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**BEFORE THE ARIZONA MEDICAL BOARD**

In the Matter of

Case No. MD-10-0928A

**DUDLEY A. HUDSPETH, M.D.**

**ORDER FOR LETTER OF REPRIMAND  
AND CONSENT TO SAME**

Holder of License No. 23299  
For the Practice of Allopathic Medicine  
In the State of Arizona

Dudley A. Hudspeth, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for Letter of Reprimand; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

**FINDINGS OF FACT**

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 23299 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-10-0928A after receiving a complaint regarding Respondent's care and treatment of an 81 year-old female patient ("RT") alleging failure to place RT on anticoagulant therapy prior to and after stent placement.

4. On September 9, 2009, Respondent saw RT for bilateral lower extremity claudication. RT had no rest pain, there were no ischemic changes and there was no loss of muscle mass. RT was a heavy smoker. RT had a non-invasive vascular study followed by an aortogram with run-off on October 5, 2009. Respondent performed a major endovascular procedure on RT's right leg on November 12, 2009. RT's left common femoral artery was punctured and a sheath was inserted in the artery. Various guide wires, catheters and balloons were used to open and insert three overlapping stents in the right superficial femoral artery. Respondent reported that the procedure was successful and that RT's pulses were improved. RT was observed by the nurses and discharged four hours later. Respondent did not re-evaluate RT

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1 prior to discharge and he did not provide RT with instructions regarding care, medications or  
2 follow up. Respondent did not document that he used Plavix postoperatively for RT. On  
3 November 24, 2009, RT presented to a different hospital with a cold and acutely ischemic right leg  
4 and she was treated by another physician. RT had numerous complications that resulted in what  
5 was described as a useless ischemic right leg with neurological damage, a dropped foot,  
6 numbness, swelling and infection.

7 5. The standard of care for an elderly patient after undergoing a major vascular  
8 procedure requires a physician to observe the patient for 24 hours or re-evaluate the patient prior  
9 to discharge and the physician is required to provide proper instruction for the care, medications  
10 and follow up.

11 6. Respondent deviated from the standard of care by discharging RT only four hours  
12 postoperatively without re-evaluation and without providing proper instructions for the care,  
13 medications and follow up.

14 7. The standard of care for a patient with a documented history of being a heavy  
15 smoker that presents with claudication requires a physician to conservatively manage the patient's  
16 care with treatments such as cessation of smoking, an exercise regimen to develop collaterals and  
17 medications such as Trental, Pletal, Plavix and Aspirin.

18 8. Respondent deviated from the standard of care by performing a major vascular  
19 procedure for RT's claudication instead of attempting to conservatively manage RT's care.

20 9. Respondent caused actual harm by performing a major vascular procedure that  
21 resulted in RT's loss of right leg use. Respondent potentially could have also caused RT to lose  
22 both legs and her life.

23 10. A physician is required to maintain adequate legible medical records containing, at a  
24 minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment,  
25 accurately document the results, indicate advice and cautionary warnings provided to the patient  
and provide sufficient information for another practitioner to assume continuity of the patient's care

DATA

1 at any point in the course of treatment. A.R.S. §32-1401(2). Respondent's medical records were  
2 inadequate because Respondent failed to document RT's Plavix prescription.

3 CONCLUSIONS OF LAW

4 1. The Board possesses jurisdiction over the subject matter hereof and over  
5 Respondent.

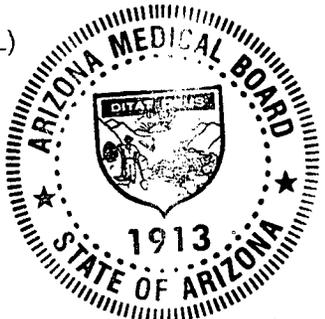
6 2. The conduct and circumstances described above constitute unprofessional conduct  
7 pursuant to A.R.S. § 32-1401 (27)(e) ("[f]ailing or refusing to maintain adequate records on a  
8 patient"); and A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or  
9 dangerous to the health of the patient or the public").

10 ORDER

11 IT IS HEREBY ORDERED THAT Respondent is issued a Letter of Reprimand.

12  
13  
14 DATED AND EFFECTIVE this 8<sup>TH</sup> day of DECEMBER, 2010.

15 (SEAL)



ARIZONA MEDICAL BOARD

By *Lisa S. Wynn*  
Lisa S. Wynn  
Executive Director

18  
19 CONSENT TO ENTRY OF ORDER

20 1. Respondent has read and understands this Consent Agreement and the stipulated  
21 Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the  
22 right to consult with legal counsel regarding this matter.

23 2. Respondent acknowledges and agrees that this Order is entered into freely and  
24 voluntarily and that no promise was made or coercion used to induce such entry.

25 3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a  
hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order

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1 in its entirety as issued by the Board, and waives any other cause of action related thereto or  
2 arising from said Order.

3 4. The Order is not effective until approved by the Board and signed by its Executive  
4 Director.

5 5. All admissions made by Respondent are solely for final disposition of this matter  
6 and any subsequent related administrative proceedings or civil litigation involving the Board and  
7 Respondent. Therefore, said admissions by Respondent are not intended or made for any other  
8 use, such as in the context of another state or federal government regulatory agency proceeding,  
9 civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

10 6. Upon signing this agreement, and returning this document (or a copy thereof) to the  
11 Board's Executive Director, Respondent may not revoke the consent to the entry of the Order.  
12 Respondent may not make any modifications to the document. Any modifications to this original  
13 document are ineffective and void unless mutually approved by the parties.

14 7. This Order is a public record that will be publicly disseminated as a formal  
15 disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on  
16 the Board's web site as a disciplinary action.

17 8. If any part of the Order is later declared void or otherwise unenforceable, the  
18 remainder of the Order in its entirety shall remain in force and effect.

19 9. If the Board does not adopt this Order, Respondent will not assert as a defense that  
20 the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar  
21 defense.

22 10. Any violation of this Order constitutes unprofessional conduct and may result in  
23 disciplinary action pursuant to A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation,  
24 consent agreement or stipulation issued or entered into by the board or its executive director under  
25 this chapter") and 32-1451.

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DUDLEY A. HUDSPETH, M.D.

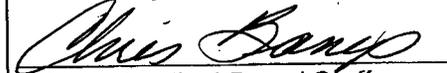
DATED: 10/4/2010

EXECUTED COPY of the foregoing mailed  
this 4th day of December 2010 to:

Dudley A. Hudspeth, MD  
ADDRESS OF RECORD

ORIGINAL of the foregoing filed  
this 4th day of December 2010 with:

Arizona Medical Board  
9545 E. Doubletree Ranch Road  
Scottsdale, AZ 85258

  
Arizona Medical Board Staff