Arizona Medical Board

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DRAFT MINUTES FOR BOARD REVIEW COMMITTEE B MEETING
Held on Tuesday, February 6, 2024
1740 W. Adams St., Board Room B • Phoenix, Arizona

Committee Members
Lois E. Krahn, M.D., Chair
Katie S. Artz, M.D., M.S.
Jodi A. Bain, M.A., J.D., LL.M.
David C. Beyer, M.D., F.A.C.R., F.A.S.T.R.O.
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: 12:57 p.m.

B. ROLL CALL
The following Committee members were present: Dr. Krahn, Dr. Gillard, Dr. Artz, Ms. Bain and Dr. Beyer.

The following Committee members were absent: Ms. Jones.

ALSO PRESENT
The following Board staff participated in the virtual meeting: Raquel Rivera, Interim Deputy Director and Michelle Robles, Board Operations Manager. Carrie Smith, Assistant Attorney General ("AAG") was also present.

C. OPENING STATEMENTS
Lois E. Krahn, M.D., Chair

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

- December 8, 2023 Review Committee B Minutes

  MOTION: Dr. Gillard moved to approve the December 8, 2023 Review Committee B.
  SECOND: Dr. Beyer.
  VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Dr. Gillard, Dr. Artz and Dr. Beyer. The following Committee member was absent: Ms. Jones. The following Committee member abstained: Ms. Bain.
  VOTE: 4-yay, 0-nay, 1-abstain, 0-recuse, 1-absent.
  MOTION PASSED.

LEGAL MATTERS

F. FORMAL INTERVIEWS

1. MD-22-0839A, SCOTT A. HAVENS, M.D., LIC. #33035
Dr. Havens was present with counsel Flynn Carey.

Board staff summarized that this case was initiated based on Dr. Haven's self-report dated August 31, 2022 that he was convicted of one count of Criminal Nuisance on August 18, 2022. According to the police report, this conviction stemmed from an incident at a local bar during which Dr. Havens got into an altercation with two other patrons and one of the patrons was injured. Police arrived and Dr. Havens failed to cooperate and ultimately police had to restrain him. Board staff determined that Dr. Havens failed to timely report the charges because on January 14, 2022, he was charged with Assault, Resisting Arrest and Failure to Obey, yet he did not report the charges until August 31, 2022. Dr. Havens indicated that he was unaware of the requirement to report within 10 days and believed that he had to report the charge at his renewal. Due to the involvement of alcohol related to the charges, Dr. Havens underwent a PHP Assessment which resulted in the recommendation that he complete an evaluation which Dr. Havens completed and subsequently entered into PHP Monitoring. SIRC reviewed the case and agreed with the PHP Assessor that Dr. Havens' lack of transparency and insight while self-reporting to work as a Medical Director of a treatment facility was highly concerning. However SIRC noted that Dr. Havens has been compliant with PHP monitoring. SIRC also sustained a violation of A.R.S. § 32-1401(27)(r) and recommended a Letter of Reprimand with 2 years of PHP probation and completion of in-person CME in boundaries.

In opening, Mr. Carey reported that the California matter is closed and that they found no deviations. Mr. Carey requested a confidential agreement in this case since there is an allegation of a misdemeanor conduct that occurred at a bar that did not happen while the physician was on call. Mr. Carey acknowledged that the physician pled guilty to public nuisance. Mr. Carey stated that alcohol played a role in this case and after a year of monitoring, Dr. Lott confirmed that he's compliant. Dr. Havens has established a good track record and has had no previous monitoring history. Mr. Carey stated that there was a late report to the Board and requested that the Board issue an Advisory Letter regarding this violation. Mr. Carey explained that the physician was not properly informed by his criminal counsel regarding the requirement to self-report. Dr. Havens has also completed two evaluations. Regarding the A.R.S. § 32-1401(27)(r) violation, Mr. Carey noted that this incident did not happen in connection with the practice of medicine. Mr. Carey requested that the Committee consider a confidential agreement with an advisory letter for a public record.

During questioning, Dr. Havens informed the Committee of the events that occurred on the evening in question that led to the Board's investigation. Dr. Havens stated that alcohol did interfere with his perception, judgement and resulting actions. Dr. Havens apologized for his behavior and recognized that he should not have intervened. Dr. Havens informed the Committee that he never drank alcohol while on shift but would drink about 2-3 times a month in social settings. Dr. Havens opined that alcohol did lead to the events of that night in a negative way and that if he didn't have alcohol his perception and actions would have been different. Dr. Havens stated that he made a mistake with his interactions with the responding officers. Dr. Havens explained that his delay in self-reporting was due to his criminal attorney advising him not to worry and that the case may be dismissed. As things proceeded and it looked like he may need to settle his criminal case, he obtained a second opinion with Mr. Carey who advised him to self-report. Dr. Havens acknowledged that a female patron was harmed due to his actions. Dr. Havens informed the Committee of the PHP program he's participating in and confirmed that he has been sober for a year.

In closing, Dr. Havens thanked the Committee for their time and stated that he would like with the PHP.

In closing, Mr. Carey stated that Dr. Havens has a criminal conviction that is a public record and that the physician has shown insight in such a way that he will succeed in the program. Mr. Carey requested a confidential agreement to continue in the PHP.

Ms. Bain inquired about what is different between the SRA and the other options.

Mr. Carey explained that the Board has two ways to handle rehabilitation. A confidential agreement for PHP participation or a public probation and disciplinary order for continued participation. Discipline would have to be reported and have additional consequences to the physician.

Ms. Smith further explained that Probation is public and an SRA is confidential; however, the substantive terms are the same. The type of order would not determine the time of the order since it is based on the recommendation. If successfully completed, the SRA can be terminated by the Executive Director. If the physician requests early termination, then it would need to go to the Board for consideration, just like a public probationary order would.

During deliberations, Dr. Krahn opined that there has been a violation in all three statutes cited. There was a delayed report, there has been an alcohol problem and there was a real or potential harm to the public.

MOTION: Dr. Krahn moved for a finding of unprofessional conduct in violation of A.R.S. §§ 32-1401(27)(a) (for a violation of A.R.S. § 32-3208(A)), (f) and (r) as stated by SIRC.
SECOND: Dr. Artz.

MOTION: Dr. Beyer 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. Bain.
VOTE: The following Board members voted in favor of the motion: Dr. Gillard, Dr. Krahn, Dr. Artz, Ms. Bain and Dr. Beyer. The following Board members were absent: Ms. Jones.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The Board entered into Executive Session at 2:48.m.
The Board returned to Open Session at 3:09 p.m.
No legal action was taken by the Board during Executive Session.

Dr. Beyer commented spoke in favor of the motion. Regarding the A.R.S. § 32-1401(27)(r) violation, Dr. Beyer opined that any physician who has been exhibiting a pattern of alcohol use disorder is potentially putting the public at risk. Dr. Krahn opined that there was a potential for harm to the public, noting that it was known that he was a physician since he informed the group. He works in the ER and has contact with police and fire personnel. His conduct with the police department was inappropriate and there is a possibility for him to interact with the same police officers in the ER, so there is a nexus with medical care. Dr. Artz reiterated that we are public figures, and the physician interacted with police and other medical professionals. Dr. Artz further noted that any one of these people from the bar could come to the emergency room and they may not have a choice not to have him as a physician, and they saw violence, aggression, and intoxication.

VOTE: The following Board members voted in favor of the motion: Dr. Gillard, Dr. Krahn, Dr. Artz, Ms. Bain and Dr. Beyer. The following Board members were absent: Ms. Jones.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Dr. Krahn opined that this was a serious incident and opined that this does rise to a level of discipline.

MOTION: Dr. Krahn moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and Two-Year Probation, retroactive to March 7, 2023, with terms and conditions consistent with his Interim Order. Within six months, complete no less than 15 hours of Board staff pre-approved Category I CME in an intensive, in-person course regarding boundaries. 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. Haven's request for termination shall be accompanied by a recommendation from his PHP Contractor stating that monitoring is no longer required.
MOTION FAILED DUE TO NO SECOND.

Dr. Gillard opined that this has been mitigated by the physician's sobriety and understanding that what he did was wrong. Dr. Gillard noted that Dr. Lott has also provided a letter of support. Dr. Gillard opined that the physician has learned his lesson and CME is not needed.

Ms. Smith explained that the term of the Order is at the discretion of the Committee but noted that the PHP evaluator recommended two years.

MOTION: Dr. Gillard moved to offer Dr. Havens a CONFIDENTIAL Stipulated Rehabilitation Agreement for PHP participation for a period of three years with terms and conditions consistent with the Interim Consent Agreement. Upon entry, issue an Advisory Letter for failing to timely report a misdemeanor charge within ten working days, exhibiting a pattern of using alcohol and for unprofessional conduct resulting in harm to the public. 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: Dr. Beyer.
Dr. Beyer noted that alcohol use disorder does not always include large amounts of drinking and commended the physician for recognizing that. Dr. Krahn commented that recovery is a journey, and that insight develops over time. Dr. Artz spoke in favor of CME regarding boundaries. Dr. Gillard spoke against the CME as it would be very difficult a job with anything posted on the Board's website when going through credentialling. Dr. Gillard opined that the physician has learned his lesson and proven that through his sobriety. Dr. Beyer noted that the Board regularly assigns advisory letters with CME. Ms. Bain noted that there has already been completion of an anger management certificate and 16 hours of DUI education. Dr. Krahn opined that boundaries CME is different from DUI and anger management because of the circumstances of this incident. Dr. Krahn continued to express concern about boundaries.

Ms. Smith explained that the current statute requires a CME Order be posted to the website.

Board staff confirmed that Dr. Havens has completed the DUI course, anger management class and 15 hours of CME in ethics and professionalism with PBI.

Dr. Krahn commented that the Board sometimes takes actions that have consequences for the physician, but that doesn't mean the Board should not take action.
VOTE: The following Board members voted in favor of the motion: Dr. Gillard, Dr. Krahn, Dr. Artz, Ms. Bain and Dr. Beyer. The following Board members were absent: Ms. Jones.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

G. FORMAL INTERVIEWS

1. MD-22-0791A, RAUL M. WEBSTER, M.D., LIC. #32815
Dr. Webster was present with counsel Flynn Carey.

Board staff summarized that the Board initiated this case after receiving notification of a malpractice settlement regarding Dr. Webster's care and treatment of a 49 year-old male patient ("CC") alleging improper performance of circumcision resulting in subsequent surgeries, painful erections, and penile deformity. On March 15, 2018, CC underwent an elective circumcision due to significant obesity with a "hidden penis" performed by Dr. Webster. In the PACU, the nurse noted penile swelling and notified Dr. Webster. He did not come to see the patient. After CC was discharged, he and his wife made numerous phone calls to the surgeon's office but were unable to speak to the surgeon. Their concern was penile swelling to the point of difficulty seeing the penis and difficulty urinating. Those calls were not documented. On March 16, 2018, CC was evaluated by Dr. Webster's colleague. CC had "severe swelling and a disrupted suture." The information was relayed to Dr. Webster who moved up the patient's postoperative visit date to 5 days later rather than the usual 2 weeks. On March 21, 2018, CC was seen by Dr. Webster for post-operative follow-up. Dr. Webster noted penile hematoma purulence and transferred CC to the ED. On March 22, 2018, Dr. Webster performed a clot evacuation and revision of the circumcision. On March 25, 2018, Dr. Webster performed an exam under anesthesia and possible further clot evacuation. On March 29, 2018, Dr. Webster performed an exam under anesthesia and cleansing of the wound. CC was discharged on March 30, 2018. On April 18, 2018, CC was seen by Dr. Webster and a ventral suture was removed. On April 25, 2018, CC was seen by Dr. Webster for follow-up. Dr. Webster noted the patient had tethering of the ventral penis. Dr. Webster consulted a plastic surgeon regarding reconstructive surgery. On June 1, 2018, CC underwent a reconstructive procedure for the tethered phallus involving full thickness skin grafting to the penis and tissue advancement to cover a 4 x 30cm wound performed by plastics. Subsequently, CC had an additional revisional surgery on November 21, 2018. The Board's Medical Consultant ("MC") reviewed the case and determined that Dr. Webster deviated from the standard of care by failing to evaluate and treat a complex patient with post-operative complications in a timely manner. The MC stated that Dr. Webster waited six days post-operatively to evaluate the patient that led to delayed recognition of the large penile hematoma causing ongoing pain and suffering and increased the risk of fibrosis and tethering that ultimately led to five additional surgical procedures. The MC noted concerns regarding Dr. Webster's practice's documentation of patient phone calls. The MC found aggravating the multiple patient/spouse phone calls to the office on day of surgery were either not relayed or responded to by the surgeon. If the doctor had seen the patient in the office preoperatively and recognized the anatomic difficulties of obesity and hidden phallus, he would have had a chance to describe the risks of circumcision in this context. The patient could then consider these coming from the operating surgeon prior to accepting the procedure. The MC also expressed concerns about the overuse of surrogates by Dr. Webster in this complex patient both pre and postoperatively. The licensee responded that he admitted the patient to the hospital and got an infectious disease consult and wound care. He took the patient to surgery on two occasions to examine the wound to make sure that the patient was not developing Fournier's gangrene. When the patient needed additional care, he was able to contact a

plastic surgeon for recommendations and care. He followed the patient regularly until he decided to seek urologic care elsewhere. SIRC noted that this case was returned for further investigation to obtain Dr. Webster's full office records which showed that on post-operative day 1, the clinical note dictated by another physician read: "Patient states he has been unable to remove his incisional dressing secondary to swelling". SIRC observed that the MC maintained the deviations for failure to provide appropriate postoperative care after a circumcision in a complex patient and for insufficient documentation.

Mr. Carey provided an opening statement, where he argued that this was a known complication of a circumcision. Mr. Carey stated that the procedure selection was correct and performed within the standard of care. Mr. Carey noted that there was some dispute over whether there was a hidden penis anatomically, and stated that Dr. Webster could explain further. Mr. Carey noted that the physician who saw the patient right after the surgery, is a urologist and is well trained to evaluate post-operative circumcision, and was in a position to coordinate care with Dr. Webster since he was the individual making the physical examination and visual observation. Dr. Webster accelerated follow-up care to five days. Mr. Carey opined that the physician who saw CC did not opine that emergent medical care was needed. Mr. Carey asserted that there was no violation by the licensee since there was significant continuity of care, including inspection by another urologist. Mr. Carey noted that there is no evidence earlier treatment would have precluded the subsequent remedial revisions. Mr. Carey cited an expert opinion provided on behalf of Dr. Webster that noted the interchangeability of practitioners in small and large offices is not only the community standard, but plays a critical role in maintaining adequate urology coverage for the state. Mr. Carey stated that the inadequate documentation allegation was due to an issue with the EMR and noted that their expert's opinion supports that the documentation was appropriate. In conclusion, Mr. Carey opined that the physician met the standard of care and requested that the Committee not find a violation in this case.

Dr. Webster provided an opening statement to the Committee where he summarized the procedure and the post-operative care. Dr. Webster noted that the urologist who saw the patient the day after surgery consulted with him, there was no urgent need to take the patient for surgery.

During questioning, Dr. Webster explained that post-operative swelling is pretty typical and that he informs patients that as long as they can void, there is no active bleeding, and the incision looks fine then there is no concern. Dr. Webster explained that the patient does not take anti-inflammatory medication or put ice for the swelling. Dr. Webster clarified that this was not a hidden penis but a retracted penis. With obese patients, he does inform them to be extra careful for Fournier's gangrene or infection. As long as they can void and the incision looks good, they can retract some of the suprapubic fat to clean it. Dr. Webster informed the Committee of the answering services that is used overnight. Dr. Webster stated that it is not unusual for a stich to get disrupted from movement. For CC, he took the whole repair down because there was a fair amount of hematoma. Dr. Webster explained that he usually uses Chromic sutures since they dissolve in two to three weeks. Dr. Webster informed the Committee that he has since changed his practice to see most of his patients post-operatively and if an AAP scheduled a patient, he spends more time in pre-operatively to explain what the post-operative care will be. For the more complex cases or if there is a complication, Dr. Webster stated that he tries to get them in sooner or have them go to the ER where he can come over and examine them himself. Dr. Webster clarified what a hidden penis is and noted that if CC had a hidden penis he would not have been able to put a dressing on him. Dr. Webster confirmed that he was able to see the area that he was operating on. Regarding the medical records, Dr. Webster explained that the Board investigation was after the malpractice case and he asked the office manager to print and send the records to the Board and assumed they were accurate.

Dr. Webster explained that in urology they are trained to be conservative and it is not uncommon to see a hematoma. With time, the edema and swelling goes down. If you rush back to surgery, it can sometimes cause more scarring. Dr. Webster stated that that after this experience, he may delay a scheduled surgery to go lay hands on a patient in this situation.

In closing, Dr. Webster stated he felt terrible about the complication and that he takes pride in his work.

In closing, Mr. Carey stated that there was continuity of care provided to this patient and that another urologist saw him within 24 hours and had a consultation. Yes, a hematoma did occur but this person came back within 24 hours and the rest of the post-operative care was accelerated. The MC did not find a violation with the additional procedures that were conducted. Dr. Webster was available by call and then conducted all the revisions. Regarding the medical records, there may have been some confusion since the malpractice case.

During deliberations, Dr. Artz agreed that there were a lot of surgical, procedures that was done appropriately. Dr. Krahn commented that we have colleagues and partners for a reason, and there was actual communication in this case. Dr. Artz opined the post-operative care was appropriate and that this was an unfortunate case for the patient. Dr. Artz noted that the missing medical record was Dr. Webster's partner, and opined that this was a case of failing to send it, not refusing. Dr. Artz opined that this record would have helped his case, that another surgeon saw his patient within 24 hours. Dr. Artz opined that this case has been settled and that there is no violation of Board statutes.

MOTION: Dr. Artz moved to dismiss.
SECOND: Dr. Gillard.
Dr. Gillard commented that these are recognized complications that occurred, but a colleague did see the patient within 24 hours. Dr. Beyer agreed that these issues have been addressed by the physician, and it is not likely that this will occur again.
VOTE: The following Board members voted in favor of the motion: Dr. Gillard, Dr. Krahn, Dr. Artz, Ms. Bain and Dr. Beyer. The following Board members were absent: Ms. Jones.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

H. FORMAL INTERVIEWS

1. MD-19-1150A, DAVID K. TOM, M.D., LIC. #43118
Dr. Tom was present with counsel Fred Cummings.

Board staff summarized that the Board initiated this investigation after receiving notification of a malpractice settlement regarding Dr. Tom's care of a 54-year-old female patient (SH). The malpractice lawsuit alleged improper performance of a cervical epidural steroid injection with subsequent sensory and motor deficits of the left upper extremity. SH initially presented to Dr. Tom on July 10, 2015. SH had an extensive past medical history and complained of chronic pain in the neck, back, face and head, arm, leg, and right hip more than left had dull/aching, sharp stabbing pins/needles/tingling, and shooting/radiating pain. She had tried physical therapy, and this only made things worse. Dr. Tom's assessment was fibromyalgia, neck pain, cervical Spondylosis without myopathy, and cervical radiculopathy. He recommended facet joint injections/medial branch blocks due to the failure of past conservative treatments. Dr. Tom discussed the treatment plan with SH but she declined to make future appointments. SH returned to the clinic over a year after her initial assessment. She began treatments for lower back pain

and had a series of trans-foraminal epidural steroid injections on August 15, 2016, and August 30, 2016. On October 4, 2016, she had reported some improvement in her symptoms and on October 8, 2016, another lumbar transforaminal epidural steroid injection bilaterally was performed and on October 17, 2016 a bilateral sacroiliac joint injection with fluoroscopic guidance was performed. On November 8, 2016, SH reported weakness, numbness, and tingling to her feet, both hands and legs. The nurse practitioner that saw her made an assessment that SH had cervicalgia, cervical radiculopathy, lumbago, and lumbar radiculopathy. Cervical epidural steroid injections with fluoroscopy for diagnostic and treatment purposes were recommended. A cervical MRI was performed on December 30, 2016, which demonstrated a pre-existing tear to the posterior annulus of the discs of SH's cervical spine at the level of C 5-6, and C 6-7. She was also noted to have mild disc bulge at the level of C 4-5, and a bulging disc at the level of C 5-6 as well as disc herniation at the level of C-7. On January 31, 2017, SH presented, complaining of continued pain radiating to both arms, and worsening numbness and tingling. She also complained of pain and tenderness to bilateral cervical paraspinal muscle areas, myofascial pain, and pain to the bilateral splenius capitus, trapezius, rhomboid, and serratus posterior and superior muscle areas. Spurling's test was noted as positive to elicit pain bilaterally. Dr. Tom performed the first of two planned cervical epidural steroid injections to C 6-7 under fluoroscopic guidance. On February 4, 2017, the patient underwent the first cervical epidural steroid injection and tolerated this procedure well. The second planned procedure was performed on February 18, 2017, and Dr. Tom indicated that the procedure went as expected. The patient was discharged from Silver Leaf Surgery Center without any complaints and had met all discharge criteria. Later that evening, the patient reported to Saint Joseph's Westgate Medical Center with left arm weakness and inability to clench and extend the fingers of her left hand and these symptoms had gotten worse throughout the day. She was later diagnosed with a cervical spinal cord injury, admitted to the intensive care unit and treated with steroids and deliberate hypertension with little or no improvement in her symptoms after three days. This case was reviewed by two MCs, both of whom concluded that Dr. Tom had deviated from the standard of care in the performance of the cervical epidural steroid injections. Dr. Tom failed to: Identify an iatrogenic spinal cord injury resulting from a cervical epidural steroid injection, obtain consent for general anesthesia and identify and treat post-procedure complications. Dr. Tom should have been treating the symptomatic right side where there was confirmatory pathology instead of treating the left side. Dr. Tom had incomplete and inaccurate documentation of needle placement with missing repeat views for needle depth and follow up imaging for vascular spread. SIRC recognized that Dr. Tom appears to have incorporated changes to his clinical practice because of previous Board action which was also related to cervical epidural steroid injection. However, this procedure caused actual harm and fell below the standard of care.

Mr. Cummings provided an opening statement to the Committee where he noted that this case is seven years old and there have been two cases with the Board regarding these injections. This case is regarding SH and the physician did not know there was an injury for some time so was not aware of a complication as she never reported back to Dr. Tom. Mr. Cummings noted that this case has most of the same concerns that were identified in the other cases that the Board has already adjudicated. The physician has already completed the recommended CME and made changes to his practice. Mr. Cummings stated that there is evidence that the issues in this case have been remediated.

During questioning, Dr. Tom reported that after the 2017 case he changed his practice to decrease the number of patients he sees, but has continued to actively practice. Dr. Tom confirmed that he does not use Propofol in these procedures. He uses conscious sedation in specific situations, and it is well documented. Dr. Tom reported that he uses mostly local anesthetic and that there is a CRNA or an anesthesiologist present during these procedures. Dr. Tom informed the Committee that he now take more images to show the path and trajectory that he is taking when completing these procedures to

address the MCs' concerns. Dr. Tom informed the Committee that he does this type of procedure about five to ten times a month and accounts for about 20-30 percent of his practice. Dr. Tom stated that in general, this procedure is not that painful however, sometimes there is a high level of anxiety and depression and there are people who request sedation. Dr. Tom noted that it is extremely common that pain providers use sedation and many of his peers did use Propofol. Dr. Tom confirmed that he only does injections at C7-T1, but at the time due to his training and SH's disc was at the C6-C7 location he did the injection at that location. Regarding the missed spinal cord injury, Dr. Tom confirmed that he was not aware of the injury until the lawsuit. SH did have a follow-up visit scheduled and when a patient misses an appointment staff typically calls the patient to reschedule. Dr. Tom informed the Committee that he has since implemented a process to place follow up call the next day or business day after the procedure. Dr. Tom informed the committee of the classes he took at the Texas symposium and that he has completed the recordkeeping course due to the previous Board action. Dr. Tom stated that he has had no complications since.

In closing, Dr. Tom stated that this case as well as the previous case has resulted in many changes to his practice to ensure that his patients are safe as possible. While there is still a risk for any of these procedures, he has learned from this process and has taken steps to ensure patient safety and to meet the standard of care.

In closing, Mr. Cummings noted that in 2017 the literature regarding conscious sedation was used and is now discouraged and the standards have evolved in the last five to seven years.

Board staff confirmed that in the prior case there is evidence that the physician did complete 17 hours of medical recordkeeping CME and 14.7 hours of cervical spine CME.

During deliberations, Dr. Gillard noted that there was a very bad outcome and opined that there has been unprofessional conduct.

MOTION: Dr. Gillard moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(e) and (r).
SECOND: Dr. Beyer.
VOTE: The following Committee members voted in favor of the motion: Dr. Artz, Ms. Bain, Dr. Beyer, 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. Gillard noted that this case predated a previous case that the Board has already adjudicated, and the physician has completed the required CME. Dr. Gillard opined that the physician has mitigated and understands the Board's concerns and that this case does not rise to the level of discipline.

MOTION: Dr. Gillard moved to issue an Advisory Letter for improper performance of a CESI procedure, failing to identify an iatrogenic spinal cord injury resulting from a CESI procedure, and 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: Dr. Beyer.
Dr. Beyer noted that no one in the office was aware that this patient was hospitalized and should be included in the language of the advisory letter. Ms. Bain asked how Dr. Tom should be responsible for missing the complication since he did not see the patient. Dr. Beyer explained that the patient was scheduled for a follow-up appointment and did not

appear, this requires additional effort on the physician to follow-up. Dr. Beyer noted that the patient ended up hospitalized prior to the follow-up appointment. Dr. Krahn commented that a follow-up appointment is expected and if they did not show up the office staff should have followed up. Dr. Beyer commented that the best care would have been for the hospital to reach out. Dr. Krahn stated that the standard of care for when a patient has a diagnostic test or procedure there should be follow up and the expectation is higher when there has been an invasive procedure with a higher risk for complication. Dr. Krahn noted that the physician has made a change to ensure that does not happen. Dr. Artz opined that the hospitalist and the ER should have called the physician and noted that it is very hard to reach out to every patient who cancels their follow-up appointment. Dr. Beyer stated that changes have been implemented for the betterment of the practice.

VOTE: The following Committee members voted in favor of the motion: Dr. Artz, Dr. Beyer, Dr. Gillard and Dr. Krahn. The following Committee member voted against the motion: Ms. Bain. 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-21-0883A. KAVEH KARANDISH, M.D., LIC. #46491
   Dr. Gillard agreed with the record.

   MOTION: Dr. Gillard moved to approve the Findings of Fact, Conclusions of Law and Order for One Year Probation. Within six months, complete the intensive, in-person course regarding medical recordkeeping offered by CPEP. Within thirty days of completing the Board ordered CME, the physician shall enroll into CPEP's personalized implementation program (PIP). The CME hours shall be in addition to the hours required for license renewal. The Probation shall terminate upon proof of successful completion of the CME coursework.
   SECOND: Dr. Artz
   VOTE: The following Committee members voted in favor of the motion: Dr. Artz, Dr. Beyer, Dr. Gillard and Dr. Krahn. The following Committee member abstained: Ms. Bain. The following Committee member was absent: Ms. Jones.
   VOTE: 4-yay, 0-nay, 1-abstain, 0-recuse, 1-absent.
   MOTION PASSED.

GENERAL BUSINESS

J. DISCUSSION REGARDING DEBRIEFING ON COMMITTEE PROCESSES

There was no discussion regarding this topic.

K. ADJOURNMENT

MOTION: Dr. Gillard moved for adjournment.
SECOND: Dr. Beyer.
VOTE: The following Committee members voted in favor of the motion: Dr. Artz, Ms. Bain, Dr. Beyer, 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 4:28 p.m.

Patricia E. McSorley, Executive Director