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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

MICHAEL RIDGE, M.D.

Holder of License No. 15513
For the Practice of Allopathic Medicine in
the State of Arizona

Docket No. 03F-15513-MDX

Case No. MD-03-0743A

**FINDINGS OF FACT, CONCLUSIONS OF
LAW AND ORDER FOR LETTER OF
REPRIMAND**

7 On April 14, 2004 this matter came before the Arizona Medical Board ("Board")
8 for oral argument and consideration of the Administrative Law Judge (ALJ) Brian Brendan
9 Tully's proposed Findings of Fact and Conclusions of Law and Recommended Order.
10 Michael Ridge, M.D. ("Respondent") was notified of the Board's intent to consider this
11 matter on the aforementioned date at the Board's public meeting. Respondent appeared
12 personally and was represented by his attorney, Scott J. Hergenroether. Assistant
13 Attorney General Stephen A. Wolf represented the State. Christine Cassetta, Assistant
14 Attorney General with the Solicitor General's Section of the Attorney General's Office,
15 was present and available to provide independent legal advice to the Board.

16 The Board, having considered the ALJ's report and the entire record in this
17 matter hereby issues the following Findings of Fact, Conclusion of Law and Order.

18 **FINDINGS OF FACT**

19 1. The Arizona Medical Board ("Board") is the duly constituted authority for the
20 regulation and control of the practice of allopathic medicine in the State of Arizona.

21 2. The Respondent, Michael Ridge, M.D., is the holder of License No. 15513 for the
22 practice of allopathic medicine in the State of Arizona.

23 3. The Board previously conducted two investigations of Dr. Ridge: Investigation
24 No. 11597, R.M. v. Michael P. Ridge, M.D., and Investigation No. 11665, M.Y.B. v.
25 Michael P. Ridge, M.D.

1 4. Those two investigations resulted in a Stipulation and Order between the Board
2 and Dr. Ridge.

3 5. In that written stipulation, which was executed by Dr. Ridge on May 11, 1998, he
4 acknowledged that "any violation of this Order constitutes unprofessional conduct within
5 A.R.S. § 32-1401(25)(r)¹, and may result in disciplinary action pursuant to A.R.S. § 32-
6 1451."

7 6. In the Stipulation and Order, the Board issued the following Order:

8 **ORDER**

9 Based on the foregoing Stipulation, IT IS HEREBY ORDERED that
10 MICHAEL P. RIDGE, M.D. shall have a female chaperone present during
11 all examinations of female patients, in all work settings. The chaperone
12 shall confirm her presence by initialing and signing each patient's chart at
13 the time of the examination.

14 7. The said Stipulation and Order was based on allegations received by the Board
15 that Dr. Ridge conducted inappropriate examinations of a sexual nature on some female
16 patients.

17 8. As a result of these allegations, Dr. Ridge underwent a criminal jury trial in Pinal
18 County Superior Court.

19 9. On September 17, 1999, a jury unanimously found Dr. Ridge not guilty of having
20 engaged in any sexually inappropriate contact with his patients.

21 10. Dr. Ridge's acquittal of those criminal charges did not invalidate the stipulated
22 order requiring a female chaperone during all examinations.

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25 ¹ Now A.R.S. § 32-1401(26)(r), which reads: Violating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under the provisions of this chapter.

1 Her previous surgeries include right shoulder and bilateral knee scope and benign breast
2 scope and benign breast lumpectomy.²

3 27. M.A. and her husband moved to Casa Grande, Arizona, from Florida in 2002.

4 28. Prior to leaving Florida, M.A. was being treated by her then primary care
5 physician, Dr. Robert Anderson, and Dr. David Glenner, who specialized in pain control
6 management.

7 29. Dr. Glenner prescribed 10 mg. of Oxycontin twice a day for M.A.

8 30. After moving to Arizona, M.A. established with Dr. Michael Hurst at the
9 Cottonwood Medical Center on December 4, 2002.

10 31. During her first visit, Dr. Hurst and M.A. went through her medications.

11 32. M.A. presented a prescription bottle for Neurontin. Neurontin is commonly used
12 for neuropathic pain and musculoskeletal pain.

13 33. M.A. presented a prescription bottle for Oxycontin, an opioid pain medication.
14 M.A. advised Dr. Hurst that she was taking 40 mg of Oxycontin three times a day.

15 34. M.A. presented a prescription bottle for Ultram, a non-narcotic, non-steroidal anti-
16 inflammatory pain medicine.

17 35. M.A. presented a prescription bottle for Celexa for her fibromyalgia.

18 36. M.A. presented prescription bottles for Flexaril and Zanaflex, which are muscle
19 relaxants.

20 37. M.A. presented a prescription bottle for Premarin for postmenopausal.

21 38. M.A. presented a prescription bottle for Atenolol for her mitral valve prolapse.

22 39. M.A. reported allergies to codeine and morphine.
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² Two of M.A.'s sisters died with breast cancer.

1 40. On that visit Dr. Hurst performed a physical examination of M.A. and because of
2 M.A.'s history of depression "a brief neurological issue, primarily just her mental status
3 issue of suicidal and homicidal" because of the types of medications she reported being
4 prescribed.

5 41. Dr. Hurst refilled all of M.A.'s prescriptions at that visit. Dr. Hurst assumed that
6 until he received M.A.'s medical records from Florida or had reasons to think otherwise,
7 the medicines and the history presented by M.A. were true. He anticipated establishing a
8 relationship with M.A. and later assessing her medications and the need for those
9 medications.

10 42. On or about January 6, 2003, M.A. was again examined by Dr. Hurst.

11 43. During the January 6, 2003 visit, M.A. reported that she had run out of her
12 Oxycontin and that her pain increased.

13 44. At that visit, Dr. Hurst rescripted M.A.'s Oxycontin at 40 mg. every eight hours.

14 45. M.A.'s next visit with Dr. Hurst was January 24, 2003. During that visit M.A.
15 asked Dr. Hurst to increase her Oxycontin dosage because the current dosage was "not
16 holding" her.

17 46. During that visit Dr. Hurst increased M.A.'s Oxycontin dosage to 80 mg every 12
18 hours.

19 47. On or about February 12, 2003 at 3:42 p.m., M.A. called the prescription line at
20 Cottonwood Medical Center from the internal medicine floor at Casa Grande Regional
21 Medical Center. M.A. left a voice mail message stating that the dosage of 80 mg of
22 Oxycontin twice daily was not working.

23 48. M.A. credibly testified that the dosage of 80 mg of Oxycontin twice daily was
24 negatively affecting her performance personally and professionally.
25

1 49. In response to M.A.'s message, Dr. Hurst advised M.A. to follow up with his
2 partner, Dr. Ridge. Dr. Hurst made the referral because he was getting beyond his
3 comfort level with the doses of Oxycontin M.A. needed. He felt that Dr. Ridge was more
4 experienced in dealing with pain medications and the management of pain patients
5 especially given Dr. Ridge's hospice background.

6 50. On or about February 28, 2003, M.A. had an appointment with Dr. Ridge at the
7 clinic.

8 51. M.A. wore a pair of old cowboy boots and a skirt to her appointment. She wore a
9 long denim skirt that was below her knees so that she did not have to wear a gown during
10 the examination.

11 52. M.A. was escorted by staff to the examination room.

12 53. Dr. Ridge later arrived and did a history taking alone with M.A. in the examination
13 room.

14 54. His nurse, Neomi Tucker, L.P.N., later entered the examination room to
15 chaperone his physical examination of M.A.

16 55. During the physical examination, M.A. laid in a prone position on the examination
17 table, which had a leg extension in use.

18 56. Dr. Ridge examined M.A.'s knees during the comprehensive physical
19 examination.

20 57. Both Dr. Ridge and Nurse Tucker credibly testified that it is their normal business
21 practice that Dr. Ridge leaves the examination room first and then Nurse Tucker. Dr.
22 Ridge routinely finishes his paperwork at a desk outside the examination room.

23 58. Both Dr. Ridge and Nurse Tucker testified that the standard business practice is
24 for staff to close the table extension and to assist a prone patient to a sitting position.
25

1 59. M.A. testified that she was still lying down on the examination table when Dr.
2 Ridge held the examination room door open for Nurse Tucker to exit before he did. As
3 Nurse Tucker exited the room, M.A. testified that Dr. Ridge started to exit, but then turned
4 around and quickly sexually assaulted her while she lay on the examination table before
5 he eventually left the room.

6 60. Dr. Ridge and Nurse Tucker testified that Dr. Ridge left the room first and that
7 M.A. was assisted to a sitting position after the examination.

8 61. After the examination, M.A. received a prescription and her super bill. She
9 proceeded from the examination room to the billing window to pay her insurance co-pay
10 obligation.

11 62. On February 28, 2003, M.A. had some lab work performed at the clinic.

12 63. After her examination and lab work, M.A. scheduled another office visit with Dr.
13 Ridge.

14 64. On February 28, 2003, M.A. did not tell any of the clinic staff about being sexually
15 assaulted by Dr. Ridge.

16 65. Prior to her next scheduled office visit with Dr. Ridge, M.A. discussed her
17 allegation of sexual assault by Dr. Ridge with her husband and several co-workers. After
18 hearing her allegation, they all suggested that she cancel her next appointment with Dr.
19 Ridge.

20 66. M.A. decided not to cancel the next office visit. She wanted to see Dr. Ridge, in
21 part, to be able to confirm to at least herself, the assault had occurred.

22 67. On March 21, 2003, M.A. had her scheduled office visit with Dr. Ridge for follow-
23 up. No examination was performed. M.A. and Dr. Ridge were alone in an examination
24 room.

1 68. At that visit, Dr. Ridge made adjustments to M.A.'s medication. He lowered her
2 Oxycontin dosage and prescribed Methadone. He also prescribed Atenol for her
3 palpitations.

4 69. During the March 21, 2003 office visit, M.A. did not confront Dr. Ridge regarding
5 his alleged sexual assault of her during the prior visit.

6 70. During the March 21, 2003 office visit, it is undisputed that Dr. Ridge's care and
7 treatment of M.A. was professional and appropriate.

8 71. On March 29, 2003; Dr. Ridge received a telephone call from a friend advising
9 him that a nurse at the hospital was telling other hospital staff that Dr. Ridge had
10 inappropriately touched her during an examination.

11 72. After discussing the telephone call with his wife, Dr. Ridge went to the hospital to
12 find and confront M.A. about her allegations.

13 73. Upon arriving at the hospital, Dr. Ridge contacted the Charge Nurse, Lula
14 Deloney. Dr. Ridge asked Nurse Deloney where M.A. was in the hospital. At the time,
15 Dr. Ridge could not recollect who M.A. was.

16 74. Nurse Deloney escorted Dr. Ridge to a temporary break room where M.A. and
17 two other staff members were having lunch.

18 75. Dr. Ridge entered the temporary break room and stood to the side. Charge
19 Nurse Deloney was behind him in the hallway. The door to the room remained open.

20 76. After asking M.A. to identify herself, Dr. Ridge confronted her about her
21 allegation. During the confrontation, M.A. stood by her allegation. Dr. Ridge informed
22 her that his clinic was firing her as a patient.

23 77. Dr. Ridge's confrontation of M.A. at the hospital was unprofessional. He could
24 have, and should have, made arrangements to meet with her with a witness in a more
25 private and professional setting.

1 78. By letter dated March 31, 2003, Douglas E. Parkin, M.D., Robert J. Kull, D.O.,
2 Michael P. Ridge, M.D., Darryl R. Brown, M.D., Michael D. Hurst, D.O., and Craig W.
3 Connor, P.A.-C of the Cottonwood Medical Center, Ltd., advised M.A. that they were
4 "withdrawing from further professional attendance upon [M.A.] and all members of [M.A.'s]
5 family in interest of patient care."

6 79. On April 7, 2003, Laurie Carroll, R.N., gave a written statement to the Casa
7 Grande Regional Medical Center. At that time, Nurse Carroll had worked at the hospital
8 for one year.

9 80. In her written statement, Nurse Carroll stated that in an early discussion with
10 M.A. the latter related "that on the second appointment she wore tight jeans and a low cut
11 blouse...Dr. Ridge did not act inappropriately at that time and as far as she was
12 concerned, it was over." Nurse Carroll confirmed her statement in her testimony.

13 81. M.A. testified that she did not wear a pair of tight jeans and a low cut blouse to
14 her second visit to Dr. Ridge.

15 82. Flora Arbizu, a nurse tech at Casa Grande Regional Medical Center, testified that
16 M.A. told her that she had gone back to Dr. Ridge for the second visit. M.A. stated that at
17 that second visit she confronted Dr. Ridge about the alleged sexual assault during the first
18 visit. M.A. stated that she told Dr. Ridge that she was very upset with his behavior and
19 that she was going follow through on it.

20 83. M.A. testified at the hearing that she did not confront Dr. Ridge about the alleged
21 sexual assault during the March 21, 2003 visit.

22 84. On or about May 2, 2003, M.A. established with Dr. Kuipers.

23 85. M.A. testified that when she explained to Dr. Kuipers the alleged sexual assault
24 performed by Dr. Ridge, that he stated: "That sorry son of a bitch. You would have
25 thought that he would have learned his lesson by now."

1 86. At the hearing Dr. Kuipers testified credibly and firmly that he had not made that
2 type of statement to M.A.

3 87. On or about June 23, 2003, M.A. filed a complaint against Dr. Ridge with the
4 Board.

5 88. By letter dated September 4, 2003, the Board's Executive Director, Barry A.
6 Cassidy, Ph.D., P.A.-C, advised Dr. Ridge of M.A.'s complaint. Dr. Ridge was advised
7 that M.A.'s allegation involved inappropriate touching after completion of examination, in
8 violation of A.R.S. §32-1401(24)(z).

9 89. Dr. Cassidy required that Dr. Ridge provide the Board with the following: a
10 complete narrative statement concerning the specific allegations made by M.A.; a
11 complete copy of M.A.'s medical records; a complete copy of office billings; and a copy of
12 all supporting documentation.

13 90. By letter dated September 5, 2003, Dr. Cassidy advised M.A. of the status of her
14 complaint.

15 91. By letter dated September 15, 2003, Dr. Ridge filed his response to the complaint
16 with the Board. He denied the allegations.

17 92. By letter dated September 30, 2003, Dr. Ridge was served with a subpoena to
18 appear on October 10, 2003, at 2:00 p.m. at the Board's offices for an investigational
19 interview.

20 93. On October 8, 2003, the Board met in an Emergency Meeting relative to M.A.'s
21 complaint and MD-03-0413 concerning allegations that Dr. Ridge violated the Board's
22 chaperone requirement.

23 94. At the end of the Board's October 8, 2003 Emergency Meeting, the Board issued
24 a new Order summarily restricting Dr. Ridge's medical practice. The Board order the
25 following:

"IT IS HEREBY ORDERED THAT:

1. Respondent's license to practice allopathic medicine in the State of Arizona, License No. 15513, is summarily restricted in that (sic) must have a chaperone present at any time he is with a female patient pending a formal hearing before a hearing officer (sic)³ from the Office of Administrative Hearings. Respondent must have the chaperone document his/her⁴ presence in the patient charts.
2. The Interim Findings of Fact and Conclusions of Law constitute written notice to Respondent of the charges of unprofessional conduct made by the Board against him. Respondent is entitled to a formal hearing to defend these charges as expeditiously as possible after the issuance of this order.
3. The Board's Executive Director is instructed to refer this matter to the Office of Administrative Hearings for scheduling of an administrative hearing to be commenced as expeditiously as possible from the date of the issuance of this order, unless stipulated and agreed otherwise by Respondent."

95. A trier of fact may rely upon the demeanor of witnesses when giving weight to the credibility of witnesses. Based upon the Administrative Law Judge's observation of M.A., Dr. Ridge and Nurse Tucker during the hearing and the evidence of record, the Administrative Law Judge finds M.A.'s testimony of the alleged sexual assault not to be credible. For example, M.A.'s claim that she was left lying on the examination table as Dr. Ridge and Nurse Tucker left the room is not plausible. It makes no sense that M.A. went back to Dr. Ridge for a second visit shortly after he allegedly committed a horrific sexual assault to her. M.A. was inconsistent on the issue of whether or not she confronted Dr Ridge on the second visit.

96. The testimonies of Dr. Ridge and Nurse Tucker are found to be credible as to the events that occurred during M.A.'s examination on February 28, 2003.

³ Pursuant to A.R.S. § 41-1092.01, the Office of Administrative Hearings employs administrative law judges.

⁴ The motion passed by the Board required a female chaperone, similar to the stipulated order. See Exhibit 2, Reporter's Transcript of Proceedings, Emergency Session Meeting, October 8, 2003, at pages 29-30.

1 97. Upon review and consideration of the evidence and testimony presented during
2 the hearing, and the Administrative Law Judge's observation of M.A., Dr. Ridge and
3 Nurse Tucker during their testimonies, the Administrative Law Judge finds that Dr. Ridge
4 did not sexually assault M.A. as she alleges at the conclusion of her examination by him
5 on February 28, 2003.

6 98. The stipulated order requires, among other things, that Dr. Ridge "shall have a
7 female chaperone present during all examinations of female patients, in all work settings."
8 There has been a dispute by the parties as to the scope of the chaperone requirement. A
9 clear reading of that requirement should leave no doubt as to what is being required. A
10 chaperone is required during "all examinations". That requirement does not mean only
11 physical examinations performed by Dr. Ridge. It also includes any examination, such as
12 a visual examination which can commence at the time a physician first observes a
13 patient. The Board's order requires that any examination of a female patient performed
14 by Dr. Ridge, whether physical or otherwise, in all settings be chaperoned.

15 99. Notwithstanding Findings of Fact Nos. 95 and 97 above, it is determined that the
16 Board properly ordered the summary restriction of Dr. Ridge's medical license at the
17 emergency meeting. It is further determined that Dr. Ridge's above-described violations
18 of the stipulated order's chaperone requirement support upholding the imposition of the
19 Board's summary restriction.

20 100. Dr. Ridge has a reputation as a competent, well respected physician in the Casa
21 Grande community.

22 101. Dr. Ridge has the following history with the Board's predecessor, the Arizona
23 Board of Medical Examiners:

- 24 a) July 1990: Advisory Letter – Failure to maintain adequate records
25 as related to history and physical findings for a patient.

1 ORDER

2 In view of the foregoing, and in light of a Letter of Reprimand being sufficient to address
3 the violation of the Board's Order and in light of a restriction of license no longer being
4 necessary, it is hereby ordered:

5 1. Respondent be issued a Letter of Reprimand in Case No. MD-03-0413 for his
6 unprofessional conduct in violation of A.R.S. § 32-1401(26)(r).

7 2. That the Stipulation and Order between Respondent and the Board dated May
8 21, ~~1988~~ ^{1988 EQ 5-6-04} is vacated.

9 3. That the Board's Interim Findings of Fact, Conclusions of Law and Order for
10 Summary Restriction of License dated October 10, 2003 is vacated.

11 4. That case No. MD-03-0743 is hereby dismissed.

12 RIGHT TO PETITION FOR REHEARING OR REVIEW

13 Respondent is hereby notified that he has the right to petition for a rehearing or review
14 by filing a petition with the Board's Executive Director within thirty (30) days after service
15 of this Order. A.R.S. § 41-1092.09. The petition must set forth legally sufficient reasons
16 for granting a rehearing. A.C.C. R4-16-102. Service of this order is effective five (5) days
17 after date of mailing. If a motion for rehearing is not filed, the Board's Order becomes
18 effective thirty-five (35) days after it is mailed to Respondent.

19 Respondent is further notified that the filing of a motion for rehearing is required to
20 preserve any rights of appeal to the Superior Court.

21 Dated this 16th day of April 2004.

22 ARIZONA MEDICAL BOARD

23 (SEAL)



24 By: Barry A. Cassidy
25 Barry A. Cassidy, Ph.D., P.A.-C
Executive Director

1 Original of the foregoing filed this
2 16th day of April, 2004, with:

3 Arizona Medical Board
4 9545 East Doubletree Ranch Road
5 Scottsdale, AZ 85258

6 Copy of the foregoing filed this
7 16th day of April, 2004, with:

8 Cliff J. Vanell, Director
9 Office of Administrative Hearings
10 1400 W. Washington, Ste. 101
11 Phoenix, AZ 85007

12 Executed copy of the foregoing mailed
13 by Certified Mail this
14 16th day of April, 2004, to:

15 Scott J. Hergenroether
16 Campbell Yost Hergenroether Clare & Norell PC
17 101 N First Ave., Suite 2500
18 Phoenix, AZ 85003-1607

19 Michael Ridge, M.D.
20 (address of record)

21 Executed copy of the foregoing mailed
22 this 16th day of April, 2004, to:

23 Stephen A. Wolf
24 Assistant Attorney General
25 Office of the Attorney General
CIV/LES
1275 W. Washington
Phoenix, Arizona 85007

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