

1 BEFORE THE BOARD OF MEDICAL EXAMINERS

2 IN THE STATE OF ARIZONA

3 In the Matter of

4 **ERNEST BARKER, M.D.**

5 Holder of License No. **16610**  
6 For the Practice of Medicine  
7 In the State of Arizona.

Board Case No. MD-01-0072

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

(Letter of Reprimand)

8 On May 1, 2002, Ernest Barker, M.D., ("Respondent") appeared before a Review  
9 Committee ("Review Committee") of the Arizona Board of Medical Examiners ("Board")  
10 without legal counsel for a formal interview pursuant to the authority vested in the Review  
11 Committee by A.R.S. § 32-1451(Q). The matter was referred to the Board for  
12 consideration at its public meeting on July 10, 2002. After due consideration of the facts  
13 and law applicable to this matter, the Board voted to issue the following findings of fact,  
14 conclusions of law and order.  
15

16 **FINDINGS OF FACT**

- 17 1. The Board is the duly constituted authority for the regulation and control of  
18 the practice of allopathic medicine in the State of Arizona.
- 19 2. Respondent is the holder of License No. 16610 for the practice of medicine  
20 in the State of Arizona.
- 21 3. The Board initiated case number MD-01-0072 after receiving a complaint  
22 regarding Respondent's care and treatment of a 61 year-old male patient ("Patient"). On  
23 February 21, 1999, Patient presented to the emergency room after falling in his home.  
24 Patient had struck his head and lost consciousness. Patient complained of neck pain,  
25 but the emergency room physician who examined patient found no neurological defects.  
Patient had undergone multiple prior back and neck surgeries with hardware having

1 previously been placed in his neck. The emergency room physician ordered x-rays of the  
2 cervical spine and a CT scan.

3 4. Respondent was responsible for reading the cervical spine films.  
4 Respondent read the films as showing no acute fracture or dislocation.

5 5. The emergency room physician diagnosed Respondent with a bruise and  
6 discharged Patient with pain medication and a soft cervical collar. Patient continued to  
7 complain of pain and follow-up films were taken on April, 1999. The follow-up films  
8 showed a fracture in the cervical spine that had been present at the time of the original  
9 emergency room visit.

10 6. The Board's Medical Consultant ("Medical Consultant") reviewed the films  
11 and found that in his radiology report Respondent incorrectly described the odontoid  
12 process as "intact;" and that the films revealed a discernible fracture through the base of  
13 the odontoid process.

14 7. In his written response to the Board's inquiry, Respondent acknowledged  
15 that he incorrectly read the cervical spine films. Respondent offered no specific  
16 explanation of having missed the fracture, but opined that his being responsible for  
17 reading a large amount of films and other distractions contributed to the error. .

18 8. At the formal interview, Respondent testified that when he looked at the  
19 films after the initial reading that he could see the fracture. Respondent testified that at  
20 the time he originally read the films he was "Radiologist of the Day" ("ROD") at Samaritan  
21 Hospital. As the ROD Respondent would begin his day at 7:00 a.m. and read all films  
22 from the emergency room, all films that were taken overnight from the different floors of  
23 the hospital, all emergency ultrasounds, films from the seven intensive care units and  
24 other films until the regularly schedule people in each specialty arrived. Respondent  
25 worked until 5:00 p.m. and read anywhere from 250 to 300 films a day. Respondent

1 testified that he was also responsible for handling consultations and phone calls with  
2 questions about scheduling, procedures or clinical questions.

3 9. Respondent testified that a Board-Certified radiologist should be able to  
4 notice a C-2 fracture on a routine basis.

5 10. Respondent testified that his current schedule and work-load are much  
6 lighter and that he currently reads approximately 80 films per day. Respondent testified  
7 that he regrets making the error in Patient's case and that he was glad to currently be  
8 working in a situation that is not as stressful or intense as his position with Good  
9 Samaritan was.

10 **CONCLUSIONS OF LAW**

11 1. The Board of Medical Examiners of the State of Arizona possesses  
12 jurisdiction over the subject matter hereof and over Respondent.

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

16 3. The conduct and circumstances above in paragraphs 4, 6 and 7 constitute  
17 unprofessional conduct pursuant to A.R.S. § 32-1401(25)(q) "[a]ny conduct or practice  
18 that is or might be harmful or dangerous to the health of the patient or the public."

19 **ORDER**

20 Based upon the foregoing Findings of Fact and Conclusions of Law, IT IS  
21 HEREBY ORDERED that Respondent is issued a Letter of Reprimand for failure to  
22 identify a potentially serious injury when reading a C-spine x-ray.

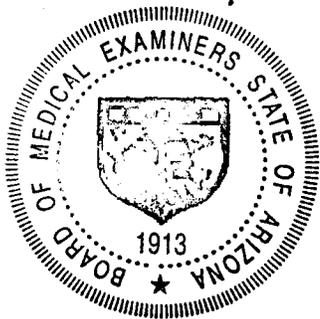
23 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

24 Respondent is hereby notified that he has the right to petition for a rehearing or  
25 review. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing or

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

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

8 DATED this 10<sup>th</sup> day of July, 2002.



BOARD OF MEDICAL EXAMINERS  
OF THE STATE OF ARIZONA

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By Barry Cassidy  
BARRY CASSIDY, Ph.D., P.A.-C.  
Executive Director

ORIGINAL of the foregoing filed this  
10<sup>th</sup> day of July, 2002 with:

The Arizona Board of Medical Examiners  
9545 East Doubletree Ranch Road  
Scottsdale, Arizona 85258

Executed copy of the foregoing  
mailed by U.S. Certified Mail this  
10<sup>th</sup> day of July, 2002, to:

Ernest Barker, M.D.  
11105 N 115th St Apt 1119  
Scottsdale AZ 85259-4024

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Copy of the foregoing hand-delivered this  
10<sup>th</sup> day of July, 2002, to:

Christine Cassetta  
Assistant Attorney General  
Sandra Waitt, Management Analyst  
Investigations (Investigation File)  
Arizona Board of Medical Examiners  
9545 East Doubletree Ranch Road  
Scottsdale, Arizona 85258

  
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