mental status exam. Dr. Patel failed to consider other diagnoses that could cause an abnormal cognitive assessment exam or mini mental status exam including anxiety and depression. The consultant additionally found that the physician failed to refer the patient to a subspecialist or obtain an MRI, and prescribed medication typically reserved for moderate to severe Alzheimer's.

Dr. Patel stated that she agreed with the consultant's assessment and that she learned a great deal from this case. She explained that this had been her patient since 2015 and was seen on numerous occasions for complaints of memory issues that were progressive. She stated that the decision may have been premature to initiate treatment with medication, but she was familiar with this patient and her history and wanted to intervene so as to prevent progression of the disease. Dr. Patel stated that since this case, she has educated herself with regard to managing and assessing people with memory issues.

President Erbstoesser recognized that Dr. Patel has learned from this matter and educated herself on the concerns raised, and stated that he found this matter does not rise to the level of discipline. The Board noted that the complainant submitted a letter in lieu of appearing today which stated that she hoped the licensee learned the proper way to present mental evaluation with the patient and score with accuracy. Vice-President Maitem stated that he appreciated the complainant's letter, recognized that the physician has educated herself to remediate the concerns raised in this case, and stated this matter does not rise to the level of Board sanction. President Erbstoesser commented that complaints of cognitive impairment and memory loss are common in primary care and stated that there are specific algorithms with which to follow including blood work to rule out reversible causes.

MOTION: Vice-President Maitem moved for dismissal.
SECOND: President Erbstoesser
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

The Board recessed from 11:21 a.m. to 11:52 a.m.

7. CONSIDERATION AND ACTION ON PROPOSED CONSENT AGREEMENTS, COMPLIANCE WITH TERMS OF BOARD ORDERS, AND REQUESTS TO MODIFY OR TERMINATE ORDERS

A. DO-17-0268A, DO-17-0269A, Brian Samuel Page, DO, LIC. #3416

Dr. Page was not present during the Board's consideration of this matter. Mary Williams, Assistant Attorney General ("AAG"), and AAG Jeanne Galvin participated on behalf of the State. AAG Michael Raine participated to provide the Board with independent legal advice.

AAG Williams reported that based on thorough review of the evidence obtained in the above referenced investigations, and in consultation with Board staff, the Consent Agreement was drafted and accepted by the licensee. AAG Williams stated that the State supported the terms of the Consent Agreement and requested the Board's acceptance to resolve these matters in lieu of proceeding to Formal Hearing.

AAG Williams explained that these cases stemmed from complaints filed by two CRNAs who previously worked in the licensee's practice, alleging that Dr. Page allowed unlicensed staff to perform duties they were not authorized to perform. During the course of the investigations, patient charts were reviewed by medical consultants who identified deviations from the standard of care with respect to Dr. Page's inadequate informed consent, unnecessary treatment and inadequate fluoroscopy images. AAG Williams stated that the Consent Agreement also captured the licensee's admission that he allowed Medical Assistants ("MAs") to position patients and the C-Arm during procedures for which he had been previously cited on three occasions by the Arizona Department of Health Services. He also admitted to allowing MAs to insert IV catheters and denied authorizing MAs to administer medications into them. MAs were also allowed to monitor patients in the postoperative area as well as count and dispose of controlled substance medications. AAG Williams added that Dr. Page reported that he hired x-ray technicians and nurses to assist him in the practice, and that he no longer owned the pain management practice.

AAG Williams stated that the Consent Agreement included probation for five years with a practice restriction prohibiting Dr. Page from practicing pain management, from serving in any managerial role, or any involvement in employee oversight for any employment. Dr. Page would be required to complete 40 hours CME and pay a Civil Penalty in the amount of $2,000. President Erbstoesser stated that he found the penalty sufficient and stated his appreciation for AAG Galvin and AAG Williams and their hard work.

MOTION: Mr. Burg moved for the Board to accept the proposed Consent Agreement.
SECOND: Vice-President Maitem
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

MOTION: President Erbstoesser moved for the Board to vacate the hearing.
SECOND: Vice-President Maitem
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

B. DO-18-0143A, James William Osborne, DO, LIC. #4439

Dr. Osborne was not present during the Board's consideration of this matter.

Board staff reported that Dr. Osborne was placed on probation for two years in April of 2019 with monitoring by Community Bridges. A compliance summary from the monitor reported that the physician has been fully compliant and completed his monitoring agreement as of April 13, 2021. Board staff stated their support for the request to terminate the Board Order. The Board considered tabling this matter while Board staff attempted to reach the licensee to discuss this matter with the Board.

Executive Director Bohall reported that the physician would not be able to participate in today's proceedings as he was traveling. He stated that Dr. Osborne has been monitored by a Board approved monitoring program and that they have recommended termination with no reported concerns regarding the physician's ability to return to practice.

MOTION: Vice-President Maitem moved for the Board to terminate the Board Order.
SECOND: Dr. Ota
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X

Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

C. DO-19-0150A, Rick Alan Shacket, DO, LIC. #4257
This matter was continued.

8. REVIEW, CONSIDERATION, AND ACTION ON APPLICATIONS FOR LICENSURE PURSUANT TO A.R.S. § 32-1822; PERMITS PURSUANT TO A.R.S. § 32-1829; AND RENEWALS OF LICENSES PURSUANT TO A.R.S. § 32-1825 (C-D) AND A.A.C. R4-22-207.

A. DO-21-0107A, Dennis Robins Solomon, LIC. #N/A

Dr. Solomon participated in the virtual meeting during the Board's consideration of this matter.

Board staff reported that Dr. Solomon applied for licensure and disclosed a number of malpractice cases. One malpractice case occurred in 1992 and settled in 1998 that involved misplacement of a tube after attempted suicide in a 23-year-old female that resulted in her death. Another malpractice case occurred in 2012 and settled in 2015 with an allegation of failure to order the appropriate testing in a patient who was seen in the emergency room with asthma and respiratory distress. Two additional malpractice cases were disclosed that were not followed through with.

Dr. Solomon explained that one case involved a patient who consumed a number of medications and that he felt gastric lavage was appropriate. Vice-President Maitem emphasized the importance of knowing the patient's aspiration risk before intubation. Dr. Solomon stated that another malpractice case involved a pediatric patient with a normal neurological exam who was given medication for a headache and sent home. The following day, the patient suffered a stroke and the parents waited two days to take him to the children's hospital. Dr. Solomon stated that he did not have many reasons to suspect the stroke given the incredibly low stroke rate in the pediatric population. In response to the Vice-President's questioning, Dr. Solomon agreed that there was a low percentage chance of serious pathology with a higher risk of radiation exposure. Vice-President Maitem commented that the physician's care and documentation were appropriate in this case.

Dr. Solomon reported that another malpractice case involved a male patient in his thirties who presented to the emergency department with ongoing respiratory distress and a history of asthma. He stated that the physical exam was unremarkable with the exception of his breathing, that a chest x-ray showed infiltrate in one of the bases and a scan showed a small pneumothorax that did not require a chest tube. The patient was admitted to the ICU and intubated 8 hours later at which time the esophageal wall was perforated and the patient ultimately died from mediastinal infection. Vice-President Maitem questioned the disadvantages of intubating a patient as this with a pneumothorax. Dr. Solomon stated that the intubation could make things worse and most likely would have also required a chest tube as well.

MOTION: Vice-President Maitem moved for the Board to grant an unrestricted license.
SECOND: Mr. Burg
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

B. DO-21-0109A, Konstantine Chris Zinis, LIC. #N/A

Dr. Zinis participated in the virtual meeting during the Board's consideration of this matter.

Board staff reported that Dr. Zinis applied for licensure and disclosed malpractice cases as well as discipline by the Colorado Board. One malpractice case occurred in 2006 and settled in 2012 with the allegation that Dr. Zinis used an intermedullary nail too short in repair of a femur fracture that resulted in refracture three months later. Another malpractice case occurred in 2007 and settled in 2012 that involved the allegation of delay in diagnosis of postoperative infection that resulted in osteomyelitis, need for further surgeries, and ultimate referral to an infectious disease expert.

Dr. Zinis explained that the first malpractice case involved a procedure performed in the late evening and the hospital did not have the correct size nail available at that time. He stated that he fixed the repair as best he could and felt it was stable enough for the patient to recover from the anesthesia and discuss returning to the operating room. He stated that the patient did not want another surgery, that he was put on severe weight bearing restrictions, and that a refracture occurred a few months later during physical therapy. Vice-President Maitem recognized that Dr. Zinis could not discuss options with the patient at the time of nail placement due to anesthesia.

Dr. Zinis reported that the second case involved wrong site surgery and stated that he implemented a more formal time out procedure following the incident. He explained that the patient underwent arthroscopic rotator cuff repair with postoperative draining, the patient returned to the office for cleaning, and the patient experienced continued drainage. Additionally, Dr. Zinis reported that the Colorado disciplinary action involved five years probation with a practice monitor. He stated that he completed monitoring and voluntarily went through CPEP.

MOTION: Vice-President Maitem moved for the Board to grant an unrestricted license.
SECOND: Dr. Ota
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

C. DO-21-0098A, Angelique Janet Ferayorni, LIC. #N/A

Dr. Ferayorni participated in the virtual meeting during the Board's consideration of this matter.

Board staff reported that Dr. Ferayorni applied for licensure and disclosed prior discipline by the Colorado Board. In November 2013, Dr. Ferayorni was issued a letter of admonishment by the Colorado Board for writing a prescription for 20ml Lortab as opposed to the intended 2ml in a 10-month-old pediatric patient diagnosed with a mouth infection. The Colorado Board found that Dr. Ferayorni failed to confirm accuracy of the prescription prior to issuing the dosage which was ten times the appropriate dose for a 10-month-old pediatric patient.

Dr. Ferayorni explained that the incident occurred at the children's hospital in Colorado where there was no prescription error monitoring at the time. She stated that she placed an extra zero on the prescription and thought the system would alert if anything was wrong. Dr. Ferayorni stated that as a result, the hospital changed systems and the Colorado Board formally sanctioned her four years later in 2013. Vice-President Maitem stated that relying on the electronic medical records system could result in serious errors involving medication dosages and interactions.

MOTION: Vice-President Maitem moved for the Board to grant an unrestricted license.
SECOND: Mr. Burg
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

D. DO-20-0200A, Victor Loria, LIC. #N/A

Dr. Loria was not present during the Board's consideration of this matter. Vice-President Maitem spoke in favor of continuing this matter to request the physician appear before the Board.

E. DO-21-0115A, Ketang H. Modi, DO, LIC. #N/A

Dr. Modi participated in the virtual meeting during the Board's consideration of this matter.

Board staff reported that Dr. Modi applied for licensure and disclosed a malpractice case that settled in 2018 for failure to mention thrombosis on left lower extremity on MRI of the knee in a 49-year-old male with knee and leg pain. The patient died 36 days later from pulmonary emboli due to DVT.

In response to the Vice-President's questioning, Dr. Modi explained that this was a rare and unique case, and that review of the MRI retrospectively, there did appear to be some signal abnormal that could suggest possible thrombosis. Dr. Modi stated that he signed off on the radiologist's report as the Medical Director and owner of the facility until the physician. Was credentialed in order to process for insurance purposes. Dr. Modi also reported that he applied for an Arizona license to provide teleradiology services.

MOTION: Mr. Burg moved for the Board to grant an unrestricted license.

SECOND: Vice-President Maitem
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

9. QUESTION AND ANSWER SESSION BETWEEN THE MEDICAL STUDENTS AND MEMBERS OF THE BOARD AND DISCUSSION RELATING TO ISSUES SURROUNDING THE PRACTICE OF OSTEOPATHIC MEDICINE.

The Board met the medical students participating in the virtual meeting and discussed current issues surrounding the practice of osteopathic medicine.

10. REVIEW, DISCUSSION AND ACTION ON THE FOLLOWING MISC. ITEMS

A. Presentation by the Executive Director of the Arizona Pharmacy Board regarding:

1. Compounding – USP 795, 797 and 800
2. FDA MOU on compounding.
3. Pharmacy technicians and Pharmacy technician trainees
4. Utilizing permitted manufacturers and permitted wholesalers for office use, dispensing, etc.

This item was continued.

B. Reappointment of Board Members: Gary Erbstoesser, DO, Jonathan Maitem, DO, Dawn Walker, DO, and Ken Ota, DO.

The Board observed the reappointment of several Board members. Dr. Ota stated his appreciation for the Board members and what he has learned from serving on the Board.

C. Appointment of New Board Members: Samara Shipon, DO – Professional Member, and Michael Goodman – Public Member

The Board observed the appointment of two new Board members. Dr. Shipon was not present during today's proceedings, and Mr. Goodman stated that he was excited to serve on the Board.

D. Expiration of Board Members Term: Douglas Cunningham, DO – Professional Member and Jerry Landau – Public Member

The Board recognized and thanked Dr. Cunningham and Mr. Landau for their service to the State of Arizona. President Erbstoesser stated his appreciation for them and pointed out that both members served as the Board's past presidents.

Dr. Cunningham stated that it was a pleasure with the Board and its staff, stated his appreciation for their contributions over the years and that this was the best experience of his life. Dr. Cunningham encouraged the medical students in attendance of today's proceedings to understand and appreciate all of the work the Board and its staff does for the osteopathic community and profession.

Executive Director Bohall reported that Mr. Landau had to depart from the meeting prior to the Board's consideration of this item and that he planned to attend the Board's next in-person session.

E. Board Meeting Dates for Calendar Year 2022

The Board observed the following proposed meeting dates:
January 29, 2022
March. 26, 2022
May 21, 2022
August 13, 2022
October 1, 2022
December 3, 2022

Executive Director Bohall reported that the chosen dates avoid the majority of major holidays and that the Board could potentially hold a special session in June 2022 to address any urgent PGT applications.

12. REVIEW, CONSIDERATION AND ACTION ON REPORTS FROM EXECUTIVE DIRECTOR.

A. Report from Board Members

Vice-President Maitem expressed his interest in reporting on the FSMB matters such as Mr. Landau had done previously. Vice-President Maitem also stated his appreciation for the Board members and their participation in these proceedings.

B. Executive Director Report

1. Financial Report

Executive Director Bohall reported that 19% of the current Fiscal Year has lapsed, that the Board received its requested appropriation, and that the Board has received around 2% of its estimated revenue.

2. Licensing and Investigations Update

Executive Director Bohall reported that the Board previously received a total of 513 applications in the last fiscal year and has received 93 applications in the first quarter of the new fiscal year. He stated that the Board was on track to continue growth in the licensing area, noting that last fiscal PGT season the Board received 576 permits, 250 of which were new and the remainder were renewals. He stated that throughout the fiscal year, the Board issued a total of 131 temporary emergency licenses.

Executive Director Bohall reported that the Board orders average four days to completion, and that the investigation team was continuing to do a great job staying on top of everything.

The Board's next meeting is scheduled for October 23, 2021, to be held in a virtual format.

3. Current Events that Affect the Board

4. Report on Director Dismissed Complaints

Executive Director Bohall reported that 5 cases were dismissed since the Board's last meeting.

12. ADJOURNMENT

MOTION: Vice-President Maitem moved for the Board to adjourn.
SECOND: Mr. Goodman
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	VOTE	Mr. Goodman	Dr. Erbstoesser	Dr. Shipon	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	5	X	X		X	X		X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2			X			X	

The Board's meeting adjourned at 1:31 p.m.

Justin Bonall, Executive Director