

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **Valery P. Sobczynski, M.D.**

4 Holder of License No. **15142**
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-08-1530A

**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 February 10, 2010. Valery P. Sobczynski, M.D., ("Respondent") appeared with legal
9 counsel, Lori Curtis, before the Board for a Formal Interview pursuant to the authority
10 vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact,
11 Conclusions of Law and Order after due consideration of the facts and law applicable to
12 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 No.15142 for the practice of allopathic
17 medicine in the State of Arizona.

18 3. The Board initiated case number MD-08-1530A after receiving notification
19 from St. Luke's Medical Center that it had summarily suspended Respondent's clinical
20 privileges in diagnostic radiology following the review of four cases of cat (CT) scan
21 interpretations.

22 4. As part of its investigation, the Board pulled four of Respondent's patient
23 charts and submitted them to an Outside Medical Consultant for review.
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1 **Patient DM**

2 5. Patient DM was a 64 year old male admitted to the hospital on November 19,
3 2008, for chest pain. He had a history of coronary disease with prior stenting. Respondent
4 reviewed DM's initial CT scan of the chest performed in the emergency room and
5 concluded that DM had a pulmonary embolism or deep venous thrombosis (DVT). Based
6 on this reading, Respondent placed the patient on Lovenox.

7 6. A subsequent analysis of DM's cardiac enzymes excluded myocardial
8 infarction and a lower extremity ultrasound showed no DVT. Hospital personnel adjusted
9 DM's medications based on these later findings and discharged him on November 21,
10 2008.

11 7. The Board's OMC found that Respondent misinterpreted DM's initial CT
12 scan as suggesting pulmonary embolism and unnecessarily placed the patient on
13 Lovenox.

14 **Patient HL**

15 8. Patient HL was a 61 year old male admitted to the hospital on November 18,
16 2008, for an episode of syncope and disorientation. Respondent interpreted HL's CT of
17 the chest as suggesting pulmonary embolism, but concluded that HL's head CT scan was
18 unremarkable with the exception of some sinus disease. Based on the finding of a
19 pulmonary embolism, Respondent started HL on Lovenox, and the patient subsequently
20 coded.

21 9. The OMC found that Respondent incorrectly interpreted the chest and head
22 CT scan, resulting in the administration of Lovenox. According to the OMC, the
23 anticoagulant effects of that medication, in turn, caused the patient to develop significant
24 intracranial hemorrhage, resulting in a code and the transfer to ICU.

1 16. The OMC found that Respondent misinterpreted MEs initial chest CT for
2 pulmonary embolism.

3 17. Based upon the review of all four patient files, the OMC concluded that
4 Respondent had a gap in his interpretive knowledge. The OMC recommended that
5 Respondent receive additional training with regard to chest and probably head CTs.

6 18. During his Formal Interview, Respondent admitted that there was a
7 deficiency in his knowledge, but he believed he had remedied that deficiency through
8 extensive study, including completion of a PACE course and more than 260 hours in
9 Continuing Medical Education.

10 19. Respondent also argued that this was an isolated incident, caused in part by
11 difficult working conditions at the hospital.

12 20. Based on its analysis of the medical record, the Board finds that this was not
13 an isolated incident, but four separate cases in which Respondent made errors that
14 caused, or had the potential to cause, patient harm.

15 21. In addition, Respondent did not recognize his mistake on his own, but only
16 took remedial action after he was suspended from the hospital.

17 22. The standard of care for the interpretation of medical imaging requires a
18 physician to correctly interpret the study.

19 23. Respondent deviated from the standard of care by failing to correctly
20 interpret the chest CT in patients DM, HL, LK, and ME.

21 24. DM was unnecessarily placed on Lovenox. Because of the incorrect
22 diagnoses of pulmonary embolism, anticoagulation was undertaken that caused HL to
23 develop significant intracranial hemorrhage resulting in a code arrest, transfer to the ICU
24 and eventually to another hospital for management of the complication. Unnecessary
25 hospital admission for anticoagulation when pneumonia was likely present in patient LK.

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CONCLUSIONS OF LAW

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

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

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

ORDER

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

IT IS HEREBY ORDERED:

1. Respondent is issued a Letter of Reprimand.

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

RIGHT TO PETITION FOR REHEARING OR REVIEW

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

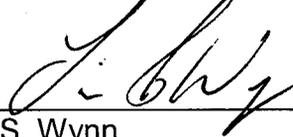
1 Respondent is further notified that the filing of a motion for rehearing or review is
2 required to preserve any rights of appeal to the Superior Court.

3 DATED AND EFFECTIVE this 16TH day of APRIL, 2010.



ARIZONA MEDICAL BOARD

By

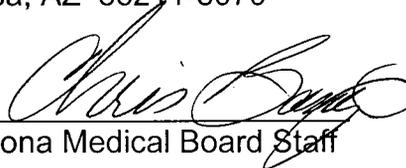

Lisa S. Wynn
Executive Director

9 ORIGINAL of the foregoing filed this
10 14th day of April, 2010 with:

11 Arizona Medical Board
12 9545 East Doubletree Ranch Road
13 Scottsdale, Arizona 85258

14 Executed copy of the foregoing
15 mailed by U.S. Mail this,
14th day of April, 2010 to:

16 Lori Curtis
17 Davis, Miles P.L.L.C.
18 P.O. Box 15070
19 Mesa, AZ 85211-3070


20 Arizona Medical Board Staff