Arizona Medical Board

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FINAL MINUTES FOR BOARD REVIEW COMMITTEE B TELECONFERENCE MEETING Held on Friday, October 6, 2023 *1740 W. Adams St. • Phoenix, Arizona*

Committee Members
Lois E. Krahn, M.D., Chair
Katie S. Artz, M.D., M.S.
David C. Beyer, M.D., F.A.C.P.
Laura Dorrell, M.S.N., R.N.
James M. Gillard, M.D., M.S., F.A.C.E.P., F.A.A.E.M.
Pamela E. Jones

GENERAL BUSINESS

A. CALL TO ORDER

Chairwoman Krahn called the Committee's meeting to order at: 8:23 a.m.

B. ROLL CALL

The following Committee members participated telephonically: Dr. Krahn, Dr. Artz, Dr. Beyer, Ms. Dorrell, Dr. Gillard and Ms. Jones.

ALSO PRESENT

The following Board staff were present: Kristina Jensen, Deputy Director and Michelle Robles, Board Operations Manager. Carrie Smith, Assistant Attorney General ("AAG") was also present.

C. OPENING STATEMENTS

D. PUBLIC STATEMENTS REGARDING MATTERS LISTED ON THE AGENDA

Individuals who addressed the Committee during the Public Statements portion of the meeting appear beneath the case.

E. APPROVAL OF MINUTES

- August 2, 2023 Review Committee B Minutes

  MOTION: Dr. Gillard moved to approve the August 2, 2023 Board Review Committee B minutes.
  SECOND: Ms. Jones.
  Ms. Jones noted an error in the vote counts.
  VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Dr. Artz, Dr. Beyer, Ms. Dorrell, Dr. Gillard and Ms. Jones.
  VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
  MOTION PASSED.

LEGAL MATTERS

F. FORMAL INTERVIEWS

1. MD-22-0911A, PATRICK L. BOSARGE, M.D., LIC. #58004
   Dr. Bosarge participated virtually with counsel Flynn Carey and Lisa Bivens.

Board staff summarized that this case was initiated after receiving a self-report that Banner University Medical Center filed an NPDB entry against Dr. Bosarge based upon its belief that his resignation from employment trigged a reporting requirement. Board staff issued a notice letter to Dr. Bosarge based on the NPDB report and documents provided by BUMC that alleged Dr. Bosarge resigned due to inappropriate conduct involving drinking alcohol and kissing with two residents, failure to maintain professional boundaries with residents while in a leadership role, and making misleading statements during the hospital investigation. Board staff obtained investigation documents from BUMC and UA which indicated that indicated that their HR department received allegations regarding two residents from June 2022. According to the HR investigative report, Banner interviewed several individuals regarding the allegations of inappropriate behavior while Dr. Bosarge and his Residents were heavily under the influence of alcohol and it was noted that this had occurred in 2021 and 2022 with two different residents, Resident A in 2021 and Resident B in 2022. It was documented that Dr. Bosarge's behavior was witnessed by several leaders and Residents, in 2021 and 2022. Banner determined that Dr. Bosarge was not forthright in the interview, stating that he couldn't remember kissing, touching, or leaning on the Resident; implied leaving in an uber alone; originally denying other inappropriate similar situations with Residents, and knowing there was an allegation of inappropriate behavior with a Resident, but when asked did not identify who it was. The investigation report by Banner stated that Dr. Bosarge displayed no awareness of how his actions have affected the Residents and failed to recognize the effect of his behavior in general. In his response, Dr. Bosarge stated in June 2021, the Department of Surgery hosted the chief resident graduation dinner. After dinner, several residents and faculty went to a bar and Resident A came and sat on Dr. Bosarge's lap while being "flirtatious and handsy". After the bar closed, they group returned back to the hotel where the dinner was held. Resident A and Dr. Bosarge broke away from the group and engaged in consensual kissing in the hotel bathroom. In the morning Resident A told Dr. Bosarge that the night before was a mistake in which Dr. Bosarge agreed. Dr. Bosarge stated that he and Resident A worked together several times after the incident, and he was not aware that Resident A ever felt uncomfortable. In regard to Resident B, Dr. Bosarge stated in June 2022, the Department of Surgery hosted the chief resident graduation dinner. Towards the end of the dinner, Resident B approached Dr. Bosarge in a flirtatious manner and encouraged him to join the group at the hotel bar after. Dr. Bosarge notes that in hindsight he should have declined the invitation. Later, Resident B kissed Dr. Bosarge and he did not resist. Dr. Bosarge stated that at the time, Resident B did not seem impaired as she is the one who initiated the kissing and consented to it. They engaged in consensual kissing at the bar. Later, Dr. Bosarge left the bar and attempted to go home alone. Resident B approached Dr. Bosarge and suggested they go to another bar. The Uber arrived and Resident B got into the car with Dr. Bosarge. Resident B vomited in the Uber and appeared to be intoxicated. Dr. Bosarge told the Uber driver to take them to her apartment so he could help Resident B get home safely. Dr. Bosarge walked Resident B to her apartment and then he left. Dr. Bosarge stated that after the incident, he and Resident B did not work together. Dr. Bosarge stated that on June 27, 2022, he was notified by University of Arizona (UA) and BUMC that there would be an employment investigation regarding an incident with a resident from earlier that month. On June 28, 2022, Dr. Bosarge was interviewed by two human resources representatives from UA and BUMC and denied lying or deliberately trying to mislead them. Dr. Bosarge stated that because of this and other personal issues relating to his family, he decided to voluntarily resign from UA on 7/22/2022. Dr. Bosarge stated that on August 1, 2022, the president of BUMC MEC notified him that he was under investigation by the medical staff. BUMC-P MEC stated that Dr. Bosarge should not resign until after the investigation was over. He stated the MEC never interviewed him and that he was cooperative. Dr. Bosarge stated that the MEC relied on the record from the employment investigation. Dr. Bosarge noted that the review was cancelled because the MEC determined that Dr. Bosarge's employment resignation with UA, triggered an automatic relinquishment of his hospital privileges at BUMC-P pursuant to hospital bylaws requiring an appointment (but not employment) by UA. In September 2022, Dr. Bosarge was notified that the MEC had decided to report to the National Practitioner Data Bank (NPDB) that he had resigned his clinical privileges effective July 22, 2022, when he left

employment with UA. UA Investigation documents included correspondence with Dr. Bosarge indicating that on June 28, 2022, he was notified of administrative leave without pay which was effective immediately until UA completed their review. No further resolution documents were provided regarding the UA investigation. Board staff noted that both Banner and Dr. Bosarge reported the resignation to the Board and it was noted that Dr. Bosarge resigned his employment with UA, resulting in the resignation of his faculty appointment at the University and automatic relinquishment of his medical staff membership and privileges. It was noted that the relinquishment occurred prior to the hospital investigation being concluded. SIRC reviewed the case and remained concerned regarding the pattern of inappropriate behaviors with residents while under the influence of alcohol and while Dr. Bosarge was in a leadership role. SIRC also remained troubled by Dr. Bosarge's lack of candor during the hospital investigation and their determination that he displayed no awareness of how his actions affected the residents. SIRC cited a lack of awareness surrounding the power imbalance that Dr. Bosarge held as a supervising physician for the residents. SIRC noted that during the hospital investigation, the residents reported feeling shame, embarrassment, and being uncomfortable working with Dr. Bosarge, which supports that the incidents may have compromised Dr. Bosarge's supervision of the residents. Therefore, SIRC also sustained a violation of A.R.S. § 32-1401(27)(r) for the conduct identified in this case. SIRC acknowledged that Dr. Bosarge completed PBI's Professional Boundaries and Ethics course in November 2022 and received 24 CME hours. However, SIRC struggled with consideration of a non-disciplinary resolution in this case noting that Dr. Bosarge engaged in sexual conduct with two residents, which constituted an egregious breach in supervisory duties. SIRC further noted that residents could be considered a vulnerable population due to the inherent power differentials embedded within medical education.

Ms. Bivens provided an opening statement to the Committee where she stated that there were two incidents of consensual kissing that did not occur during the practice of medicine. Ms. Bivens stated that this is not predatory behavior. There was an employment HR investigation, third parties speculated that it was potentially problematic, and that drinking was involved. The physician did not lie during the investigation, he hesitated when he was put on the spot by the HR investigators. The HR investigation took place by the university not the hospital looking at conflict of interest policies. The hospital's MEC investigation was called off so there was not an opportunity for a review among his peers. Ms. Bivens opined that the three violations cited in the SIRC report do not apply and that there is no evidence of patient harm. The doctor did not falsify or hide information in the practice of medicine, and there was not an issue regarding his supervision in a healthcare setting.

During questioning, Dr. Bosarge explained that the resident's graduation dinner was an annual event and is sponsored by the university. Dr. Bosarge informed the committee of what occurred in the 2021 incident and that he did not exhibit good judgement. After the incident, he and the resident had a discussion where they agreed that it was a mistake and that it would not happen again. Dr. Bosarge acknowledged that this probably did negatively affect the resident emotionally but opined that it did not affect her performance as a resident. During the 2022 incident, Dr. Bosarge informed the Committee of what occurred after the resident's dinner. Dr. Bosarge explained that they communicated via text the next morning where they both admitted to being intoxicated. Dr. Bosarge agreed that when not maintaining professional boundaries it can have a negative effect on people. Dr. Bosarge clarified his statement about not knowing who the resident was. He explained that he was trying to tell the HR representatives that he didn't have a full recollection of that evening and that although he took EK home he was not sure who he kissed that night. Dr. Bosarge stated that when he resigned in 2022 he was on administrative leave at that time. After the HR investigation was completed, he had discussions with his direct supervisor and the dean of the College of Medicine and due to this unprofessional behavior it was clear that he would not continue to be able to supervise residents in this setting so he chose to resign from his position at that time. Dr. Bosarge noted that it was not made clear that that resignation was also a resignation from Banner and that there would be a medical investigation committee. He thought he

still had privileges at the hospital. Dr. Bosarge confirmed which CME courses that he took and noted that he learned that he is held to a higher standard of boundaries simply because he has the ability to practice medicine. Dr. Bosarge stated that strong professional boundaries prevent conflicts of interest and power differentials. Dr. Bosarge stated that he has taken steps to ensure that this will not happen again.

Dr. Gillard inquired if staff interviewed these residents.

Board staff explained that they relied on the hospital files which included interviews with the residents.

Dr. Bosarge confirmed that these two residents had not graduated at the dinner and that they were junior residents. Dr. Bosarge agreed that he was in a mentor position and acknowledged that there was a concern that the other residents who witnessed this behavior could have felt there was an advantage or disadvantage. Dr. Bosarge stated that he does not have an issue with alcohol, but in these celebratory situations he got carried away.

Dr. Beyer stated that although this was not a healthcare setting, these were residents that he was supervising.

Dr. Bosarge confirmed that the first resident was supervised going forward for a year and the second resident was not as HR had started an investigation and he was placed on administrative leave. Dr. Bosarge agreed that if this investigation had not occurred he would have been supervising her.

MOTION: Dr. Gillard 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. Dorrell.
VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Dr. Artz, Dr. Beyer, Ms. Dorrell, Dr. Gillard and Ms. Jones.
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

The Board entered into Executive Session at 9:47 a.m.
The Board returned to Open Session at 10:03 a.m.
No legal action was taken by the Board during Executive Session.

Dr. Beyer inquired about document from Banner University dated 1/9/23 and noted that it is clearly a hospital document. Dr. Beyer asked Dr. Bosarge if he was aware of it.

Dr. Bosarge stated that he was not aware of it.

Board staff confirmed that this file was in the records received from Banner University and this information was based on the UA investigation.

Dr. Beyer stated that this document is clearly a hospital investigative document.

Dr. Bosarge reiterated that he is unsure if he has seen the referenced document and that the department does not conduct the peer review investigation as there is a hospital peer review committee.

Board staff confirmed that the document was included in the file when Board staff requested a supplemental response from Dr. Bosarge.

Ms. Bivens provided a closing statement to the Committee. Ms. Bivens stated that there is no professional violation here and requested the issuance of an Advisory Letter to document the concern.

In closing, Board staff commented that the description of "Peer Review" records instead of an employee or investigative file does not have any impact on the conduct investigated or violations sustained in the Investigation Report. Dr. Bosarge's conduct spurred an investigation at an institutional level which determined he violated the conflict of interest policy and should not be permitted to interact with students. Board staff noted that Peer Review was going to be initiated; however, the MEC determined that Dr. Bosarge's employment resignation triggered a relinquishment of his hospital privileges.

During deliberations, Ms. Jones found that there has been a violation of the medical practice act in this case.

MOTION: Ms. Jones moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(r), (u) and (jj).
SECOND: Dr. Beyer.
Dr. Beyer stated that it is important to acknowledge the seriousness of these actions. Dr. Beyer stated that it is important for a resident to that an attending is an appropriate supervisor and an educator. These activities compromised the ability for the physician to have the trust and comfort of these residents. The mere fact that there was regret on the part of the residents could have affected the care of the patient and affected the supervisory role. Dr. Beyer opined that the violations of A.R.S. §§ 32-1401(27)(r) and (jj) are sustained. Regarding the A.R.S. § 32-1401(27)(u) violation, clearly the physician was evasive with his interactions when this was being investigated. Dr. Beyer further commented that a departmental investigation is official. Dr. Krahn agreed that there was potential for patient harm. A resident is trying to perform and meet the expectations of the supervisor and with this conduct the potential for patient harm exists. Dr. Krahn further noted that this was a resident in the middle of training; there were years for potential ongoing contact. This put the effected residents in a very difficult position.
VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Dr. Artz, Dr. Beyer, Ms. Dorrell, Dr. Gillard and Ms. Jones.
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

Ms. Jones noted that there are mitigating factors, as the doctor has demonstrated recognition of the issues. He has taken the PRoBE course, two sexual boundaries courses and has changed factors in his practice. There are aggravating factors as well. The physician did violate the code of conduct for UA and Banner. This egregious behavior occurred not once, but twice. He took advantage of two female residents who were in vulnerable states and was in a position of authority of these residents and there was potential for patient harm. Ms. Jones noted that the Board does not know the impact that this had on the other residents who where there and witnessed this.

MOTION: Ms. Jones moved for a draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure.
SECOND: Dr. Krahn.
Dr. Gillard spoke against discipline due to the mitigating factors. There was bad behavior, but the physician did not initiate the bad behavior. This was a self-report and there was no complaint to the Board from either of the residents. The physician has taken considerable CME and taken full responsibility for his actions. Dr. Gillard opined that this does not rise to the level of a Decree of Censure. Dr. Beyer disagreed and opined that this rises to the level of discipline and that this was an egregious act that took place in two consecutive years at the same event. This was shocking and whether there have been other consequences or not is not the Board's issue, the Board is clearly justified in a disciplinary outcome. Dr. Beyer opined that a Decree of Censure is a higher level of censure for a physician who has already taken steps to mitigate the issue and to ensure that this does not happen again.
VOTE: The following Committee members voted in favor of the motion: Dr. Krahn and Ms. Jones. The following Committee members voted against the motion: Dr. Artz, Dr. Beyer, Ms. Dorrell and Dr. Gillard.
VOTE: 2-yay, 4-nay, 0-abstain, 0-recuse, 0-absent.

MOTION FAILED.

MOTION: Dr. Beyer moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand.
SECOND: Dr. Artz.
Dr. Gillard spoke against the motion due to the mitigating factors. Dr. Artz spoke for the motion, and noted that although she appreciates the physician's time and attempt to move forward but would have liked to see that happen after the first incident and not the second as this shows a pattern. Ms. Jones commented that the Board should not consider who initiated the bad behavior as the physician partook in the bad behavior. The physician has shown a pattern, and this has impacted these two residents based on their testimony. Dr. Krahn agreed that this was egregious and does not view the fact that the residents did not complain as a weakness, as it is extremely difficult to complain about a supervisor. Dr. Krahn expressed concern with the definition of the practice of medicine as a medical setting only; as the dynamics of the medical team do affect the practice of medicine.
VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Dr. Artz, Dr. Beyer, Ms. Dorrell and Ms. Jones. The following Committee member voted against the motion: Dr. Gillard.
VOTE: 5-yay, 1-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

G. FORMAL INTERVIEWS

1. MD-19-0071A, CONNIE HOH, M.D., LIC. #45182
Dr. Hoh participated virtually with counsel Flynn Carrey.

Board staff summarized that this case was initiated on January 17, 2019 to address Dr. Hoh's self-report that she was charged with aggravated assault and resisting arrest. Dr. Hoh ultimately pled guilty to aggravated assault, a class 6 felony. Dr. Hoh was charged on September 14, 2018 and her self-report was dated October 31, 2018 therefore, it was a late report. During the course of this investigation, Dr. Hoh has undergone two separate PHP Assessments and a comprehensive evaluation. After her first PHP Assessment, Dr. Hoh entered into her first PHP Agreement and then promptly indicated she didn't want to be in monitoring, so she entered into an Interim Practice Restriction. A short time later, Dr. Hoh requested that the Board lift that restriction and underwent the second PHP Assessment. Dr. Hoh entered into a second Interim PHP Agreement which she is on now. The second PHP Assessor specifically recommended that she have a worksite monitor and Board staff explained this to Dr. Hoh that this would apply to any job that required her medical license. Dr. Hoh failed to submit these worksite monitors to the PHP Monitor for approval or to submit letters from these worksite monitors to her PHP Monitor confirming that they had been informed of her situation with the Board. Dr. Hoh's explanation was that she instructed the worksite monitors to submit letters to her PHP Monitor. However, this part of the notification was Dr. Hoh's responsibility under her agreement, not the worksite monitor's responsibility. Board staff noted that the PHP Assessor specifically described these worksite monitors as colleagues or supervisors and yet Board staff noted that these unapproved worksite monitors included a registered nurse, a nurse practitioner, an unlicensed person and a physician not licensed or physically present in Arizona. Board staff had similar issues with Dr. Hoh submitting a provider for approval and failing to disclose to Board staff that the provider only worked in telemedicine, which would not be appropriate in this situation. The second Assessor stated that Dr. Hoh's case is very complex and that there is no question that she has a significant condition that impacted her ability to practice medicine. The second Assessor found that Dr. Hoh is safe to return to practice medicine under very specific conditions which included PHP Monitoring for the remainder of her career and working alongside a colleague or supervisor who is aware of the situation. The second Assessor noted that he recognized that his recommendations were restrictive and would likely limit some employment opportunities for Dr. Hoh; however, that they would allow her to achieve her goal of returning to practice while mitigating risks to both her and the public as much as possible. Dr. Hoh's attorney's request for Dr. Hoh to be provided a non-disciplinary

confidential agreement for PHP Monitoring despite the violations identified. However, SIRC stated that Dr. Hoh's failure to ensure a strict adherence to the Interim Consent Agreement and the very specific conditions that would make her safe to practice medicine was concerning and caused SIRC to question whether Dr. Hoh can be regulated by the Board. Therefore, SIRC recommended a Letter of Reprimand and minimum Five Year PHP Probation consistent with the terms of her Interim Consent Agreement.

Mr. Carey provided an opening statement to the Committee and noted that this case is different than a typical drug or alcohol case. Mr. Carey requested a confidential monitoring agreement; which would give the physician an initial opportunity to be successful and if there is an issue of non-compliance the Board has machinery to address that. Mr. Carey stated that there was a late report from Dr. Hoh but there was no prejudice on her part. Mr. Carey explained that she was delayed to her arrest and treatment. Regarding the r violation, Mr. Carey stated this should not be used as a law enforcement tool. Regarding the s violation, Mr. Carey noted that there was a level of monitoring, and the physician has been educated for what that monitoring should look like and that she is ultimately responsible. Mr. Cared noted that Dr. Hoh has completed 250 of education, which shows her commitment to being regulated and her ability to practice medicine. Mr. Carey requested a confidential agreement and the issuance of an Advisory letter to document the issues.

During questioning, Dr. Hoh informed the Committee of her understanding of her responsibilities to comply with the Interim Practice Restriction (IPR). Dr. Hoh explained that she initially requested the IPR and withdrew from the PHP due to financial concerns and that she was unsure if she would be employable. Dr. Hoh confirmed that she understood that once the restriction was lifted she would need a work monitor in place and would need to inform her employer that she was involved in the PHP and about her diagnosis. Dr. Hoh confirmed that she provided future employers with the Gateway email but did not follow up on it; which was a mistake. Dr. Hoh informed the Committee of how her monitors were selected. Dr. Hoh confirmed that she passed her board recertification and completed 250 hours of CME.

In closing, Mr. Carey stated that they are not arguing about the facts of the case but on how to address it. This is a person who has made attempts to continue her ongoing education and obtain employment and to be transparent about her situation. There is an element of substantial compliance. Mr. Carey reiterated that a confidential agreement allows the Board to monitor and put guardrails in place. Mr. Carey noted that there was a discussion of retroactivity to the most recent ICA and requested that be considered.

Dr. Beyer inquired about the possibility of a confidential agreement.

Ms. Smith informed the Committee that if they voted to offer a confidential agreement it should be with terms and conditions consistent with the current monitoring agreement.

Mr. Carey agreed that they were comfortable with the terms and conditions of the current agreement.

During deliberations, Dr. Krahn opined that there was a deviation from compliance.

MOTION: Dr. Krahn moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(s).
SECOND: Dr. Gillard.
VOTE: The following Committee members voted in favor of the motion: Dr. Artz, Dr. Beyer, Ms. Dorrell, Dr. Gillard, Dr. Krahn and Ms. Jones.
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

Dr. Krahn opined that given the mitigation and additional information obtained during the interview that there is a need for disciplinary action.

MOTION: Dr. Krahn moved to offer a Confidential Stipulated Rehabilitation Agreement for PHP participation consistent with the terms and conditions in her interim order, retroactive to September 15, 2021. If the licensee fails to sign the SRA, the case will return to the Board.
SECOND: Dr. Beyer.
Dr. Krahn opined that this protects the public and allows the physician an opportunity to be compliant. Dr. Gillard opined that a non-disciplinary Advisory Letter for tracking would be appropriate. Dr. Krahn noted that there were extenuating circumstances for the licensee to comply with the reporting timeframe. Dr. Beyer opined that an Advisory Letter is appropriate and that this does not rise to the level of discipline. Dr. Beyer noted that the Advisory Letter would need to be in conjunction with the SRA.
MOTION WITHDRAWN.

MOTION: Dr. Krahn moved to issue an Advisory Letter for violating a Board order. While the licensee has demonstrated substantial compliance through rehabilitation that has mitigated 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. Offer a Confidential Stipulated Rehabilitation Agreement for PHP participation consistent with the terms and conditions in her interim order, retroactive to September 15, 2021. If the licensee fails to sign the SRA, the case will return to the Board.
SECOND: Dr. Beyer.
VOTE: The following Committee members voted in favor of the motion: Dr. Artz, Dr. Beyer, Ms. Dorrell, Dr. Gillard, Dr. Krahn and Ms. Jones.
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

H. FORMAL INTERVIEWS

1. MD-22-0951A, PRASAD S. RAVI, M.D., LIC. #53608
Dr. Ravi participated virtually with counsel Jay Fradkin.

Board staff summarized that this case was initiated after receiving notification of a malpractice settlement regarding Dr. Ravi's care and treatment of a 17-year-old male patient ("BK") alleging failure to order an inpatient cardiac MRI and premature discharge of a patient resulting in death. On September 23, 2020, BK presented to an urgent care with complaints of tachycardia. An EKG was interpreted as normal and the patient was discharged home. The next day the patient returned with complaints of heart palpitations, chest pain, dizziness, and a feeling described as giddy. Along with the chest pain he now had an abnormal EKG. The ED physician contacted Dr. Ravi who recommended transfer to Banner Desert Medical Center (BDMC). On September 24, 2020, BK was admitted to Cardon Children's Medical Center (CCMC) at BDMC. Dr. Ravi's differential diagnosis included pericarditis, myocarditis, and vasospasm. A troponin-T high sensitivity was performed with the resultant number of 11. Since this was a high number a series of high sensitivity troponins were repeated approximately six hours apart. In addition to the abnormal troponin levels the patient continued to have chest pain and was noted to be hypertensive. During the hospitalization, BK continued to have brief periods of chest pain, and tachycardia that were similar to previous episodes. Dr. Ravi noted that the patient had palpitations, and sinus tachycardia with transient ST segment changes on EKG. Dr. Ravi also noted that the high sensitivity troponins "were" borderline high but coming down. Dr. Ravi stated that if the next troponin was down trending the patient could be discharged. On September 26, 2020, BK was discharged with instructions to follow-up with cardiology within 3-4 days. On September 29, 2020, 0648, BK was found on the kitchen floor unresponsive and pulseless. EMS was called and resuscitative efforts were started and continued at the hospital but no cardiac activity was obtained, and the patient was severely acidotic. At 0734, BK was pronounced dead. An autopsy was performed, and the cause of death was listed as Takayasu arteritis involving the coronary arteries.

The Board's Medical Consultant ("MC") reviewed the case and determined that Dr. Ravi deviated from the standard of care by failing to order a cardiac MRI in a patient with abnormal troponin levels and discharging a patient with an abnormal EKG, elevated troponin, and intermittent chest pain. The MC stated that a complete workup of the heart should have been performed prior to discharge which would have included an MRI, and possible cardiac catheterization to examine the coronary arteries which in this case at autopsy were found to be severely stenotic. The Licensee responded that the patient was kept in the hospital and closely monitored for about two days, and it was reassuring that he was stable with normalizing troponins and his pain was not always associated with EKG changes and he opined that his cardiac MRI and additional investigations could be done on an outpatient base. SIRC remained troubled by the tragic outcome of the case and the inadequate workup of the patient who had demonstrated an abnormal EKG, elevated troponin, and intermittent chest pain throughout his hospitalization. SIRC acknowledged that this was a highly unusual presentation of an otherwise healthy 17-year-old.

Mr. Fradkin provided an opening statement to the Committee where he stated that Banner had control over the settlement. This was a tragic and unexpected outcome and noted that SIRC initially recommended an Advisory Letter. Counsel agreed that this does not rise to the level of discipline.

Dr. Ravi provided an opening statement to the Committee and explained that the patient presented with normal or borderline high normal troponin levels and then trended down within a few hours of monitoring. Dr. Ravi explained that the suspicion was myocarditis or myopericarditis with the trend that happened. Dr. Ravi explained that BK was kept for observations for two days with one bump in the troponin and it came back to normal. There were transient ST changes. There were chest pain episodes with normal EKG's and telemetry findings. He was clinically stable. His blood pressure was sort of on the high end, but did not find it troubling in a teenager who's clinically doing well with their blood pressure issues. Dr. Ravi explained that he discussed the findings and the differential diagnosis with the family. Dr. Ravi informed the family that he was safe to go home, with the idea that he would not be stressing himself, and to go to the emergency room or call 911 if the symptoms start to get any worse.

During questioning, Dr. Beyer inquired about the change in troponin levels over time and how it factored into the decision to discharge the patient home.

Dr. Ravi explained that he continued to closely monitor the patient due to the increased troponins. The troponin then dropped down from 17 to 10 and ultimately 11. Dr. Ravi stated that the two numbers were within normal limits and the trend was down. The differential diagnosis was myocarditis and pericarditis. Dr. Ravi explained that if he was having myocardial infarctions, the sensitive troponins would trend up significantly higher, rather than actually coming down. Dr. Ravi stated that he had another discussion with the cardiac MRI specialist about the patient being seen for follow up testing and a cardiac MRI. Dr. Ravi stated that this was an unfortunate case and in the future he would be more respectful of the situation and hopefully do the right thing from the patient care standpoint.

Dr. Ravi explained that the ST segment depression was why he had mentioned coronary vasospasm as one of the possibilities, which could be secondary to the cardiac inflammation process that had been happening. Dr. Ravi stated that his concern was with the coronary issue being vasospasm probably secondary to inflammatory process leading to that transient ischemic episode. This was the reason for keeping the patient for observations. Dr. Ravi reiterated that he wanted a cardiac MRI but it was not a rush because the patient was clinically doing well and his EKG's had reverted back to normal. At the same time the troponin starting to trend down, his EKG and follow-up EKG's were normal and he had chest pains without any telemetry changes or EKG changes so at that point Dr. Ravi thought and discussed with the family that there is no need to rush to do investigations right at that point in time. He spoke to them about the conditions that he

was worried about in the patient's case and the need to kind of do the testing appropriately at the particular time with it was clinically called for. Dr. Ravi stated that it sounded like the family was comfortable with his explanation of the diagnosis and his concerns that it was some non-specific chest pain and that there's a possibility that an inflammatory process could be going on. The mom did call that Monday morning to schedule a follow up appointment.

In closing, Mr. Fradkin noted that the young man was not doing well, and the parents did not call 911 or bring him in and he collapsed Tuesday morning. The parents were told if anything like that happened to return. Mr. Fradkin stated that Dr. Ravi was within the standard of care and urged the Committee not to issue discipline.

In closing, Dr. Ravi stated that after reviewing the autopsy and histology report, he came to the final diagnosis of Takayasu arteritis and possible IgG4 Disease. Takayasu itself is a very rare condition to encounter and Dr. Ravie stated that he was not aware that IgG4 could lead to a situation like this. Based on this experience, Dr. Ravi stated he is trying to write a report on this clinical situation so that it can be available to his colleagues that there is a something like this which can be devastating for patients.

MOTION: Dr. Beyer moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(r).
SECOND: Dr. Gillard.
VOTE: The following Committee members voted in favor of the motion: Dr. Artz, Dr. Beyer, Ms. Dorrell, Dr. Gillard and Dr. Krahn. The following Committee member was absent: Ms. Jones.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Dr. Beyer opined that a Letter of Reprimand is appropriate.

MOTION: Dr. Beyer moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand.
SECOND: Dr. Gillard.
Dr. Beyer noted that although the troponin levels are part of the problem, the patient's EKG findings and tachycardia were potentially indicative of ischemia. Dr. Beyer stated that the seriousness of this situation was not addressed during the hospitalization and expressed concern that the patient experienced chest pain within 12 hours prior to discharge. Dr. Beyer acknowledged that although the parents were instructed to return if things worsened it would be difficult to know when chest pain is too much. Dr. Beyer opined that sending a patient home with ongoing chest pain that hasn't been fully evaluated, and might be potentially ischemic and relying on the troponin level rises to the level of a letter of reprimand. Dr. Gillard agreed that ongoing chest pain with EKG changes and troponin required further evaluation in the cath lab or at least a CT angiogram or a coronary angiogram. There are a lot of other things that could cause it that should be on a differential diagnosis to take a step to move on to answer these questions. Dr. Artz spoke against the motion as this is very rare and agreed with the initial recommendation for an Advisory Letter. Dr. Artz noted that Dr. Ravi has gone through all the research to further educate himself to ensure that this doesn't happen again and is trying to further educate his peers. Dr. Artz further commented that given the malpractice the physician has learned from this. Dr. Krahn spoke for the motion. This was a situation where hospital care and the availability of rapid response or code teams is appropriate. Although the final diagnosis was rare, the signals were pointing to there being problem that need an explanation and the tragic outcome that happened was death.
VOTE: The following Committee members voted in favor of the motion: Dr. Beyer, Ms. Dorrell, Dr. Gillard and Dr. Krahn. The following Committee voted against the motion: Dr. Artz. The following Committee member was absent: Ms. Jones.
VOTE: 4-yay, 1-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

CONSENT AGENDA

I. APPROVAL OF DRAFT FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

1. MD-22-0487B, PETER J. MATTHEWS, M.D., LIC. #18945
   Dr. Gillard noted that the physician did not dispute any of the findings.

   MOTION: Dr. Gillard moved to approve the Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and One Year Probation. Within six months, complete PACE's Managing High Impact Emotional for Healthcare Professionals course. The CME hours shall be in addition to the hours required for license renewal. Dr. Matthews shall continue treatment with his current provider and comply with any recommendations for treatment. Dr. Matthews shall instruct the therapist to submit quarterly reports to the Board. Dr. Matthews shall be responsible for all costs of the treatment and preparation of the quarterly reports. The Probation shall not terminate except upon affirmative request of the physician and approval by the Board, and Dr. Matthew's request for termination shall be accompanied by a letter of support from his treating provider.
   SECOND: Artz.
   VOTE: The following Committee members voted in favor of the motion: Dr. Artz, Dr. Beyer, Ms. Dorrell, Dr. Gillard and Dr. Krahn. The following Committee member was absent: Ms. Jones.
   VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
   MOTION PASSED.

GENERAL BUSINESS

J. DISCUSSION REGARDING DEBRIEFING ON COMMITTEE PROCESSES

Dr. Krahn noted that these were complicated cases and thanked everyone for their efforts. Dr. Beyer noted that reminders to attorneys to keep to their time limits may be needed.

K. ADJOURNMENT

MOTION: Dr. Beyer moved for adjournment.
SECOND: Ms. Dorrell.
VOTE: The following Committee members voted in favor of the motion: Dr. Artz, Dr. Beyer, Ms. Dorrell, Dr. Gillard and Dr. Krahn. The following Committee member was absent: Ms. Jones.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The meeting adjourned at: 1:04 p.m.

Patricia E. McSorley, Executive Director