Arizona Medical Board

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FINAL MINUTES FOR BOARD REVIEW COMMITTEE B TELECONFERENCE MEETING
Held on Monday, October 25, 2021
1740 W. Adams St., Board Room A • Phoenix, Arizona

Committee Members
Gary R. Figge, M.D., Chair
Bruce A. Bethancourt, M.D., F.A.C.P.
David C. Beyer, M.D., F.A.C.R., F.A.S.T.R.O.
Laura Dorrell, M.S.N., R.N.
Eileen M. Oswald

GENERAL BUSINESS

A. CALL TO ORDER
Chairman Figge called the Committee's meeting to order at 8:01am

B. ROLL CALL
The following Committee members participated in the virtual meeting: Dr. Figge, Dr. Bethancourt, Dr. Beyer, Ms. Dorrell and Ms. Oswald.

ALSO PRESENT
The following Board staff participated in the virtual meeting: Kristina Jensen; Deputy Director; Raquel Rivera, Investigations Manager; Kathleen Coffer, MD; Medical Consultant; Heather Foster, Board Operations Department; and, Amy Skaggs; SIRC Coordinator. Mary Williams, Assistant Attorney General ("AAG") was also present.

C. OPENING STATEMENTS
Dr. Figge informed participants of the civility policy.

D. PUBLIC STATEMENTS REGARDING MATTERS LISTED ON THE AGENDA
Individuals that addressed the Committee during the Public Statements portion of the virtual meeting appear beneath the matter(s) referenced.

E. APPROVAL OF MINUTES

- February 11, 2021 Board Review Committee B Teleconference

  MOTION: Dr. Beyer moved for the Committee to approve the February 11, 2021 Board Review Committee B Teleconference.
  SECOND: Ms. Oswald.
  VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Dr. Beyer, Ms. Dorrell and Ms. Oswald.
  VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
  MOTION PASSED.

LEGAL MATTERS

F. FORMAL INTERVIEWS.

1. MD-20-0969A, AMIT M. PATEL, M.D., LIC. #45755

Dr. Patel participated virtually with counsel Scott King. R.R. addressed the Committee during the public statements.

Board staff informed the Committee that this complaint is by a former employee of Dr. Patel alleging failure to adequately sedate patient, failure to address pain, and inadequate care and treatment. JB is a 20 year old female who underwent a radio frequency ablation. The Medical Consultant (MC) found deviations from the standard care because Dr. Patel failed to follow the standard of the American Society of Anesthesiology Monitoring Guidelines for monitoring a patient while sedated and post-sedation. The MC determined that the medical records were inadequate in terms of documentation, missing information and that no recovery room records were provided. It was unclear if a licensed and qualified medical provider was present to monitor the patient while under sedation. Credentials of the practice for office-based moderate sedation and credential/licenses of the personnel involved in the sedation were missing.
In his opening statement, Dr. Patel stated that he performed an uncomplicated radio frequency ablation on a 20 year old patient JB to treat her lumbar spondylosis. Dr. Patel explained the procedure to the Committee. Dr. Patel stated that a board-certified anesthesiologist administered 80mg of propofol IV to JB and then monitored her during the 12 minutes while she was under sedation in compliance with sedation monitoring standards. JB's vitals were within normal limits throughout the procedure were documented in the anesthesia record. Dr. Patel noted that the post-operative care records were provided and he can provide them again if needed. As charted in the post-anesthesia note JB was doing well with no apparent anesthesia complications at the time of her discharge to her car via wheelchair. JB suffered no potential or actual harm during or after her procedure. Dr. Patel noted the letter provided from the Arizona Department of Health stating they had completed a thorough investigation of Integrity Pain and Anesthesia on March 12. 2020 and determined there were no deficiencies and issued a license for Integrity Pain and Anesthesia, PPLC to operate as a pain management clinic. Dr. Patel stated that his treatment of JB met the standard of care and asked that the case be dismissed.

Mr. King reiterated that a board certified anesthesiologist was indeed in the procedure room to monitor patient JB during the procedure. The anesthesiologist's signature was on the anesthesiology notes. Mr. King requested that this case dismissed as Dr. Patel violated no statutory rules or regulations.

During questioning, Dr. Figge noted that the anesthesiologist's name mentioned during the opening statements was the first time ever Dr. Patel mentions another physician or anesthesiologist. Dr. Figge noted as previously stated, Dr. Patel couldn't administer the medication and monitor the patient while performing the procedure which was the crux of this case. Dr. Patel confirmed that the patient was not harmed during the procedure and did not file the complaint; it was an ex-employee. Dr. Figge commented that despite all the records provided there no actual documentation of an actual physical and history on the patient prior to the procedure. The issue is not so much regarding the care rendered but regarding the missing documentation. Dr. Patel noted that on the April 9, 2020 progress note it documents the physical and history. On the day of the procedure, Dr. Patel explained that there was a physical exam, a medication list and history. Dr. Patel states the physical and history exam is under the "objective" section and on the day of the procedure there is a portion for the physical exam. Dr. Patel stated that it is the anesthesiologist's signature on the anesthesia record which you can compare against his own signature. Dr. Patel also noted that the anesthesiologist's name is on the Anesthesiology consent form.

Dr. Beyer commented that he cannot find the anesthesiologist's name on the Anesthesiology consent form and inquired about Dr. Patel's office procedures. Dr. Patel explained that all procedures are office based with the exception of the spinal cord stimulators that are completed in a surgical center. Dr. Patel explained that DHS has certified him to be able to perform in-office procedures and grant a license based on a yearly investigation. Dr. Patel confirmed that he does own part of the office and is not an

employee. The anesthesiologists do not bill separately for simple in-office procedures but will bill separately for longer in-depth procedures like the spinal cord stimulator procedure. Dr. Patel mentioned there is more than one anesthesiologist provider on call. For example, The anesthesiologist would step in for him and he would step in for him. The anesthesia nurse made racially insensitive comments to one of the employees and the administrator asked the CRNA to step out and that the anesthesiologist could step in for her. Dr. Patel also noted that there are two other CRNA's that can be called in if a nurse called out. Dr. Patel agreed with Committee members that the anesthesiologist record is confusing with regards to who is providing the anesthesia. Dr. Patel informed the Committee of the process of checking in the patients, who provides the consent forms, and who else is in the room during the procedure.

Dr. Beyer inquired about the A.R.S. § 32-1401(27)(r) violation and if it was on the presumption that Dr. Patel provided the anesthesiology on JB himself. Dr. Ashby commented that the main concern is the lack of documentation regarding the person present providing anesthesiology for patient JB.

In closing, Mr. King apologized for the lack of documentation but confirmed that there was an anesthesiologist present to administer the medication and monitor patient JB. Mr. King reiterated that the patient did not sustain any harm and it was a disgruntled ex-employee who made the complaint to the board and further requests that the Committee dismiss the case.

In closing, Dr. Patel stated he understands it is his responsibility to provide excellent care to patients to the best of his ability and appreciates the committee for keeping him honest.

Dr. Ashby confirmed that the concern was regarding the lack of documentation of the certification of the person providing the anesthesiology care of the patient.

During deliberations, Dr. Figge opined that there was an A.R.S. § 32-1401(27)(e) violation of unprofessional conduct for inadequate documentation but opined there was no A.R.S. § 32-1401(27)(r) violation for harm to the public.

MOTION: Dr. Figge moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(e) for inadequate records.
SECOND: Dr. Bethancourt.
Dr. Bethancourt stated that the consent form is inadequate and the anesthesia note does not provide record that the anesthesiologist is in the procedure room and further provided proof of the violation.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Dr. Beyer, Ms. Dorrell and Ms. Oswald.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

Dr. Figge commented that assumptions and logic do not substitute documentation and opined that Dr. Patel has learned from this experience and where improvements can be made. Dr. Figge opined that this case does not rise to the level of discipline and does not require CME in medical records.

MOTION: Dr. Figge moved to issue an Advisory Letter for inadequate documentation. While there is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee.
SECOND: Dr. Beyer.
Dr. Beyer commented that it is not out of the realm of possibility that a physician would have an unqualified induvial in the room to monitor vitals. Dr. Beyer opined that the physician should understand why there was a concern but agreed that this does not rise to the level of discipline.

VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Dr. Beyer, Ms. Dorrell and Ms. Oswald.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

G. FORMAL INTERVIEWS

1. MD-20-0554A, MEENOR SAGAR, M.D., LIC. #40769
   Dr. Sagar participated virtually with counsel Scott King.

   Board staff summarized that this case is based on a malpractice case regarding the care and treatment of RS, a 76 year old male who underwent CT guided percutaneous core biopsy of a pulmonary lesion. Pre-operative lab showed an elevated white blood cell count, low hematocrit and low platelet count of 36,000. Post-procedure, Dr. Sagar noticed R.S. was having moderate hemoptysis. The patient was transferred to the emergency room. The patient continued to deteriorate, coded, was resuscitated. The emergency room doctor arranged for air transport to another facility, but R.S. coded before transfer and could not be resuscitated. He was pronounced dead three hours after the start of the procedure. The MC reviewed the case and found Dr. Patel deviated from the standard of care by performing a CT guided core biopsy of the left lung without ensuring the platelet count had reached an acceptable level and performing the procedure in a facility that lacked adequate support services in the event of complication. Actual harm was excessive bleeding and death.

   In opening, Dr. Sagar apologized for his lack of cooperation with the Board's investigation. Dr. Sagar explained the he performed R.S.'s CT guided percutaneous core biopsy of a lesion in the left upper lobe of the lung at South Lake Hospital. He ordered pre-operative labs that showed, among other things, a low platelet count of 36,000. Dr. Sagar explained that the pre-operative nurses did not interpret the lab work. Instead, they would tell me any highs or lows contained in the lab report itself. In R.S.'s case, there was an "L" meaning "low" next to his platelet count result. Unfortunately, the pre-operative nurse did not inform me of the low platelet count before the biopsy. Had she done so, I would have never performed the biopsy. Dr. Sagar took full responsibility for this tragic error and stated that he has since changed his practice. He now personally reviews all pre-operative labs before performing any procedure and have incorporated pertinent labs as part of our timeline discussion before any invasive study as an additional safety measure. Dr. Sagar stated that South Lake Hospital did have the adequate support to treat this patient and informed the Committee of the steps that were taken to treat RS. Dr. Sagar respectfully asked the Committee to take into consideration that he has taken full responsibility for this tragic error and have had no prior complaints, never had his hospital privileges or medical license restricted, suspended or revoked.

   During questioning, Dr. Sagar explained his experience with complications prior to this case. Some patients will develop hemoptysis that is self-limiting Pneumothorax, which is common among certain patients, especially with COPD lung lesions, so all those complications are manageable. Dr. Sagar stated had he known the platelet count he would have postponed the procedure and called the oncologist to see what they should do. Patients requiring platelets are usually admitted and once the count is at an adequate level the biopsy will be done. Dr. Sagar noted that in this case the patient had comorbidities and that unfortunately he was not able to be resuscitated. Dr. Sagar stated that the low platelet count definitely played a role the hemorrhage and commented that if the biopsy had never been done this whole incident would not have happened. Dr. Sagar explained that he forwarded this case to risk management department as he was not aware of the Board's process. He had assumed the narrative of what had transpired had been forwarded to the Board and apologized that it had not been submitted timely to the Board. Dr. Sagar explained that SR was being prepared to transfer to another hospital in the rare event he needed cardiothoracic intervention. The plan was to first stabilize the patient and then transfer him to the Level 1 Trauma Center, RMC, where all the high acuity cases get transferred to. Dr. Sagar confirmed that had he seen the platelet count he would have had decided that the patient needed a transfusion prior to the biopsy.

In closing, Dr. Sagar stated that he takes patient safety very seriously and that something like this should not happen. Dr. Sagar reiterated that this has changed the way he practices day to day.

Mr. King also provided a closing argument on behalf of his client.

During deliberations, Dr. Bethancourt opined that there has been unprofessional conduct and that the cause of death in this incident came by lung hemorrhage caused by the biopsy, but exacerbated by the fact that there was a low platelet count. Dr. Bethancourt opined that the physician conducting the biopsy should have looked at the CBC and the platelet count prior to performing the procedure.

MOTION: Dr. Bethancourt moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(r) and (ee) for reasons stated by SIRC.
SECOND: Ms. Oswald.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Dr. Beyer, Ms. Dorrell and Ms. Oswald.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

Dr. Bethancourt opined that this case rises to the level of disciplinary action.

MOTION: Dr. Bethancourt moved for the Committee to issue a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and Probation. Within six months, complete no less than 4 hours of Board staff pre-approved Category I CME in preoperative optimization in evaluation of procedures. The CME hours shall be in addition to the hours required for license renewal. The Probation shall terminate upon proof of successful completion of the CME coursework.
SECOND: Ms. Dorrell.
Dr Beyer spoke against this motion as it is not a case of the physician not understanding the pre-operative evaluation of the patient; it is that he failed to do it. The physician knows this is a basic thing he should have done and CME would not change anything. Dr. Beyer spoke in favor of the Letter of Reprimand because a fundamental step in the care of patients was left out. Ms. Oswald agreed with Dr. Beyer's comments. The physician did not meet the standard of care but knew what it was. Dr. Figge found it mitigating that this case was a result of a malpractice suit which in itself is a learning experience. Dr. Figge commented that this was a very unfortunate outcome which can happen but was aggravated by the fact that the thrombocytopenia was not recognized.
VOTE: The following Committee members voted in favor of the motion: Dr. Bethancourt and Ms. Dorell. The following Committee members voted against the motion: Dr. Figge, Dr. Beyer and Ms. Oswald.
VOTE: 2-yay, 3-nay, 0-abstain, 0-recuse, 0-absent.
MOTION FAILED.

MOTION: Dr. Beyer moved for the Committee to issue a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand.
SECOND: Ms. Oswald.
Dr. Bethancourt commented that given the physician's statements and having gone to court he hopes the physician has completely reviewed everything and supports the motion.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Dr. Beyer, Ms. Dorrell and Ms. Oswald.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

H. FORMAL INTERVIEWS

1. MD-20-0851A, DAVID J. KAPLAN, M.D., LIC. #44477

Dr. Kaplan participated virtually with counsel Andrew Plattner. M.C. addressed the Committee prior to the formal interview.

Board staff summarized that the Board initiated the case after receiving a complaint regarding Dr. Kaplan's urological care of patient MC. MC had a three piece placed inflatable penile prosthesis (IPP) resulting in pain, swelling and blood clots in his urine. MC sought care with another urologist who performed surgery to remove the IPP. MC established care with Dr. Kaplan in 2016 after prostate cancer surgery. MC underwent the IPP surgery on August 7, 2020. On August 10, 2020, MC presented to Dr. Kaplan's office for foley removal. On August 17, 2020 Dr. Kaplan diagnosed a hematoma and prescribed Bactrim for 14 days. On August 21, 2020, MC called Dr. Kaplan's office and reported extreme pain and bleeding. MC was prescribed Tramadol 50mg every six hours as needed. On August 24, 2020, MC presented to Dr. Kaplan's office and the swelling and bruising was markedly improved. Dr. Kaplan prescribed Clindamycin 600mg three times daily for 7 days. On September 3, 2020, MC called Dr. Kaplan's office and reported that he was still having a lot of blood in his urine. On September 10, 2020, MC was seen by another urologist for a second opinion. The urologist noted severe swelling and weeping purulent fluid and was tenderness. The urologist prescribed an antibiotic and noted a penile prosthesis infection and possible urethral injury and planned further workup. On September 14, 2020, MC presented to Dr. Kaplan's office who identified a pinhole skin opening over the pump in the scrotum. Clindamycin 600mg three times daily was prescribed for 7 days and follow-up in one week. On September 16, 2020, MC was seen by the new urologist. Scrotal erosion with penile prosthesis infection was noted. MC was scheduled for an urgent penile prosthesis removal. On September 17, 2020, MC's penile prosthesis, pump and reservoir were removed. MC continued follow up with his new urologist. The Medical Consultant determined that Dr. Kaplan deviated from the standard of care by failing to document the patient's complaint of blood in the urine in the clinic notes. The medical consultant also stated that a cystoscopy and urine culture should have been performed to rule out a urine infection or urethral injury. The medical consultant found that Dr. Kaplan continued prescribing post-operative antibiotics in the setting of device erosion. The medical consultant noted that Dr. Kaplan's documentation was hard to read and included cutting and pasting without regard to relevant current information.

In opening, Dr. Kaplan stated that this is a regrettable incident as it relates to a complicated medical procedure with a foreign body in a patient with multiple prior pelvic surgeries for cancer issues. This patient had pre-existing urinary incontinence require prior catheterization and end stage erectile disfunction treatments. Dr. Kaplan informed the Committee of his treatment of MC and the documented informed consent of common risks of infection and erosion of the surgery. Dr. Kaplan stated that this patient developed a hematoma after surgery which was the cause of his scrotal swelling. This ultimately led to the erosion. This is different from a patient who has had a prothesis in for several years and the device itself erodes through. Dr. Kaplan explained that his concern was that this hematoma could put pressure on the incision causing the incision to open and cause a disruption. For these reasons he decided to put the patient on antibiotics to avoid infection of the hematoma not due to concern of infection itself which is what actually occurred. Dr. Kaplan explained why he chose the antibiotics that he did. Dr. Kaplan agrees that this patient had experienced blood in the urine and this was documented. Dr. Kaplan explained that the issue here is the patient has had urinary retention in the past and has required intermittent catheterization prior to him treating the patient in 2016. The patient did develop urinary retention after the surgery and he had to institute the catheterization. In this setting the most common source for the blood in the urine was due to intermittent catheterization post-operatively rather than the uncommon of a urethral erosion. Dr. Kaplan recognizes that this case is an opportunity to learn in retrospect how he could have approached this and protocol for salvage. Dr. Kaplan stated he takes these concerns seriously and that this patient was not neglected as he had weekly follow up or sooner an a couple of time when he called the office he was seen that day and when offered to come in and the patient refused that was documented. Dr. Kaplan stated he regrets the morbidity and discomfort the patient experienced.

During questioning, Dr. Kaplan explained to the committee the procedure and how it is possible during the dilation process for the dilators to cross over from one corpora to the other. Dr. Kaplan stated that in spite of this cross over through the corpora patients can still have a successful outcome and have a functioning penile prosthesis. Dr. Kaplan informed the Committee that the patient's developed the hematoma and swelling was at the penile scrotal junction at the base of the penis which was the site of the transverse incision. Dr. Kaplan explained his reasoning behind prescribing the Bactrim since his concern was not erosion but wound dehiscence from the hematoma. Dr. Beyer inquired whether the patient's intermittent self-catheterization could contribute to the exposure. Dr. Kaplan commented that the corpora can be thinned out when dilated and the intermitted catheterization multiple times a day can cause a disruption in the urethra. If there is a foreign body near the thinned out area of the urethra it can be perforated and can cause this kind of infection. Dr. Kaplan also noted that this patient had an infection more typical of a urinary pathogen than a skin flora. Dr. Kaplan read through one of the medical records and explained how they are completed; who completes the separate parts and that he likes to have a running record for someone who's not familiar with the case.

Dr. Beyer commented that it is difficult to read and follow the medical records without having the physician present to explain them.

Dr. Kaplan stated that he understands how the medical records could be confusing. Dr. Kaplan stated that this was a thoughtful approach to this patient's care however there was unfortunate outcome. There are many patients who have their penile prosthesis salvaged with antibiotic therapy. Dr. Kaplan stated he agreed with the explant but noted that the second opinion did not immediately recommend getting the patient to the ER but instructed him to have his follow up visit. Dr. Kaplan opined this is not a case of absolute right or wrong. Dr. Kaplan informed the Committee that he has learned from this case and has implemented changes to his medical records to be clearer and to improve his care to future patients.

Mr. Plattner provided a closing statement on behalf of his client.

Board staff clarified the MC's supplemental response comments. The MC stated that he did not know Dr. Kaplan or did not know of him before this case investigation was assigned to him. Board staff also noted that the operative report by the second urologist stated that "using bovine electrocautery, we resected the edges of the necrotic skin around the erosion site. Once this was completed, we were then able to pass a small mosquito around the clamp to free up the pocket. Purulence was noted, and at this time, we then obtained wound cultures."

Dr. Kaplan explained that he was aware of the medical consultant's employment at the practice immediately as he is part owner and they subsequently went through a contentious separations. The separation was completed October 1st of this year. Dr. Kaplan opined this is a conflict of interest in this case.

Board staff clarified the timeframe of the MC report and the physician's notice for a supplemental response. At the time Dr. Kaplan was asked for a supplemental response he was not aware of who the medical consultant was. Once he was informed of who the MC was Dr. Kaplan voiced his objection. Board staff explained the process in the event of a conflict of interest.

During deliberation, Dr. Beyer opined there has been unprofessional conduct regarding failing to adequate medical records. Dr. Beyer opined there is not enough to sustain the § 32-1401(27)(r) violation which is conduct that might be harmful to the patient or public. Dr. Beyer opined Dr. Kaplan's care was not negligent and that he adequately and properly cared for the patient. Dr. Beyer found it mitigating that he regularly followed up with the patient. The care was not well documented in the medical record.

MOTION: Dr. Beyer moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(e) reasons stated by SIRC.
SECOND: Dr. Bethancourt.
Dr. Bethancourt commented regarding the conflict of interest that there are copious providers and there is only one page that identifies the group. Dr. Beyer noted that over the past decade there has been a lot of consolidation of groups and believed that the medical consultant did not know of the potential conflict until staff made him aware. Dr. Beyer opined that even if there was a conflict of interest this does not affect the finding of the e violation and that the committee is able to make the determination itself. Dr. Bethancourt further commented that the medical records would be difficult to be read by another provider and it is good that the physician has made changes to his record.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Dr. Beyer, Ms. Dorrell and Ms. Oswald.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

Dr. Beyer opined that this does not rise to the level of discipline and stated that the records can be corrected by the physician.

MOTION: Dr. Beyer moved to issue an Advisory Letter and Order for Non-Disciplinary CME for inadequate documentation. While there is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee. Within six months, complete no less than 10 hours of Board staff pre-approved Category I CME in an intensive, in person course regarding medical recordkeeping. The CME hours shall be in addition to the hours required for license renewal.
SECOND: Dr. Bethancourt.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Dr. Beyer, Ms. Dorrell and Ms. Oswald.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

I. FORMAL INTERVIEWS

1. THIS CASE HAS BEEN PULLED FROM THE AGENDA.

GENERAL BUSINESS

J. DISCUSSION REGARDING DEBRIEFING ON COMMITTEE PROCESSES

Committee members commented that public speakers once they have become disruptive should be muted so as not to disrupt the flow of the meeting per the civility policy.

K. ADJOURNMENT

MOTION: Dr. Beyer moved for the Committee to adjourn.
SECOND: Dr. Dorrell.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Dr. Beyer, Ms. Dorrell and Ms. Oswald.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

The Committee's meeting adjourned at 10:56 a.m.

Patricia E. McSorley, Executive Director