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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of
ROBERT J. ALLEN, M.D.
Holder of License No. **15874**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-05-0576A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER**
(Letter of Reprimand and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 8, 2006. Robert J. Allen, M.D., ("Respondent") appeared before the Board 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. 15874 for the practice of allopathic medicine in the State of Arizona.
3. The Board initiated case number MD-05-0576A after receiving notification of a malpractice settlement regarding Respondent's care and treatment of a fifty-seven year-old female ("MC"). MC had a known history of hyperlipidemia, hypertension, diabetes mellitus, depression and tobacco use. MC was admitted to the hospital in September 2001 with chest pain and underwent a treadmill stress test that was terminated because of fatigue, left leg pain, and chest pain. MC did not follow up with a cardiologist after discharge from the hospital because she believed there was nothing wrong with her heart. MC first presented to Respondent's office on September 7, 2001 with a chief complaint of chest pain with pressure to her jaw. MC was seen by Respondent's Physician Assistant ("PA") who ordered an EKG that was read as normal sinus

1 rhythm and non-specific ST abnormalities. PA noted a strong family history of coronary artery
2 disease, MC's father having died at fifty-nine years-old from a myocardial infarction, and her
3 brother having coronary bypass. PA suggested a cardiology referral to the same physician who
4 had done MC's stress test in the hospital, but there is no indication the PA spoke with this
5 physician.

6 4. Respondent saw MC on September 24, 2001. A note in the chart notes no change
7 in MC's history. MC next visited Respondent on March 18, 2002, April 18, 2002 (with a chief
8 complaint of shortness of breath with exertion) and May 13, 2002 (with a chief complaint of
9 pressure discomfort in her chest). MC last saw Respondent on June 24, 2002 complaining of
10 constipation secondary to her medication, but in Respondent's history and physical is a note of
11 chest tightness with exertion. MC died of a heart attack on July 17, 2002.

12 5. Respondent testified the allegations against him that he failed to diagnose
13 coronary artery disease and failed to aggressively refer MC for a cardiology consult are untrue.
14 Respondent testified he has been in practice for thirty-four years and is fairly familiar with
15 symptoms of heart disease. Respondent stresses to his office staff that if a patient calls or comes
16 in with chest pain the patient is to be seen immediately. Respondent testified MC was seen in his
17 office within two days of her discharge from the hospital. Respondent noted he recognized MC
18 had chest pain, shortness of breath with exertion, and multiple risk factors, but she also came to
19 the office after having been in the hospital for three days. Respondent testified MC was told at the
20 hospital that her cardiac workup was normal. Respondent testified MC was referred by his office
21 to a cardiologist and was told because she had private insurance she did not need a referral and
22 could go to any cardiologist she wanted. Respondent testified MC was adamant about not
23 wanting to get a cardiac consultation even though she was told several times during the office
24 visits the risks of her condition.

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1 6. The Board asked who reads EKG's taken in Respondent's office. Respondent
2 testified it would depend on what was found on the EKG, but generally it would be one of the
3 doctors in his office or, if there is a question, it would be faxed to a cardiologist for an
4 interpretation. Respondent testified he did not see MC at her office visit and he did not see the
5 EKG on that date. Respondent testified his office received some of MC's hospital records a long
6 time after she presented, including the stress test that was read as clinically and electronically
7 normal.

8 7. The Board directed Respondent to the hospital EKG from September 3, 2001 and
9 asked if he saw anything abnormal. Respondent did not. The Board then directed Respondent to
10 the EKG taken in his office on September 7, 2001 and asked if there was any difference between
11 the September 3 and September 7, 2001 EKGs. Respondent testified there are possibly some ST
12 wave changes and acknowledged there was ST segment depression in leads 1 and 2 and V5 and
13 6. The Board asked if this concerned Respondent with a patient complaining of chest pain.
14 Respondent testified MC was not having chest pain when she was seen in his office. The Board
15 noted MC's chief complaint on that visit was exertional chest pain radiating to her jaw.
16 Respondent testified this is what MC said when she was in the hospital and she never had chest
17 pain in his office, because if she did, she would have been immediately sent to the hospital in an
18 ambulance. The Board asked if the September 7, 2001 EKG was seen by a physician.
19 Respondent testified he could not say whether or not he saw it because he did not sign it and that
20 is one of the changes that he has made to office policy.

21 8. Respondent testified MC was referred to cardiology and was seen again in two
22 weeks for follow-up blood work. The Board asked if MC's complaint continued to be chest pain.
23 Respondent testified when he saw MC she indicated she was in the office to go over her blood
24 work, but she was continuing to have exertional chest pain. The Board noted that in
25 Respondent's chart after this visit were notations of his trying to contact MC to tell her to go see a

1 cardiologist, but he did not see her again until March 2002. Respondent testified when MC was
2 seen at the end of September she was told to come back in two weeks, but she did not keep that
3 appointment or an appointment in November. The Board asked if MC complained of chest pain at
4 the March visit. Respondent testified through history he talked to her to see if it had gotten worse
5 or if there had been any changes. The Board asked when Respondent received the hospital
6 treadmill test and the nuclear test read by another physician. Respondent testified MC's treadmill
7 test was not read and forwarded to him until March and the diagnosis was precordial chest pain
8 or chest wall pain. The Board noted according to the hospital record the test was done on
9 September 4 and dictated by November 30.

10 9. The Board directed Respondent to the body of the EKG report where it says there
11 were some mild perfusion defects, but they could not be sure where they were from and that the
12 exercise was stopped because of fatigue, left leg and chest pain. The Board noted MC also had
13 equivocal ST wave changes, so it really was not a negative study. The Board noted it understood
14 the difficulty of dealing with a patient who does not follow-up on a recommended referral, but
15 asked what Respondent could have done differently for MC. Respondent testified he has spent a
16 lot of time thinking about this case and there have been many changes. Respondent directed the
17 Board to the physician notes from the hospital where it says the nuclear stress test is normal and
18 that MC was told it was normal. The Board asked what Respondent thought the rate of false
19 negatives was in women. Respondent testified it was probably fairly high. Respondent testified he
20 should have documented he recommend MC see a cardiologist and he could have discharged
21 her as a patient because she continued to refuse to follow his advice, or he could have invited the
22 family in and tried to get them to encourage her to go to the cardiologist because of her history of
23 chest pain, her classical history of angina, and her cardiac symptoms.

24 10. The Board asked what Respondent had done to improve the reading of EKGs in
25 his office because the first EKG that was read by a nurse practitioner was suggestive of ischemia.

1 Respondent testified every EKG is still not read by a physician, only those where there is a
2 questionable EKG and he has several cardiologists that are very helpful in interpreting and
3 reading the EKGs. Respondent testified MC's office EKG was done two days after she left the
4 hospital and had a complete cardiac workup, but her symptoms were not much better.
5 Respondent noted MC was not sick like she was in the hospital, was not in severe pain, (as
6 opposed to the hospital when she was in excruciating, typical pain they thought could be a heart
7 attack), was asymptomatic, and did not have any problems except with exertional pain. The
8 Board noted the problem was that Respondent did not have the EKG from the hospital when MC
9 presented with severe pain and her EKG's were normal. The Board noted the EKG in
10 Respondent's office was abnormal even though MC was not actively having chest pain and asked
11 if there was any significance to an abnormal EKG two days after being in the hospital for acute
12 chest pain. Respondent testified there was.

13 11. The Board asked why Respondent did not have all the EKGs done in his office
14 looked at by a cardiologist. Respondent testified he would look into the expense of doing that.
15 The Board asked why Respondent would not just make sure a physician in the office reviewed all
16 EKGs. Respondent testified that was a good idea. The Board directed Respondent back to MC's
17 first visit when she came in with EKG changes and she did not have any positive findings while
18 she was in the hospital, but two days later when she saw Respondent there are ST wave
19 changes even though Respondent says she was asymptomatic. The Board asked if Respondent
20 tried to make an appointment with a cardiologist on MC's behalf or simply suggested she go see
21 a cardiologist. Respondent testified MC was referred to a cardiologist through the referral
22 department because patients usually need a referral, but they found out MC did not need a
23 referral. MC was called one or two days later and told she did not need a referral and could go to
24 a cardiologist on her own without a referral. Respondent reiterated MC did not have chest pain
25 when she was in his office. The Board again directed Respondent to his progress note on the

1 date of this visit that contains an initial complaint of chest pain radiating to the jaw. The Board
2 asked if Respondent agreed that, in light of MC's complaint and finding of EKG changes, should
3 he just tell MC to go to the cardiologist. Respondent testified he should not. The Board noted that
4 appeared to be exactly what he did. Respondent testified MC was in no distress and was having
5 no problems and, because he did not have the hospital records, he had nothing to compare to.
6 Respondent noted if MC had been in severe pain his policy is that she would go by ambulance to
7 the hospital. The Board asked what MC's chief complaint on intake of shortness of breath, pain
8 radiating to the jaw meant. Respondent testified he was not explaining that well and that a few
9 days earlier MC had chest pain that did not go away and radiated to the jaw and she went to the
10 hospital, was evaluated and was told to see a primary care physician. Respondent testified the
11 note about this pain related to the pain MC had when she was admitted to the hospital, not at her
12 office visit. Respondent also noted he did not see the EKG from MC's first visit.

13 12. The Board asked if it was correct to give MC the option of seeing any cardiologist
14 when he sees changes in the EKG. Respondent testified some people would like to see another
15 cardiologist and some people may not have liked the cardiologist they saw at the hospital, but he
16 does not know what MC's reason was. Respondent testified he referred MC to the cardiologist
17 who performed the stress test in the hospital. The Board noted the changes on the EKG were
18 acute and MC needed to be seen by a cardiologist emergently. The Board asked if MC had all of
19 the major components identified as contributing to heart disease – if she was sort of a poster child
20 for a heart attack. Respondent testified MC was. The Board noted there was an EKG done by a
21 PA in his office and asked Respondent if he could not have just called the hospital and asked
22 them to fax MC's records so he could have compared the EKGs. Respondent testified he did not
23 know if the PA did this or not, but it is not that easy to get records from the hospital.

24 13. The Board asked Respondent to articulate the standard of care in family practice
25 in 2001, when MC was first seen, regarding immediate emergent referral for a cardiac evaluation,

1 cardiac cath. Respondent testified the standard of care would have been to have MC see a
2 cardiologist as soon as possible. The Board clarified with Respondent that he would have been
3 able to get MC an appointment with a cardiologist on the same day he recommended she see a
4 cardiologist. The Board asked why then did he not immediately make an appointment for MC
5 when she was first seen. Respondent testified he could not speak for the PA who first saw MC,
6 but when he saw MC she refused to go because, in her mind, everything was normal.
7 Respondent testified he had learned a lot from MC's case and his office is trying to make it so it is
8 common that referral appointments are made by the office.

9 14. Respondent testified he wanted the Board to know he is very aware of the cardiac
10 risk factors and he knows he tried to get MC to see a cardiologist. Respondent noted MC was not
11 having an acute problem when she came in and she had a complete cardiac workup in the
12 hospital. Respondent noted in both MC's mind and the hospital records she had a normal workup.
13 Respondent testified he has made changes to prevent this from happening and to help patients
14 with their referrals and to evaluate EKGs in a better manner. Respondent noted he hopes to be
15 able to help patients even though they refuse a referral.

16 15. The standard of care required the EKG be read by a qualified interpreter, MC be
17 advised of the benefits and risks, and timely referred to a cardiologist for additional workup.

18 16. Respondent deviated from the standard of care because he did not ensure the
19 EKG was read by a qualified interpreter, did not advise MC of the benefits and risks, and did not
20 aggressively refer MC for a cardiovascular evaluation.

21 17. MC died from a sudden heart attack that may have been prevented if she was
22 seen by a cardiologist.

23 18. It is mitigating that MC was not compliant, however, she did not appear to realize
24 the seriousness of her condition.

25

1 DATED this 11th day of August, 2006.



THE ARIZONA MEDICAL BOARD

By *Timothy C. Miller*
TIMOTHY C. MILLER, J.D.
Executive Director

7 ORIGINAL of the foregoing filed this
8 11th day of August, 2006 with:

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

10 Executed copy of the foregoing
11 mailed by U.S. Certified Mail this
12 11th day of August, 2006, to:

13 Robert J. Allen, M.D.
14 Address of Record

15 *Timothy C. Miller*