

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **WILLIAM A. CALDERWOOD, M.D.**

4 License No. 11658
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Case No. MD-10-0144A
**FINDINGS OF FACT, CONCLUSIONS
OF LAW AND ORDER FOR LETTER
OF REPRIMAND AND PROBATION**

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on
8 December 8, 2010. William A. Calderwood, M.D. ("Respondent") appeared with legal
9 counsel before the Board for a Formal Interview pursuant to the authority vested in the
10 Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of
11 Law and Order after due consideration of the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

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

15 2. Respondent is the holder of license number 11658 for the practice of
16 allopathic medicine in the State of Arizona.

17 3. The Board initiated case number MD-10-0144A after receiving notification of
18 a malpractice settlement regarding Respondent's care and treatment of a 59 year-old
19 female patient ("DF") alleging failure to advise DF of an abnormal chest x-ray, resulting in
20 a 15-month delay in diagnosis of lung cancer.

21 4. DF established care with Respondent in 2002 with a previous medical history
22 significant for myocardial infarction, prior stroke, hyperlipidemia and tobacco use.
23 Respondent's progress notes were brief and often did not include history of present illness
24 information.
25

1 5. On January 18, 2007, Respondent saw DF and ordered a chest x-ray and
2 labs. The chest x-ray was performed the following day and showed a 1.6cm soft tissue
3 round mass in the right upper lobe. Correlation with prior studies was recommended and
4 Respondent's impression indicated that malignancy could not be excluded. Respondent
5 did not inform DF of the results. At subsequent appointments on February 19, 2007 and
6 February 19, 2008, Respondent failed to address the chest x-ray and made only sparse
7 chart notes with minimal history of present illness documentation.

8 6. Respondent ordered a CT scan, which was performed on May 20, 2008, and
9 showed left axillary lymph node prominence with a 17mm left axillary node. The
10 previously identified right upper lobe nodule now measured 3.7cm. Massive right hilar,
11 paratracheal and mediastinal adenopathy were noted with the largest nodes in the right
12 suprahilar/paratracheal region measuring 2.7cm and 2.8cm. There was also a 2cm right
13 perihilar mass and a 2.7cm right hilar mass. Additional findings included bilateral adrenal
14 masses.

15 7. DF was seen by a pulmonologist the same day and a percutaneous lung
16 aspiration biopsy was arranged. Core needle biopsies of the right lung mass performed on
17 May 23, 2008 showed moderately well-differentiated pulmonary adenocarcinoma. DF was
18 referred to oncology where a staging work up was arranged and chemotherapy was
19 initiated. Multiple chemotherapy regimens were subsequently tried and palliative radiation
20 was added. DF showed improvement and reduction of tumor mass on VP-16 and
21 Cisplatin. In October 2009, staging showed disease progression and DF was started on
22 Alimta.

23 8. At the Formal Interview, Respondent informed the Board that he had made a
24 number of changes to his practice since this incident occurred. He stated that he has
25 created a tracking document that his staff gives him every time a patient does not show up

1 for a follow-up appointment. He then orders his staff to contact the patient to reschedule,
2 send a letter to remind the patient or send a certified letter as soon as possible in cases
3 where follow-up is necessary. In addition, Respondent testified that he had installed an
4 electronic medical record keeping system in his office. Finally, Respondent informed the
5 Board that he had undergone a nine month audit from MICA and completed five online
6 CME course in charting and practice systems.

7 9. The standard of care requires a physician to discuss abnormal x-ray findings
8 with the patient and to include the patient in the discussion of the planned diagnostic work
9 up.

10 10. Respondent deviated from the standard of care by failing to inform DF of her
11 abnormal January 19, 2007 chest x-ray finding for a period of fifteen months after receiving
12 the x-ray report.

13 11. The standard of care requires a physician to perform additional timely
14 imaging studies to further evaluate the patient's right upper lobe mass and refer the patient
15 to a pulmonary consultant to evaluate for biopsy or excision of the lung mass.

16 12. Respondent deviated from the standard of care by failing to perform
17 additional timely imaging studies to further evaluate the right upper lobe mass and by
18 failing to refer DF to a pulmonary consultant to evaluate for biopsy or excision of the lung
19 mass.

20 13. DF was potentially harmed by Respondent's delay in the diagnosis of DF's
21 adenocarcinoma of the lung as the delay in the diagnosis may have caused the lung
22 cancer to be diagnosed at a later stage, when it was inoperable, and there was no chance
23 of curative resection.

24 14. A physician is required to maintain adequate legible medical records
25 containing, at a minimum, sufficient information to identify the patient, support the

1 diagnosis, justify the treatment, accurately document the results, indicate advice and
2 cautionary warnings provided to the patient and provide sufficient information for another
3 practitioner to assume continuity of the patient's care at any point in the course of
4 treatment. A.R.S. §32-1401(2). Respondent's medical records were inadequate because
5 the progress notes for DF were brief and often did not include history of present illness
6 information. Also, DF's chest x-ray was not addressed and chart notes for DF were sparse
7 with minimal history of present illness documentation.

8
9 **CONCLUSIONS OF LAW**

10 1. The Board possesses jurisdiction over the subject matter hereof and over
11 Respondent.

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

16
17 **ORDER**

18 IT IS HEREBY ORDERED THAT:

19 1. Respondent is issued a Letter of Reprimand and Probation.

20 2. Respondent is placed on probation for **one year** with the following terms and
21 conditions:

22 a. Respondent shall within **one year** of the effective date of this Order
23 complete the PACE medical recordkeeping course. The course hours shall be in addition
24 to the CME hours required for the biennial renewal of medical licensure. The probation
25 shall terminate upon successful completion of the course work.

1 b. Obey All Laws

2 Respondent shall obey all state, federal and local laws, all rules governing the
3 practice of medicine in Arizona, and remain in full compliance with any court ordered
4 criminal probation, payments and other orders.

5 c. Tolling

6 In the event Respondent should leave Arizona to reside or practice outside
7 the State or for any reason should Respondent stop practicing medicine in Arizona,
8 Respondent shall notify the Executive Director in writing within ten days of departure and
9 return or the dates of non-practice within Arizona. Non-practice is defined as any period of
10 time exceeding thirty days during which Respondent is not engaging in the practice of
11 medicine. Periods of temporary or permanent residence or practice outside Arizona or of
12 non-practice within Arizona, will not apply to the reduction of the probationary period.

13 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

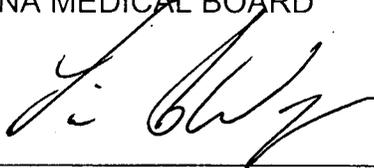
14 Respondent is hereby notified that he has the right to petition for a rehearing or
15 review. The petition for rehearing or review must be filed with the Board's Executive
16 Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The
17 petition for rehearing or review must set forth legally sufficient reasons for granting a
18 rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after
19 date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed,
20 the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

21 Respondent is further notified that the filing of a motion for rehearing or review is
22 required to preserve any rights of appeal to the Superior Court.

1 DATED AND EFFECTIVE this 10TH day of FEBRUARY, 2011.



ARIZONA MEDICAL BOARD

By 
Lisa S. Wynn
Executive Director

8 EXECUTED COPY of the foregoing mailed
9 this 10th day of February 2011 to:

10 Mr. Jeffrey J. Campbell
11 CAMPBELL YOST CLARE & NORELL PC
12 101 North First Avenue, Suite 2500
Phoenix, Arizona 85003
Attorneys for Respondent

13 ORIGINAL of the foregoing filed
14 this 10th day of February 2011 with:

15 Arizona Medical Board
16 9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

17 
18 Arizona Medical Board Staff