

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **MILES W. HOWARD, M.D.**

4 Holder of License No. 21113  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona

Case No. MD-09-0232A

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

7 Miles W. Howard, M.D. ("Respondent") elects to permanently waive any right to a  
8 hearing and appeal with respect to this Order for Letter of Reprimand; admits the  
9 jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order  
10 by the Board.

11 **FINDINGS OF FACT**

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

14 2. Respondent is the holder of license number 21113 for the practice of  
15 allopathic medicine in the State of Arizona.

16 3. The Board initiated case number MD-09-0232A after receiving notification  
17 from a medical center stating that Respondent's privileges were suspended due to his  
18 failure to complete an assessment of his knowledge and management of pregnancy  
19 induced hypertension (PIH) and hemolysis, elevated liver enzymes, low platelets (HELLP)  
20 syndrome. Three patient charts were reviewed and deviations were found in all three.

21 4. Specifically, a twenty-one year-old female patient ("JR") arrived at the  
22 hospital in active labor. Another provider unsuccessfully attempted to arrest the labor.  
23 Respondent arrived at the hospital and evaluated JR's status. Respondent discontinued  
24 her medications, ordered Pitocin stimulation, and left the delivery area before the covering  
25 physician arrived. JR rapidly progressed to complete dilatation and when Respondent was

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1 paged, he was unavailable to perform the delivery. Subsequently, another physician  
2 performs the delivery.

3 5. The standard of care in a patient presenting in premature labor requires a  
4 physician to attempt to arrest the labor and if unsuccessful, delivery with appropriate  
5 personnel in attendance should be carried out with proper planning should the infant  
6 require transportation to a different facility.

7 6. Respondent deviated from the standard of care because he did not attempt  
8 to arrest JR's labor, rather he initiated Pitocin stimulation when JR was already in labor  
9 and then left the area without arranging coverage of her delivery when he was not  
10 available.

11 7. There was potential for complications of a premature delivery for JR and the  
12 fetus, particularly without a physician in attendance.

13 8. Patient LF, a thirty-one year old female, was under Respondent's care at 31  
14 weeks gestation and required surgery for persistent infection subsequent to an open left  
15 tibial fracture to remove the infected hardware. Upon admission to the hospital, an  
16 elevated blood pressure and protein in LF's urine was noted. On LF's third hospital day,  
17 Respondent noted that she was hypertensive; however, it was not noted whether he  
18 considered a diagnosis of pre-eclampsia and further evaluated her by ordering laboratory  
19 studies even though the internal medicine evaluations stated that pre-eclampsia was the  
20 probable diagnosis. Respondent subsequently documented that LF may be discharged  
21 without further evaluation or treatment. LF was later transferred to labor and deliver due to  
22 contractions and was managed by other providers. LF was transferred to a high-risk center  
23 with a diagnosis of severe pre-eclampsia.

1           9.     The standard of care of care in a patient presenting with hypertension in the  
2 third trimester requires a physician to evaluate for pre-eclampsia and if diagnosed, to  
3 institute appropriate evaluations and treatments for this type of high-risk patient.

4           10.    Respondent deviated from the standard of care because he did not diagnose  
5 and manage LF severe pre-eclampsia.

6           11.    LF was transferred to labor and deliver and delivered a premature infant.  
7 Respondent's failure to diagnose and treat LF's severe pre-eclampsia could have led to  
8 eclampsia and all related complications.

9           12.    Patient PT, a twenty-one year old female, was admitted to the hospital for  
10 evaluation of pre-eclampsia. PT had an elevated blood pressure, headaches and lower  
11 extremity edema. Respondent saw her on August 18, 2007, but she was not seen again  
12 until August 20, 2007 by the covering physician at which time she was found in respiratory  
13 distress. During that time, the nursing staff contacted Respondent on several occasions  
14 and on one occasion requested an on-site assessment; however, Respondent did not  
15 present to see PT. Subsequently, PT was transferred to the intensive care unit (ICU) and  
16 treated for acute respiratory distress syndrome (ARDS) and septic shock. PT later  
17 developed cardiac arrest and died.

18           13.    The standard of care in a patient admitted for evaluation of pre-eclampsia  
19 requires a physician to conduct a thorough evaluation, to closely monitor the patient's  
20 status to detect acceleration of the process and to determine appropriate treatment  
21 options.

22           14.    Respondent deviated from the standard of care because he did not evaluate  
23 PT more frequently, he did not closely monitor her status to detect acceleration of the  
24 process and he did not treat her by active management.

1 15. PT required treatment in the ICU for ARDS and septic shock and eventually  
2 died. Had PT's problems been addressed sooner during her hospitalization, PT's demise  
3 may have been prevented. When a patient is diagnosed with severe pre-eclampsia and is  
4 not actively managed, the risk of eclampsia exists with its numerous complications,  
5 including death.

6 16. A physician is required to maintain adequate legible medical records  
7 containing, at a minimum, sufficient information to identify the patient, support the  
8 diagnosis, justify the treatment, accurately document the results, indicate advice and  
9 cautionary warnings provided to the patient and provide sufficient information for another  
10 practitioner to assume continuity of the patient's care at any point in the course of  
11 treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because there  
12 was no documentation that Respondent presented to see PT and whether he considered a  
13 diagnosis of pre-eclampsia for LF.

14 **CONCLUSIONS OF LAW**

15 1. The Board possesses jurisdiction over the subject matter hereof and over  
16 Respondent.

17 2. 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 A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or  
20 might be harmful or dangerous to the health of the patient or the public.").

21 **ORDER**

22 IT IS HEREBY ORDERED THAT:

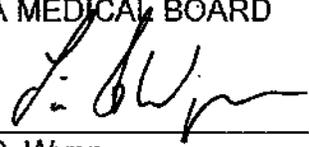
- 23 1. Respondent is issued a Letter of Reprimand.  
24 2. Respondent shall within six months of the effective date of this Order obtain  
25 15 - 20 hours of Board Staff pre-approved non-disciplinary Category I Continuing Medical

1 Education (CME) in medical recordkeeping at the Physician Assessment and Clinical  
2 Education Program. Respondent shall provide Board Staff with satisfactory proof of  
3 attendance. The CME hours shall be in addition to the hours required for the biennial  
4 renewal of medical license.

5 DATED AND EFFECTIVE this 2<sup>nd</sup> day of DECEMBER, 2009.



8 ARIZONA MEDICAL BOARD

9 By   
10 Lisa S. Wynn

11 Executive Director

12 **CONSENT TO ENTRY OF ORDER**

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

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

18 3. By consenting to this Order, Respondent voluntarily relinquishes any rights to  
19 a hearing or judicial review in state or federal court on the matters alleged, or to challenge  
20 this Order in its entirety as issued by the Board, and waives any other cause of action  
21 related thereto or arising from said Order.

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

24 5. All admissions made by Respondent are solely for final disposition of this  
25 matter and any subsequent related administrative proceedings or civil litigation involving  
the Board and Respondent. Therefore, said admissions by Respondent are not intended  
or made for any other use, such as in the context of another state or federal government

1 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or  
2 any other state or federal court.

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

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

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

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

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

20 Miles W. Howard DATED: November 27, 2009  
21 MILES W. HOWARD, M.D.

22  
23 EXECUTED COPY of the foregoing mailed  
this 2<sup>nd</sup> day of December, 2009 to:

24 Stephen Myers  
25 Myers & Jenkins  
One E. Camelback Road, Suite 500  
Phoenix, Arizona 85012

1 EXECUTED COPY of the foregoing mailed  
2 this 2<sup>nd</sup> day of December, 2009 to:

3 Miles W. Howard, M.D.  
4 Address of Record

5 ORIGINAL of the foregoing filed  
6 this 2<sup>nd</sup> day of December, 2009 with:

7 Arizona Medical Board  
8 9545 E. Doubletree Ranch Road  
9 Scottsdale, AZ 85258

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12 Arizona Medical Board Staff  
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