

1 BEFORE THE ARIZONA MEDICAL BOARD

2
3 In the Matter of

4 **KATHLEEN K. FRY, M.D.**

5 Holder of License No. 15481
6 For the Practice of Allopathic Medicine
7 In the State of Arizona.

Board Case No. MD-02-0426A

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

(Letter of Reprimand and Civil Penalty)

8 The Arizona Medical Board ("Board") considered this matter at its public meeting
9 on December 11, 2003. Kathleen Fry, M.D., ("Respondent") appeared before the Board
10 with legal counsel Winn Sammons for a formal interview pursuant to the authority vested
11 in the Board by A.R.S. § 32-1451(H). After due consideration of the facts and law
12 applicable to this matter, the Board voted to issue the following findings of fact,
13 conclusions of law and order.

14 **FINDINGS OF FACT**

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

17 2. Respondent is the holder of License No. 15481 for the practice of allopathic
18 medicine in the State of Arizona.

19 3. The Board initiated case number MD-02-0426A after receiving notification
20 of a malpractice judgment entered against Respondent regarding her care and treatment
21 of a 45 year-old female patient ("RB"). RB presented to Respondent in October 1998 for
22 a repeat pap smear because, although an April 1998 pap smear was normal, RB had
23 some inflammation. The examination revealed no abnormal findings. At the October
24 1998 visit RB complained of pain with intercourse at the site of her episiotomy scar.
25 Respondent noted in RB's records "tender episiotomy scar with laxity at introitus" and her

1 plan for a scar revision. On October 29, 1998 RB signed an informed consent form on
2 which she consented to an "Episiotomy scar revision" due to "Vulvodynia." The
3 procedure was scheduled for November 3, 1998.

4 4. On November 2, 1998 Respondent completed an admission history and
5 physical listing RB's condition as "Tender episiotomy scar with laxity at introitus." On
6 November 3, 1998 Respondent performed surgery on RB, specifically a "Perineal repair
7 with labioplasty," not the scar revision as scheduled and consented to. Respondent's
8 operative report notes that RB had "elongated labia, which were marked and injected with
9 Pitressin. The labia were then trimmed and re-sutured."

10 5. Respondent testified that her mistake in this case was that RB had wanted
11 a perineoplasty to make her vagina "less floppy", but since RB was dating one of the
12 anesthesiologists at the hospital, she was very concerned that the anesthesiologist would
13 find out what procedure she was having done. Respondent stated that in the interest of
14 keeping the information from the anesthesiologist she did not write down her usual
15 detailed notes and used rather cursory notes. Respondent testified that the lack of
16 detailed notes led to her confusion at the point where she sat down in front of RB to
17 perform a procedure.

18 6. Respondent was asked to elaborate on RB's initial complaint of a tender
19 episiotomy scar. Respondent testified that the complaint was more a matter of irritation
20 and the laxity of the back portion of the vagina was actually irritating when RB had
21 intercourse. Respondent stated that, although she did not put this in RB's notes, that RB
22 was concerned because her boyfriend had told her that her vagina was "too floppy."

23 7. Respondent was asked the differential diagnosis of painful intercourse.
24 Respondent stated that there are two types, superficial dyspareunia (pain) and deep
25 pain. Respondent noted that deep pain would be deep pain with penetration, which was

1 not RB's main complaint. Respondent stated that RB's complaint was primary superficial
2 pain at the point of entry. Respondent was asked if she had documented that RB's pain
3 was superficial and not deep. Respondent stated that she had not. Respondent agreed
4 that her documentation of RB's pain was pretty sparse.

5 8. Respondent was asked whether the documentation in RB's chart of the
6 October 9 visit is her usual documentation for this sort of patient or whether this
7 sparseness was due to what Respondent had related about RB not wanting hospital
8 personnel to know the details of the gynecologic findings. Respondent stated that the
9 issue of hospital personnel was one of the reasons she kept the record sparse.
10 However, Respondent did acknowledge that the office record referred to would not have
11 accompanied RB to the hospital and would have remained in her office records.

12 9. Respondent was asked whether the physical findings, the medical decision-
13 making and the discussion of risks and benefits of surgery are all adequately
14 documented in the October 9 note. Respondent stated that it was not and that it is her
15 usual manner to dictate a note at the time of the pre-operative examination and include
16 that with the chart going to the hospital. Respondent noted that in this note she would
17 discuss in more detail the plan, the procedure and so on. Respondent stated that
18 because of RB's concern that there not be much information in the chart, she did not
19 dictate her usual preoperative history and physical and used the abbreviated form from
20 the hospital instead. Respondent agreed that it was incorrect to use a different
21 documentation standard for a patient who had privacy concerns as opposed to any other
22 patient.

23 10. Respondent acknowledged that the plan indicated in the October 9 note
24 was a scar revision and that RB signed a consent for an episiotomy scar revision and that
25 the chief complaint or reason for the surgery was vulvadenia. Respondent acknowledged

1 that the surgery she actually performed on RB was a labioplasty where she trimmed the
2 labia minora. Respondent also acknowledged that there was nothing in her October 9
3 findings that suggested that the labia minora were a problem or an issue that she needed
4 to address or that RB wanted addressed. Respondent was then asked how the surgery
5 went from an episiotomy scar revision to a labioplasty. Respondent stated that she
6 believes the mistake was made from when she had the visit in her office before she sat
7 down to do the procedure. Respondent noted that when she came to the hospital and
8 saw that this is what she had been scheduled to do in her mind she was thinking this is
9 the patient who did not want her to put much documentation in the chart. Respondent
10 stated that when she sat down in front of RB to perform a procedure and saw elongated
11 labia she thought she was supposed to do a labioplasty instead of the scheduled scar
12 revision.

13 11. Respondent admitted to performing the wrong procedure on RB.
14 Respondent acknowledged that a labioplasty would not solve RB's problem of
15 dyspareunia. The performance of the labioplasty was not medically necessary.

16 12. The standard of care required Respondent to perform an appropriate
17 workup for the patient's complaint, both by history and physical examination and other
18 testing and to appropriately document that workup and to perform the procedure
19 recommended to the patient and to which the patient consented.

20 13. Respondent fell below the standard of care because she did not perform an
21 appropriate workup for the patient's complaint, both by history and physical examination
22 and other testing and did not appropriately document that workup and perform the
23 procedure recommended to the patient and to which the patient consented.

24 14. RB was harmed because she sustained some disfigurement as a result of
25 the performance of the incorrect surgery and underwent mental anguish.

1 **CONCLUSIONS OF LAW**

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

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

7 3. The conduct and circumstances described above constitutes unprofessional
8 conduct pursuant to A.R.S. § § 32-1401(26¹)(q) (“[a]ny conduct or practice that is or might
9 be harmful or dangerous to the health of the patient or the public;”); and 32-1401(26)(II)
10 (“[c]onduct that the board determines is gross negligence, repeated negligence or
11 negligence resulting in harm to or the death of a patient.”)

12 **ORDER**

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

14 IT IS HEREBY ORDERED that:

15 1. Respondent is issued a Letter of Reprimand for failure to perform the
16 operative procedure recommended to the patient and consented to by the patient and for
17 performing a surgical procedure that was not medically necessary.

18 2. Respondent shall pay a \$1,000 civil penalty within 60 days of the effective
19 date of this Order.

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

21 Respondent is hereby notified that she has the right to petition for a rehearing or
22 review. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing or
23 review must be filed with the Board’s Executive Director within thirty (30) days after
24

25 _____
¹ Formerly A.R.S. § 32-1401(24). Renumbered effective September 18, 2003.

1 service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient
2 reasons for granting a rehearing or review. Service of this order is effective five (5) days
3 after date of mailing. If a motion for rehearing or review is not filed, the Board's Order
4 becomes effective thirty-five (35) days after it is mailed to Respondent.

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

7 DATED this 17th day of February, 2004.



8 THE ARIZONA MEDICAL BOARD

9
10
11 By Amanda Dickel
12 BARRY A. CASSIDY, Ph.D., PA-C
13 Executive Director

14 ORIGINAL of the foregoing filed this
17th day of February, 2004 with:

15 Arizona Medical Board
16 9545 East Doubletree Ranch Road
17 Scottsdale, Arizona 85258

18 Executed copy of the foregoing
19 mailed by U.S. Certified Mail this
17th day of February, 2004, to:

20 Winn Sammons
21 Sanders & Parks PC
22 3030 North Third Street - Suite 1300
23 Phoenix, Arizona 85012-3099

24 Executed copy of the foregoing
25 mailed by U.S. Mail this
17th day of February, 2004, to:

Kathleen Fry, M.D.
Address of Record

Lisa McGraw