

1 express or implied, of the Board's statutory authority or jurisdiction regarding any other
2 pending or future investigation, action or proceeding. The acceptance of this Consent
3 Agreement does not preclude any other agency, subdivision or officer of this State from
4 instituting other civil or criminal proceedings with respect to the conduct that is the subject
5 of this Consent Agreement.

6 6. All admissions made by Respondent are solely for final disposition of this
7 matter and any subsequent related administrative proceedings or civil litigation involving
8 the Board and Respondent. Therefore, said admissions by Respondent are not intended
9 or made for any other use, such as in the context of another state or federal government
10 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or
11 any other state or federal court.

12 7. Upon signing this agreement, and returning this document (or a copy thereof) to
13 the Board's Executive Director, Respondent may not revoke the acceptance of the
14 Consent Agreement. Respondent may not make any modifications to the document. Any
15 modifications to this original document are ineffective and void unless mutually approved
16 by the parties.

17 8. If the Board does not adopt this Consent Agreement, Respondent will not
18 assert as a defense that the Board's consideration of this Consent Agreement constitutes
19 bias, prejudice, prejudgment or other similar defense.

20 9. This Consent Agreement, once approved and signed, is a public record that will
21 be publicly disseminated as a formal action of the Board and will be reported to the
22 National Practitioner Data Bank and to the Arizona Medical Board's website.

23 10. If any part of the Consent Agreement is later declared void or otherwise
24 unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force
25 and effect.

1 11. Any violation of this Consent Agreement constitutes unprofessional conduct
 2 and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order,
 3 probation, consent agreement or stipulation issued or entered into by the board or its
 4 executive director under this chapter") and 32-1451.

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 7 M. Cecilia Durban Dimaano, M.D.
 8 M. CECILIA DURBAN DIMAANO, M.D.

DATED: 10.30.07

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1 **FINDINGS OF FACT**

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

4 2. Respondent is the holder of license number 13509 for the practice of
5 allopathic medicine in the State of Arizona.

6 3. The Board initiated case number MD-07-0245A after receiving notification
7 from a hospital ("Hospital") that Respondent resigned on April 5, 2007 while under
8 investigation for failure to respond to pages and for failure to conduct post-operative
9 rounds. During the investigation, Staff reviewed eight patients' medical records and found
10 deviations in six records.

11 4. On January 7, 2005, LB was admitted to the Hospital for induction. On
12 January 12, 2005, LB had heavy bleeding and Hospital staff made multiple attempts to
13 reach Respondent at her home, on her cell phone and paged her answering service. By
14 6:55 a.m., Respondent had not responded to any of the phone calls. Hospital staff then
15 contacted another physician who rendered care to LB. At 8:35 a.m., Respondent arrived at
16 the Hospital to see LB.

17 5. On June 2, 2005, DW was admitted to the hospital in premature labor.
18 Hospital staff called Respondent at 8:45 p.m. and 9:20 p.m. Respondent did not respond
19 to either call. Hospital Staff contacted another physician who rendered care to DW.

20 6. On June 12, 2005, EA presented to the Hospital complaining of premature
21 labor, including abdominal pains and contractions. Hospital staff made several attempts to
22 contact Respondent, including leaving messages at her home, on her cell phone and with
23 her office manager. After several attempts to contact Respondent, Hospital staff contacted
24 another physician who rendered care to EA. Respondent eventually responded
25 approximately two hours after the initial call.

1 7. On April 28, 2006, SF was admitted to the Hospital for an exploratory
2 laparotomy for pelvic pain and with a history of endometriosis. Respondent consulted a
3 urologist and stents were placed prior to the procedure which revealed extensive pelvic
4 adhesions, which were lysed. However, the planned laparotomy was unable to be
5 performed. SF developed numerous post-operative complications for which consultations
6 were obtained, including urology, general surgery, and cardiology and pulmonary. On April
7 29, 2006, SF asked to see Respondent. Respondent was paged at 9:00 a.m., but she did
8 not respond until 11:00 a.m. on the next day. Respondent documented progress notes on
9 April 30, 2006 through May 3, 2006; May 6, 2006 and May 7, 2006, but failed to examine
10 or evaluate SF's status on a regular basis to maintain on-going care until her discharge on
11 May 15, 2006.

12 8. On June 16, 2006, MK was admitted to the hospital and underwent a
13 hysterectomy. Respondent did not evaluate MK postoperatively until June 19, 2006
14 indicating, Respondent did not examine and evaluate DS's status on a regular basis and
15 maintain on-going care.

16 9. On December 16, 2006, DS was admitted to the hospital in labor. DS
17 progressed in labor to deliver an infant on December 17, 2006. Respondent was DS's
18 primary physician of record, but did not see or evaluate DS's status while she was
19 hospitalized.

20 10. The standard of care requires a physician providing care for a patient in the
21 hospital to respond to phone calls from Hospital staff in a timely manner.

22 11. Respondent deviated from the standard of care because she did not respond
23 in a timely manner to Hospital staff's phone calls regarding EA's care and she did not
24 respond at all to staff's phone calls regarding care for LB and DW.

25

1 12. The standard of care requires a physician to examine and evaluate the
2 patient's status on a regular basis and maintain on-going care.

3 13. Respondent deviated from the standard of care because she did not
4 examine and evaluate SF's, MK's and DS's status on a regular basis and she did not
5 maintain on-going care.

6 14. Due to Respondent's delay in response, LB continued to have bleeding and
7 required three units of red blood cells and, with the significant bleeding, she could have
8 died. Additionally, a delay in DW's and EA's treatment could have lead to premature
9 delivery. There was no harm identified for SF, MK and DS.

10 **CONCLUSIONS OF LAW**

11 1. The Board possesses jurisdiction over the subject matter hereof and over
12 Respondent.

13 2. The conduct and circumstances described above constitute unprofessional
14 conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be
15 harmful or dangerous to the health of the patient or the public.") and A.R.S. § 32-1401
16 (27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or
17 negligence resulting in harm to or the death of a patient.").

18 **ORDER**

19 IT IS HEREBY ORDERED THAT:

20 1. Respondent is issued a Letter of Reprimand for failure to respond to hospital
21 staff in a timely manner or at times, not at all and for failure to examine, evaluate and
22 monitor patients on a regular basis.

23 2. This Order is the final disposition of case number MD-07-0245A.

24 DATED AND EFFECTIVE this 14th day of December, 2007.



ARIZONA MEDICAL BOARD

By *Amanda Diehl*
AMANDA J. DIEHL
Deputy Executive Director

5 ORIGINAL of the foregoing filed
this 14th day of December 2007 with:

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

9 EXECUTED COPY of the foregoing mailed
this 14th day of December 2007 to:

10 M. Cecilia D. Dimaano, M.D.
11 Address of Record

12 *[Signature]*
13 Investigational Review