

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **DEREK LANDAN, M.D.**

4 Holder of License No. **28634**  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona.

Board Case No. MD-07-0526A

**FINDINGS OF FACT,  
CONCLUSIONS OF LAW AND ORDER**

(Letter of Reprimand)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on  
8 April 2, 2009. Derek Landan, M.D., ("Respondent") appeared with legal counsel, Sarah L.  
9 Sato, before the Board for a formal interview pursuant to the authority vested in the Board  
10 by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law  
11 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 No. 28634 for the practice of allopathic  
16 medicine in the State of Arizona.

17 3. The Board initiated case number MD-07-0526A after receiving notification of  
18 a malpractice settlement involving Dr. Landan's care and treatment of a 20 year-old  
19 female patient ("CM") alleging Dr. Landan's unnecessary and inadequate performance of a  
20 surgical procedure.

21 4. CM presented to the hospital on August 19, 2005, complaining of abdominal  
22 pain, nausea and vomiting. She stated that she had intermittent episodes of severe  
23 stabbing pain in the upper right quadrant, along with some nausea and vomiting,  
24 sometimes radiating through to her back.

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1           5.     At the time of her admission to the hospital, CM did not have a fever and her  
2 pulse and blood pressure were stable.

3           6.     CM mentioned that she had undergone an abdominal ultrasound within the  
4 last few weeks, but the admitting physician, who did not have access to the films, was  
5 concerned about the possibility of gallbladder disease and thus ordered an ultrasound at  
6 the hospital.

7           7.     Blood tests revealed that one of the liver enzymes (AST) was minimally  
8 elevated at 55 and the WBC was slightly elevated at approximately 14,000. The remaining  
9 liver counts were normal, as were the lipase and other blood and urine tests.

10          8.     The ultrasound revealed a normal gallbladder without any stones, normal  
11 common bile duct and a prominent cystic duct at 10 mm.

12          9.     After the test results were reviewed, CM was admitted to the hospital with a  
13 recommendation that a biliary scan (HIDA) be performed.

14          10.    Respondent saw the patient the same day that she was admitted to the  
15 hospital. He consulted with the patient and reviewed her ultrasound, serum level of lipase  
16 and urine pregnancy test. He noted that she denied any fever and was not jaundiced.

17          11.    After the consultation, Respondent decided to perform an  
18 esophagogastroduodenoscopy (EGD) and an endoscopic retrograde cholangiography with  
19 endoscopic biliary sphincterotomy (ERCP), which he scheduled for later that day.

20          12.    The Board's Outside Medical Consultant (OMC) opined that there was no  
21 documented indication for performing an ERCP. The patient did not have fever, did not  
22 appear septic and was not jaundiced. Therefore, there was no evidence that the patient  
23 was suffering from cholangitis. Moreover, according to the OMC, an ultrasound showing  
24 a dilated cystic duct, by itself, is not an adequate reason for performing an ERCP.

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1           13. After performing the EGD, which revealed mild inflammation in the  
2 duodenum, Respondent then proceeded with the ERCP. According to Respondent's  
3 dictated operative report, which was electronically authenticated by Respondent on August  
4 23, 2005, four days after the surgery, the procedure occurred as follows:

5                   Cannulation was carried out. A guidewire was passed easily  
6 without any resistance whatsoever. Sphincterotomy was  
then performed. Full cholangiogram was attempted.

7                   The contrast flow appeared to either fill the gallbladder or the  
8 retroperitoneum. The area was manipulated. Suction was  
9 used and bile was seen to flow out from the area of the  
sphincterotomy. Because of the concern for possible  
perforation, all instruments were withdrawn.

10           14. During the formal interview, Respondent testified that he performed the  
11 cholangiogram prior to the sphincterotomy. When confronted with the contradiction  
12 between his testimony and his operative report, Respondent claimed that he had dictated  
13 the report incorrectly.

14           15. After the surgery, an emergency CT scan confirmed the presence of a  
15 perforation of the retroperitoneum.

16           16. On August 25, 2005, CM was discharged from the hospital.

17           17. On August 29, 2005, CM presented at another hospital complaining of  
18 abdominal pain. She was hospitalized until October 19, 2005 and underwent multiple  
19 surgeries for abscess due to pancreatic fistula and leakage from the prior perforation  
20 during ERCP. She was hospitalized again from January 29, 2006 to February 2, 2006 for  
21 pancreatitis.

22           18. The Board's Outside Medical Consultant concluded that Respondent's  
23 medical records were inadequate because Dr. Landan did not document any discussion of  
24 the risks, benefits and alternatives of ERCP or EGD with the patient. Dr. Landan also  
25

1 failed to indicate in the medical records the reason for performing an ERCP before the  
2 procedure.

3 19. The standard of care requires a physician to obtain appropriate diagnostic  
4 tests and then review the results of the diagnostic studies before performing an ERCP.

5 20. Dr. Landan deviated from the standard of care by performing an ERCP that  
6 was not indicated by history and diagnostic tests.

7 21. CM suffered actual harm when she underwent an ERCP without proper  
8 indication at the time of presentation to the hospital. She had a perforation of the  
9 duodenum resulting in complications and additional hospitalizations for major abdominal  
10 surgeries.

### 11 **CONCLUSIONS OF LAW**

12 1. The Arizona Medical Board possesses jurisdiction over the subject matter  
13 hereof and over Respondent.

14 2. The Board has received substantial evidence supporting the Findings of Fact  
15 described above and said findings constitute unprofessional conduct or other grounds for  
16 the Board to take disciplinary action.

17 3. The conduct and circumstances described above constitute unprofessional  
18 conduct pursuant to A.R.S. § 32-1401(27)(e) (“(f)ailing or refusing to maintain adequate  
19 records on a patient”) and § 32-1401(27)(q) (“[a]ny conduct that is or might be harmful or  
20 dangerous to the health of the patient or the public.”).

### 21 **ORDER**

22 Based upon the foregoing Findings of Fact and Conclusions of Law,

23 IT IS HEREBY ORDERED:

24 1. Respondent is issued a Letter of Reprimand.

25 2. The Board retains jurisdiction and may initiate new action based upon

1 any violation of this Order.

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

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

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

12 DATED this 14<sup>th</sup> day of June, 2009



13 THE ARIZONA MEDICAL BOARD

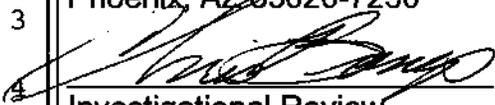
14 By *Lisa S. Wynn*  
15 Lisa S. Wynn  
16 Executive Director

17 ORIGINAL of the foregoing filed this  
18 14<sup>th</sup> day of June, 2009 with:

19 Arizona Medical Board  
20 9545 East Doubletree Ranch Road  
21 Scottsdale, Arizona 85258

22 Executed copy of the foregoing  
23 mailed by U.S. Mail this  
24 14<sup>th</sup> day of June, 2009 to:  
25

1 Sarah L. Sato, Esq.  
2 Olson, Jantsch & Bakker  
3 7243 North 16<sup>th</sup> Street  
4 Phoenix, AZ 85020-7250



Investigational Review

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