Arizona Medical Board

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FINAL MINUTES FOR BOARD REVIEW COMMITTEE A MEETING
Held on Friday, December 8, 2023
1740 W. Adams St. • Phoenix, Arizona

Committee Members
Gary R. Figge, M.D., Chair
Jodi A. Bain, M.A., J.D., LL.M.
Bruce A. Bethancourt, M.D., F.A.C.R., F.A.S.T.R.O.
R. Screven Farmer, M.D.
Constantine Moschonas, M.D., F.A.A.N.
Eileen M. Oswald

GENERAL BUSINESS

A. CALL TO ORDER

Chairman Figge called the Committee's meeting to order at 1:18 p.m.

B. ROLL CALL

The following Committee members were present: Dr. Figge, Dr. Farmer, Ms. Bain and Ms. Oswald.

The following Committee members were absent: Dr. Bethancourt and Dr. Moschonas.

ALSO PRESENT

The following Board staff participated in the virtual meeting: Patricia E. McSorley, Executive Director; Heather Foster, Public Records Coordinator; and Amy Skaggs, SIRC Coordinator; Investigations. Elizabeth Campbell, 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 appear beneath the case.

E. APPROVAL OF MINUTES

- October 6, 2023 Review Committee A Minutes

  Ms. Bain noted a voting error under Item H regarding her being absent.

  MOTION: Ms. Bain moved to approve the October 6, 2023 Review Committee A minutes.
  SECOND: Ms. Oswald.
  VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Farmer, Ms. Bain and Ms. Oswald. The following Committee members were absent: Dr. Bethancourt and Dr. Moschonas.
  VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
  MOTION PASSED.

LEGAL MATTERS

F. FORMAL INTERVIEWS

1. MD-23-0135A, SURENDHER LOKAREDDY, M.D., LIC. #22345

   Dr. Lokareddy was present with counsel Stephen Bullington.

   Board staff summarized that KS was a 30 year old who was seen at 21 weeks with a fetal demise. She was admitted after being administered Cytotec. Spontaneous delivery ensued but retained placenta was identified. Note was made that the patient had a didelphic uterus extending into the vagina with the pregnancy in the right horn. A D&C was carried out with suction and a sharp curette used. Five days later the patient presented with pain and a fever of 100.8 reported the previous day. No examination or temperature was checked though the heart rate was 130 with a blood pressure of 112/69. A CBC was ordered along with Clindamycin initiated. Two weeks later, the patient called the office with heavy bleeding, clots, fatigue and dizziness. She was told to come into the office the next day for a CBC or to go to the Emergency Department (ED) if significant issues persisted. Upon presentation to the ED, she reported the same problems along with right pelvic pain and shortness of breath. She was afebrile but the heart rate was 127 and blood pressure was 109/79. H&H was 7.0/21. Transfusion and ultrasound along with observation were ordered with the results of the ultrasound showing thickening with possible retained products of conception. The following day, Dr. Lokareddy took KS to surgery with D&C carried out of both horns of the uterus. Pathology revealed retained products of conception with chorionic villi identified. A total of five units were transfused with a final H&H of 8.8/26.6. SIRC recommended a Letter of Reprimand for failure to fully examine a patient with post-procedure worrisome symptoms.

   In opening, Dr. Lokareddy stated that his care of this patient was appropriate. He makes great efforts to see patients who need to be seen immediately. Patients always have access to him and their charts. When lab results are abnormal, they are contacted directly by staff with further directions. Dr. Lokareddy informed the Committee of the patient's office visit on December 14th. Dr. Lokareddy endometritis was at the top of his differential diagnosis since the symptoms are fever, tachycardia, tenderness and paint. Retained products of conception was included in his differential diagnosis but he considered this a low possibility as it is rare after a D&C procedure. Especially with ultrasound guidance and the patient's symptoms were not consistent with retained products of conception, which included heavy vaginal bleeding. On December 27th, the patient called the office and reported bleeding. She was instructed to go to the ED if the bleeding and symptoms were significant and she was also offered the option to be seen in the office the next morning if the symptoms were not severe. The patient elected to go to the ED, where she had a pelvic ultrasound. Dr. Lokareddy stated he attended the patient in the ED. The next day she was taken to the OR for retaining products of conception. She was discharged the next day and followed up a week later and her examination was completely normal. She was discharged from care and instructed to follow-up with the primary care physician. Dr. Lokareddy opined that his care of this patient was reasonable, but he has since changed his practice and has instructed his staff to obtain and record a temperature for every post-op patient, whether symptomatic or not. Dr. Lokareddy noted that this patient had a double uterus and double cervix, which made her care more difficult, and may explain some of the problems with the retained products of conception. Dr. Lokareddy stated that this patient was never ignored or unattended and that he ultimately made the diagnosis and properly treated the patient for that condition.

   During questioning, Dr. Lokareddy explained what a didelphic uterus is and why the D&C is more difficult. Dr. Lokareddy explained that a didelphic uterus is rare and that this was the first time he had to do a D&C on one. Dr. Lokareddy informed the Committee that he had used a real time ultrasound while doing the D&C to make sure that there wasn't any products of conception left behind. Dr. Lokareddy stated that he did the D&C on both uteruses.

Dr. Figge commented that the MC agreed that given the difficulty the D&C was done appropriately.

Regarding the MC's allegation of the physician's consideration that this could be products of conception, Dr. Lokareddy stated that it was on his differential diagnosis. Dr. Lokareddy explained that he felt the D&C was pretty complete to prevent any retained products of conception. Dr. Lokareddy explained that he did not do an ultrasound at the time of the five day follow up after the delivery because the patient was not in any distress and had no bleeding or discharge that would trigger him to think that there might be some tissue left behind. Dr. Lokareddy stated that he regrets not taking the temperature and has since changed his policy. Regarding the allegation that he did not examine the patient during the visit, Dr. Lokareddy reiterated that the patient was not in distress and that she was very vague about her symptoms. Dr. Lokareddy felt there was an infection and that is why he treated her with the broad spectrum antibiotic. He instructed the patient to call him back if she didn't feel better and then she can go into labor and delivery or be admitted to the ED. Regarding her abnormal white blood cell count no one called her about it from his office but noted that she has access to her records. Dr. Lokareddy felt that even six days later the abnormal white blood cell count was from the difficult D&C. On December 27th the ED contacted him and he saw her that night and offered her a D&C, which she declined. Dr. Lokareddy informed the Committee that she had an episode of bleeding at 5:00 a.m. so he took her to the operating room at 5:30 a.m. Dr. Lokareddy confirmed the pathology report and confirmed that it was retained products of conception. His response to the MC was different because he observed blood clots. Dr. Lokareddy explained the MC's comment about retained placenta being the most common second trimester complication. This does raise the index of suspension, but Dr. Lokareddy stated that he did the ultrasound in real time while he was doing the procedure and made sure he didn't see any placental tissue on the ultrasound that differentiates it from the normal urine muscle.

Board staff opined that it would be appropriate to get an ultrasound if a patient presented with postoperative complaints, even without bleeding present, considering that the second trimester is at high risk for retained placenta. As noted by the physician, with a double uterus it is very difficult to make sure that everything is out. Board staff noted that the ultrasound on the 27th did state that it could be a blood clot, hematoma or retained products of conception. Had it been done at the time she presented five days post operative that might have been seen and prevented the delay in care.

Dr. Lokareddy agreed that in hindsight the ultrasound should have been done at the five-day post-op visit. Dr. Lokareddy noted that the ultrasound did not note that she had a didelphic uterus and a didelphic uterus would have a thickened endometrium separating the 2 horns of the uterus.

Board staff informed the Committee of the different stages of a didelphic uterus and based on the records this patient was complete. The patient had two uteruses, a cervix for each and a separation in the vagina. Board staff stated that it is a known entity, although rare, and an OBGYN should be able to manage it. Board staff stated that the issue in this case is that the highest risk for retained placenta is in the second trimester.

Dr. Lokareddy confirmed that he was aware of the didelphic uterus and confirmed that the D&C was done on both side to ensure that it was truly empty.

In closing, Mr. Bullington opined that a Letter of Reprimand is excessive in a case like this and that some of the analysis in this case is done with retrospective information. Mr. Bullington noted that the number one sign of retained products is heavy vaginal bleeding, which the patient did not have. It was reasonable at the time for Dr. Lokareddy to have a working diagnosis of endometritis and although there was a slight delay in making the diagnosis, under the circumstances with the patient's presentation, it was reasonable for Dr. Lokareddy to manage the patient the way he did. Regarding the discrepancy of

whether there were retained products or not, in the pre and post records Dr. Lokareddy describes this is retained products.

During deliberations, Dr. Figge opined that there has been an (r) violation.

MOTION: Dr. Figge moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(r) for reasons as stated by SIRC.
SECOND: Dr. Farmer.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Farmer, Ms. Bain and Ms. Oswald. The following Committee members were absent: Dr. Bethancourt and Dr. Moschonas.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

Dr. Figge commented that this is a very unique and unusual situation and that some of the judgement is in hindsight. There were also some missed opportunities. Dr. Figge found it mitigating that the physician has changed his practice to get a temperature check on postoperative patient and being more generous toward getting a follow up ultrasound. Dr. Figge expressed concern that the physician did not examine the patient and that he did not check the temperature when she said she had a fever the evening before. Dr. Figge spoke in favor of an Advisory Letter. Dr. Farmer acknowledged that there are mitigating factors but expressed concern regarding a lack of thorough exam, and that blood work wasn't looked at and an ultrasound wasn't done. Ms. Oswald agreed that there were a lot of missed opportunities and the index of suspicion should have been higher. Ms. Bain commented that there is a suspicion that this patient might not have spoken up regarding her pain. Ms. Bain opined that going through this process is educational and that discipline may not be helpful in this situation. Dr. Farmer noted the previous Advisory Letter that was issued. Dr. Farmer stated that at five days post-op there were very clear warning signs and missed opportunities. Dr. Figge stated that as an emergency physician, bleeding is a huge issue and the physician should have been more concerned of infection. Dr. Figge stated that both infection and products of conception should have been evaluated. Dr. Figge opined that this does not rise to the level of discipline.

MOTION: Dr. Figge moved to issue an Advisory Letter for failing to timely evaluate and treat a post-partum patient presenting with tachycardia, fever, and pain for retained products of conception. While the licensee has demonstrated substantial compliance through rehabilitation or remediation 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.
SECOND: Ms. Bain.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Ms. Bain and Ms. Oswald. The following Committee member voted against the motion: Dr. Farmer. The following Committee members were absent: Dr. Bethancourt and Dr. Moschonas.
VOTE: 3-yay, 1-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

G. FORMAL INTERVIEWS

1. MD-21-0972A, TODD K. MALAN M.D., LIC. #24655

Dr. Malan was present without counsel.

Dr. Malan made a request for extension given the document that was uploaded to his file that was not related to his file.

Committee members considered and discussed Dr. Malan's request for continuation and agreed to move forward with the formal interview today.

Board staff is in receipt of a request from Dr. Malan yesterday around 5pm reporting an incorrect document in his case citing his need for an extension because of this. Board staff will confirm that an incorrect document was uploaded to his case inadvertently on 10/3/23 relating to a different physician; however, this was well after the investigation report, request for SR, and SIRCs review of the case which means that this document was not part of the case file when the statutory violations were identified nor was it utilized to sustain any violation. Board staff also noted that Dr. Malan was previously scheduled for a formal interview in October but requested and was granted an extension until this meeting. All information in the case file was and has been available to Dr. Malan since November 2022, (prior to the October meeting), and again prior to this meeting.

Ms. Bain confirmed that this document was not part of the review process, and that this was an error and not part of the consideration.

MOTION: Ms. Bain moved to deny the request for an extension.
SECOND: Ms. Oswald.
Ms. Oswald clarified that his October 4th request for extension was not to obtain counsel but was due to illness.

Ms. Campbell confirmed that the physician does have a right not to appear today and if the physician choses not to participate in the formal interview the matter would be referred to formal hearing. He would still have the right to counsel during the formal hearing process.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Farmer, Ms. Bain and Ms. Oswald. The following Committee members were absent: Dr. Bethancourt and Dr. Moschonas.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

Committee members confirmed for the record that the document that was inadvertently uploaded will not impact their decision or result in any bias, and that they will be able to make their determination today based upon the facts and circumstances of Dr. Malan's case.

Dr. Malin agreed to proceed with the formal interview.

Board staff summarized that this case was initiated after a complaint from EW alleging that Dr. Malan charged him for stem cell therapy treatment, which was never provided. EW reported that he paid a total of $14,900 but due to scheduling issues and office closures, he did not have any treatment rendered and Dr. Malan had not reimbursed him for the payment rendered despite the lack of treatment. EW noted that the credit card company denied his dispute due to it being past the 60 day timeframe from the charges. The complainant has requested reimbursement of the $14,900 paid. In his response, Dr. Malan reported that EW made the decision to delay scheduling indefinitely, and that his office made attempts to explain to EW about how to receive a refund, which he declined and instead made his 2nd deposit. Dr. Malan maintained that EW was advised that he would not be eligible for a refund if he was at all considering not moving forward with the procedure. Dr. Malan reported that his office made multiple attempts to reach EW to assist with a partial refund, but he would not return their calls and noted that he reached out to EW after receipt of the complaint and EW reported no longer being in pain or in need of surgery. Board staff obtained minimal records from Dr. Malan which confirmed that his office attempted to contact EW from 4/25/22 to 6/8/22 to discuss the refund. There was also documentation that Dr. Malan spoke with EW in September, 2020 and reminded of the merchant services account and process for requesting a refund. In April 2022, Dr. Malan spoke to EW and explained he was beyond the time to process a refund and to pursue the matter through his credit card company and if denied, he would see what he could do to assist EW. Records confirm that EW paid $14,900 for 3 procedures and it is admitted that these procedures were not performed. The treatment plan was

dated for 11/27/19 but was not signed and it was noted that half of the surgical fee was required at scheduling and was non-refundable. Board staff requested Dr. Malan's Merchant Services Year End Policy as referenced in his response and noted that the policy states "The patient care counselor is responsible for contacting all patients or prospective patients with partial or full credit as an unearned revenue prior to 120 days from initial payment. At that time the patient care counselor must receive verification from the patient if they wish to maintain a credit in their account. It is highly advisable that the patient request a refund from their credit card company or bank to avoid the loss of that ability based on a delay in notification. The patient care counselor should inform the patient why chargebacks must be processed through merchant services. If there is any doubt or concern as to the patients understanding of this policy, a refund request should be initiated by the patient care counselor." Board staff determined that EW paid $14,900 to Dr. Malan for stem cell therapy and did not receive the treatment for the services paid. Board staff noted that the documentation provided by Dr. Malan supports that his office made attempts to reach the patient to discuss his treatment plan, scheduling, and refund requests. However, it is unequivocal that EW paid for treatment that he did not receive. SIRC reviewed the case and stated that patients should be responsible for timely follow-up in pursuit of a refund but there were office closures due to COVID and a sabbatical that prevented scheduling. It remained unclear why the office didn't initiate a refund after experiencing issues in scheduling the patient or address what occurred to the unearned revenue. Therefore, SIRC recommended a Letter of Reprimand for charging for services not rendered and determined that reimbursement of $14,900 was appropriate in this case.

Ms. Oswald reiterated for the record that Committee members have reviewed all investigative documents in the file and are not taking into consideration the document uploaded in error.

During questioning, Dr. Malan confirmed that he received a total of $14,900 in three installments and that the services were not provided. Dr. Malan explained that the $14,900 that the patient paid went to the merchant services account, which he can withdraw from. Dr. Malan agreed that this was incoming revenue to his company. Dr. Malan stated that the refund process was explained to the complainant. Dr. Malan explained the refund must be processed through the merchant services account so that he or the patient should have to pay the 8 percent merchant services' fee. Dr. Malan stated that they attempted to get the patient a full refund through merchant services, but he did not follow the appropriate venue. Dr. Malan noted the office policy so that the patient care counselor does not overlook or forget a patient who did not get scheduled. The patient care counselor, by the end of the year, must account for all fees that were obtained where services were not provided. In the circumstance where the patient does not understand the refund process, then they are supposed to come to himself or the office manager and initiate a refund policy internally.

Ms. Oswald stated that there is a clear pattern of not being connected to the patient.

Dr. Malan disagreed with that statement and stated that there is documentation of the office staff attempting to contact this patient to make sure that there was ensured follow-up. Dr. Malan stated that he made numerous attempts to mitigate the situation and to resolve the issue.

MOTION: Ms. Bain moved for the Committee to enter into Executive Session to obtain legal advice pursuant to A.R.S. § 38-431.03(A)(3).
SECOND: Ms. Oswald.
VOTE: The following Board members voted in favor of the motion: Dr. Figge, Dr. Farmer, Ms. Bain and Ms. Oswald. The following Board members were absent: Dr. Bethancourt and Dr. Moschonas.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

The Committee entered into Executive Session at 3:02 p.m.
The Committee returned to Open Session at 3:21 p.m.
No legal action was taken by the Board during Executive Session.

In closing, Dr. Malan stated that he would have much rather paid to make this go away but opined that he felt he went above and beyond to ensure that this individual was contacted and understood the policy before he decided to make another payment. The patient refused to provide the required information for the bank to get the refund. Dr. Malan stated that there was an error in the investigation report that was inaccurate. The patient was instructed that they were still open to helping him obtain a refund and to work with merchant services to get this resolved. This individual never reached out to Dr. Landers, who was another resource for the patient to get taken care of by an expert in this field.

Board staff confirmed that the language in the investigation report was taken directly from the physician's response to staff.

During deliberations, Ms. Oswald opined that there has been unprofessional conduct. Ms. Oswald stated that the statute is quite clear that one cannot charge for services not rendered. Ms. Oswald further stated that it is clear that $14,900 was collected for services not rendered.

MOTION: Ms. Oswald moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(v) for reasons as stated by SIRC.
SECOND: Dr. Farmer.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Farmer, Ms. Bain and Ms. Oswald. The following Committee members were absent: Dr. Bethancourt and Dr. Moschonas.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

Ms. Oswald opined that discipline is indicated and agreed with SIRC's recommendation.

MOTION: Ms. Oswald moved to issue Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and Probation with Reimbursement. Dr. Malan shall reimburse the patient within ninety days via certified funds in the amount of $14,900. The Probation shall not terminate except upon affirmative request of the physician and approval by the Board, and Dr. Malan's request for termination shall be accompanied by proof of payment.
SECOND: Dr. Farmer.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Farmer, Ms. Bain and Ms. Oswald. The following Committee members were absent: Dr. Bethancourt and Dr. Moschonas.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

H. FORMAL INTERVIEWS

1. MD-23-0104A, JOHN P. GRAZIANO, M.D., LIC. #16985
   Dr. Graziano was present with counsel Michelle Jager.

   Board staff summarized that Dr. Graziano cared for a patient who presented with elevated blood pressures (BP) and pedal edema in the third trimester. No testing was carried out at that time. A note was made that the patient also had an elevated one hour glucola earlier in the pregnancy without further follow up. The patient subsequently was seen at a hospital at 36 plus weeks gestation with proteinuria, pedal edema, BP of 151/105, weight gain and hyper-reflexia. The platelet count was 89,000. Admission with induction and administration of magnesium sulfate was recommended but the patient left against medical advice. The patient was instructed then to take to bedrest by the physician without any further testing done. Induction had been declined by the patient at

subsequent visits. The patient presented two weeks later at St. Joseph's Hospital with BP of 190/100. Delivery was carried out by C-Section with magnesium sulfate and antihypertensives required. The concern is in regards to the patient's pre-eclampsia not having been appropriately managed. Dr. Graziano stated that he sends his laboratory studies out of state for cost savings for the patient limiting timely results being obtained. The patient was noted to have insurance through her employment, through CIGNA, which would have in all likely hood covered the appropriate testing. SIRC noted that Dr. Graziano deviated from the standard of care in managing a high-risk patient with abnormal glucola and pre-eclampsia.

In opening, Dr. Graziano summarized the care and treatment that he provided to RF. Regarding testing for gestational diabetes, Dr. Graziano stated that he did a one hour glucose test. The result was 145 so he recommended that the patient undergo a three hour glucose tolerance test; however, the patient declined because she would have had to pay out of pocket. Dr. Graziano noted that the patient's husband had insurance and his wife was enrolled but her pregnancy care was not covered only in the event of hospitalization. Dr. Graziano stated that he had a thorough discussion with her regarding a proper diet to minimize the risk of gestational diabetes and recommended daily exercise. On January 3, 2023 RF's blood pressure was 142/93 and 148/90 and she complained of swelling in her hands and feet. She was informed of pregnancy induced hypertension warnings and was instructed to go on strict bed rest. RF agreed to check her blood pressure at home four times a day and to notify the clinic or go to the hospital if her condition worsened or if her blood pressure increased. Dr. Graziano informed the committee of RF's blood pressure and symptoms at her January 12th visit and that he notified the doctor at the hospital and the labor and delivery triage nurse of the patient and his concerns about a worsening condition. RF was diagnosed with preeclampsia and was admitted to the hospital's labor and delivery unit with the intention to start magnesium sulfate to prevent seizures and blood pressure medications. RF declined admission and signed out against medical advice. RF was given very extensive warning by the admitting nurse, the midwife and doctor. On January 13th, one day after leaving the hospital, the clinic was notified and they contacted RF and strongly encouraged her to go back to be induced. On January 17th, the patient was seen in the clinic within elevated blood pressure and she was encouraged to go to the hospital to be induced and the patient stated that she did not want to be induced and wanted a natural delivery. On January 26th, RF presented to St. Joseph's with persevere preeclampsia and had a primary c-section. The treating physician at St. Joseph's made the complaint to the Board was not aware that the patient had been seen at the hospital and declined treatment and signed out against medical advice.

During questioning, Dr. Graziano explained that he was not aware until the next day that the patient had presented to the hospital. When he saw the patient on the 3rd, the patient had agreed to bed rest and to take her blood pressure four times a day. She was instructed that if there were signs of headache, blurred vision or worsening symptoms that she needed to go to the hospital. Dr. Graziano admitted that he did not always document the extended discussions that he had with the patient. Dr. Graziano stated that he recommended on the 13th that the patient return to the hospital to be induced and had a five day follow-up on the 17th and then the 24th where she was encouraged to go the hospital. Dr. Graziano opined that it was his fault that he did not document these visits. Dr. Graziano informed the Committee of the limitations, equipment and volume of patients of the clinic that he volunteers at. Dr. Graziano explained that it is not feasible to do the three hour glucose test in the clinic so he gives a referral to a local lab which can be expensive.

Dr. Farmer commented that there were two big areas of concern here. Regarding were laboratories ordered that could have been obtain prior to presenting to TMC which have been somewhat mitigated by the changes the clinic has made but the patient could have been sent to the hospital if labs were necessary. Dr. Farmer stated that the biggest issue is that the urgency of coaching to the patient to go to the hospital and get delivered doesn't seem to be documented.

Dr. Graziano confirmed that the husband's insurance did not cover pregnancy so if the patient went to the hospital or other labs outside of the clinic it wouldn't have been covered.

In closing, Ms. Jager stated that in the handwritten notes there was some documentation of his recommendations and the physician has changed the clinic's practices to document when the patient declines. The patient was seen frequently and when Dr. Graziano made recommendations that were declined, he tried to work with the patient. Dr. Graziano had to honor the patient's decisions. When she left the hospital she did understand the warnings that were expressed to her by the multiple healthcare providers and she did go to St. Joseph's.

Board staff noted that in the hospital records, as far as the insurance it shows Cigna Open Access Plan Plus and the subscriber is the patient and the subscriber's employee is Geico. By all appearances it appears this was the patient's insurance, not the spouse's.

During deliberations, Dr. Farmer noted that in the original complaint, RF made the statement that she was unaware of the risk for pre-eclampsia and there is no documentation that the patient was properly counseled. Dr. Farmer opined that there is a documentation issue here. The second concern is the follow up on the lab results. It does appear that there was insurance and if not the patient could be sent to the hospital. Dr. Farmer noted that he cannot imagine that when the patient went to TMC that those providers would not educate her as well. Ms. Bain questioned that in this volunteer free clinic setting with what was available and that the patient went to the hospital and left again, is that enough to determine that the patient was informed and went forward with the plan for a natural birth. Dr. Farmer noted that this is an extremely sick patient with potential for serious issues. Dr. Farmer noted the various clinic visits and lack of documentation and opined that this conduct even in a free clinic setting was unprofessional conduct. Ms. Oswald agreed that it would have been clearer if the documentation was better. There were missed opportunities and there should have been more action and stronger recommendation. Dr. Figge commented that it is very difficult to open and run a free clinic and that the physician does not have access to resources. Dr. Figge agreed that the documentation was lacking but believed the physician when he says he warned the patient. Dr. Figge agreed that even in this difficult clinic setting the same standard of care should be met and opined that the physician tried. Dr. Figge commented that regarding the patient harm violation, in hindsight there were missed opportunities but given the situation and population the physician did the best that he could. Dr. Figge further noted that this was not a patient complaint; this was a young physician with all the resources available who filed the complaint. Dr. Farmer opined that SIRC's recommendation is appropriate.

MOTION: Dr. Farmer moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(e) for reasons as stated by SIRC.
SECOND: Ms. Oswald.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Farmer, Ms. Bain and Ms. Oswald. The following Committee members were absent: Dr. Bethancourt and Dr. Moschonas.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

MOTION: Dr. Farmer moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(r).
Dr. Famer commented that it is hard to make clear what is patient refusal, the physician not issuing orders and what is due to limited resources.
MOTION FAILED DUE TO NO SECOND.

Dr. Farmer opined that there has been significant mitigation of the quality-of-care concerns but that there is still some questions regarding the recordkeeping issues.

MOTION: Dr. Farmer 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 6 hours of Board staff pre-approved Category I CME regarding medical recordkeeping in obstetrical care. The CME hours shall be in addition to the hours required for license renewal.
SECOND: MS. Oswald.
Ms. Bain agreed with the advisory letter but found it hard to reconcile the CME would benefit, and questioned how the physician could change his practice since the clinic uses paper records and not EMR. Dr. Farmer stated that the physician needs training on what needs to be documented on perinatal visits. Ms. Oswald opined that this would also serve the patients in terms of the importance of thorough communication and documentation.

The Board's Chief Medical Consultant confirmed that CME regarding documenting relevant issues would be available and recommended six hours. Board staff agreed that documentation, whether on paper or electronically, is important and any record needs to be documented in reasonable detail in what was discussed and what the patient elected to do. Board staff opined that this is not a communication issue and that this physician is seasoned enough to know what is required in preeclampsia, the issue is the documentation.

Dr. Figge spoke against the motion and opined that an advisory letter is sufficient.
VOTE: The following Committee members voted in favor of the motion: Dr. Farmer and Ms. Oswald. The following Board members voted against the motion: Dr. Figge and Ms. Bain. The following Committee members were absent: Dr. Bethancourt and Dr. Moschonas.
VOTE: 2-yay, 2-nay, 0-abstain, 0-recuse, 2-absent.
MOTION FAILED.

MOTION: Dr. Farmer moved to issue an Advisory Letter for inadequate documentation. While the licensee has demonstrated substantial compliance through rehabilitation or remediation 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.
SECOND: Ms. Oswald.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Farmer, Ms. Bain and Ms. Oswald. The following Committee members were absent: Dr. Bethancourt and Dr. Moschonas.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

CONSENT AGENDA

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

1. MD-22-0427A, MITCHELL C. KAYE, M.D., LIC. #25021

MOTION: Dr. Farmer moved to the draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and One Year Probation to include completion of CPEP's Improving Inter-Professional Communication course within 6 months and completion of the Physicians Universal Leadership Skills Education (P.U.L.S.E.) 360 Intensive Program within 12 months. The CME hours shall be in addition to the hours required for license renewal. The Probation shall not terminate except upon affirmative request of the physician and approval by the Board, and Dr. Kaye's

request for termination shall be accompanied by proof of successful completion of the CME.
SECOND: Ms. Oswald.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Farmer, Ms. Bain and Ms. Oswald. The following Committee members were absent: Dr. Bethancourt and Dr. Moschonas.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

GENERAL BUSINESS

J. DISCUSSION REGARDING DEBRIEFING ON COMMITTEE PROCESSES

There was no discussion for this topic.

K. ADJOURNMENT

MOTION: Dr. Farmer moved for adjournment.
SECOND: Ms. Bain.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Farmer, Ms. Bain and Ms. Oswald. The following Committee members were absent: Dr. Bethancourt and Dr. Moschonas.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

The meeting adjourned at: 4:47 p.m.

Patricia E. McSorley, Executive Director