Governor
Douglas Ducey

ARIZONA BOARD OF OSTEOPATHIC EXAMINERS IN MEDICINE AND SURGERY
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Gary A. Erbstoesser, D.O., V.P.
Douglas L. Cunningham, D.O.
Jonathan Maitem, D.O.
Jeffrey H. Burg, AIF
Dawn K. Walker, D.O.
Ken S. Ota, D.O.

Executive Director
Justin Bohall

DRAFT MINUTES FOR VIRTUAL MEETING OF THE ARIZONA BOARD OFOSTEOPATHIC EXAMINERS IN MEDICINE AND SURGERY

Held Virtually on Saturday, May 30, 2020

1. CALL TO ORDER

Board President Landau called the meeting to order at 8:31 a.m.

President Landau thanked the Board members and staff for facilitating today's proceedings, and read aloud the Board's Mission Statement: "The mission of the Board is to protect the public by setting educational and training standards for licensure, and by reviewing complaints made against osteopathic physicians, interns, and residents to ensure that their conduct meets the standards of the profession, as defined in law (A.R.S. § 32-1854)."

2. ROLL CALL AND REVIEW OF AGENDA

	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Present:	X	X	X		X	X	X
Absent:				X			

3. REVIEW, CONSIDERATION AND APPROVAL OF MINUTES

A. February 29, 2020 Open Session Minutes

MOTION: Dr. Cunningham moved for the Board to approve the February 29, 2020 Open Session Minutes.
SECOND: Dr. Erbstoesser
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

B. February 29, 2020 Executive Session Minutes

MOTION: Dr. Cunningham moved for the Board to approve the February 29, 2020 Executive Session Minutes.
SECOND: Dr. Erbstoesser
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

C. April 6, 2020 Open Session Minutes

MOTION: Dr. Cunningham moved for the Board to approve the April 6, 2020 Open Session Minutes.
SECOND: Dr. Ota
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

D. April 25, 2020 Open Session Minutes

MOTION: Dr. Cunningham moved for the Board to approve the April 25, 2020 Open Session Minutes.
SECOND: Dr. Erbstoesser
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

E. April 25, 2020 Executive Session Minutes

MOTION: Dr. Cunningham moved for the Board to approve the April 25, 2020 Executive Session Minutes.
SECOND: Dr. Walker
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

4. REVIEW, DISCUSSION, AND ACTION ON CASE REVIEWS OF ALLEGATIONS OF UNPROFESSIONAL CONDUCT A.R.S. § 32-1855(D).

A. DO-19-0136A, Robert Frank Altamura DO, LIC. #1842

Dr. Altamura participated in the virtual meeting with Attorney Vinnie Lichvar during the Board's consideration of this case. Dr. Altamura informed the Board that he graduated in 1978 and that he relocated to Arizona in 1982 and ultimately combined practices with a colleague that has grown to five offices. He stated that his practice most of his career consisted of acute care in the hospital and office, and that he has never had a complaint of this nature in his almost forty years of practice. Dr. Altamura stated that he believed the complaint stemmed from the mother's misperception of the visit. He explained that he felt she wanted input regarding the uncircumcised newborn, and he admitted that he misinterpreted her statement that she stated that the baby was intact.

Dr. Cunningham questioned whether there was miscommunication due to a language or cultural barrier. Dr. Altamura stated that was not the case, and that he thought the rapport was rather good. Dr Cunningham questioned whether retracting the foreskin was part of the doctor's routine examination of a newborn. Dr. Altamura stated that he performs a thorough examination that involves examining the foreskin and retracting in a non-forceful fashion. Dr. Altamura explained that it was at that point in his exam that the mother may have believed he was trying to retract the foreskin forcefully which he stated is not true. He stated that the exam was normal and routine. Dr. Erbstoesser noted that retracting the skin is necessary in pediatric examination. Mr. Landau commented that the issue in this case involved the mother's wishes to not have the retracting occur during the exam. Mr. Landau stated that while there appeared to be a communication issue in this case, he found that the examination was within the standard of care.

MOTION: Dr. Cunningham moved for dismissal.
SECOND: Dr. Erbstoesser
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

B. DO-19-0217A, Justin Blake Garrison DO, LIC. #006511

Dr. Garrison participated in the virtual meeting during the Board's consideration of this case. He reported that he graduated in 2013 and completed a family medicine residency in Kingman, Arizona in 2016. Dr. Garrison stated that he currently runs a busy outpatient practice and also serves as the Medical Director for all of primary care at the Kingman Regional Medical Center. He stated that since 2014, he has served as a contracted physician for social security, performing disability examinations. He explained that he performed a standardized physical exam in July 2019 for the complainant in this case pursuant to his contracted services for social security. Dr. Garrison stated that he recalled a routine encounter and that the complainant was satisfied with the exam. He stated that the claimant filed the complaint with the Board after receiving an unfavorable ruling. Dr. Garrison pointed out that he did recommend disability for the claimant as a result of his examination, and stated that his exam is not the determining factor for individuals to receive approval for disability benefits.

Dr. Cunningham noted that the OMC found that the exam was appropriate. Dr. Cunningham stated that he was satisfied with Dr. Garrison's testimony.

MOTION: Dr. Cunningham moved for dismissal.
SECOND: Dr. Ota
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

C. DO-19-0234A, Mark Richard Rosenberg DO, LIC. #2245

Dr. Rosenberg participated in the virtual meeting with Attorney Robin Burgess during the Board's consideration of this matter. Dr. Rosenberg stated that he graduated in 1978, he is board certified in dermatology and has been in practice for over thirty years. He stated that the complaint stemmed from a family dispute between two sisters and did not directly involve him. Dr. Rosenberg explained that he did not know the complainant, had never met her, and she was not his patient. He noted that the complaint in this case alleged that he provided injectable materials for his Medical Assistant (MA)

to use and profit from. Dr. Rosenberg reported that the MA was hired around July 2019, and stated that an adequate investigator would have ended any speculation of his involvement.

Mr. Landau clarified that it is the Board's job to protect the public. He stated that the Board's duty is to review and act upon complaints. Mr. Landau stated that while he understands the licensee's frustration, the investigator on this matter is highly experienced in conducting the Board's investigations. Mr. Landau stated that Dr. Rosenberg's comments that the Board's investigation was inaccurate or insufficient is misplaced.

Ms. Burgess stated that the physician was quite frustrated and that she did not feel his anger was misplaced. She reiterated that the complaint in this case stemmed from a family dispute between two sisters. Ms. Burgess informed the Board that the alleged incident occurred prior to the MA working for Dr. Rosenberg, and she stated that there is no evidence that the MA did anything inappropriate during her employment with Dr. Rosenberg and his practice. Ms. Burgess reported that after receiving the complaint, the mA was removed from working with Dr. Rosenberg, placed on leave for one week while a thorough investigation was conducted by the practice, and has since been placed with the group's traveling physician to serve as coordinator and assistant. Ms. Burgess clarified that Dr. Rosenberg's frustration stems from a situation that involved a retaliatory measure taken by the sister to impact the MA's ability to work, and has directly affected him. She stated that Dr. Rosenberg has practiced for over thirty years with no prior Board history.

Dr. Cunningham noted that the Board's investigation revealed that the MA had prior convictions involving theft and assault. Dr. Cunningham noted that counsel had stated that a clear background check was obtained at the time of the MA's hiring. Ms. Burgess clarified that the third party company that the group uses to conduct background checks did not query city courts, and that the convictions did not appear in their search of county court records. She assured the Board that the practice has improved its background checks by including city court records going forward. She stated that the hiring of staff is done on a corporate level through the Human Resources Department, and that Dr. Rosenberg is not involved in that process.

The Board thanked the investigator for his thorough investigation of this case.

MOTION: Dr. Erbstoesser moved for dismissal.
SECOND: Dr. Ota
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

Mr. Landau stated that he understood the physician's frustration and clarified that the Board has the legal authority and duty to review complaints.

5. REVIEW, DISCUSSION AND ACTION ON INVESTIGATIVE HEARINGS PURSUANT TO A.R.S. § 32-1855(E).

A. DO-19-0021A, Leslie Diane Edison DO, LIC. #2491

This matter was considered under agenda item number 8B.

B. DO-19-0113A, David E Hatfield DO, LIC. #2913

Dr. Hatfield participated in the virtual meeting with Attorney Andrew Plattner during the Board's

consideration of this case. Dr. Hatfield stated that he has been practicing family medicine in the east valley for almost 24 years. Dr. Prah summarized that the complaint alleged Dr. Hatfield prescribed Soma to a patient that he was aware had been discharged from a pain management clinic for failing urine drug testing, and was using marijuana and methamphetamines. The patient was a 41 year-old male who was first seen by Dr. Hatfield in October of 2015. Dr. Hatfield saw the patient several times for various concerns including knee pain, shoulder pain, and back pain. During his treatment of the patient, Dr. Hatfield referred the patient to specialists including pain management. The patient also saw several other providers in the clinic, and was followed by the PA for most of 2017 and 2018. Dr. Prah stated that based on her review of the medical records, she found that Dr. Hatfield did not document any of the controlled substances that he prescribed to the patient. The Board noted that Dr. Hatfield was not the PA's supervisor and that the PA had not been referred to the Arizona Regulatory Board of Physician Assistants for review.

Dr. Hatfield stated that documentation relating to the patient's prescriptions was available in the chart on their EMR system. Dr. Prah recognized that the Board may not have received the entire EMR file as the prescriptions were not included in the Board's file. In response to Dr. Erbstoesser's questioning, Dr. Hatfield confirmed that he did not document his prescribing of Oxycodone to the patient in October of 2015 in the plan portion of the patient's chart. Dr. Cunningham questioned whether the licensee prescribes Soma regularly in his current practice. Dr. Hatfield stated that their practice now has a pain policy in place that follows CDC guidelines. Dr. Cunningham expressed his concerns regarding Dr. Hatfield prescribing #120 Soma with two refills for this patient. Dr. Hatfield stated that he understood the expressed concerns, and that his practice has addressed this with their new pain policy. He also informed the Board that the providers in the group have undergone extensive training in addiction medicine. Dr. Hatfield additionally reported that he has completed extensive CME in opioid prescribing.

Mr. Plattner stated that based upon the Board's review and questioning, the physician has met the standard of care in this case. He stated that the only concern in this case related to medical recordkeeping, and that they could provide the Board with sufficient documentation to demonstrate that the records were adequate. For these reasons, Mr. Plattner asked that the Board consider dismissing this matter.

MOTION: Dr. Cunningham moved for dismissal.
SECOND: Mr. Burg
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

AAG Galvin requested the licensee submit to the Board documentation relating to the prescriptions to ensure that the Board's investigative file is complete. Mr. Plattner and Dr. Hatfield agreed to do so. The Board discussed whether a referral should be made to the Arizona Regulatory Board of Physician Assistants for review of the PA involved in this patient's care. Dr. Hatfield pointed out that the PA's prescribing practices have changed and that the PA was involved in the practice council that developed the new pain policy to help mitigate the risk with these patients. The Board elected to not make a referral at this time.

C. DO-19-0075A, Michael Andrew Trainor DO, LIC. #4039

Dr. Trainor participated in the virtual meeting during the Board's consideration of this matter. He reported that he is board certified and fellowship trained in orthopedic spine surgery. He stated that

he graduated in 1998, completed residency training in 2003 and went on to complete an orthopedic spine and neurosurgery fellowship in Kentucky. Thereafter, Dr. Trainor joined a private practice in Prescott where he worked from 2004-2015. He then relocated to Nevada to join his twin brother who is also a surgeon, in a group practice with other colleagues. Dr. Trainor stated that he has maintained his Arizona license due to his service on MICA's Board of Trustees in Arizona. Dr. Prah summarized that the case was reviewed by a board certified spine surgeon and involved a female patient who underwent spine surgery performed by Dr. Trainor on June 15, 2017. The surgery was complicated by a dural tear that was recognized intraoperatively and repaired. The patient was taken back to surgery a few days later for another dural tear repair. The patient was later discharged and readmitted to return to surgery on June 20th for repair of a dural tear. The patient was brought back to surgery again on September 11, 2017 for evaluation of seroma. The OMC found that while the initial surgery did help with the patient's lower extremity pain, further documentation of the radiculopathy via EMG or nerve conduction studies was warranted to properly indicate the patient for surgery. The OMC also found that MRI without foraminal stenosis and small tear as what was noted on this patient was not an appropriate indication for surgical intervention.

Dr. Trainor explained that the patient sustained an initial dural tear that was repaired during the surgery, was returned to surgery a second time for a dural tear at a different site, and the third time that the patient was returned to surgery involved another dural tear. He stated that the last time the patient was brought back to surgery several months later at which time a sterile seroma was noted and in light of those findings, an outpatient procedure was performed and the patient was ultimately discharged without complication following that procedure. Dr. Trainor stated that he submitted documentation to the Board including additional hospital notes from physical therapy as well as evidence-based guidelines regarding the diagnosis and treatment of lumbar radiculopathy.

Dr. Trainor stated that based on his training and almost 17 years of experience as well as evidence-based literature, he respectfully and categorically disagreed with the OMC regarding necessity for EMG and nerve conduction studies prior to proceeding to surgical intervention. He stated that according to the literature, electrodiagnostic studies should only be used to confirm the presence of comorbid conditions. Dr. Trainor stated that he believed there was no deviation from the standard of care that occurred in this case and that this is supported the findings at surgery as well as the patient's intended outcome of elimination of radicular leg pain. In response to the OMC's concerns relating to mobilization of the patient following surgery, Dr. Trainor stated that the notes from physical therapy demonstrate that the patient remained in bed for approximately 15-16 hours following the initial surgery and was then slowly mobilized per physical therapy protocols.

In response to Dr. Erbstoesser's line of questioning, Dr. Trainor explained that he believed the second dural tear was due to a bone spoke following removal of the inflamed ligament at the time of the prior procedure, that the third dural tear may have been due to thinning of the dural tube at the time of the previous procedure, and that the fourth surgery was performed due to findings of a benign seroma. Dr. Trainor stated that this was the first time in his career that he has had to take a patient back to surgery for two dural tears and subsequent seroma. Dr. Erbstoesser agreed with the licensee's comments that nerve conduction studies were not required prior to proceeding to surgery in this case and are typically done to identify other comorbid conditions. The Board noted that a malpractice claim was filed against Dr. Trainor and involved this patient's care, and Dr. Trainor reported that the case is currently in the discovery phase.

Dr. Cunningham commented that the physician appeared to have tried his best to mitigate multiple complications in this patient. He questioned whether the physician learned anything from this case. Dr. Trainor stated that he discusses with patients attempts at additional non-surgical measures, and that this has been instituted in his practice. He stated he learned to give patients more direction and has done so with subsequent patients. He stated that he insists that patients undergo additional spinal injections before considering surgical intervention.

MOTION: Dr. Erbstoesser moved for dismissal.
SECOND: Dr. Cunningham
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

D. DO-19-0041A, Brendan Francis Curley DO, LIC. #006468

AAG Galvin was recused from this case. AAG Seth Hargraves was available for legal advice in this case. Dr. Curley participated in the virtual meeting during the Board consideration of this matter. Complainant LG also participated in the Board's virtual meeting. Dr. Curley stated that he completed medical school in 2007, and attended internal medicine residency as well as a hematology and oncology fellowship from 2011-2014. He stated he is board certified in internal medicine and medical oncology, and has been practicing in Scottsdale since 2014. Dr. Prah summarized that the case was reviewed by a board certified oncologist. The case involved a 52 year-old female who was seen by Dr. Curley for estrogen positive breast cancer. The patient's medical history included hysterectomy at the age of 36 with her ovaries left intact. The OMC observed that Dr. Curley started the patient on aromatase inhibitors without luteinizing hormone-releasing hormone agonist and without performing lab work to determine if the patient was menopausal.

Dr. Curley stated that patients with hormone positive breast cancer require risk reduction therapy following surgery. He stated that he assesses the patient's menopausal status, he reviews the patient's symptoms, interviews the patient, and reviews prior records. Mr. Landau stated that based on his review of the investigative file as a public member of the Board, he found that the physician made an assumption that the patient was post-menopausal without performing the appropriate testing. Dr. Curley stated that the patient was seen by other specialists prior to presenting to him, who deemed the patient post-menopausal, and that he discusses menopause status with patients when seen by him. He stated that lab testing is not a perfect measure to determine the status of menopause, and that it is considered in conjunction with the physician's clinical judgment. Dr. Curley stated that he based his clinical decision on the patient's age, symptoms, ethnic background, all of which he stated pointed to someone who likely had undergone menopause years before.

Dr. Cunningham questioned Dr. Curley as to why he did not perform the appropriate testing to determine this patient's menopause status. Dr. Curley explained that breast cancer patients do not have as much blood draws as other patients, and that patients with early stage breast cancer are typically monitored or surveilled with imaging, history and physical to find whether the patient has signs or symptoms of recurring disease. Dr. Curley stated that the patient was seen by two gynecologists prior to presenting to him, and that he relied on their testing that reported the patient as post-menopausal. Dr. Curley clarified that he did not have the patient's records from the two gynecologists, and assured the Board that he did request them for review. Mr. Burg observed that part of the patient's complaint involved her inability to get ahold of the doctor. Dr. Curley stated that during that time, their office was transitioning to a new EMR and that patient messages were difficult to manage. He stated that the patient spoke to multiple individuals in the office regarding her concerns and that at that time, she no longer wanted to discuss the situation with him directly.

LG addressed the Board, stating that she did not understand why the physician did not respond to her two certified letters requesting a response. LG stated that she told the physician that she did not know her menopause status, and that she knows that use of aromatase inhibitors increases estrogen, which was demonstrated by subsequent labs. LG stated that Dr. Curley failed to perform the proper testing, and that she became very sick as a result of taking the aromatase inhibitors started by Dr. Curley. Dr.

Cunningham expressed his concerns with this case, and stated that not only was testing not done, but there was also poor communication within the office and with the physician. Dr. Cunningham stated that he was not satisfied with the doctor's response to this patient, noting that these types of patients are at a very delicate time in their life after being diagnosed with breast cancer. Dr. Curley stated that the side effects reported by the patient are common side effects of aromatase inhibitors and that he counseled the patient in that regard during the patient encounter.

The Board questioned Dr. Curley as to whether he received the patient's communications following their encounter. Dr. Curley stated that the communications were not missed, but were intercepted by someone else in the office as the patient no longer wanted him as her oncologist. LG clarified that the two certified letters were addressed directly to Dr. Curley, and that she was also concerned that the physician documented that he examined her at each visit when this did not happen over the course of fourteen months. Dr. Curley apologized to LG for what she has experienced, and for the poor communication. He stated that he maintains that he provided the appropriate medication and reiterated that the side effects experienced are common side effects of the aromatase inhibitor. LG stated that she did not believe that the physician never received the letters, and that the doctor should be held accountable for increasing the chances of disease reoccurrence.

Mr. Burg recalled LG's statements that there was incorrect information placed in the patient's chart with regard to examinations performed at each visit. Dr. Curley stated that he disagreed with LG's claim, and that his usual practice is to perform a physical examination at each visit. LG reiterated that the exams were not done at each visit. Dr. Erbstoesser stated that he found the physician violated statute relating to the failure to order proper testing, poor documentation in the chart as well as poor communication. Board members also discussed that this case rises to the level of discipline given the violations identified. Dr. Cunningham spoke in favor of issuing a disciplinary Administrative Warning. Dr. Walker proposed adding the requirement to complete CME in physician-patient communication.

MOTION: Mr. Landau moved for the Board to find violations of A.R.S. §§ 32-1854(6) and (39).
SECOND: Dr. Cunningham
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

MOTION: Dr. Cunningham moved for the Board to issue a disciplinary Administrative Warning with the requirement to complete 20 hours of pre-approved CME in patient-physician communication in addition to CME requirements for license renewal, to be completed within six months.
SECOND: Dr. Walker
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota

Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

E. DO-18-0085A, Zachary F. Veres DO, LIC. #4202

Dr. Veres participated in the virtual meeting with Attorney Sara Stark during the Board's consideration of this case. Dr. Veres stated that he graduated in 2003 and has held licensure in Arizona and Ohio. He reported that he currently works full-time in Ohio and is certified by the College of Sports Medicine. Dr. Prah summarized that this matter stemmed from a complaint alleging that Dr. Veres wrote prescriptions for patients via telemedicine in states where he does not hold licensure. The complaint also alleged that the physician was not complying with proper telemedicine guidelines in that he did not seek approval from Medicare for telemedicine, did not perform the appropriate evaluations, and may have failed to schedule follow up care for patients. Dr. Prah stated that investigation by Medicare revealed a telemarketing scheme where Medicare patients were contacted and asked if they had pain and if they would be interested in trying a new prescription cream. Patients were then contacted by the physician and a prescription would be issued and filled by a mail-order pharmacy, and patients were not charged the 20% co-pay required by Medicare. Dr. Prah added that one company that the physician worked for was ultimately indicted and pled guilty to multiple charges. Dr. Prah stated that she attempted to subpoena the records for the patients in this case, but was not successful in doing so as each company she contacted indicated that they did not have patient records.

Dr. Prah reported that during the course of the Board's investigation, the CSPMP was queried which demonstrated that Dr. Veres prescribed controlled substances to four patients in Arizona during 2014-2016. Board staff subpoenaed the patients' records from the doctor's office and attempted to subpoena the records from the company he was working for at the time, and all that was received from the company was a series of emails between patient AM and several other providers including Dr. Veres. There were no progress notes or consultations included in the documentation originally submitted by the company. Dr. Veres later submitted medical records for patient AM which were different than what the Board received from the company. The chart provided by Dr. Veres included progress notes that were not sent by the company to the Board. Dr. Prah stated that review of the records provided by Dr. Veres revealed that the patient's prior records were not requested or reviewed prior to prescribing Nuvigil 250mg, and the same prescription was issued in December of 2015 without any documented discussion regarding symptoms and prior records were not requested or reviewed. There was also no documentation relating to a prescription written in October of 2015. Dr. Prah stated that Dr. Veres appeared to share an office with his father, Dr. Frank Veres, and that on one occasion, there was confusion regarding who had written a prescription for patient JN. Dr. Prah stated that concerns raised in this case related to patient AM in that the physician did not appear to obtain consent for examination via telemedicine, did not document that the patient was seen via real-time videoconference, no prior records were reviewed to verify the history reported, urine drug screens were not performed, and the CSPMP was not queried. Dr. Prah stated that it was not clear whether patient JN was issued by Dr. Veres or his father, Dr. Frank Veres, but noted that the original prescription obtained from the pharmacy shows Dr. Veres' name circled at the top of the script with an illegible signature.

Dr. Veres stated that an EMR was used for patients he saw via telemedicine, and that he provided the Board with the records he was able to download from the company's EMR portal. He stated that the file demonstrated that he saw the patient via videoconferencing and that the patient consented to the treatment prior to any consultation. He stated that he reached out to the company multiple times and stressed to them the importance of submitting the entire patient file to the Board. With regard to patient JN, Dr. Veres stated that the signature on the script is not his own, and that he reached out to the pharmacy multiple times to clarify. Dr. Veres stated that JN was not his patient. Ms. Stark stated that Dr. Veres is not the legal custodian of the records, but provided the Board with what he was able to obtain from the patient's file. She stated that each time the physician met with the patient, he reviewed the medical record and was able to review any of the patient's past consultations with other providers in the group. Ms. Stark stated that Dr. Veres' initial consultation with AM was done on March 31, 2015 via videoconferencing and no prescription was issued at that time. Ms. Stark stated that when Dr. Veres did issue a prescription for AM in October 2015, he had already established a

patient-doctor relationship by that time and was not required to continue with videoconferencing. In the matter of patient JN, Dr. Frank Veres provided an affidavit explaining that JN is his patient and Ms. Stark pointed out that the signature on the affidavit matched the signature on the prescription from the pharmacy. In response to the allegation that the physician failed to query the CSPMP database, Ms. Stark pointed out that this requirement did not apply to treatment provided prior to October of 2017.

The Board observed that the records submitted by the company for patient AM were in the form of a spreadsheet. Dr. Erbstoesser questioned how many states Dr. Veres was licensed. Dr. Veres confirmed that he is licensed in Ohio, Arizona, Florida, Georgia, Idaho, Utah, Virginia, New York, California, Indiana, and Michigan. Mr. Landau questioned whether the Board needed to obtain further information from the group prior to proceeding in this case. Dr. Cunningham agreed and stated that he was concerned that the physician did not maintain adequate records in this case. Dr. Cunningham questioned the physician as to whether the physician was being investigated by any other state board. Dr. Veres confirmed that he was not, and reported that he has not been sanctioned by any other board. The Board discussed returning the case for further investigation to obtain additional medical records for patient AM from the group prior to taking any action in this case. The Board elected to continue this matter in order for staff to perform further investigation, and to return to the Board at its August 2020 regular meeting.

F. DO-19-0164A, Russell Todd Imboden DO, LIC. #4433

This matter was considered under agenda item number 8A.

G. DO-19-0150A, Rick Alan Shacket DO, LIC. #4257

Dr. Shacket participated in the virtual meeting with Attorney Kraig Marton during the Board's consideration of this case. Dr. Shacket reported that he did his residency training in proctology and has been practicing in Arizona for over ten years. Dr. Prah summarized that this case was reviewed by a board certified gastroenterologist and involved a 72 year-old female who underwent colonoscopy performed by Dr. Shacket with resultant mesenteric tear at the transverse colon that required repair. The patient developed complications following the repair of the hematoma, including pneumonia, respiratory failure, and sepsis. The OMC who reviewed the case found that the complication was a result of excessive looping of the scope during colonoscopy, and Dr. Shacket did not document the time of the scope withdrawal. The OMC commented that while mesenteric tear is not a common complication of colonoscopy, this type of complication can occur due to increased pressure during colonoscopy.

Dr. Brian Gillis, a board-certified proctologist, addressed the Board on behalf of Dr. Shacket. He stated that he was involved in the medical malpractice claim, and has reviewed the case in its entirety. Dr. Gillis stated that while mesenteric tear is a rare complication of colonoscopy, it may occur more often than what is known as it may not be reported due to it often resolving on its own. He stated that the preferred treatment for this type of complication is to treat conservatively if the patient is hemodynamically stable. He stated that the reason for measurements on the colonoscope is for demarcating lesions to help delineate where lesions are located as the scope is advanced. Dr. Gillis stated that when faced with looping of the scope, the typical action is to have the patient change position, pull back and try to retorque the scope, or have someone place abdominal pressure on the patient.

Mr. Marton stated that they did not believe the physician breached the standard of care in this case or engaged in any improper conduct in performing this patient's colonoscopy that resulted in an unfortunate, unanticipated, and extremely rare complication. Dr. Shacket stated that he appreciated the case being called to the Board's attention as it has given him the time to reflect and research action mechanisms for mesenteric tears. Dr. Cunningham questioned the physician regarding the length of the scope utilized to perform the colonoscopy, and asked why such a length did not raise any concerns. Dr. Shacket stated it is more common than not to use all 165 cm of the scope during colonoscopy. He stated that perhaps the nurse was placing too much pressure on the scope and tore the mesentery from the inside. Dr. Erbstoesser questioned the physician's ability to continue to perform colonoscopies, noting that the physician reported that he performs around 50 scopes a year. Dr. Shacket stated that he has performed thousands of colonoscopies and believes he is proficient in doing them.

Dr. Ota questioned the licensee regarding the withdrawal time and whether the physician recalled it

to be excessively longer than usual. Dr. Shacket stated that the scope withdrawal was 11 minutes, and was documented via photographs taken at the time he reached the cecum and a photo of the rectum after the scope was withdrawn. Dr. Shacket reported that the case was not reviewed by the hospital's peer review committee. Dr. Shacket reiterated that the complication is rare, and stated that he is sorry for the outcome, but glad to have had an opportunity to reflect, research and learn more about it. Mr. Marton stated that the idea that the complication was caused by some breach in the standard of care has not been established in this case. He stated that the fact that the physician used the full scope is not significant, and that the withdrawal time was appropriate. Mr. Marton stated that this case deserves to be studied, but does not warrant disciplinary action.

Dr. Cunningham stated that most people would agree that 80 cm is the average scope length used during colonoscopy. Dr. Cunningham stated that he believed the physician missed the looping of the scope, and that the withdrawal time was not properly documented. Dr. Cunningham questioned a PACE evaluation was warranted to determine the physician's proficiency in performing colonoscopies. Dr. Walker agreed with Dr. Cunningham's comments, and stated that she was concerned regarding this physician's proficiency and that assessment was warranted. Mr. Landau also agreed with the comments made by other members, and stated that an assessment should be performed prior to the Board making a determination in this case.

MOTION: Dr. Cunningham moved for the Board to issue an Interim Order requiring the licensee to schedule a PACE evaluation within 60 days, and to complete the PACE evaluation within six months. The matter shall return to the Board following receipt of the evaluation results.
SECOND: Dr. Erbstoesser
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

H. DO-20-0067A, Jeffery Ray Gamber DO, LIC. #4326

Dr. Gamber participated in the virtual meeting during the Board's consideration of this matter. He reported that he graduated in 2000, completed six years of residency in 2006, and has a private practice.

MOTION: Dr. Cunningham moved for the Board to enter into Executive Session to discuss confidential health information and to obtain legal advice pursuant to A.R.S. § 38-431-03(A)(2) and (3).
SECOND: Mr. Burg
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X

Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

The Board entered into Executive Session at 2:33 p.m.
The Board returned to Open Session at 3:38 p.m.
No legal action was taken by the Board during Executive Session.

MOTION: Mr. Landau moved for the Board to place the license on Five Years' Probation for monitoring with terms to include undergoing evaluation with a Board-approved psychiatrist, undergoing a complete physical by a Board-approved primary care provider, completion of an intensive outpatient substance abuse program, work hours restriction of 40 hours per week, substance abuse monitoring, and to return to the Board for a progress update at its August 15, 2020 meeting.
SECOND: Dr. Cunningham
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

6. REVIEW, CONSIDERATION, AND ACTION ON APPLICATIONS FOR LICENSURE PURSUANT TO A.R.S. § 32-1822; PERMITS PURSUANT TO A.R.S. § 32-1829; AND RENEWALS OF LICENSES PURSUANT TO A.R.S. § 32-1825 (C-D) AND A.A.C. R4-22-207.

A. DO-20-0052A, Mark Yee-Jen Liu, LIC. #N/A

Dr. Liu participated in the virtual meeting during the Board's consideration of this matter. Dr. Prah summarized that Dr. Liu applied for an Arizona license in January of 2020 and disclosed on his application a malpractice settlement paid on his behalf in 2008. She stated that Dr. Liu was trained and credentialed to perform obstetrics and that he was licensed in Washington and Hawaii. The malpractice settlement involved an incident wherein Dr. Liu was delivering a baby, noted concerning fetal hart tones, and contacted the obstetrician on-call for assistance. The on-call obstetrician responded approximately 23 minutes later and assured Dr. Liu that he could initiated Pitocin and expect a vaginal delivery. Dr. Liu proceeded with labor and attempted a vacuum delivery; however, the hospital had recently purchased new vacuum equipment to which Dr. Liu was not familiar. The unfortunate results of labor included the baby having seizures and abnormal neuromotor development.

Dr. Liu stated that he attended college on a navy scholarship and graduated in 1998. Thereafter, he went on to an internship at a naval hospital. He then served for two years on a navy ship and did a tour to the Gulf at that time. Dr. Liu stated that he returned to and completed residency in 2003, and then went on to do a utilization tour overseas at a naval hospital in Japan, which is where the patient care took place that was involved in the malpractice settlement. Dr. Liu stated that following his honorable discharge, he went into private practice for some years, and then went on to Hawaii for ten years at the Army Medical Center. In 2017, Dr. Liu returned to the main land and went back into private practice. Dr. Liu stated that he joined the VA in Washington and was the Chief of Primary Care. He was eventually promoted to Chief of Staff, and has relocated to Tucson in April of 2020. He stated that he has accepted a position with the VA and that he is proud to be able to continue to

serve in the VA as a veteran himself.

Dr. Liu stated that the case was a very unfortunate event, and that he was very saddened by the adverse outcome at the time. He stated that a risk managing investigation at the hospital did not find fault in what he did, and that it was felt the on-call obstetrician had an ethical obligation to have assisted and did not do so. Dr. Liu stated that the Surgeon General proceeded to include four providers in his report, including Dr. Liu and the on-call obstetrician. He stated that he disagreed and filed an appeal to the Surgeon General's Office, but did not receive a response. Dr. Liu stated that he has no prior disciplinary history and that he has not had issue obtaining credentials in other states.

Dr. Cunningham spoke in support of granting an unrestricted license, and thanked Dr. Liu for his service.

MOTION: Dr. Cunningham moved for the Board to grant an unrestricted license.
SECOND: Dr. Ota
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

B. DO-20-0065A, Dominick Anthony Grosso, LIC. #N/A

Dr. Grosso participated in the virtual meeting during the Board's consideration of this matter. Dr. Prah summarized that Dr. Grosso applied for Arizona licensure in December of 2019 and disclosed a pending malpractice case on his license application and that staff was not able to obtain all of the patient records. Dr. Grosso stated that he graduated in 1983 and completed internship and residency training from 1983-1986. He stated that he has practiced continuously since 1984 and that because he wanted more of a relationship with his patients, he transitioned from the emergency room to private practice. Dr. Grosso reported that he has held licensure in New Jersey, became a diplomate of the American Board of Internal Medicine in 1986, was a first class FAA medical examiner and has also provided other similar services including CDL examinations. Dr. Grosso added that his volunteer work included working at the HIV and medical clinic of the hospital, as well as some work in Haiti after the earthquake in January 2010.

Dr. Grosso explained that on September 18, 2017, the patient presented to his private practice for back pain among other issues, and stated that due to the patient's advanced age, he performed additional testing in the office. Three days later, the patient's wife called the doctor's office with complaints of further back pain. Dr. Grosso stated that he was arranging for an outpatient MRI after receiving the lab work, and that the patient's wife was anxious and wanted him admitted. Dr. Grosso stated that the order for the MRI was changed to inpatient, and that the MRI showed an unusual type of osteomyelitis organism. He stated that the patient's condition was improving, but his family wanted to admit him into hospice care. The patient was subsequently entered into hospice where he expired two days later. Dr. Grosso stated that he felt the hospice admission was premature as the patient was improving.

Mr. Landau questioned the physician regarding his plans for practicing in Arizona. Dr. Grosso stated that he plans to retire at some point, but wanted to do Locum Tenens work. He stated that he enjoys working in the clinic and plans to do more volunteer work. He reported that he plans to stay in New Jersey for at least another year before relocating to Arizona. In response to Dr. Erbstoesser's questioning, Dr. Grosso stated that the patient was being seen by multiple specialists, including urology. AAG Galvin confirmed that the Board would have the ability to review the medical

malpractice claim if it results in an adverse outcome, even if licensure were to be approved at this time.

MOTION: Dr. Cunningham moved for the Board to grant an unrestricted license and instructed Dr. Grosso to keep the Board updated regarding the pending malpractice claim.
SECOND: Dr. Walker
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

7. CONSIDERATION AND ACTION ON COMPLIANCE WITH TERMS OF BOARD ORDERS AND REQUESTS TO MODIFY OR TERMINATE ORDERS, PURSUANT TO A.R.S. § 32-1855(E) AND (I).

A. DO-19-0213A, Thomas Zachary Emel DO, LIC. #007877

Dr. Emel participated in the virtual meeting during the Board's consideration of this matter. He reported that things are going well with his residency program, which should be completed around July 3, 2020. He stated that he has one appointment left to complete his intensive outpatient treatment program. The Board questioned the licensee regarding his plans after completing his residency program in July. Dr. Emel stated that he has struggled with obtaining gainful employment due to the restriction on his license. Executive Director Bohall informed the Board that staff received communication from a potential employer who indicated their needs with regard to the work hour restriction, and assured that 12 hour shifts would be followed by a recovery time. Mr. Landau proposed limiting the work week hours to 36 hours and allow the licensee the ability to work with some flexibility within those hours.

Dr. Emel requested the Board consider allowing him to work a total of forty hours as he is seeking full-time employment in order to receive benefits to help with his current health issues. Dr. Cunningham spoke in support of allowing the physician to work full-time to allow him to qualify for benefits to allow for continued care.

MOTION: Dr. Cunningham moved for the Board to amend its Order to allow the physician to work 40 hours per week at his discretion. This matter shall return to the Board for a progress update at its August 15, 2020 meeting.
SECOND: Dr. Walker
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							

Absent:	1				X			

8. REVIEW, DISCUSSION, CONSIDERATION, AND POSSIBLE ACTION RELATING TO A PROPOSED CONSENT AGREEMENT AND VACATING INVESTIGATIVE HEARING.

A. DO-19-0164A, Russell Todd Imboden DO, LIC. #4433

Attorney Kraig Marton participated in the virtual meeting during the Board's consideration of this matter on behalf of Dr. Imboden. Executive Director Bohall informed the Board that staff worked with Dr. Imboden's counsel and have agreed upon a Consent Agreement for the Board's consideration. Mr. Landau proposed changes to the Consent Agreement, including replacing "coincide" with "run concurrently" on page 5, line 18 so as to clarify that the Arizona probation does not terminate at the time that the Missouri probation is terminated. Mr. Landau proposed moving line 19 to line 8 on page 6 for better placement. He also requested that "and when" be inserted in the next sentence between "determine whether" and "to lift the…".

Mr. Marton stated that he had a high degree of confidence that his client will accept the Board's changes to the Consent Agreement as suggested. AAG Galvin confirmed that the Board's suggested changes were acceptable.

MOTION: Dr. Cunningham moved for the Board to accept the proposed Consent Agreement with the suggested changes, and to vacate the Investigative Hearing in this case.
SECOND: Dr. Erbstoesser
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

B. DO-19-0012A, Leslie Diane Edison DO, LIC. #2491

Dr. Edison did not participate in the virtual meeting during the Board's consideration of this matter. Executive Director Bohall stated that the proposed Consent Agreement in this case included two years' probation with assessment of a $1,000 Civil Penalty, requirement to complete the PACE prescribing course, and periodic chart reviews in addition to the standard probationary terms. Dr. Cunningham questioned the schedule of the chart reviews. Executive Director Bohall clarified that the first review is scheduled to be performed within thirty days after completion of the CME and quarterly or every six months thereafter. The Board discussed the Executive Director's ability to use his discretion for the timing of the chart reviews in consultation with Dr. Prah. Dr. Walker proposed including a requirement to complete a CME course in boundaries. Executive Director Bohall informed the Board that a portion of the PACE prescribing course covers the subject of patient boundaries. He also clarified that a chart review was not conducted during the course of the investigation.

MOTION: Dr. Cunningham moved for the Board to accept the proposed Consent Agreement in this case.
SECOND: Dr. Erbstoesser
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

9. REVIEW, CONSIDERATION AND ACTION ON REPORTS FROM EXECUTIVE DIRECTOR.

A. Report on Director Dismissed Complaints

Executive Director Bohall reported that 10 complaints were dismissed since his last report, and confirmed that the complainant's are notified of the dismissal and their ability to request a review of the decision to the Board.

B. Executive Director Report

1. Financial Report

Executive Director Bohall reported that the Fiscal Year ends June 30, 2020, and that the Board is on track to meet the budget. He stated that the expected revenue was exceeded prior to the Board waiving certain licensing fees during the current COVID crisis. He stated that this will be revisited at a later time for the Board to consider resuming collecting those fees again.

2. Current Events that Affect the Board

Executive Director Bohall stated that the Agency is taking the necessary precautions in order to implement appropriate measures to ensure the safety of Board members, staff, and the public during this time.

3. Licensing and Investigations Update

Executive Director Bohall reported that license applications are taking one month on average to process, and that staff continues to work productively under the current circumstances. He stated that investigations are on track, with only a few awaiting the initial investigation phase.

4. Legislative Update

Mr. Landau reported that the Senate came in last week with intention of running around 30 bills through and subsequently ended the legislative session. He stated that it was unclear whether special sessions will be held. Mr. Landau stated that he will be forwarding to the Executive Director a list of bills that he has been tracking.

5. Update of COVID-19 Temporary Licensing Process under A.R.S. § 32-3124

Executive Director Bohall reported that 56 temporary licenses have been issued. He stated that a couple of physicians have requested and received the 2nd thirty day license and have requested for an additional thirty days. He stated that the physicians were instructed to apply for full licensure and request a 250 day temporary license.

10. ADJOURNMENT

MOTION: Dr. Cunningham moved for adjournment.
SECOND: Dr. Erbstoesser
VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	6	X	X	X		X	X	X
Nay:	0							
Abstain/Recuse:	0							
Absent:	1				X			

The Board's meeting adjourned at 4:21 p.m.

_____
Justin Bohall, Executive Director