Governor
Douglas Ducey

ARIZONA BOARD OF OSTEOPATHIC EXAMINERS IN MEDICINE AND SURGERY
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Jerry G. Landau, J.D., Pres.
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 on Saturday, September 26, 2020

1. CALL TO ORDER

Board President Landau called the meeting to order at 8:33 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	X
Absent:							

3. CALL TO THE PUBLIC

A. President Landau welcomed the medical students from Arizona College of Osteopathic Medicine at Midwestern University, A.T. Still University Kirksville College of Osteopathic Medicine and A.T. Still University School of Osteopathic Medicine in Arizona.

B. No individuals addressed the Board during the Call to the Public portion of the meeting.

4. REVIEW, CONSIDERATION AND APPROVAL OF MINUTES

A. August 15, 2020 Open Session

Dr. Maitem noted a typographical error under item number 5.A. and requested to change references to "***informal*** investigative hearing" to "***formal*** investigative hearing."

MOTION: Dr. Erbstoesser moved for the Board to approve the August 15, 2020 Open Session as amended.
SECOND: Dr. Walker
VOTE: 0-yay, 0-nay, 0-abstain, 1-recuse, 0-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:	1					X		
Absent:	0							

B. August 15, 2020 Executive Session Minutes

MOTION: Dr. Maitem moved for the Board to approve the August 15, 2020 Executive Session.
SECOND: Dr. Walker
VOTE: 6-yay, 0-nay, 0-abstain, 1-recuse, 0-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:	1					X		
Absent:	0							

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

A. DO-18-0078A, Ryan Scott Southworth DO, LIC. #005891

Dr. Southworth was present during the Board's consideration of this matter.

Dr. Southworth stated that he graduated medical school in 2008 and completed an emergency medicine residency. He reported that he is a fellow of the American College of Emergency Physicians, and served as a critical care transport for the United States Airforce.

Dr. Maitem thanked Dr. Southworth for his service to the Country and for his service as a frontline healthcare provider. Dr. Maitem stated that based on his review of the case, he found that the physician met the standard of care and that this matter does not rise to the level of a statutory violation. Dr. Southworth stated that he is always grateful for the opportunity to learn from his patients in every case. He stated that he learned from this case the importance of re-educating the patient and family as well as better documentation. Dr. Cunningham questioned whether the physician ever ambulated the patient during the ER visit. Dr. Southworth explained that the patient's prosthesis was not functioning correctly and that he felt it was not safe to attempt to ambulate the patient at that time. He stated that he did order a physical therapy session prior to transferring the patient for hospital admission. Dr. Cunningham stated his concerns regarding the lack of a more thorough examination, and that he found this did not rise to the level of a standard of care deviation or statutory violation.

MOTION: Dr. Maitem moved for dismissal.

SECOND: Dr. Ota
VOTE: 7-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	7	X	X	X	X	X	X	X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	0							

B. DO-19-0224A, Soaman Dizechi DO, LIC. #N/A

Dr. Dizechi participated in the virtual meeting during the Board's consideration of this matter.

Mr. Landau noted that this case stemmed from Dr. Dizechi having entered into a Consent Agreement with the Ohio Board for improperly accessing a medical record in violation of HIPAA and the Medical Practice Act. The Board noted that Dr. Dizechi complied with the Ohio Consent Agreement requirements to complete CME and paid a fine. Dr. Dizechi reported that he attended medical school in California and that he currently works as a hospitalist in Ohio.

Executive Director Bohall informed the Board that this matter was reported by Dr. Dizechi's counsel. Dr. Dizechi confirmed, and stated that he was advised to report the incident to any state he has held licensure. He explained that he previously held a training license in Arizona for his final months of his internal medicine residency. Dr. Dizechi confirmed that he is currently not licensed in Arizona and that he has not filed an application for Arizona licensure. Mr. Landau questioned whether the Board needed to vacate the hearing in this matter. AAG Galvin advised that the complaint be closed and that the public record not reflect that a complaint was opened due to a lack of jurisdiction by this Board.

Mr. Landau instructed the Executive Director to close the complaint and the record not reflect that a complaint was opened based on a lack of jurisdiction.

C. DO-19-0121A, Gwen A Levitt DO, LIC. #2656

Dr. Levitt did not participate in the virtual meeting during the Board's consideration of this matter.

The Board noted that this was a tragic case. Dr. Maitem stated that he found the standard of care was followed based on his review of the file. Mr. Landau agreed and stated that there did not appear to be a connection between the suicidal psychiatric admission and the subsequently alleged homicidal behavior by the patient.

MOTION: Dr. Maitem moved for dismissal.
SECOND: Dr. Cunningham
VOTE: 7-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	7	X	X	X	X	X	X	X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	0							

D. DO-20-0031A, Regina Ann Conley Hart DO, LIC. #006640

Dr. Hart did not participate in the virtual meeting during the Board's consideration of this matter.

Dr. Maitem stated that this was an unfortunate and tragic case. He stated that based on his review of the file, it appeared that the physician's care was appropriate.

MOTION: Dr. Maitem moved for dismissal.
SECOND: Dr. Walker
VOTE: 7-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	7	X	X	X	X	X	X	X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	0							

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

A. DO-18-0177A, Jacqueline Belen DO, LIC. #005080

Dr. Belen and Attorney Robert Stultz participated in the virtual meeting during the Board's consideration of this matter.

Board staff summarized that this matter was reviewed by a board-certified OB/GYN and involved a 48 year-old who requested permanent contraception. Dr. Belen suggested the Essure device and performed the procedure on August 16, 2016. The night of surgery, the patient had heavy vaginal bleeding and continuous pain. She returned for follow up on August 26th and reported continued pelvic pain and dyspareunia. An ultrasound showed normal findings and that the Essure implants were in place. The patient's pain persisted and on September 13th she underwent laparoscopy with no significant abnormalities noted. The patient returned to Dr. Belen's office the following day without a scheduled appointment and reportedly waited in the lobby for three hours and was then told that she could not be seen and needed to schedule an appointment. The patient returned on September 19th for a scheduled appointment where she discussed with the physician her continued pain and she was informed that she may need to undergo a hysterectomy in the future. In December of 2016, the patient presented to a different physician who performed laparoscopy on the 28th with

removal of the Essure implants and tubal coagulation. The surgeon's operative report described bilateral adhesions and a longstanding pelvic inflammatory process. The Medical Consultant (MC) noted that the Essure device has been noted to cause pelvic inflammation and pelvic pain, and was pulled from the market in December of 2018. The MC felt that the office staff may have lacked compassion for the patient, and also commented that there may have been an infection in the tubes and ovary at the time of the first laparoscopy and possible use of antibiotics may have changed the course of the patient's disease.

Dr. Belen reported that she is board certified in obstetrics and gynecology, and that she has been in practice for 15 years with the last 12 exclusively in the field of gynecology. She stated that she first saw this patient in 2016 for a well-woman examination and consultation for permanent birth control. She reviewed with the patient the options available for permanent contraception and discussed the associated risks and benefits. Dr. Belen stated that in 2016, there were two options available for permanent contraception and that the patient was seeking the option with the least amount of recovery time. Dr. Belen stated the patient agreed that the Essure device was the best choice for her. At her postoperative appointment, the patient complained of right-sided pelvic pain and a diagnostic laparotomy was performed to determine the reason for the patient's pain. Dr. Belen stated that there was no evidence of infection or perforation at that time to the uterus or tubes, and she discussed with the patient her options to continue observation or laparoscopy to remove the right fallopian tube. The patient elected observation due to the associated risks and thereafter chose to seek further care elsewhere. Dr. Belen stated she felt her care was appropriate though the desired outcome was not achieved. She stated that the initial procedure that was elected was well within the standard of care in 2016.

Mr. Stultz noted that the MC was not critical of Dr. Belen's performance of the implantation of the Essure device. He stated that the subsequent laparoscopy performed on September 13th did identify adhesions in the abdominal wall area of the umbilicus that were related to prior abdominal surgeries and not the Essure device implantation. Mr. Stultz stated that a course of antibiotic would not have altered the patient's outcome. He stated that when presented with discrepancies between the medical record and the patient's complaint, the MC appeared to weigh in favor of the complaint that was filed two years after the medical treatment occurred and not the contradictory information contained in the medical records reviewed. Mr. Stultz stated that Dr. Belen has dedicated her practice to her patients and cares very much about their wellbeing. He stated that she has no prior Board history and asked the Board to dismiss this case.

Dr. Erbstoesser stated that his concerns related to the patient care management in this case. He questioned Dr. Belen regarding the patient presenting to her office without a scheduled appointment. Dr. Belen stated that the amount of time the patient waited in the lobby that day was unclear, and that she was offered the opportunity to be seen by the triage nurse as her symptoms were not related to any gynecological complaint. The patient was also offered an appointment for the following day. She stated that the patient's complaints were related to anesthesia and that the triage nurse was highly qualified and experienced in seeing postoperative patients. Mr. Landau recognized that the incident occurred four years ago and while Dr. Belen was part of a different practice at that time. Dr. Maitem stated that he was not concerned with the patient waiting to be seen by the physician that day as there have been instances where a patient does not show for a scheduled appointment and may have an opportunity to see the patient waiting in the lobby. Mr. Landau stated his concerns regarding the patient waiting for three hours in the waiting room. Dr. Erbstoesser noted that Dr. Belen testified that the patient's complaints were not related to the surgery and that she refused to be seen by the triage nurse, and he stated that the encounter should have been documented. Dr. Belen reported that a note was made regarding offering the patient a next-day appointment and that she was offered to be seen by the triage nurse.

Dr. Cunningham stated that based on his review of the case, he felt that the situation could have been handled a little better. He stated that the patient clearly lost confidence in the physician and her office, and that he hoped the physician has learned from this case to be more sensitive with difficult patients in order for them to feel that they are still being taken care of. Dr. Cunningham stated that he did not find that this matter rises to the level of a violation and spoke in support of dismissal.

MOTION: Dr. Cunningham moved for dismissal.

SECOND: Dr. Erbstoesser

Dr. Erbstoesser noted that the patient requested her records from the office and was informed that the printer was broken. The patient became angry and threatening, and moments later was provided a copy of her chart. Dr. Belen reiterated that she is no longer with that group practice and that it was not uncommon for it to take some time for the patient's records to print out. Dr. Maitem noted that the MC expressed concern with possible standard of care issue relating to inflammatory changes. He stated that the patient's persistent presentations with complaints of pain needed to be addressed. Mr. Landau stated that the communication could have been better between the patient and the physician as well as with the office staff.

VOTE: 6-yay, 1-nay, 0-abstain, 0-recuse, 0-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:	1				X			
Abstain/ Recuse:	0							
Absent:	0							

B. DO-18-0105A, Ayad Agha DO, LIC. #4341

Dr. Agha and Attorney Russ Skelton participated in the virtual meeting during the Board's consideration of this matter. Traci Pritchard, MD and Suemoy Wallace, MD also participated in the virtual meeting on behalf of Dr. Agha.

Board staff summarized that this matter was reviewed by a board-certified interventional radiology Medical Consultant (MC). The MC reviewed the original complaint and materials in January of 2019, and had concerns that Dr. Agha may have been overly aggressive in his treatment of the patient. The MC noted that the venogram and catheter directed thrombolysis for a popliteal vein clot was very aggressive, and that the procedure is usually reserved for severely symptomatic cases. The MC stated that treatment of an uncomplicated lower extremity DVT with low clot burden is oral coagulation, which had been started by the patient's primary care provider. The MC noted indications for an IVC filter would include DVT with contraindications for anticoagulation, progression of the DVT despite anticoagulation, poor cardiopulmonary condition where even a small PE could be fatal and high risk for DVT/PE in non-ambulatory patients such as following trauma. The MC noted that the patient did not have any of these indications. The MC found that there was no evidence to support the need for thrombolysis of PE in this case, and questioned whether this was an isolated case or if this was an established pattern of unusual care.

Based on the MC's concerns, Board staff subpoenaed Dr. Agha's procedure logs and randomly selected ten charts for quality of care review. The MC opined that the treatment algorithm used by Dr. Agha appeared to be very consistent. A patient with an acute lower extremity DVT would have an IVC filter placed, followed at the same session with thrombolysis and thrombectomy of the clot. The patient would later return for IVC filter removal. Out of the ten patients, three had involvement of only the lower superficial femoral and popliteal veins. The MC stated that the standard of care for those cases would have been to document the clinical factors that justified aggressive treatment. The MC recognized a pattern of reflexively performing thrombolysis/thrombectomy for all cases. The MC commented that there did not appear to be any attempt to identify the benefits of treatment for these patients, and any identified DVT received the same treatment as the more extensive DVT.

Dr. Agha reported that he attended medical school in Chicago, and that he currently practices vascular interventional radiology as well as diagnostic imaging and radiology. He stated that he

received a call regarding this patient three or four days after an ultrasound showed clots in the popliteal vein and was complaining of pain. The patient was brought in and examination revealed leg swelling and severe pelvic pain. The patient elected to proceed with the procedure, which he stated was minimally invasive and an IVC filter was placed. Dr. Agha explained that he has done this for a long time, and that he has found that many patients have passed away from not placing an IVC filter for a small clot to the lung or heart. Mr. Skelton stated that Dr. Agha believes that the complaint should be dismissed. He stated that it was inappropriate for an ER physician who generated this complaint to redirect the patient away from his practice. Mr. Skelton stated that Drs. Pritchard and Wallace were participating today to speak very favorably of the physician and his practice. Mr. Skelton also pointed out that Dr. Agha had mentioned that this was his third complaint from the same group and was not generated by the patient or the referring physician.

Dr. Erbstoesser requested the physician to expand further on the group practice. Dr. Agha stated that he left the group in 2010, and stated that the MC who reviewed the case was familiar with him and that he informed Board staff of this during the course of the investigation. Dr. Maitem stated that he disagreed with the physician's comments that the procedures are non-invasive, and that he agreed with the MC that the treatment appeared to be more aggressive than what is always necessary. Board staff reported that Dr. Agha did previously inform the staff that the MC may be conflicted, but did not provide any details regarding his concerns. Dr. Cunningham stated that based on his review of the case, there did appear to be aggressive treatment rendered when compared to what he has seen with other interventional radiologists. Mr. Landau stated his concerns regarding the patients not being seen on a case-by-case basis and lack of documentation regarding the reason for the aggressive treatment. Mr. Landau stated he was also concerned regarding the physician's comments that this is a minimally invasive procedure. Dr. Agha stated that it is an office based procedure and that the procedure itself is not aggressive. He stated that he is very careful in his patient selection and that his treatment is not "one size fits all." He stated that the majority of his patients receive medications only and do not undergo any procedures.

Dr. Pritchard stated that she worked very closely with Dr. Agha from 2006 to 2014. She stated that based on her experience with Dr. Agha, he is a very unique person in radiology who sees patients for who they are. She stated that she sees these clots all of the time progress into more morbidity and invasive procedures, and that they can be treated early as a form of prevention. Dr. Wallace stated that she worked with Dr. Agha in Phoenix for a number of years. She stated that there are a number of medical centers conducting research and studies relating to more catheter directed intervention to prevent complications that can lead to long term complications and long term anticoagulation therapy. She stated that Dr. Agha is up to date with current medical literature and has tried to improve himself and be consistent with keeping up with new practices and advances in his area of practice.

Mr. Landau stated that based on his review of the case, it appeared that the physician's treatment was standardized among his patients. Dr. Erbstoesser recognized that Dr. Agha is a specialist in his field of medicine, and that two highly qualified physicians presented during today's proceedings to testify regarding Dr. Agha's character and qualifications. He noted that thrombotic therapy is evolving, and that his concerns have been alleviated by the testimony heard today. Dr. Maitem stated his concerns regarding the need to weigh the risks and benefits for anticoagulation versus proceeding to thrombolysis. He spoke in favor of issuing a non-disciplinary Letter of Concern to resolve this matter.

MOTION: Dr. Maitem moved for the Board to issue a non-disciplinary Letter of Concern for lack of documentation regarding risks and benefits, and failure to properly document the reasons for more aggressive care.
SECOND: Dr. Erbstoesser

Mr. Landau spoke in favor of the motion and stated that discipline was not warranted.

VOTE: 4-yay, 3-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	4	X	X		X		X	
Nay:	3			X		X		X
Abstain/ Recuse:	0							
Absent:	0							

C. DO-19-0235A, Jerome Matthew Guanciale DO, LIC. #4732

Dr. Guanciale participated in the virtual meeting during the Board's consideration of this matter.

Board staff summarized that Dr. Guanciale was named in a malpractice case that occurred in North Carolina and involved a patient that underwent laparoscopic cholecystectomy on October 22, 2015. According to the licensee, the patient returned five days later complainant of rectal bleeding. According to the lawsuit, the patient returned complaining of upper abdominal pain, rectal bleeding, and orange urine. Due to the patient's family history of colon cancer, she underwent a colonoscopy with no significant findings. On November 2nd, the patient presented to the ER with signs consistent with obstructive jaundice and was found to have obstruction of her common bile duct.

Dr. Guanciale reported that he graduated medical school in 1986 and has practiced general surgery since completing his postgraduate training. He stated that currently resides and practices general surgery in Oregon. Dr. Guanciale explained that the patient was morbidly obese and presented to the ER with acute cholecystitis and had multiple comorbidities. He stated that he uses the same spiel on all patients with risks and benefits as well as possible complications of converting a laparoscopic procedure to an open procedure. Dr. Guanciale stated that during the procedure, the gall bladder was being removed when they encountered some bleeding. He identified the artery that was bleeding and clipped it. He stated that the patient returned with complaints of rectal bleeding, and that she did not complain of dark urine at that time. He offered to perform a colonoscopy where he believes he may have found a small fissure. The patient subsequently underwent ERCP at another facility where it was found that her duct was obstructed.

Dr. Maitem noted that this case involved a complicated patient with multiple risk factors, and that the settlement was low. Dr. Maitem also noted that the outcome is a recognized complication and stated that he did not find it rises to the level of a standard of care deviation or statutory violation. In response to Dr. Erbstoesser's questioning, Dr. Guanciale stated that the patient had refused colonoscopy in the past, and that the patient's bleeding did not streak the stool and there was no associated pain. He stated that he suggested colonoscopy for this patient based on her family history of colon cancer and refusal to do it in the past. Dr. Guanciale also pointed out that this was his first lawsuit in thirty years of practicing.

MOTION: Dr. Maitem moved for dismissal.
SECOND: Mr. Burg
VOTE: 7-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	7	X	X	X	X	X	X	X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	0							

7. 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-20-0143A, Marc Everett Lynch, LIC. #N/A

Dr. Lynch participated in the virtual meeting during the Board's consideration of this matter.

Dr. Lynch reported that he graduated medical school in 1995 and entered private pain management practice in 1996 in California. Dr. Lynch added that he partnered with a colleague with a similar pain management practice and currently have a large pain management practice in Southern California. Dr. Lynch stated that he had no independent recollection of the incident that led to the malpractice settlement. He stated that it may have occurred in 1998 or 1999, and that the suit alleged the patient experienced issues with her right arm and hand after cervical epidural.

MOTION: Mr. Landau moved for the Board to enter into Executive Session to review confidential information and to obtain legal advice pursuant to A.R.S. § 38-431.03(A)(2) and (3).
SECOND: Dr. Maitem
VOTE: 7-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	7	X	X	X	X	X	X	X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	0							

The Board entered into Executive Session at 10:33 a.m.
The Board returned to Open Session at 10:43 a.m.
No legal action was taken by the Board during Executive Session.

MOTION: Dr. Cunningham moved for the Board to issue an unrestricted license.
SECOND: Mr. Burg
VOTE: 7-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	7	X	X	X	X	X	X	X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	0							

B. DO-20-0142A, Jason Alan Kole, LIC. #N/A

Dr. Kole participated in the virtual meeting during the Board's consideration of this matter.

Board staff summarized that Dr. Kole applied for an Arizona license in March of 2020 and disclosed a prior malpractice case that occurred in 1998 and involved failure to diagnose pneumonia in a newborn that resulted in death. Dr. Kole reported that he attended medical school in Illinois where he continues to practice. He stated that he applied for Arizona licensure to continue his work with Tucson and Yuma Regional Medical Centers. Dr. Kole stated that the malpractice case occurred in 1998 and involved patient NM. The charge nurse showed Dr. Kole an overread from the radiologist of an x-ray that showed an abnormal finding of possible infiltrate. Dr. Kole stated that the charge nurse was given the responsibility to contact the patient's mother. He stated it was unclear what had transpired, but subsequently within 12-18 hours, the mother returned to the ER and the child was deceased. Dr. Kole confirmed that he was not the ER physician who initially cared for the patient, and that this case created a few failure points in their system for reading of x-rays.

MOTION: Dr. Maitem moved for the Board to issue an unrestricted license.
SECOND: Dr. Walker
VOTE: 7-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	7	X	X	X	X	X	X	X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	0							

C. DO-20-0141A, Marvin Lynn Faulkner, LIC. #N/A

Dr. Faulkner participated in the virtual meeting during the Board's consideration of this matter.

Board staff summarized that Dr. Faulkner applied for an Arizona license and disclosed action by the Texas Board after they found that he failed to maintain appropriate medical records in his treatment of eight chronic pain patients. Dr. Faulkner was required to complete 16 CME hours in recordkeeping and risk management, and he was also required to pay a $3,000 fine.

Dr. Faulkner reported that he attended medical school in Kirksville, and completed postgraduate

training in Ohio. He stated that he currently practices in Kansas City and previously served in the United States Military for eight years. Dr. Faulkner explained that the Texas Board matter has been his only sanction in his 33 years of practice, the last 20 of which primarily in pain management. He stated that he sent 12 charts to the Texas Board per their request, and they found that three or four of the twelve could have had better documentation regarding the patients needing continual opioid therapies. He reported that he complied with the terms of his Texas Order.

Mr. Landau recognized that the Texas matter initially involved concerns regarding Dr. Faulkner's opioid prescribing practices and resulted with concerns relating to medical recordkeeping only. Dr. Faulkner stated that he did not have specific plans of practicing in Arizona, but has applied for medical licensure in multiple states with plans to travel.

MOTION: Mr. Burg moved for the Board to issue an unrestricted license.
SECOND: Dr. Maitem
VOTE: 7-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	7	X	X	X	X	X	X	X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	0							

D. DO-20-0122A, Charles Marion Celestina, LIC. #N/A

Dr. Celestina participated in the virtual meeting during the Board's consideration of this matter.

Board staff summarized that Dr. Celestina applied for an Arizona license in March of 2020 and disclosed a 2016 malpractice case that involved failure to diagnose and treat sepsis in a 60 year-old female patient. Dr. Celestina reported that he graduated from medical school in 1990, completed a family medicine residency in family medicine and emergency medicine in 1995, and that he practiced in Ohio from 1991 until the present. He stated that he applied for Arizona licensure to be closer to family and to eventually retire in Arizona. Dr. Celestina explained that the malpractice case involved a postoperative female patient who presented to the ER afebrile with left-sided abdominal pain that the surgeon believed may have been incisional pain. Dr. Celestina stated that he performed an abdominal pain work-up and obtained a CAT scan that showed typical findings of a patient post laparoscopic cystectomy. Dr. Celestina stated that he communicated with the surgeon, started the patient on IV fluids including antibiotics, and initiated the process of admitting her to the ICU. He stated that after his shift, the patient rapidly developed abdominal sepsis and the night surgeon operated on the patient with findings including abdominal laceration and bowel peritonitis. The patient expired the following morning.

Dr. Maitem questioned whether the patient's tachycardia improved during Dr. Celestina's shift, and whether her blood pressure was stable during that time. Dr. Celestina reported that the patient's tachycardia stayed the same and that she became hypotensive after his shift ended. Dr. Maitem stated that based on his review of the case, it appeared that the physician managed the patient appropriately in the ER. He recognized the tragic outcome, and stated that the physician could not have done anything different.

MOTION: Dr. Maitem moved for the Board to issue an unrestricted license.
SECOND: Dr. Ota
VOTE: 7-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	7	X	X	X	X	X	X	X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	0							

E. DO-20-0123A, Jason Murri, LIC. #N/A

Dr. Murri did not participate in the virtual meeting. The Board tabled this item until its November 2020 meeting.

F. DO-20-0148A, Matthew J Pautz, LIC. #N/A

Dr. Pautz participated in the virtual meeting during the Board's consideration of this matter.

Board staff summarized that Dr. Pautz applied for an Arizona license in May of 2020 and disclosed 11 prior malpractice cases, two of which resulted in settlement payment while the remaining nine were dropped or dismissed at trial. The applicant also disclosed that his hospital privileges were summarily suspended pending investigation regarding a patient admitted to the ER. According to an NPDB report, Dr. Pautz's hospital privileges were suspended in June of 2012 by the Medical Executive Committee, he refused to participate in the hearing due to what he claimed was bias, and the Board of Directors upheld the decision to suspend indefinitely in October of 2012.

Dr. Pautz reported that after graduating medical school, he completed a residency in Pennsylvania, and currently resides and practices general orthopedic surgery in California. He stated that he applied for an Arizona license due to the volatile climate in California. Dr. Pautz stated that he believed he had been named in so many malpractice suits due to the litigious nature in California, and that he believed he provided patients with too much information that they do not know how to process. He stated that he has learned how to limit what they need to know and in better terms that they can understand. He pointed out that he has not been named in a malpractice suit in over ten years. Of the two cases that resulted in settlement, Dr. Pautz explained that one involved a complex patient that he operated on for a broken leg and later required additional surgery due to concerns for compartment syndrome. He stated that the second case involved a simple fracture in a patient he had diagnosed with complex regional pain syndrome who did not return to him for follow up treatment.

Mr. Landau commented that Dr. Pautz's testimony seemed to imply that he felt he did not do anything wrong and was not responsible for the outcome in both malpractice cases that resulted in payment. Dr. Pautz stated that he is very good at what he does and that he felt he did not have good representation in the lawsuits. He informed the Board that he has plans to graduate law school in California and is hopeful to practice law in California after passing the bar exam.

Dr. Pautz stated that the 2012 emergency suspension of his hospital privileges was the result of three incidents, one of which involved prescribing of a fentanyl patch for a patient's clavicle fracture that a pharmacist refused to fill, another concerned a patient post toe amputation complaining of nausea for whom he prescribed Compazine Q 4 PRN, and the third involved a somnolent patient that the nurse thought was overdosing on narcotics. Dr. Pautz stated that he believed the real reason for his emergency suspension regarded a foundation created by the hospital and he was their competition. Dr. Pautz stated that a partial suspension occurred in 2018 at a different hospital that involved a patient with an open pilon fracture. He stated that the case was reviewed and there was no finding of a deviation from the standard of care and the suspension was later lifted. He reported that both suspensions were reviewed by the California Board and found there were no deviations from the standard of care.

The Board noted that the 2018 incident did not appear to have been reported to the NPDB. Dr. Maitem stated his concerns regarding the physician's testimony related to the compartment syndrome case, and disagreed with the physician's comments that fasciotomy is considered a relatively benign procedure. Mr. Burg stated his concerns regarding Dr. Pautz's comments of the litigious nature in California, and stated that if this were true, the Board would see more malpractice histories in physician's relocating from California. Dr. Erbstoesser questioned whether the licensee felt that he was being targeted. Dr. Pautz stated that he recognized he could come off as standoffish, and stated that he will fight when he feels he is right. Dr. Maitem suggested obtaining further information relating to the 2018 incident prior to consideration of licensure. Mr. Landau agreed and proposed tabling this matter until further information is obtained.

The Board tabled this item until its November 2020 meeting and directed for Board staff to obtain additional information regarding the 2018 incident involving suspension of the physician's hospital privileges.

G. DO-20-0155A, Blake Wade Berman, LIC. #N/A

Dr. Berman participated in the virtual meeting during the Board's consideration of this matter.

Dr. Berman reported that he attended medical school in California where he currently practices medicine. He stated that he trained in general surgery and neurosurgery, and that he feels he has exhausted what he wanted to accomplish in academic medicine, and wishes to re-enter private practice. Dr. Berman reported that he has joined a colleague's private general neurosurgery practice in California and has privileges at multiple hospitals. Dr. Berman reported that he currently has two pending malpractice claims.

The first malpractice case occurred at Desert Regional Medical Center and involved a male patient who underwent successful anterior infusion at two adjacent levels with postoperative imaging that showed a fluid collection in the compartment where surgery was performed. Dr. Berman stated that in order to further evaluate what the fluid collection might be, he felt that it was in the patient's best interest to re-explore and obtain a culture to determine whether there was an infection or reason for the patient's continued complaint of difficulty swallowing. The patient was returned to surgery and a defect was noted in the hypopharynx. Thoracic surgery was consulted, and they instituted platinum level postoperative management, activating every service in the hospital. He stated that the patient was later transferred to the university hospital where she underwent successful deconstruction of the defect, and transferred back to the hospital where they continued to follow the patient to completion. Dr. Berman stated that he communicated with the physicians at the university hospital and that they agreed that in order to reduce the possibility of infection, removal of the hardware was warranted.

Dr. Berman explained that the second matter involved a patient that he had seen at Desert Regional Medical Center and followed him to his subsequent private practice. He stated that he followed the patient for a while, and that he had clear findings of L5 weakness and radiculopathy in the left leg. The patient continued to develop progressive radiculopathy postoperatively that ultimately resulted in more severe weakness. Dr. Berman stated that the patient was found to have a malpositioned screw at S1 that did not appear to violate the canal, and discussed repositioning with the patient and obtained multiple CT scans that showed it was not violating a nerve root. Dr. Berman returned the patient for re-exploration of the area due to complaints of persistent worsening radiating pain in the left leg. There was no continued compressive abnormality noted, and Dr. Berman repositioned the screw in the ideal position. The patient's weakness continued to progress, and he ultimately left the practice.

Mr. Landau questioned the applicant regarding his plans if granted Arizona licensure. Dr. Berman stated that he applied for medical licenses in Arizona and Nevada in order to increase the scope of his ability to practice neurosurgery, but has no plans to relocate at this time.

MOTION: Dr. Maitem moved for the Board to issue an unrestricted license.
SECOND: Dr. Erbstoesser
VOTE: 7-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	7	X	X	X	X	X	X	X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	0							

8. REVIEW, CONSIDERATION, AND ACTION ON COMPLIANCE WITH TERMS OF BOARD ORDERS AND REQUESTS TO MODIFY OR TERMINATE ORDER OR ISSUE SUMMARY ACTION.

A. DO-20-0098A, Michael Joseph Carchedi LIC. #N/A

Dr. Carchedi participated in the virtual meeting during the Board's consideration of this matter.

MOTION: Dr. Cunningham moved for the Board to enter into Executive Session to review confidential information and to obtain legal advice pursuant to A.R.S. § 38-431.03(A)(2) and (3).
SECOND: Dr. Maitem
VOTE: 7-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	7	X	X	X	X	X	X	X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	0							

The Board entered into Executive Session at 12:59 p.m.
The Board returned to Open Session at 1:38 p.m.
No legal action was taken by the Board during Executive Session.

MOTION: Mr. Landau moved for the Board to proceed as discussed in Executive Session.
SECOND: Dr. Cunningham
VOTE: 7-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	7	X	X	X	X	X	X	X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	0							

9. REVIEW, DISCUSSION AND ACTION ON THE FOLLOWING MISC. ITEMS

A. Review and Approval of Calendar Year 2021 Board Meeting Dates

Executive Director Bohall stated that the calendar for 2021 has been drafted with 8 proposed meeting dates. He also asked the Board to consider whether it would like to continue holding its meetings on Saturdays. The consensus of the Board was to continue convening on Saturdays, and it was noted that the Board's last meeting in 2021 will be held in December.

B. Discussion and Designation of 2020 Annual House of Delegates and Business Meeting of the Advocates for the American Osteopathic Association (AOA).

Executive Director Bohall stated that a request was made to delegate a Board member to participate in the 2020 Annual Meeting scheduled for October 18th. Dr. Cunningham volunteered to participate on behalf of the Board.

C. Policy on Interim Orders for PACE evaluations

Executive Director Bohall stated that the discussion had come up in a couple of cases that were moved all the way through the investigative process to the Board for investigative hearing when the Medical Consultant recommended a PACE evaluation. In those cases, the Board has agreed with the recommendation for PACE and returned the cases to issue Interim Orders to do so and then the matters were later returned to the Board for further consideration. He stated that the process may be streamlined by the Board authorizing the Executive Director to issue the Interim Orders based on the Medical Consultant's recommendations prior to bringing the matters before the Board. AAG Galvin pointed out that pursuant to A.R.S. § 32-1804, subparagraph 14, the Executive Director has the authority to issue such Interim Orders as the PACE evaluations are deemed investigative tools. The Board directed staff to draft the policy and to implement this process.

D. Discussion of Confidential Program Policy Committee

Mr. Landau stated that the Board should revisit the parameters and qualifications for the confidentiality program, and would like to appoint a Committee to research information and make recommendations to the Board. Mr. Landau appointed Dr. Erbstoesser as Committee Chair, and to include as members Mr. Burg and Dr. Walker. Mr. Landau instructed the Committee members to review the Board's current policy, and instructed the Executive Director to obtain examples or information of confidential programs from other boards. AAG Galvin suggested the Committee invite an addictionologist to offer input, and Dr. Prah was also invited to participate in the Committee.

10. QUESTION AND ANSWER SESSION BETWEEN THE MEDICAL STUDENTS AND MEMBERS OF THE BOARD AND DISCUSSION RELATING TO ISSUES SURROUNDING THE PRACTICE OF OSTEOPATHIC MEDICINE.

The Board met the medical students participating in the virtual meeting and discussed current issues surrounding the practice of osteopathic medicine.

11. REVIEW, CONSIDERATION AND ACTION ON REPORTS FROM EXECUTIVE

DIRECTOR.

A. Report on Director Dismissed Complaints

Executive Director Bohall reported that a total of 3 cases were dismissed since the Board's last meeting.

B. Review and discussion of policy regarding the issuance of Interim Orders.

Please see the discussion captured under agenda item number 9.C.

C. Executive Director Report

1. Financial Report

Executive Director Bohall reported that the Board is in its second quarter of the current fiscal year, and has used 22% of its appropriation. He stated that the Board's revenue is low due to the Board's approval to waive certain licensing fees in light of the public health crisis. He stated that is will not be detrimental to the Board's operations. He stated that staff will continue to monitor this and will revisit when necessary.

2. Current Events that Affect the Board

No Additional topics were reported at this time.

3. Licensing and Investigations Update

Executive Director Bohall provided an update on the Licensing and Investigations Process. He noted an 20% increase in licensing applications in the last fiscal year.

4. Legislative Update

Mr. Landau stated that there have been talks of a special session, but that it is less likely to be held due to the upcoming election.

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

Executive Director Bohall reported that the Board has received and issued a total of 83 temporary licenses.

12. ADJOURNMENT

MOTION: Dr. Maitem moved for adjournment.
SECOND: Dr. Walker
VOTE: 7-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

	VOTE	Mr. Landau	Dr. Erbstoesser	Dr. Cunningham	Dr. Maitem	Mr. Burg	Dr. Walker	Dr. Ota
Yay:	7	X	X	X	X	X	X	X
Nay:	0							
Abstain/ Recuse:	0							
Absent:	0							

The Board's meeting adjourned at 1:59 p.m.

Justin Bohall, Executive Director