BEFORE THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS

IN MEDICINE AND SURGERY

IN THE MATTER OF: **PAUL BLUMBERG, D.O.** **Holder of License No. 1597** For the practice of osteopathic medicine in the State of Arizona	**Case Nos.: 3492, 3508, 3529, 3739M, 3748, 3799 & 3861** **CONSENT AGREEMENT TO FINDINGS OF FACT, CONCLUSIONS OF LAW ORDER**

By mutual agreement and understanding, the Arizona Board of Osteopathic Examiners (hereafter "Board") and Paul Blumberg, D.O. (hereinafter "Respondent"), the parties, hereto agree to the following disposition to this matter.

1. Respondent acknowledges that he has read this Consent Agreement and Order; and, Respondent is aware of and understands the content of these documents.

2. Respondent understands that by entering into this Consent Agreement and Order, he voluntarily relinquishes any rights to a hearing on the matters alleged as grounds for Board action or to seek judicial review of the Consent Agreement and Order in state or federal court.

3. Respondent understands that this Consent Agreement and Order will not become effective unless approved by the Board and signed by its Executive Director.

4. Respondent further understands that this Consent Order and Order, once approved and signed, shall constitute a public record which will be disseminated as a formal action of the Board.

5. Respondent without admitting responsibility acknowledges and accepts the imposition of the statement of facts and conclusions of law and Order contained in the Consent Agreement and Order.

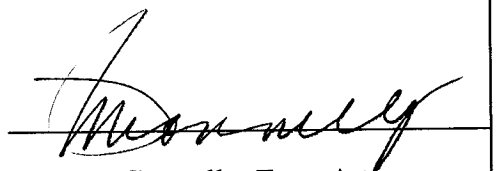
6. All admissions made by Respondent are solely for final disposition of this matter

and any subsequent administrative proceedings or litigation involving the Board, Respondent and the State of Arizona; and, therefore, said admissions by Respondent are not intended for any other purpose, or for use in any other administrative regulatory proceeding, or litigation in another state or federal court.

7. Respondent acknowledges and agrees that upon signing and returning this document (or a copy thereof) to the Board's Executive Director, he may not later revoke or amend any part of the Consent Agreement and Order, without first obtaining Board approval.

REVIEWED AND ACCEPTED THIS 18th DAY OF OCTOBER, 2007.

Paul Blumberg, D.O., Respondent



Thomas Connelly, Esq., Attorney for the Respondent

JURISDICTIONAL STATEMENTS

1. The Board is empowered, pursuant to A.R.S. §§ 32-1800 et seq. to regulate the licensing and practice of osteopathic medicine in Arizona.

2. The Board has the authority to informally dispose by stipulation, agreed settlement, consent order or default pursuant to A.R.S. § 41-1092.05 (F) (5).

3. Respondent holds license No. 1597 to practice osteopathic medicine in Arizona.

FINDINGS OF FACT

CASE No. 3492

4. On February 14, 2004, the Board received a complaint from J.G containing several allegations for a "tummy tuck" procedure that the Respondent performed in February of 2003.

5. J.G. alleged in her complaint that she has "been left with crooked and unnecessary scarring following this procedure." Respondent's records indicate JG did sign an informed consent to the procedure which detailed the fact that scarring is a known risk. A further review of the record in this matter also disclosed that Respondent performed a mild liposuction procedure in conjunction with the abdominoplasty procedure, but the informed consent signed by JG did not include written provisions related to the included liposuction procedure.

6. Respondent's position is that all aspects of the procedure(s) were explained to the patient prior to surgery, including the mild contouring liposuction, and there is a chart note indicating detailed discussions about the procedure were held. However, neither the chart note nor the detailed abdominoplasty informed consent executed by JG referenced the "mild liposuction" procedure.

CASE No. 3508

7. On March 24, 2005, the Board received a complaint from C.G alleging that the Respondent had failed to complete the surgery as agreed. Specifically, the complainant stated that Respondent agreed to do a breast augmentation and was going to put 450cc in each breast and perform an areola reduction. The operative report indicates Respondent put 435cc in the left breast and 465cc in the right.

8. Patient C.G. later complained one breast did not settle evenly with the other, however, records indicate this is a known and consented to risk, and the deviation amounted to approximately one centimeter.

9. A review of Respondent's records and the informed consent do specifically indicate that although amounts are discussed pre-surgery, the patient does consent to permit the doctor to deviate from these amounts during surgery to achieve what he believes will be uniformity of appearance.

10. Patient CG went to another doctor for reconstructive surgery. Upon removal of

the implants by the new physician, there were some discrepancies noted as to fill volume of the implants as compared to Respondent's medical records. CG also alleged in her complaint that records were not timely forwarded upon request.

CASE No. 3748

11. On July 6, 2006, the Board received a complaint from K.Y. alleging complications from a breast augmentation surgery that was completed on April 6, 2006 resulting in an infection and the removal of the implants on or about April 15, 2006.

12. Patient K.Y alleged inadequate post-operative care resulted in her having to be seen by several other physicians in attempting to manage the infection and subsequent removal of both implants by Respondent. A review of the various records indicates that K.Y. missed several post-operative appointments with Respondent and elected to see other physicians (primary care and ER) closer to her residence.

CASE No. 3529

13. On May 5, 2005 the Arizona Department of Health Services notified the Board that they had found The Blumberg Center in violation of operating a healthcare institution without a license because they were providing general anesthesia.

14. In addition, in a letter dated May 3, 2005 from the Program Manager with the Arizona department of Health Services stated that The Blumberg Center had been in violation of the aforementioned requirement in 2002, 2003, 2004, and 2005.

15. On or about November 30, 2005 Blumberg Center agreed to pay the Arizona Department of Health Services a $5,000.00 civil penalty for failure to comply with their licensing requirements.

16. The Respondent is the owner and operator of The Blumberg Center and has operated the business since its inception in 1993.

17. In a letter dated May 12, 2006, the Respondent notified the Board that he no

longer practices general anesthesia at his surgical center. They only use conscious sedation which does not require licensure with the Department of Health Services.

CASE No. 3739M

18. On May 15, 2006, Respondent informed the Board of the details of CV2003-001027, which was a medical malpractice complaint filed in the Maricopa County Superior Court by M.L. The former patient did not file a complaint with this Board.

19. The Respondent voluntarily notified the Board of this matter during his license renewal process with the Board in December 2005. The complaint involved a breast augmentation performed on patient M.L. on or about February 11, 2002.

20. Respondent's record keeping in this matter appears inadequate and/or lacked adequate detail.

CASE No. 3861

21. On March 2, 2007, the Board received a complaint from E.T. alleging complications resulting from an abdominoplasty (tummy tuck) surgery that was completed on August 11, 2006. The complainant stated that she was in intense pain and subsequently developed an infection which was not adequately treated by Respondent through August 19, 2006.

22. The chart notes reveal Respondent performed the surgery on a Friday and prescribed both Percocet and antibiotics. Thereafter, the chart notes indicate E.T. contacted the office to advise she had scratched off one of the sutures the following week. During that same week following surgery, Respondent performed two post-surgical examinations of E.T. and noted no signs or symptoms of infection. On August 19, 2006, Respondent departed for a lengthy vacation and transferred care of any patients to Dr. Marvin Borsand.

23. Patient E.T. was seen and treated for an infection and post operative healing issues by Dr. Borsand from August 22, 2006 through September 7, 2006. Care and treatment of

E.T. was returned to Respondent on September 7, 2006, and both physicians examined E.T. on that date noting no presence of infection.

24. Notwithstanding that most care was performed by Dr. Borsand, Patient E.T. also raises a records issue, contending that Respondent did not provide adequate informed consent for the liposuction completed during the abdominoplasty. Full and detailed informed consents and risk disclosures were signed by E.T. for the abdominoplasty procedure. However, although Respondent alleges and chart notes indicate the procedure was fully explained to E.T., specific details or consents related to the mild liposuction performed in conjunction with the abdominoplasty are lacking.

CASE No. 3799

25. On October 17, 2006, the Board received a complaint from M.F. alleging complications from a breast augmentation surgery that was completed on January 5, 2004. The complainant stated that she agreed with the Respondent to make her breasts symmetrical as possible by increasing her left implant volume to correct the asymmetry. Respondent's medical records indicated that the right implant received 500 cc and the left implant only 480 cc, making the previous asymmetry greater.

26. Patient M.F. also alleged that she was in pain, that her right breast was rippling, and that it was not softening. Some of these symptoms continued as she developed a capsular contracture. Respondent recommended follow-up examinations, but M.F. did not contact or return to Respondent's office for several months. Respondent performed a follow up surgical procedure on November 18, 2004. After that surgery, patient M.F. alleged that the pain became extreme and the right breast became swollen. Respondent responded to this by surgically draining the breast and inserted a drain.

27. Patient M.F. stated that she continued to have pain and drainage over a course of several weeks. The records confirm Respondent examined M.F. on December 8, 2004, under

10x magnification and noted the wound may be opening, but on that date it appeared intact and the implant secure.

28. Thereafter, the records provide some indication Respondent likely examined M.F. two more times between December 8, 2004 and December 27, 2004; however, those records were misplaced by Respondent's third-party dictation service, leaving M.F.'s record incomplete.

29. The next chart note is dated December 27, 2004 when Respondent notes, again under 10x magnification, that the right implant became visible out of an incision. Respondent removed the implant and specifically noted no signs or symptoms of infection. Patient M.F. alleges she later developed an infection which Respondent failed to manage and prevent by prescribing antibiotics at the time of removal. M.F., did not, however, seek further follow-up care with Respondent or otherwise contact Respondent after December 27, 2004.

30. Respondent had issues with incomplete medical records, adequacy of response to a records request and follow through with agreed upon services involving Patient M.F.

CONCLUSIONS OF LAW

1. Pursuant to A.R.S. § 32-1800, et seq. the Arizona Board of Osteopathic Examiners in Medicine and Surgery has subject matter and personal jurisdiction in this matter.

2. The conduct and circumstances described in the Findings of Fact above constitute unprofessional conduct as defined in the following paragraphs of A.R.S. § 32-1854:

> (6) Engaging in the practice of medicine in a manner that harms or may harm a patient or that the Board determines falls below the community standard.
> (21) Failing or refusing to establish and maintain adequate records on a patient.
> (28) Failing to make patient medical records in the physician's possession promptly available.
> (35) Unprofessional conduct includes the following act; violating a federal, a state law or a rule applicable to the practice of medicine.
> (38) Any conduct or practice that endangers a patient's or the public's health or may reasonably be expected to do so.

ORDER

NOW, THEREFORE, IT IS ORDERED AND AGREED AS FOLLOWS:

Pursuant to the provisions of A.R.S. §§ 32-1855 (D) and (I), that PAUL BLUMBERG, D.O., ("Respondent") shall be issued a **DECREE OF CENSURE.**

IT IS FURTHER ORDERED AND AGREED THAT License No. 1597 held by Respondent shall be **SUSPENDED** for **SIX (6) months**; however, it is ordered and agreed **STAYING THE SUSPENSION**, and placing Respondent on **PROBATION** for a period of two (2) years from the date of this order with the following terms and conditions of probation as set forth herein:

1. Respondent shall, at his own expense, hire or appoint an independent Board Certified Plastic or Cosmetic Surgeon to observe the next TWENTY-FIVE (25) Breast Augmentation and/or abdominoplasty surgeries that Respondent completes. The observer shall update the Board of the surgeries and his/her opinion on surgical skill and technique of the Respondent as it applies to the prevailing standard of care.

2. Respondent shall obtain THIRTY (30) hours of additional CME in the area of identification and care of post surgical infections and patient communications. CME shall be in addition to that normally required and shall be completed with SIX (6) months of the effective date of this Order.

3. Respondent shall, at his own expense, undergo and successfully complete both Phase I and II given by Physician Assessment and Clinical Education Program ("PACE") at the University of California, San Diego to determine Respondent's ability to safely practice medicine and surgery in the State of Arizona. Respondent shall provide a Certificate of Completion prior to the end of his probationary time frame.

4. Respondent shall, at his own expense, participate in and complete a pre-approved mini-residency and/or fellowship, or its equivalent, in the area of his current practice (cosmetic surgery). The program shall be pre-approved by the Board's Executive Director and shall be completed within the 1st year of Probation.

5. Respondent shall, at his own expense, hire an office management consultant ("Consultant") to review his record keeping practices, office staff responsibilities, physician/patient communication documentation and consent forms and overall office policies. This requirement is imposed to address overall record concerns existing, or which may exist, prior to the date of this Order. Respondent shall provide a copy of the recommendations of the Consultant to the Board and shall implement all of the recommendations within six (6) months of the date of this Order. The purpose of having this done is to ensure that Respondent is adhering with generally accepted standards of care and in compliance with all state and federal statutory mandates. The Consultant shall be pre-approved by the Executive Director.

6. The Board or its designee shall determine Respondent's compliance and/or noncompliance with the stayed portion of this Order. If the Board or its designee determines that Respondent has been non-compliant with any of the terms of this Order during the probationary period, the stay of the suspension shall be lifted and Respondent shall begin his suspension as previously ordered.

7. Respondent shall also, as part of his probation appear before the Board, upon receipt of a request by written or telephonic notification from the Board's executive director which shall be given at least five (5) days prior to the Board meeting.

8. In the event Respondent moves and ceases to practice medicine in Arizona, he shall give written notice to the Board of his new residence address within twenty (20) days of moving; and, the terms and duration of probation may be stayed by the Board until Respondent returns to practice medicine in Arizona.

9. Respondent's failure to comply with the requirements of this Order shall constitute unprofessional conduct as defined at A.R.S. § 32-1854(26), as amended, and may be considered as grounds for further disciplinary action (e.g., suspension or revocation of license) in the event that Respondent fails to comply with any of the requirements of this Order.

ISSUED THIS 18TH DAY OF OCTOBER, 2007.

STATE OF ARIZONA

BOARD OF OSTEOPATHIC EXAMINERS IN MEDICINE AND SURGERY

By: _____
Jack Confer, Executive Director

Original "Consent Agreement" filed this 18TH day of OCTOBER, 2007 with the:

Arizona Board of Osteopathic Examiners
In Medicine and Surgery
9535 East Doubletree Ranch Road
Scottsdale AZ 85258-5539

Copy of the foregoing "Consent Agreement" sent via certified, return receipt requested this 18TH day of OCTOBER, 2007 to:

Paul Blumberg, D.O.
455 North Mesa Drive, #15
Phoenix, AZ 85201

Copies of the foregoing "Consent Agreement" sent via regular mail this 18TH day of October, 2007 to:

Blair Driggs, AAG
Office of the Attorney General CIV/LES
1275 West Washington
Phoenix AZ 85007

Thomas M. Connelly, Esq.
2425 East Camelback Road, Suite 880
Phoenix, AZ 85016