# Arizona Medical Board

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## DRAFT MINUTES FOR BOARD REVIEW COMMITTEE A TELECONFERENCE MEETING
## Held on Wednesday, December 1, 2021
## *1740 W. Adams St., Board Room A • Phoenix, Arizona*

***Committee Members***
R. Screven Farmer, M.D., Chair
Jodi A. Bain, M.A., J.D., LL.M.
James M. Gillard, M.D., M.S., F.A.C.E.P., F.A.A.E.M.
Pamela E. Jones
Lois E. Krahn, M.D.

## GENERAL BUSINESS

### A. CALL TO ORDER
Chairman Farmer called the Committee's meeting to order at 8:08 a.m.

### B. ROLL CALL
The following Committee members participated in the virtual meeting: Dr. Farmer, Ms. Bain, Dr. Gillard, Ms. Jones and Dr. Krahn.

### ALSO PRESENT
The following Board staff participated in the virtual meeting: Patricia McSorley, Executive Director; William Wolf, M.D., Chief Medical Consultant and Michelle Robles, Board Operations Manager. Carrie Smith, Assistant Attorney General ("AAG") was also present.

### C. OPENING STATEMENTS
Chairman Farmer read the civility policy for the record.

### D. PUBLIC STATEMENTS REGARDING MATTERS LISTED ON THE AGENDA
No individuals addressed the Committee during the Public Statements portion of the meeting.

### E. APPROVAL OF MINUTES

- October 25, 2021 Board Review Committee A Teleconference

  **MOTION: Dr. Krahn moved for the Committee to approve the October 25, 2021 Board Review Committee A Teleconference.**
  **SECOND: Dr. Gillard.**
  **VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Gillard, Ms. Jones and Dr. Krahn. The following Committee member abstained: Ms. Bain.**
  **VOTE: 4-yay, 0-nay, 1-abstain, 0-recuse, 0-absent.**
  **MOTION PASSED.**

## LEGAL MATTERS

## F. FORMAL INTERVIEWS

1. MD-20-0784A, THOMAS J. RICK, M.D., LIC. #23545

Dr. Rick participated virtually with counsel Mike Goldberg. Ms. Jones and Dr. Gillard stated that they know the physician, but it will not affect her ability to adjudicate.

Board staff summarized that this case was initiated after receiving notification from the National Practitioner Data Bank (NPDB) that Dr. Rick's Hospital clinical privileges were suspended for failing to recognize an incorrectly placed central venous catheter and subsequently revoked for failure to comply with a remedial action plan instituted after reinstatement of his privileges. The Board's Medical Consultant ("MC") determined that Dr. Rick deviated from the standard of care by failing to identify a misplaced central venous catheter resulting in a massive right pleural effusion, contribution to intraoperative hemodynamic instability, hypoxia, and metabolic abnormalities. SIRC also discussed Dr. Rick's failure to complete the Hospital recommendations for five proctored cases resulting in loss of hospital privileges, which he cited COVID-19 and decreased volume preventing him from completion. SIRC noted that Dr. Rick was given a year to complete the proctored cases and failed to do so. SIRC observed that Dr. Rick provided a certificate of completion for a course in CVC insertion completed in October 2018; however, there was no information provided regarding the amount of continuing medical education ("CME") hours received. SIRC noted that there was actual harm in this case resulting in a massive right pleural effusion requiring chest tube placement, contribution of intraoperative hemodynamic instability, hypoxia, and metabolic abnormalities. SIRC remained concerned with Dr. Rick's position that his care was appropriate. SIRC recommended a Letter of Reprimand and Probation requiring the completion of 10 hours of intensive, in-person CME in medical recordkeeping.

Mr. Goldberg provided an opening statement on behalf of Dr. Rick, stating that the NPDB report had nothing to do with scrutiny or criticism regarding the care provided in the case but more so regarding his failure to comply with the FPPE.

Dr. Rick provided an opening statement on his own behalf. He stated that his actions in this case were not a violation of the standard of care. The Peer review suspended his staff privileges for thirty days and required five proctored CVC cases. This facility was the only one he was covering high acuity cases that required CVC, and since he was prohibited from working he was unable to acquire any proctored cases. After the suspension was lifted he was able to complete one case but was unable to complete the rest due to the COVID pandemic. The hospital administration reported to the NPDB that his privileges were revoked for failure to comply with the corrective action plan.

During questioning, Dr. Rick explained the sequence of events for the procedure at issue.

Dr. Farmer expressed concern, that given the sequence of events, that immediately upon taking the patient out of prone position the patient should have been evaluated to confirm any suspicion that the central line was out of place.

Dr. Rick explained the timing of the X-ray and CAT scan and his decision making during that time.

Dr. Farmer expressed concern that he was unable to locate in the records a summary of events and decision making in the form of a narrative.

Dr. Rick explained that he documented in the anesthetic records in the Remarks section and that he inscribed postoperatively. When an official report from the radiologist confirmed that the line was misplaced and there was an infusion, a surgeon was contacted to help with the chest tube and the patient was revived.

In closing, Mr. Goldberg requested that there be no discipline in this case.

In closing, Board staff noted that Dr. Rick's initial reply to the Board states that catheter placement was confirmed by smooth aspiration of blood through both ports and the double catheter, and that line ran freely without application of any pressure on the fluid. Board staff further noted that the initial narrative did not mention of any transducer or transduction of the pressure fluids.

During deliberation, Dr. Farmer expressed sympathy for some circumstances in this case; however noted that he had significant concerns, and discussed his opinions on the case. Dr. Farmer commented that given the unusual complication, the physician should have dictated a note. Dr. Farmer opined that the medical recordkeeping had significant gaps. Dr. Gillard agreed with the medical records issue but noted that although this was a very unfortunate complication, it is not unheard of when you place a lot of central lines. Dr. Krahn commented that in reviewing the medical records it is difficult to understand what the physician's decision making and thought processes were. Dr. Krahn also expressed concern that the physician did not respond to the remedial plan.

**MOTION: Dr. Farmer moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(e) and (r) for reasons as stated by SIRC.**
**SECOND: Dr. Krahn.**
**VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Ms. Bain, Dr. Gillard, Ms. Jones and Dr. Krahn.**
**VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

Dr. Farmer commented that if the Board had a narrative of the decision making it would be easier to decide on a sanction. Dr. Farmer also struggled with the delay in care. Dr. Gillard stated that there is some hindsight when you start off getting a very good return on the line with returning blood freely. Dr. Gillard opined that this does not rise to the level of discipline given that the physician has already completed CME. Dr. Krahn expressed sympathy for the situation but expressed concern on how the physician responded. Dr. Farmer noted that there is plenty of education regarding central line placement complications, treatment of the complications and managing patients in a prone position.

**MOTION: Ms. Bain moved for the Board to enter into Executive Session to obtain legal advice pursuant to A.R.S. § 38-431.03(A)(3).**
**SECOND: Dr. Krahn.**
**VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Ms. Bain, Dr. Gillard, Ms. Jones and Dr. Krahn.**
**VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

The Board entered into Executive Session at 9:02 a.m.
The Board returned to Open Session at 9:18 a.m.
No legal action was taken by the Board during Executive Session.

Dr. Farmer noted the lack of recordkeeping and the delay in diagnosis and opined that discipline is warranted in this case. Dr. Farmer suggested a Letter of Reprimand and Probation or Probation for CME for recordkeeping, central line placement and handling of complications in a prone patient.

Board members noted that the physician was no longer virtually present and confirmed with his counsel that it was appropriate to proceed.

**MOTION: Dr. Farmer moved for the Committee to issue a Draft Findings of Fact, Conclusions of Law and Order for Probation to complete CME. 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, and no less than 3 hours of Board staff pre-approved Category I CME in management of central line complications. 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.**
**SECOND: Dr. Krahn.**

In response to a Committee member's inquiry, Ms. Smith informed the Committee that Dr. Rick stated that he took a CVC program but it did not appear to award any CME credits.

Dr. Gillard spoke against discipline due to the unusual outcome and suggested for tracking purposes an Advisory Letter for failure to respond to the complications in a timely manner, as well as an order for non-disciplinary CME. Dr. Farmer opined that this case rises to the level of discipline due to the inconsistency in the response. Dr. Gillard confirmed that the physician has a previous Advisory Letter in the past but it is not related.
**VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Ms. Bain, Ms. Jones and Dr. Krahn. The following Committee member voted against the motion: Dr. Gillard.**
**VOTE: 4-yay, 1-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

## G. FORMAL INTERVIEWS

1. MD-20-0981A, ASHISH PERSHAD, M.D., LIC. #25732
Dr. Pershad was present virtually with counsel Steve Myers.

Board staff summarized that the Board initiated the case after receiving notification from the NDPB that he voluntarily surrendered hospital privileges while undergoing investigation. The Board received notification from his employer that Dr. Pershad was terminated from employment from engaging in unprofessional conduct. He was previously placed on a corrective action plan in December 2019 for behavior towards fellow team members. His recent conduct towards fellow health care team member, a nurse, fell short of the corrective action plan. Peer Review documentation showed that Dr. Pershad was placed on performance improvement plan in October, 2017 for excessive personal communication in the work environment which resulted in him going uninvited to a team member's home. In December of 2019, Dr. Pershad was placed on an additional performance improvement plan for making physical contact with a team member. Dr. Pershad was also removed as medical director if the catheter lab and was required to take an educational course. In August of 2020, a nurse alleged that Dr. Pershad behaved in a retaliatory manner towards her and several members of the nursing team related to an incident report she filed on a patient who did not have IV access when taken in to a procedure. Two nurses witnessed Dr. Pershad confront the complainant directly and four nurses were asked by Dr. Pershad where the complainant was on any given day. Dr. Pershad's alleged behavior was substantiated and assessed as retaliation. HR recommended termination. Board Staff obtained peer review records from the hospital concerning the incident report and noted that the Medical Executive Committee voted to terminate Dr. Pershad's privileges on October 26, 2020 prior to his resignation in October 30, 2020. Dr. Pershad requested to resign his privileges prior to the Medical Executive Committee action was taken. The hospital agreed to accept the resignation while under investigation and reported it. Dr. Pershad completed PBI's course in Elevating Civility and Communication in Health Care Medical course and PBI's Ethics and Professionalism Course. SIRC recognized remedial action taken by the physician.

Dr. Pershad provided an opening statement to the Board. Dr. Pershad stated that he was employed by Hospital Medical Group as the Chief of Interventional Cardiology for 7 years. The Medical Group terminated his employment in 2020 due to violation of his contract related to the two HR complaints. He chose to resign based on the recommendation from his counsel. Dr. Pershad went on to describe the two incidents and stated that he takes full responsibility for his role in both complaints. He has used this as tremendous learning opportunity.

Mr. Myers also provided an opening statement on behalf of the physician and requested that the Board not issue discipline given the remediation.

During questioning, Dr. Pershad explained the circumstances around what occurred in two incidents. Dr. Prashad identified his triggers, which have changed over time. Over the past year and a half he has learned to balance his work life and to say "no" when he is overwhelmed in an appropriate way. Dr. Pershad informed the Board that he is still participating in the PBI virtual seminars and stated that it has been an incredible experience to learn from others and to grow.

In closing, Mr. Myers stated that the public would not benefit from disciplining Dr. Pershad.

During deliberation, Ms. Jones noted that there were no quality of care issues with a patient; however, she noted that a hostile work environment can lead to patient care issues. Ms. Jones found it concerning that Dr. Pershad exhibited inappropriate conduct but found it mitigating that the physician has completed 52 hours of CME, continuing to participate in PBI's virtual session and had created a personal improvement plan in three different areas. Ms. Jones opined that the physician is taking active positive steps in his new working environment and has letters of support.

**MOTION: Ms. Jones moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(r) for reasons as stated by SIRC.**
**SECOND: Dr. Gillard.**
**VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Ms. Bain, Dr. Gillard, Ms. Jones and Dr. Krahn.**
**VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

**MOTION: Ms. Jones moved to issue an Advisory Letter for unprofessional clinical communication with hospital staff. While the licensee has demonstrated substantial compliance through rehabilitation or remediation that mitigates the need for disciplinary action, the Board believes that repetition of the activities that led to the investigation may result in further Board action against the licensee.**
**SECOND: Dr. Gillard.**
Dr. Gillard spoke in favor of the Advisory Letter recognizing the completed CME and mitigating circumstances.
**VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Ms. Bain, Dr. Gillard, Ms. Jones and Dr. Krahn.**
**VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

## H. FORMAL INTERVIEWS

1. MD-19-1206A, NICHOLAS A. RANSOM, M.D., LIC. #18436
   Dr. Ransom was present virtually with counsel Steve Myers.

   Board staff summarized that this case was initiated based on communication from a Hospital reported that it had summarily suspended the physician's privileges on August

28, 2019. The suspension was lifted on September 10, 2019 after Dr. Ransom accepted the MEC's corrective action plan. The complaint stated that Dr. Ransom had performed a wrong level cervical surgery; however, he failed to disclose this in the medical records. Dr. Ransom reported his suspension was not due to the wrong site surgery or inaccurate dictation but because of his late arrival at the committee meeting evaluating this event. The case was reviewed by a MC who determined that Dr. Ransom deviated from the standard of care by not accurately documenting the performance of a wrong level spinal surgery in the operative report at the time of the occurrence. The MC further stated that Dr. Ransom's narrative statement implied that he intended to perform surgery at both levels rather than stating the facts of what had transpired based on the radiographic record. Dr. Ransom completed PBI's Medical Ethics and Professionalism course.

Dr. Ransom provided an opening statement to the Board. Dr. Ransom stated that when he noticed the procedure was performed at the wrong level once it was completed, he informed the team. He then revised the procedure to the correct level. Dr. Ransom stated that he did not dictate his post-operative note immediately after surgery which is his usual custom. He explained the situation to the hospital CEO and the patient. The patient expressed understanding. During the time he was dictating the operative report, he glossed over the error he made. Dr. Ransom stated he has no defense for his actions and has since entered counseling to understand why he would make such a misleading operative report. The review committee required him to amend the operative note and complete a CME course in ethics. He completed the course and the matter was closed.

Mr. Myers provided an opening statement on behalf of the physician and requested a non-disciplinary resolution.

During questioning, Dr. Ransom stated that he was aware of the date and time of the MEC meeting but was unable to attend as he had an emergency call. He was unable to reschedule. Dr. Ransom stated that the committee instructed him to amend his operative note since it did not reflect what happened. Dr. Ransom admitted that he should have amended the report from the start. Dr. Ransom noted that the patient was very understanding and at no point expressed hostility over the event.

Board staff informed the Committee that this notification came from the hospital as it is a requirement in statute and an investigation was opened. Additional Board staff noted that the operative report listed "none" under complications and that there was no evidence of a discussion with the patient regarding the fusion level.

Mr. Myers informed the Committee that Dr. Ransom was instructed to speak with the patient by the hospital CEO.

Dr. Ransom provided the Committee with a timeline of events. The surgery was performed in the morning and he was contacted by the CEO later that day. He was instructed to speak to the patient and complete his dictation. He spoke with the patient that afternoon and completed his dictation the following morning. Dr. Ransom explained that he continued to treat the patient over the course of three months and wrote brief notes regarding the patient's progress.

In closing, Mr. Myers requested the physician not be disciplined.

During deliberation, Dr. Krahn commented that this is a serious matter with wrong level surgery and a misleading operative note. Dr. Krahn acknowledged the physician's willingness to acknowledge that mistakes were made and his efforts to remediate the mistakes. Dr. Krahn opined that this was a learning experience and for that reason this case does not reach the level of discipline.

**MOTION: Dr. Krahn moved for dismissal.**

**SECOND: Dr. Gillard.**
Ms. Bain opined that this case should not be dismissed, opining that what happened with this patient was egregious and should not have happened. Ms. Bain noted that the physician only fixed the record once someone realized what happened. Ms. Bain commented that discipline is another question, but opined that there was a violation for failing to maintain medical records at the time it occurred. Dr. Krahn stated that she appreciated these comments.

**MOTION WITHDRAWN.**

Dr. Farmer discussed the Committee's options given the circumstances of the case and commented that he disagreed with a finding that there was not a violation of statute in the case of falsifying a record.

Ms. Smith clarified that SIRC sustained violations of both A.R.S. §§ 32-1401(27)(e) and (r)..

**MOTION: Dr. Krahn moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(e) and (r) for reasons as stated by SIRC.**
**SECOND: Ms. Bain.**
Dr. Gillard commented that the process is split into two parts, to establish whether or not unprofessional misconduct occurred and if it should be non-disciplinary for tracking purposes.
**VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Ms. Bain, Dr. Gillard, Ms. Jones and Dr. Krahn.**
**VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

Dr. Krahn opined that these are serious matters and that what happened was unacceptable. She further commented that the physician has addressed this matter, and due to mitigating circumstances she found that this does not rise to a Letter of Reprimand, and moved for an Advisory Letter.

**MOTION: Dr. Krahn moved to issue an Advisory Letter for performance of a wrong-level spinal surgery and for failing to initially and accurately document the performance of the wrong-level spinal surgery. While the licensee has demonstrated substantial compliance through rehabilitation or remediation that mitigates the need for disciplinary action, the Board believes that repetition of the activities that led to the investigation may result in further Board action against the licensee.**
**SECOND: Dr. Gillard.**
Dr. Farmer opined that the physician had taken the matter very seriously, and spoke in favor of an Advisory Letter. Dr. Gillard commented that this was handled at the local level and that the suspension appears to be an administrative lapse. Ms. Jones noted the remedial efforts of the physician. Dr. Krahn commented that the suspension could have been prevented if the physician had been more available.
**VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Gillard, Ms. Jones and Dr. Krahn. The following Committee member voted against the motion: Ms. Bain.**
**VOTE: 4-yay, 1-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

## I. FORMAL INTERVIEWS

1. THIS CASE HAS BEEN PULLED FROM THE AGENDA.

## J. FORMAL INTERVIEWS

1. MD-20-0999A, CHINEDU N. NWABUEZE, M.D., LIC. #59422

Dr. Nwabueze was present virtually without counsel.

Board staff summarized that the case was initiated based on a notification that the California Board placed him on probation for three years with a requirement to complete of an ethics course. Board staff summarized the findings of the California Board's investigation. On November 13, 2020, California Board issued Dr. Nwabueze a three year probationary license and required him to complete an ethics course. On July 1, 2021, Dr. Nwabueze completed NetCE's Medical Ethics for Physicians course. On March 15, 2021, the Illinois Board placed Dr. Nwabueze's medical license on indefinite probation based on the California Board action. The Order noted that Dr. Nwabueze cannot petition for restoration until his California license is restored to full unencumbered status. On March 5, 2021, the Texas Board issued Dr. Nwabueze a waiver order that requires him to successfully complete the terms of the California Board order. Board staff noted that Dr. Nwabueze obtained his Arizona license through the Compact with Illinois as his State of Principal Licensure. Board staff observed that Dr. Nwabueze documented that he completed USMLE Step 2 CK and Step 3 in two attempts on his Compact license application. SIRC discussed that there was no disciplinary action by any jurisdiction prior to the date of Dr. Nwabueze's Arizona license application and the Compact application does not ask for information regarding discipline and/or problems during a physician's post-graduate training. For these reasons, SIRC was reassured that Dr. Nwabueze's initial license was appropriately obtained and recommended a Letter of Reprimand based on the California action.

Dr. Nwabueze's provided an opening statement and explained the administrative errors that resulted in the failure to accurately complete the California license application. Dr. Nwabueze confirmed he is in compliance with the California Order.

In response to a Committee member's question, Board staff explained the Arizona Board's process for terminating a probationary order.

Ms. Bain noted that at the time of the physician's Arizona license application via Compact, there was no violation and complied with Arizona's application requirements.

Dr. Nwabueze stated that he has to complete all three years of the California probation order, despite the fact that he has completed the substantive requirements. He has completed everything that was required in Texas from the CME standpoint. Dr. Nwabueze noted that other states have reviewed his initial application with them for licensure and determined that he was forthcoming. Dr. Nwabueze explained the incident that occurred during residency and noted that it did not involve patient care. He completed the action plan that included a number of modules and a presentation before other residents regarding a specific medical topic. Dr. Nwabueze stated that this experience has taught him to personally complete any new state license applications himself so that he can verify the information.

Ms. Bain commented that she appreciates the physician's candor and agreed that he is ultimately responsible for what is submitted in his application.

**MOTION: Ms. Bain moved for the Board to enter into Executive Session to obtain legal advice pursuant to A.R.S. § 38-431.03(A)(3).**
**SECOND: Ms. Jones.**
**VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Ms. Bain, Dr. Gillard, Ms. Jones and Dr. Krahn.**
**VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

The Board entered into Executive Session at 12:08 p.m.
The Board returned to Open Session at 12:24 a.m.
No legal action was taken by the Board during Executive Session.

Dr. Gillard noted the physician has 27 active licenses in the US.

Board staff confirmed that there hasn't been any significant discipline taken by any other state based on what was heard.

Dr. Gillard commented that the physician obtain his license via the Compact and was in full compliance with Arizona's statutes.

Board staff explained that SIRC determined that there was a violation of A.R.S. § 32-1401(27)(p) for the action taken by the California Board .

In closing, Dr. Nwabueze thanked the Committee for allowing him to speak on the matter.

**MOTION: Ms. Bain moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(p) for reasons as stated by SIRC.**
**SECOND: Ms. Jones.**
Dr. Gillard spoke against finding unprofessional conduct as the physician was compliant with Arizona's rules and statutes. Ms. Bain noted that the unprofessional conduct was clearly established, but stated that the question of whether discipline should be imposed is separate.
**VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Ms. Bain, Ms. Jones and Dr. Krahn. The following Committee member voted against the motion: Dr. Gillard.**
**VOTE: 4-yay, 1-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

Ms. Bain commented that she is torn between issuing an Advisory Letter for tracking and dismissing this case. Dr. Gillard opined that tracking is not necessary.

**MOTION: Dr. Gillard moved to dismiss.**
**SECOND: Dr. Krahn.**
**VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Gillard, Ms. Jones and Dr. Krahn. The following Committee member abstained: Ms. Bain.**
**VOTE: 4-yay, 0-nay, 1-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

## GENERAL BUSINESS

### K. APPROVAL OF DRAFT FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

1. MD-20-0660A, MD-20-1055A, LEE S. YOSOWITZ M.D., LIC. #12610

In response to a Committee member's question, Ms. Smith confirmed that Ms. Jones is not required to abstain since she was not present for this interview if she has reviewed all the information.

Dr. Gillard summarized that this physician was interviewed in October for complications arising from a forceps delivery.

**MOTION: Dr. Gillard moved for the Committee to approve the draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand and Probation. Within six months complete the Improving Inter-Professional Communication Course offered by CPEP. 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.**
**SECOND: Dr. Krahn.**
**VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Gillard, Ms. Jones and Dr. Krahn. The following Committee member abstained: Ms. Bain.**
**VOTE: 4-yay, 0-nay, 1-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

## L. DISCUSSION REGARDING DEBRIEFING ON COMMITTEE PROCESSES

Dr. Farmer appreciated how smoothly these conferences go and staff's effort. Ms. Bain inquired about returning to in-person meetings. Dr. Farmer noted that this will be discussed with the full Board but does plan to continue this Committee process going into next year given the volume of cases.

## M. ADJOURNMENT

**MOTION: Ms. Bain moved for the Committee to adjourn.**
**SECOND: Dr. Gillard.**
**VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Ms. Bain, Dr. Gillard, Ms. Jones and Dr. Krahn.**
**VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

The Committee's meeting adjourned at 12:38 p.m.

Patricia E. McSorley, Executive Director