Governor
Douglas Ducey

ARIZONA BOARD OF OSTEOPATHIC EXAMINERS IN MEDICINE AND SURGERY
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Board Members
Douglas Cunningham, D.O., Pres
Jerry G. Landau, J.D., V.P.
Gary Erbstoesser, D.O.
Jonathan Maitem, D.O.
Martin Reiss, D.O.
Christopher Spiekerman, D.O.
Jeffrey H. Burg

Executive Director
Justin Bohall

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

Held on Saturday, September 14, 2019
At: Office of the Arizona Board of Osteopathic Examiners
1740 W Adams St • Phoenix, Arizona Board Room A

1. CALL TO ORDER

Board President Cunningham called the meeting to order at 8:05 a.m.

2. ROLL CALL AND REVIEW OF AGENDA

	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Present:	X	X	X	X	X		
Absent:						X	X

3. CALL TO THE PUBLIC

President Cunningham 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)."

A. President Cunningham 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. Scott Steingard, DO, Chairman of the Federation of State Medical Boards (FSMB), spoke during the Call to the Public and updated the Board regarding licensing and regulation matters addressed at the FSMB.

President Cunningham instructed staff to agendize the FSMB matters for discussion at a future Board meeting.

4. REVIEW, CONSIDERATION, AND APPROVAL OF MINUTES

A. August 10, 2019, Open Session

MOTION: Dr. Maitem moved to approve the August 10, 2019, Open Session.
SECOND: Dr. Erbstoesser
VOTE: 4-yay, 0-nay, 0-abstain, 1-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	4	X	X	X	X			
Nay:	0							
Abstain/ Recuse:	1					X		
Absent:	2						X	X

B. August 10, 2019, Executive Session

MOTION: Dr. Maitem moved to approve the August 10, 2019, Executive Session.
SECOND: Dr. Erbstoesser
VOTE: 4-yay, 0-nay, 0-abstain, 1-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	4	X	X	X	X			
Nay:	0							
Abstain/ Recuse:	1					X		
Absent:	2						X	X

C. March 23, 2019, Special Meeting Draft Minutes

MOTION: Dr. Maitem moved to approve the March 23, 2019, Special Meeting Draft Minutes.
SECOND: Mr. Landau
VOTE: 4-yay, 0-nay, 0-abstain, 1-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	4	X	X		X	X		
Nay:	0							
Abstain/ Recuse:	1			X				

Absent:	2						X	X

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

A. DO-19-0025A, Michael Napese Lokale, DO, LIC. #005981

Dr. Lokale was present during the Board's consideration of this matter. Dr. Lokale stated that once he became aware that only a CBC had been ordered for the patient's lab draw, he attempted to correct the error. In response to Dr. Erbstoesser's line of questioning, Dr. Lokale explained that at the time, they were having issues with their voicemail system after switching software and that there had been a lot of crossover. Dr. Lokale informed the Board that the administration has been made aware of the system issues and are working on making the necessary improvements.

Mr. Landau stated that he had additional questions for the licensee and spoke in favor of proceeding to Investigative Hearing.

Complainant LM was also present and addressed the Board. She stated that the patient has had a diagnosis of genetic hemochromatosis for the past 20 years and required regular lab draws for monitoring. LM stated that after the patient had lab work done in Dr. Lokale's office, they did not hear back regarding the results. She stated the patient was not feeling well and she attempted to contact the office on multiple occasions with no response to her messages. LM further reported that she presented to the office for a scheduled appointment that she was not aware had been canceled, and ultimately had the authorities called on her by the staff. LM stated she was able to obtain a copy of the patient's records at that time, which showed that there had been no testing done to monitor the patient's longstanding diagnosis of hemochromatosis. LM was able to schedule another appointment, which she later presented in order to question the physician regarding the breakdown in communication.

MOTION: Mr. Landau moved for the matter to proceed to Investigative Hearing.
SECOND: Dr. Erbstoesser
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	5	X	X	X	X	X		
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2						X	X

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

A. DO-18-0066A, Michael James Tuttle, DO, LIC. #005688

Dr. Tuttle was present with Attorney James Goodwin. Board staff summarized that the case involved a 37-year-old patient that was scheduled for spinal cord stimulator with light anesthesia. Following the administration of oxygen, versed, and propofol, the patient had heavy secretions and she required suctioning and received a breathing treatment. Nursing notes documented that the

patient was stable at the time of discharge and was instructed to go to the ER if she developed any cough, wheezing, or shortness of breath. The patient did not require tracheotomy or intubation during the procedure that involved Dr. Tuttle. The Board noted that the patient was suctioned after propofol and versed were administered due to concerns regarding exacerbation of asthma and potential for aspiration. It was noted that the patient did not exhibit signs of aspiration, but rather was admitted to the ER for asthma exacerbation with a negative chest x-ray and she was discharged two days later on cough syrup with codeine. According to the patient's complaint, she had difficulty breathing and moving when she awoke from anesthesia and was reportedly treated in the ER for aspiration pneumonia and asthma.

Dr. Tuttle addressed the Board, stating that his main concern was to protect and secure the patient's airway and evaluate for aspiration after developing a cough. He stated that he could not in good faith sedate the patient any further and discussed terminating the procedure with the surgeon in order to suction the patient and confirm that she was stable. Dr. Tuttle explained that it appeared to be an exacerbation of the patient's asthma and there was no aspiration that had occurred. Dr. Tuttle assured the Board that staff followed the proper criteria for discharging the patient. He stated that the surgeon agreed with the recommendation to abort the case.

Complainant TM was present with Attorney Kevin Chapman. TM stated that she was not aware that she did not have aspiration pneumonia. She stated that her concerns regarded the handling of the mistake, and added that she was not made aware that she was suctioned in the procedure room. TM reported that by the time she arrived at home following discharge, she had difficulty breathing and swallowing, and presented to the ER approximately four hours after discharge.

Dr. Maitem apologized to the patient for her experience and stated that he did not find a standard of care violation in this case.

MOTION: Dr. Maitem moved for dismissal.
SECOND: Mr. Landau

Mr. Landau stated that he could see the patient's frustration with seeking relief from surgery that was ultimately canceled. Mr. Landau echoed Dr. Maitem's comments regarding the lack of a standard of care violation in this case, and he spoke in favor of the motion to dismiss.

VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	5	X	X	X	X	X		
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2						X	X

B. DO-18-0031A, Kingwai Lui, DO, LIC.#007422

Dr. Lui was present with Attorney James Kaucher and Co-Counsel, Ms. Heather Bohnke. Board staff summarized that the case involved a 21-year-old female patient that presented to the crisis response center on the petition by her family who was concerned about her progressively worsening mental status. The Medical Consultant (MC) who reviewed the case found that Dr. Lui may have deviated from the standard of care in that a full and detailed assessment was not obtained. The

Board was informed that the patient attempted suicide one month following her presentation to the crisis center with possible permanent damage due to the self-inflicted injuries.

Dr. Lui addressed the Board, stating that the patient did not demonstrate any signs of psychosis at the time that he saw her in the crisis center. Dr. Lui stated that the patient was very coherent and cooperative, and was able to discuss the exact events that led to her admission. He agreed that the assessment could have been more detailed, but not in the setting of a crisis center.

Dr. Reiss questioned what was done to assess the patient for suicidality at the time of her admission. Dr. Lui explained that based on his assessment of the patient, she was very high functioning and did not warrant any type of inpatient hospitalization. Dr. Reiss referred the Board's members to the assessment notes in the patient's chart and the Board elected to enter into Executive Session to review the confidential information.

MOTION: President Cunningham moved for the Board to enter into Executive Session to discuss confidential information pursuant to A.R.S. 38-431.03(A)(2).
SECOND: Dr. Maitem
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	5	X	X	X	X	X		
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2						X	X

The Board entered into Executive Session at 8:48 a.m.
The Board returned to Open Session at 9:03 a.m.
No legal action was taken by the Board during Executive Session.

Dr. Reiss observed that Dr. Lui's evaluation was adequate under the circumstances, with the exception of the documentation pertaining to the suicide evaluation, and noted that Dr. Lui's attending physician signed off on the assessment. Dr. Reiss also noted that there was an adequate disposition plan provided as well. Dr. Maitem noted that the patient's mother brought her to the crisis center and questioned whether Dr. Lui typically speaks to the individuals in attendance with the patient. Dr. Lui explained that the collateral information is usually obtained by the crisis workers due to the high volume of patients and that the crisis team communicates to him if the family wishes to speak to him.

President Cunningham questioned the physician regarding what he would do differently if presented with a similar patient in the future. Dr. Lui stated that the decision to discharge the patient would not change, but that communication could be improved between him and the crisis workers in that setting. Dr. Erbstoesser stated that the physician should expand his questioning of patients regarding thoughts of self-harm and suggested that he go beyond only asking if the patient is suicidal. Dr. Reiss stated that he believed this has been a learning experience for the physician, and considered recommending dismissal. Dr. Reiss pointed out that Dr. Lui was a resident at the time of the incident and that his attending physician signed off on his assessment of the patient in this case.

MOTION: Dr. Reiss moved for dismissal.
SECOND: Dr. Maitem

President Cunningham agreed with Dr. Reiss' comments and stated that even residents under supervising physicians are accountable for the patient's care. President Cunningham spoke in favor of the motion for dismissal. Mr. Landau also spoke in support of the motion.

VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	5	X	X	X	X	X		
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2						X	X

C. DO-18-0142C, John Daryl Thompson, DO, LIC.#4022

Dr. Thompson was present with Attorney Scott King. Complainant CW was present during the Board's consideration of this matter, and Complainant TK participated telephonically.

Board staff summarized that the case involved an 86-year-old patient (JK) who underwent Open Reduction Internal Fixation (ORIF) of a knee fracture performed by Dr. Thompson on December 20, 2017. Five days later, JK was discharged to a rehabilitation center with instructions to follow up at the CORE Institute on January 11, 2018, approximately three weeks following orthopedic surgery. JK's postoperative course involved two subsequent incisions and drainage (I&D) procedures, both of which were performed by Dr. Thompson's partners from the CORE Institute. After an extended hospital stay and multiple challenges with treatment, JK expired on February 15, 2018 at an extended care facility. The MC who reviewed the case found that there were areas of deviation from the standard of care involving a lack of postoperative orthopedic follow-up. The MC opined that the patient's sepsis may have been identified at an earlier stage, had JK been seen for postoperative follow-up by an orthopedist during his time at the rehabilitation center.

Dr. Thompson addressed the Board stating that based on the ability to increase JK's mobility and to prevent long-term sequelae from the fracture, they elected to proceed to surgery. Dr. Thompson explained that he performed a basic ORIF of the fracture and that the only unique factor of the case was the use of a venous tourniquet. Dr. Thompson stated that JK was seen in the hospital daily until the time of discharge to the rehab center and that he was scheduled for follow up in 2-3 weeks as is standard for total joint replacement procedures. Dr. Thompson pointed out that he did not have much involvement in JK's care, and that JK was later admitted to a hospital that the physician does not frequent. Dr. Thompson added that he was on vacation the week that JK was admitted to the hospital.

TK, a board-certified ER physician in another state, addressed the Board regarding his concerns relating to Dr. Thompson's care of his father, JK. He stated that JK's death was directly and/or indirectly due to medical malpractice and hospital function failures. TK stated that there were profound delays in postoperative orthopedic evaluation, antibiotics administration, and returning JK to surgery to address the septic knee. TK stated he believed JK's entire medical team failed him in this case. TK added that the physician was responsible for the mid-level providers attending to JK and is ultimately responsible for the inadequate care provided. CW, an ultrasound technician, and

daughter of JK, also addressed the Board and provided pre and postoperative photographs of JK's infected knee for the Board's review. CW stated that she visited JK frequently during his hospitalization and that there was clear evidence of medical negligence in this case.

Mr. King addressed the Board, pointing out a five day period wherein JK was pending sepsis after an elevated WBC was noted on December 29th at the rehab facility until JK was brought to the ER on January 3, 2018. He stated that Dr. Thompson was not made aware of the problems experienced by JK after discharge to the rehabilitation center. Dr. Erbstoesser expressed concern regarding the lack of supervision of the PAs that were involved in JK's care. Dr. Erbstoesser stated that he was also concerned with the fact that JK had three different surgeons addressing the wound, the first of which was Dr. Thompson's original surgery. He questioned Dr. Thompson regarding whether the physician felt obligated to see the patient after becoming aware that his colleagues had intervened with the knee issues. Dr. Thompson stated that he and his colleagues take full responsibility for the care provided by the PAs. He stated that his partners are board-certified and fellowship-trained surgeons and that he trusts their medical judgment and patient care.

President Cunningham stated his concerns regarded the fragmentation of care in the case and added that the physician was responsible for the patient as he was the original surgeon on the case. Dr. Thompson stated that he has substantial empathy for the ultimate patient outcome of the case. He stated that he wishes he would have seen the patient within a few days of his initial surgery. Dr. Reiss expressed concern that the physician appeared to not take responsibility for the outcome. Dr. Thompson acknowledged that evaluating the wound more frequently may have had an impact on the overall outcome of the case.

MOTION: President Cunningham moved for the Board to enter into Executive Session to obtain legal advice pursuant to A.R.S. 38-431.03(A)(3).
SECOND: Dr. Maitem
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	5	X	X	X	X	X		
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2						X	X

The Board entered into Executive Session at 11:10 a.m.
The Board returned to Open Session at 11:22 a.m.
No legal action was taken by the Board during Executive Session.

Mr. King readdressed the Board stating that this was not a case of patient abandonment. He stated that JK had two board-certified orthopedic surgeons and PAs involved in his care and that there is no statute or rule that prevents the physician from instructing his well-qualified partners to care for his patient. Mr. King also pointed out that Dr. Thompson testified that he would not have deviated from what his partners did to treat the patient.

Dr. Erbstoesser commented that the physician should have followed the patient more closely in the postoperative setting and not rely solely on others calling to make him aware of the circumstances. Dr. Erbstoesser stated that the physician was aware of the patient's high risk and required closer

follow up care.

TK readdressed the Board and stated that the physician was made aware of the circumstances surrounding JK's postoperative complications as early as January 5th. TK questioned whether the rehab facility staff attempted to reach the surgeon prior to the January 3rd presentation to the ER.

Mr. Landau instructed the Board's staff to refer Dr. Thompson's partners as well as the PAs to the Medical Board and the Regulatory Board of PAs for review of their involvement in JK's care. Mr. King reported that the other providers have been referred to their respective regulatory boards. Mr. Landau proposed issuing Dr. Thompson a Letter of Concern to resolve the case, for failing to see the patient earlier than three weeks postoperatively.

MOTION: Mr. Landau moved for the Board to issue a Letter of Concern for failure to properly conduct follow-ups with patient JK that resulted in deviation in the standard of care.
SECOND: President Cunningham
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	5	X	X	X	X	X		
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2						X	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-19-0005A, DO-19-0145A, Anthony Christopher Pozun, DO, LIC. #3684

Dr. Pozun was present during the Board's consideration of this case. Board staff summarized that Dr. Pozun has been on Probation since May 23, 2019 for monitoring through the Physician Health Program (PHP). The Board was informed that Dr. Pozun violated his Board Order on July 4, 2019 by consuming alcohol and the physician contacted the Board the following day to report that his random drug screen would show a positive result. The physician voluntarily reported to Calvary for treatment and thereafter entered a PHP for further aftercare monitoring. Board staff reported that Dr. Pozun has since been compliant with the terms of his monitoring agreement.

Dr. Pozun reported that he was 70 days into his recovery. He explained that when he could not refrain from consuming alcohol in violation of his Board Order, he realized that he had a true problem and voluntarily sought treatment. Dr. Pozun informed the Board that he is currently enrolled in a 12-step program, has a sponsor, attends four meetings a week, and sees a therapist on a weekly basis. Mr. Landau proposed extending the monitoring agreement an additional three years for a total of five years PHP participation, noting that the original Board Order dated May 23, 2019, was issued for two years' monitoring. The Board noted that the physician had the ability to request early termination from the Order. Dr. Pozun stated that he is committed to lifelong sobriety and was in agreement with extending his PHP monitoring for a total of five years.

MOTION: Mr. Landau moved for the Board to find that Dr. Pozun violated his May 23, 2019 Board Order by consuming alcohol.
SECOND: Dr. Erbstoesser
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	5	X	X	X	X	X		
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2						X	X

Mr. Landau proposed mirroring the terms of the original monitoring agreement and extending the Probation for a total of five years of aftercare monitoring.

MOTION: Mr. Landau moved for the Board to offer Dr. Pozun a Consent Agreement for Five Year Probation with terms similar to the May 23, 2019 Board Order issued in case number DO-19-0005A.
SECOND: President Cunningham
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	5	X	X	X	X	X		
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2						X	X

The Board instructed staff to schedule this matter for the Board's January 2020 meeting to assess the physician's progress in PHP.

B. DO-18-0172A, Brian Joseph Coates, DO, LIC. #005837
Dr. Coates was present during the Board's consideration of this matter.

MOTION: President Cunningham moved for the Board to enter into Executive Session to discuss confidential information pursuant to A.R.S. 38-431.03(A)(2).
SECOND: Dr. Maitem
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	5	X	X	X	X	X		
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2						X	X

The Board entered into Executive Session at 12:51 p.m.
The Board returned to Open Session at 1:00 p.m.
No legal action was taken by the Board during Executive Session.

MOTION: President Cunningham moved for the Board to modify the Probation from five years to two years, and to remove the outpatient course requirement.
SECOND: Mr. Landau
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	5	X	X	X	X	X		
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2						X	X

C. DO-18-0155A, Joseph Christopher Thompson, DO, LIC. #007732
Dr. Thompson was present with Attorney David Cohen.

MOTION: President Cunningham moved for the Board to enter into Executive Session to discuss confidential information pursuant to A.R.S. 38-431.03(A)(2).
SECOND: Dr. Maitem
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg

Yay:	5	X	X	X	X	X		
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2						X	X

The Board entered into Executive Session at 1:03 p.m.
The Board returned to Open Session at 1:11 p.m.
No legal action was taken by the Board during Executive Session.

8. 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-19-0144A, Lori Ann Claypool, LIC. #N/A

Dr. Claypool was present during the Board's consideration of this matter. Dr. Claypool applied for an Arizona osteopathic license and disclosed seven prior malpractice settlements on her application. Dr. Claypool also reported that she was disciplined by the Michigan Board for failing to meet CME requirements for license renewal.

Board staff summarized that Dr. Claypool holds licensure in three other states and is board certified. The Board was informed that Dr. Claypool was disciplined by the Michigan Board in 2016 for failure to meet renewal requirements in that she failed to complete the required CME hours. Dr. Claypool complied with her disciplinary Order issued by Michigan and the Probation was terminated in 2017. The Board noted that Illinois subsequently disciplined Dr. Claypool for the action taken by the Michigan Board.

Board staff also summarized for the Board the seven reported malpractice claims involving Dr. Claypool. A case that occurred in 1999 involved a patient who underwent laparoscopic surgery who was found several days postoperatively to have suffered a bowel perforation that was repaired by the general surgeon. A case that occurred in 2003 involved a female patient that underwent hysterectomy and was admitted for a wound infection. A case occurred in 2010 that involved a patient that underwent laparoscopic oophorectomy who was later noted to have a perforation of the sigmoid colon. A case that occurred in 2012 involved a surgical patient who developed a vesicular vaginal fistula that required repair. A case that occurred in 2015 involved a surgical patient who sustained a bladder injury that was not recognized at the time of surgery and required multiple subsequent surgeries to repair. A case in 2013 involved labor induction and cesarean section that resulted in complications. The patient was later admitted to the ICU with sepsis where she expired. A case from 2000 involved a patient who underwent vaginal hysterectomy and experienced bowel leakage from the vagina postoperatively. The patient was found to have a bowel defect.

Dr. Reiss questioned the physician's proficiency and Board members discussed requesting that the applicant complete a PACE evaluation prior to consideration of licensure.

Dr. Claypool addressed the Board regarding her plans for practicing in Arizona if the license is approved. She also explained the circumstances surrounding each malpractice claim that was disclosed on the application. Mr. Landau spoke in favor of a PACE evaluation in light of the reported seven malpractice cases. Dr. Claypool informed the Board that she has no desire to perform major gynecological surgeries going forward. She further explained the circumstances surrounding the Michigan Board discipline and stated that she complied with terms of that Board's Order.

Board members expressed their concerns for licensure given the numerous malpractice cases involving the physician and discussed offering the applicant an Interim Consent Agreement

requiring her to complete a PACE evaluation.

MOTION: President Cunningham moved for the Board to offer Dr. Claypool an Interim Consent Agreement requiring the physician to undergo a PACE evaluation. Dr. Claypool shall enroll with PACE by November 1, 2019, and the evaluation shall be completed by February 1, 2020. If the physician does not enter into the agreement within two weeks, she shall have the opportunity to withdraw her license application within seven days thereafter. If the application is not withdrawn by the seventh day, the license shall be formally denied and reported to the national databank accordingly.
SECOND: Dr. Maitem
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	5	X	X	X	X	X		
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2						X	X

B. DO-19-0148A, Byron F Katzur Tsang, LIC. #N/A

Dr. Tsang was present during the Board's consideration of the license application. Board staff summarized that the applicant meets the education, training, and exam requirements for Arizona licensure. However, Dr. Tsang disclosed a prior malpractice claim on his license application. The case occurred in 2009 and involved a 12-year-old male who was treated for right ankle swelling and difficulty with weight-bearing. The patient was treated and discharged with a splint in place and later presented to a different ER after symptoms persisted.

Board members noted the large award that was paid out on behalf of the physicians involved in the case. Dr. Tsang explained that the patient was reported to have later required plastic surgery and extensive physical therapy. Dr. Erbstoesser stated he felt that the physician was involved in the patient's care in the early stages of the disease process. Dr. Maitem questioned the physician with regard to how his practice has changed after going through the experience of a malpractice claim. Dr. Tsang reported that he is extraordinarily vigilant with vitals and how they correlate with the clinical picture. Dr. Maitem spoke in favor of granting the license.

MOTION: Dr. Maitem moved for the Board to grant licensure.
SECOND: Dr. Erbstoesser
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	5	X	X	X	X	X		

Nay:	0							
Abstain/ Recuse:	0							
Absent:	2						X	X

C. DO-19-0086A, Timothy Francis Timmons, LIC. #N/A

Dr. Maitem was temporarily excused from the meeting at 1:45 pm and returned at 1:57 pm. Dr. Maitem was absent for the voting on this matter.

Dr. Timmons was present during the Board's consideration of the license application. Board staff summarized that the applicant meets the education, training, and exam requirements for Arizona licensure. However, Dr. Timmons disclosed on his license application a prior malpractice claim from the care provided between February 2007 and January 2008. The malpractice suit alleged medical negligence in that there was a failure to properly monitor and treat Hepatitis C, and failure to diagnose liver cancer. It was found that Dr. Timmons failed to properly document in detail his recommendation for the patient to follow up with gastroenterology regarding the Hepatitis C diagnosis.

Dr. Timmons explained that the patient had a distant history of drug abuse and that he referred the patient to a GI specialist for workup and monitoring of the Hepatitis C diagnosis. According to Dr. Timmons, the patient told him that he did not need the referral as he was already under the care of a gastroenterologist. Dr. Timmons did not document the patient's statements in the chart. Dr. Timmons stated that it became clear that the patient was not being monitored by gastroenterology, and one year later was found to have an inoperable adenocarcinoma. Dr. Timmons informed the Board that he had only seen the patient on six occasions from February 2007 to January 2008. He reported that he is now more proactive in attempting to get the patients to return for follow up and to follow through with referrals.

MOTION: Dr. Erbstoesser moved for the Board to grant licensure.
SECOND: President Cunningham
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	4	X	X	X		X		
Nay:	0							
Abstain/ Recuse:	0							
Absent:	3				X		X	X

D. DO-19-0064A, Jay Siu, LIC. #N/A

Dr. Siu was present during the Board's consideration of this matter. Board staff summarized that the applicant meets the education, training, and exam requirements for Arizona licensure. However, Dr. Siu disclosed on the application that he was placed on academic probation on three different occasions, each incident further extending his training contract. The reported reasoning behind the probations involved untimely attendance and unexcused absences. There was also an incident in October of 2018 that involved Dr. Siu placing a line without supervision that resulted in an adverse

event. In November of 2018, Dr. Siu was informed by the program that they did not intend to renew his contract for the next training year. Dr. Siu reported that he appealed that decision, but his appeal was denied and the decision to not renew his contract was upheld. The Board was also informed that Dr. Siu was granted a probationary license in Texas that requires supervised practice for a period of two years. Dr. Siu had indicated that he would be acceptable of a probationary license similar to the terms of the Texas Board's Order.

Dr. Siu addressed the Board, stating that he is in the process of applying to other residency programs, but wishes to seek licensure in Arizona to allow him to find work that will strengthen his experience as a medical professional. Board members expressed their concerns regarding granting licensure under the circumstances, given the reported history of issues during residency training that demonstrated a pattern of problems over the span of three years. Dr. Erbstoesser questioned whether the Board would benefit from having the physician undergo a PACE evaluation to assess his proficiency. The Board discussed the physician returning to Texas to complete his probationary license and noted that he had the ability to reapply for Arizona licensure in the future after completing further training.

MOTION: President Cunningham moved for the Board to allow the applicant to withdraw the license application within ten business days. If not withdrawn by the tenth day, the license shall be formally denied.
SECOND: Dr. Maitem
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	5	X	X	X	X	X		
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2						X	X

9. 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 in attendance and discussed current issues surrounding the practice of Osteopathic Medicine.

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

Calendar Year 2020 Board Meeting Dates

The Board reviewed the proposed meeting dates and there were no scheduling conflicts reported.

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

A. Report on Executive Director Dismissed Complaints

Executive Director Bohall reported that six complaints were dismissed after review by the Investigator or Medical Consultant.

B. Executive Director Report

1. Financial Report
2. Current Events that Affect the Board
3. Licensing and Investigations Update

Executive Director Bohall informed the Board that there are currently 60 cases pending review by the Investigator or Medical Consultant. He reported that the Agency has used approximately 12% of its appropriation for the current Fiscal Year. He added that the number of days for staff to process a license application has been decreased to 35 days and that the average timeframe to issue a final Board Order is 3 days.

12. ADJOURNMENT

MOTION: President Cunningham moved for adjournment.
SECOND: Dr. Maitem
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

	Vote	Dr. Cunningham	Mr. Landau	Dr. Erbstoesser	Dr. Maitem	Dr. Reiss	Dr. Spiekerman	Mr. Burg
Yay:	5	X	X	X	X	X		
Nay:	0							
Abstain/ Recuse:	0							
Absent:	2						X	X

The Board's meeting adjourned at 2:20 p.m.

_____
Justin Bohall, Executive Director