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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

JOE TAKAKAZU HAYASHI, M.D.

Holder of License No. **12865**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-06-0277A

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

(Decree of Censure and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 7, 2007. Joe T. Hayashi, M.D., ("Respondent") appeared before the Board with legal counsel Richard K. Delo for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

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

2. Respondent is the holder of License No. 12865 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-0277A after receiving a complaint regarding Respondent's care and treatment of a sixty-five year-old female patient ("HP") alleging Respondent failed to provide proper medical management. Respondent became HP's primary care physician in 2003 and followed her for multiple medical conditions including anticoagulation management for prosthetic heart valves in the aortic and mitral positions, numbness of her feet, hypertension, and a history of nervous breakdown. Respondent set a goal INR of 2.5 to 3.5 and monitored HP's INR approximately monthly. Some of the INR values were reported as: 2.6 in December 2003, 2.4 in January 2004, 3.1 in March 2004, 1.6 and 4.0 in June 2004, 2.3 in July

1 2004, 3.0 in September 2004, 2.0 in October 2004, 2.0 and 1.6 November 2004, and 1.8 in
2 December 2004. A majority of these INRs are subtherapeutic and the record does not reflect
3 Respondent intervened in any way.

4 4. On December 6, 2004 HP suffered a cerebrovascular accident in the middle
5 cerebral artery resulting initially in aphasia and hemiparesis. HP was hospitalized and treated with
6 low molecular weight heparin until her INR increased into the goal range. The mechanism of HP's
7 stroke was found to be cardioembolic from the prosthetic valves. HP was discharged from the
8 hospital to a skilled nursing facility for ongoing therapy.

9 5. Respondent did not make any adjustment in HP's dosages in response to the
10 January 2004 INR because he did not want to micromanage the INRs and have them get super-
11 therapeutic and yo-yo up and down. When HP's INR dropped to 1.9 in April 2004 he did not know
12 if it was an aberration in the lab test so he did not make any adjustment and decided to re-check
13 it at a later time. When HP's June 1, 2004 INR was 1.6 he raised the Warfarin by two milligrams
14 per week and when she came back three weeks later the INR was supertherapeutic at 4.0.
15 Respondent then backed the dose down because he did not want HP to have complications from
16 bleeding.

17 6. On July 16, 2004 HP's INR was 2.3 and Respondent felt this was fairly close to the
18 therapeutic range of 2.5 to 3.5 so he did not make any adjustments and on September 9 it was at
19 3.0 and he maintained the same dose. When the October 1 and November 1 were low at 2.0 he
20 was hesitant to change the dose and did not because of the supertherapeutic effect he got in
21 June when he increased the dose by two milligrams. According to Respondent, he was not
22 aware of the pro time done on November 30 and a medical assistant kept the dose the same and
23 told HP to come back in one month. Respondent saw HP in the office three days later for a
24 complete physical (late on a Friday afternoon) and he saw the low pro time in her chart and he
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1 recommended she come back on the following Monday, but she had the stroke before she could
2 return.

3 7. Respondent practices internal medicine and monitors approximately 60 patients
4 that are anticoagulated. Respondent assumed HP had a mechanical heart valve and
5 acknowledged the type of valve and the INR requirement for each type matters if a patient needs
6 to be anticoagulated. Respondent admitted HP being in atrial fibrillation, having had a past stroke
7 and having presumed mechanical heart valves, should have made him more concerned about
8 maintaining a therapeutic INR and it was an aggravating factor that HP was at risk for stroke.

9 8. When Respondent began seeing HP she was taking Digitek, Atenolol, Warfarin
10 and Prempro. The Prempro raises a red flag about the possibility of clots, but Respondent
11 maintained HP on it because she came to him on it. Because HP had an artificial valve, atrial
12 fibrillation and was on Coumadin and Prempro, the risks of keeping her on Prempro outweighed
13 the benefits. There is no note in Respondent's chart that he ever counseled HP that taking
14 hormone replacement therapy might have been an increased risk. Respondent was not sure what
15 happened in his office that HP's subtherapeutic INR was not called to his attention, but now all
16 pro times, all lab tests and X-rays go through Respondent and the medical assistants have no
17 authority to notify patients of test results and he has a pro time book that is maintained on a
18 regular basis that gives the therapeutic ranges and the doses of Coumadin and any adjustments
19 that are made and when the patient should follow-up. Respondent did not make any changes in
20 HP's dosage from October 1, 2004 forward.

21 9. When HP was in Respondent's office on the last visit (Friday afternoon) and he
22 saw the 1.6 INR reading he did not do anything because the last time he had adjusted her
23 medications the INR jumped to 4.0 and he was concerned about it getting over the range and
24 most of his patient complications had been bleeds rather than clots and he was cautious about
25 that. Respondent did not order a repeat INR when he saw HP on this visit and instructed her to

1 return on Monday because the labs would have been closed at the time he saw her. HP could
2 have gone to a hospital for the test. The 1.6 INR had been drawn three days prior to the Friday
3 visit. Respondent would have rather had HP in the higher therapeutic range, but did not give her
4 anything to supplement her dosage of anticoagulation and planned to do so when he saw her on
5 Monday.

6 10. The standard of care requires a physician to address subtherapeutic INRs in a
7 patient with a mechanical valve in light of other multiple risk factors for increased
8 hypocoaguability.

9 11. Respondent deviated from the standard of care because he set a therapeutic INR
10 range for a patient with a mechanical valve at 2.5 to 3.5, but failed to act when the patient's INR
11 was 1.6.

12 12. HP's subtherapeutic INRs resulted in a cerebrovascular accident in the territory of
13 the Middle Cerebral Artery initially resulting in aphasia and hemiparesis. HP reports difficulty with
14 speech and memory. HP's subtherapeutic INRs put her at risk of valve thrombosis.

15 13. A physician must appropriately direct, collaborate with or directly supervise and
16 medical assistant ("MA") employed by, supervised by, or assigned to the physician. Respondent
17 did not appropriately direct, collaborate with, or directly supervise his MA and she did not inform
18 him of HP's November 30 pro time and kept HP's dose the same even though there was a
19 change in pro time.

20 14. Respondent's past disciplinary history with the Board involving failure to act on an
21 elevated platelet count is an aggravating factor.

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1 **CONCLUSIONS OF LAW**

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

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

7 3. The conduct and circumstances described above constitutes unprofessional
8 conduct pursuant to A.R.S. § 32-1401(27)(q) (“[a]ny conduct or practice which is or might be
9 harmful or dangerous to the health of the patient or the public”); A.R.S. § 32-1401(27)(II)
10 (“[c]onduct that that board determines is gross negligence, repeated negligence or negligence
11 resulting in harm to or the death of a patient”); and A.R.S. § 32-1401(27)(ii) (“[l]ack of or
12 inappropriate direction, collaboration or direct supervision of a medical assistant or a licensed,
13 certified or registered health care provider employed by, supervised by or assigned to the
14 physician.”).

15 **ORDER**

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

17 IT IS HEREBY ORDERED:

18 1. Respondent is issued a Decree of Censure for failure to recognize the importance
19 of maintaining an adequate INR in light of multiple other risk factors for increased hypocoaguability
20 and for failure to properly supervise a medical assistant.

21 2. Respondent is placed on probation for two years with the following terms and
22 conditions:

23 a. Within 60 days Respondent shall, at his own expense, undergo an evaluation by
24 Physician Assessment and Clinical Education Program (“PACE”) at the University of California,
25 San Diego School of Medicine for general and internal medicine. Any and all reports, assessments

1 or other documents generated by PACE shall be forwarded by PACE to the Board for review.
2 Respondent shall comply with any recommendations made by PACE unless otherwise ordered by
3 the Board.

4 b. Board Staff or its agents shall conduct random chart reviews.

5 c. Respondent shall obey all federal, state, and local laws and all rules governing the
6 practice of medicine in Arizona.

7 d. Completion of the PACE course will not terminate the probation.

8 3. In the event Respondent should leave Arizona to reside or practice outside the
9 State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall
10 notify the Executive Director in writing within ten days of departure and return or the dates of non-
11 practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during
12 which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent
13 residence or practice outside Arizona or of non-practice within Arizona, will not apply to the
14 reduction of the probationary period.

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

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

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

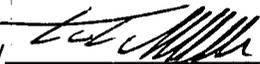
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DATED this 13th day of April 2007.



THE ARIZONA MEDICAL BOARD

By 
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this
13th day of April 2007 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Mail this
13th day of April 2007, to:

Richard K. Delo
Jennings, Strouss & Salmon, PLC
201 East Washington Street – 11th Floor
Phoenix, Arizona 85004-2385

Joe T. Hayashi, M.D.
Address of Record

