

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **FRANK PALLARES, M.D.**

4 Holder of License No. 41363
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Case No. MD-12-1458A

**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 February 4, 2016. Frank Pallares, M.D. ("Respondent"), appeared before the Board for a
9 Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H).
10 The Board voted to issue Findings of Fact, Conclusions of Law and Order after due
11 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 41363 for the practice of
16 allopathic medicine in the State of Arizona.

17 3. The Board initiated case number MD-12-1458A after receiving a report from
18 the hospital where Respondent held privileges ("Hospital") stating that Respondent had
19 resigned during a review of multiple patient charts prompted by concerns regarding poor
20 clinical judgment and inattention to details.

21 4. A Medical Consultant ("MC") reviewed five of Respondent's patient charts.

22 5. Patient DW was an 80 year-old male admitted to the Hospital with near
23 syncope. DW's hospitalization records did not reference a pacer interrogation, but
24 Respondent commented that pacer interrogation was "normal" when checked several
25 months prior. The MC found that DW's pacer Holter function should have been reviewed

1 to identify or exclude concerns regarding known interactions between neurostimulators
2 and pacers that can lead to tachycardias and bradycardias.

3 6. Patient RC was a 56 year-old male seen by Respondent to review the results
4 of outpatient imaging. A trans-esophageal echocardiogram showed the presence of
5 severe left ventricular ("LV") dysfunction, event monitoring documented episodes of
6 monomorphic ventricular tachycardia ("VT"), and nuclear stress imaging suggested the
7 presence of an inferior wall infarct. RC's clinical presentation included multiple episodes of
8 near syncope and chest discomfort suggestive of angina. Following admission,
9 Respondent performed a cardiac catheterization on RC. Respondent found that RC had
10 normal coronary arteries and severe global LV dysfunction. Respondent diagnosed RC
11 with non-ischemic cardiomyopathy and treated him with intravenous and oral Amiodarone.
12 RC was subsequently discharged and transported by car to another hospital for
13 implantation of an implantable cardioverter-defibrillator ("ICD").

14 7. The MC found that Respondent's failure to treat RC's LV dysfunction with
15 modern medications represents a deviation from the standard of care. Specifically, the
16 MC noted that VT ablation should have been considered. Further, the MC found that it
17 was not safe or proper to allow RC to use unmonitored transportation from one hospital to
18 another, especially given that RC presented with both VT and pre-syncope.

19 8. DF, a 59 year-old male, presented to the Hospital following a prolonged
20 episode of chest pain. Initial cardiovascular ("CV") markers suggested the presence of
21 myocardial injury, though DF's electrocardiograms were unremarkable. DF initially wanted
22 to leave the Hospital to seek care at the Veterans Administration Hospital ("VA"), but was
23 convinced to stay. Though he was clinically stable, DF's CV markers evolved in a pattern
24 strongly suggestive of a non-ST elevation myocardial infarction. He was treated with low
25 molecular weight heparin, aspirin, beta blockade and nitrates. DF again insisted on going

1 to the VA. He was discharged without transfer, following a day of stability that included a
2 ten-minute walk on the ward that did not precipitate symptoms, according to Respondent.
3 By his own admission, Respondent was unable to contact cardiology at the VA and
4 therefore, DF did not have a committed VA caregiver upon Hospital discharge. The MC
5 stated that DF should have been transferred by resuscitation-capable transport, with
6 uninterrupted medical therapy for acute coronary syndrome, and with arrangements made
7 for a cardiology admission at the receiving hospital.

8 9. The standard of care requires a physician to review the pacer's Holter
9 function to identify or exclude any interaction between the neurostimulators and
10 pacemaker. Respondent deviated from the standard of care by failing to assess DW's
11 pacer and its Holter function, and by failing to recognize the potential for an adverse
12 interaction between the neurostimulators and pacemaker.

13 10. The standard of care requires a physician to employ the use of monitored
14 transportation when transferring a patient with VT and pre-syncope to another facility.
15 Respondent deviated from the standard of care by allowing RC to use unmonitored
16 transportation to another hospital for ICD implantation.

17 11. The standard of care requires transfer by resuscitative-capable
18 transportation with uninterrupted medical therapy and with arrangements made for a
19 cardiology admission at the receiving hospital. Respondent deviated from the standard of
20 care by discharging DF without transfer, and by failing to contact the VA to arrange for
21 cardiology admission.

22 12. There are known interactions between neurostimulators and pacers that can
23 lead to both tachycardias and bradycardias. Serious complications, including death, can
24 arise when a patient with significant cardiac problems, including acute coronary syndrome,
25

1 is transported unmonitored from one facility to another, without resuscitation capable
2 transport and without continuous medical therapy.

3 13. On June 6-7, 2014, Respondent underwent Phase I of the Physician
4 Assessment and Clinical Education ("PACE") Program. The initial PACE report stated that
5 Respondent's performance on Phase I of the evaluation was variable and recommended
6 that Respondent complete a neuropsychological/fitness for duty evaluation prior to
7 completion of Phase II.

8 14. On March 9, 2015, Respondent presented for Phase II of PACE without
9 undergoing the neuropsychological evaluation recommended in the Phase I report.
10 Respondent also did not complete Phase II of the evaluation due to alleged unprofessional
11 conduct during the clinical evaluation portion of the program, resulting in Respondent
12 being "indefinitely barred" from returning to complete Phase II absent a neuropsychological
13 evaluation.

14 15. On June 25, 2015, Respondent completed a neuropsychological evaluation,
15 although Respondent failed to ensure that the evaluator was approved by the Board prior
16 to completion of the evaluation. The evaluator found that Respondent exhibited areas of
17 poor performance especially when compared to a younger population; however, the
18 magnitude of Respondent's difficulties did not rise to the level of a cognitive disorder or
19 account for his episodes of poor judgment.

20 16. PACE ultimately found that there is not sufficient evidence to indicate that
21 Respondent is unsafe to practice medicine based on his Phase I performance, but
22 expressed that they were troubled by his professionalism. Concern was raised that
23 Respondent's deficits in professionalism could potentially compromise patient safety.
24 PACE recommended that Respondent undergo a psychiatric evaluation and enroll in an
25 anger management course.

1 ORDER

2 IT IS HEREBY ORDERED THAT:

3 1. Respondent is issued a Letter of Reprimand.

4 2. Respondent's license is placed on probation for two years, with the following
5 terms and conditions:

6 **a. Practice Restriction and Competency Evaluation**

7 Respondent's practice is immediately restricted for up to nine months in that he
8 shall not practice medicine in the State of Arizona and is prohibited from prescribing any
9 form of treatment including prescription medications until Respondent completes a
10 competency evaluation offered by the Center for Personalized Education for Physicians
11 ("CPEP"). Respondent shall register for the course within 30 days from the date of this
12 Order. Respondent is responsible for all expenses relating to the evaluation and/or
13 treatment. CPEP is conducting the evaluation and report solely for the benefit of the
14 Board. Respondent shall comply with any recommendations made by CPEP and
15 approved by Board staff, including any requirements for practice monitoring or continuing
16 medical education. If CPEP finds that Respondent is safe to practice without any
17 additional recommended training, monitoring or education, Respondent may immediately
18 apply to the Executive Director to terminate this Practice Restriction. Respondent shall
19 provide a copy of this Order to CPEP and shall sign a consent form to release all
20 confidential evaluation results to the Board. Because Respondent is undergoing this
21 evaluation under Board Order, he shall instruct any attorney retained on his behalf not to
22 contact CPEP. Any questions or concerns must be addressed to Board staff.

23 **b. Chart Reviews**

24 Board staff or its agents shall conduct periodic chart reviews. The periodic chart
25 reviews shall involve current patients' charts. Respondent shall bear all costs associated

1 with the chart reviews. Based upon the chart review, the Board retains jurisdiction to take
2 additional disciplinary or remedial action.

3 3. Prior to the termination of Probation, Respondent must submit a written
4 request to the Board for release from the terms of this Order. Respondent's request for
5 release will be placed on the next pending Board agenda, provided a complete submission
6 is received by Board staff no less than 14 days prior to the Board meeting. Respondent's
7 request for release must provide the Board with evidence establishing that he has
8 successfully satisfied all of the terms and conditions of this Order. The Board has the sole
9 discretion to determine whether all of the terms and conditions of this Order have been
10 met or whether to take any other action that is consistent with its statutory and regulatory
11 authority.

12 4. The Board retains jurisdiction and may initiate new action based upon any
13 violation of this Order.

14 **NOTICE OF FINAL AGENCY ACTION**

15 Respondent is hereby notified that this order is immediately effective and is a final
16 agency action for purposes of judicial review. A.A.C. R4-16-103(B).

17
18 DATED AND EFFECTIVE this 5th day of February, 2016.

19
20 ARIZONA MEDICAL BOARD

21 By Patricia E. McSorley
22 Patricia E. McSorley
23 Executive Director
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EXECUTED COPY of the foregoing mailed
this 5th day of February, 2016 to:

Frank Pallares, M.D.
Address of Record

ORIGINAL of the foregoing filed
this 5th day of February, 2016 with:

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

Mary Bobey
Board Staff