

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **ABDULKADIR A. HOURANI, M.D.**

4 Holder of License No. 25270
5 For the Practice of Allopathic Medicine
6 In the State of Arizona

Case No. MD-12-0120A
MD-12-0123A

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

(Letter of Reprimand and Probation)

7
8 The Arizona Medical Board ("Board") considered this matter at its public meeting on
9 October 3, 2012. Abdulkadir A. Hourani, M.D. ("Respondent") appeared with legal counsel,
10 Paul Giancola, before the Board for a formal interview pursuant to the authority vested in
11 the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions
12 of Law and Order after due consideration of the facts and law applicable to this matter.

13 **FINDINGS OF FACT**

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

16 2. Respondent is the holder of license number 25270 for the practice of
17 allopathic medicine in the State of Arizona.

18 3. The Board initiated case number MD-12-0120A after receiving a complaint
19 regarding Respondent's care and treatment of a 68 year-old male patient ("MV") alleging
20 failure to timely place a chest tube in MV. The Board initiated case number MD-12-0123A
21 after receiving a complaint regarding Respondent's care and treatment of a 75 year-old
22 male patient ("RJ") alleging failure to adequately examine the patient, and reporting that
23 false statements were made in the patient's chart.

24

25

Case no. MD-12-0120A

1
2 4. On July 21, 2011, MV was first seen by Respondent for evaluation of a lung
3 mass and enlarged lymph nodes. Respondent performed a bronchoscopy with biopsy and
4 diagnosed lung cancer from the right lung. MV was treated by an oncologist for metastatic
5 lung cancer.

6 5. On November 16, 2011, MV was seen by the oncologist complaining of
7 dyspnea on exertion, continuous need for oxygen, and chest and shoulder pain. A chest x-
8 ray revealed a completely opacified right chest, with shift of the mediastinum to the left.
9 The radiologist commented that the x-ray was significantly worse than two months prior.
10 MV was sent to Respondent's office, who arranged for hospital admission that evening.

11 6. Respondent saw MV in the hospital later that evening and deemed him to be
12 stable. The nurse reported to Respondent that MV could not tolerate the decubitus chest
13 x-ray as he became short of breath and panicked. He was also noted to be diaphoretic and
14 hypothermic with a temperature of 95.8. Respondent planned to perform chest tube
15 placement the next day.

16 7. At the Formal Interview, Respondent testified that he did not want to perform
17 the chest tube placement in the evening because he would not be at the hospital if
18 complications arose. Moreover, he did not think that MV's situation was an emergency
19 requiring immediate treatment.

20 8. Six hours later, MV was found unresponsive by a nurse and he was noted to
21 be in cardiac arrest. Resuscitation was initiated, MV was intubated, and he was transferred
22 to ICU. The intensivist performed immediate chest tube placement for the continuing
23 pulseless rhythm, where 8000cc of fluid was obtained. Despite some improvements, MV
24 remained on the ventilator until his wife requested comfort care. MV expired on November
25 20, 2011.

1 physical exam, and that he dictated his consultation note at that time. Respondent stated
2 that the mistakes in the chart were exactly what RJ told him.

3 16. Based upon the Formal Interview, the Board determined there was
4 miscommunication between Respondent and RJ, resulting in erroneous recordkeeping by
5 Respondent. Moreover, the Board concluded that Respondent failed to review available
6 documents that might have clarified some aspects of the patient's history.

7 **CONCLUSIONS OF LAW**

8
9 1. The Board possesses jurisdiction over the subject matter hereof and over
10 Respondent.

11 2. The conduct and circumstances described above constitute unprofessional
12 conduct pursuant to A.R.S. § 32-1401(27)(e) (“[f]ailing or refusing to maintain adequate
13 records on a patient.”).

14 3. The conduct and circumstances described above constitute unprofessional
15 conduct pursuant to A.R.S. § 32-1401(27)(q) (“[a]ny conduct or practice that is or might be
16 harmful or dangerous to the health of the patient or the public”).

17 **ORDER**

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

19 IT IS HEREBY ORDERED:

20 1. Respondent is issued a Letter of Reprimand.

21 2. Respondent is placed on probation for **six months** with the following terms
22 and conditions:

23 a. Continuing Medical Education

24 Respondent shall within six months of the effective date of this Order obtain -
25 **15-20 hours** of Board Staff pre-approved Category I Continuing Medical Education (CME)

1 in the treatment of pulmonary emergencies and provide Board Staff with satisfactory proof
2 of attendance. The CME hours shall be in addition to the hours required for the annual
3 renewal of licensure. The probation shall terminate upon successful completion of the
4 CME.

5 c. Obey All Laws

6 Respondent shall obey all state, federal and local laws, all rules governing
7 the performance of health care tasks in Arizona, and remain in full compliance with any
8 court order criminal probation, payments and other orders.

9 3. The Board retains jurisdiction and may initiate new action based upon any
10 violation of this Order.

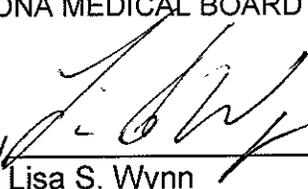
11
12 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

13
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.
23
24
25

1 DATED this 6th day of December, 2012

2 THE ARIZONA MEDICAL BOARD

3
4 By 

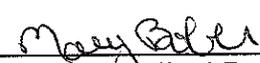
5 Lisa S. Wynn
6 Executive Director

7 EXECUTED COPY of the foregoing mailed
8 this 6th day of December, 2012 to:

9 Paul Giancola, Esq.
10 Snell & Wilmer LLP
11 400 East Van Buren
12 Phoenix, AZ 85004-2202

13 ORIGINAL of the foregoing filed
14 this 6th day of December, 2012 with:

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

18 
19 _____
20 Arizona Medical Board Staff
21
22
23
24
25