

1 BEFORE THE ARIZONA MEDICAL BOARD

2
3 In the Matter of

Board Case No. MD-01-0669

4 **J. MICHAEL KASSENBRUCK, M.D.**

5 Holder of License No. 17245
6 For the Practice of Medicine
7 In the State of Arizona.

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

(Letter of Reprimand)

8 This matter was considered by the Arizona Medical Board ("Board") at its public
9 meeting on August 7, 2002. J. Michael Kassenbrock, M.D., ("Respondent") appeared
10 before the Board without legal counsel for a formal interview pursuant to the authority
11 vested 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
16 1. The Board is the duly constituted authority for the regulation and control of
17 the practice of allopathic medicine in the State of Arizona.

18 2. Respondent is the holder of License No. 17245 for the practice of medicine
19 in the State of Arizona.

20 3. The Board initiated case number MD-01-0669 after notification of a
21 malpractice settlement regarding Respondent's care and treatment of a 51 year-old
22 female patient ("J.K.").

23 4. J.K. presented to a treating physician in April 1995 with an enlarged uterus
24 secondary to fibroids. The physician recommended surgical intervention. A standard
25 preoperative chest x-ray was taken on April 10, 1995 and reported as abnormal. The
physician requested a follow-up x-ray that was performed on April 11, 1995 and also

1 reported as abnormal. The physician went ahead with the surgery as scheduled. J.K,
2 was not informed of the abnormal chest x-ray nor was she advised to seek follow-up care
3 regarding the abnormal x-ray.

4 5. In 1997 J.K. underwent a mammogram that was reported as abnormal.
5 J.K. was referred to Respondent for treatment. Respondent recommended an out-patient
6 biopsy. A pre-operative chest x-ray was taken and it revealed a more significant
7 abnormality than that seen in the 1995 x-ray and previous comparison films were
8 requested. Respondent took no action regarding the x-rays. In 1999, J.K. was seen by a
9 Doctor of Osteopathy ("D.O") for a cough. In 2000, the D.O. ordered chest x-rays, a CT
10 scan and further biopsy studies that revealed that J.K. had lung cancer.

11 6. The Board's Medical Consultant opined that Respondent violated the
12 standard of care when he failed to review the preoperative study that he had ordered and
13 when he failed to take further action taken on the abnormal studies. The Medical
14 Consultant also stated that a surgeon is obligated to have all of the appropriate tests in
15 front of him/her and, if he/she does not, any elective procedure should not be performed.
16 The surgeon must be aware of everything he/she ordered or make a note in the chart as
17 to why it is not relevant to the situation.

18 7. At the formal interview Respondent testified that his practice during his
19 residency was to perform an EKG and pre-operative chest x-rays on patients over 50
20 years old. Respondent stated that in his residency an anesthesiologist reviewed test
21 results and his assumption in this case was that such a review had taken place.
22 Respondent testified that he never saw the report of the x-ray although it was filed at
23 some point in his office. Respondent stated that during the time in question his office had
24 several high school students who were responsible for filing documents and who were
25 instructed that reports were to be reviewed and initialed by the physician prior to being

1 filed. Respondent stated that J.K.'s chart was not initialed and the test results were in the
2 back of J.K.'s chart.

3 8. Respondent testified that although the physician who orders the test,
4 whether ordering it for another physician or not, is ultimately responsible for checking the
5 x-rays, laboratory reports or EKG reports, during his residency and in his practice up until
6 that point that had not been his policy. Respondent stated that he expected the
7 anesthesiologist who had gone over the results to bring the abnormality to his attention
8 and that this had not happened. Respondent testified that since J.K.'s case he has
9 employed an office manager who runs his office more tightly and verifies that the
10 reviewing physician has initialed a test result before it is filed in a patient's chart.

11 9. In response to a query from the Board Respondent agreed that because of
12 his omission J.K. had a delay in the diagnosis and treatment of a neoplasm. Respondent
13 added that the abnormality had been seen on a chest x-ray at least two years prior to his
14 treating J.K.

15 10. The standard of care required Respondent to review the pre-operative
16 studies he ordered.

17 11. Respondent did not meet the standard of care in that he did not review the
18 pre-operative studies.

19 12. There was potential harm to J.K. in that there was a delay in the diagnosis
20 and treatment of a neoplasm.

21 CONCLUSIONS OF LAW

22 1. The Arizona Medical Board possesses jurisdiction over the subject matter
23 hereof and over Respondent.

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1 DATED this 3rd day of October, 2002.



THE ARIZONA MEDICAL BOARD

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

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9 ORIGINAL of the foregoing filed this
3rd day of OCTOBER, 2002 with:

10 Arizona Medical Board
11 9545 East Doubletree Ranch Road
12 Scottsdale, Arizona 85258

13 Executed copy of the foregoing
14 mailed by U.S. Certified Mail this
3rd day of OCTOBER, 2002, to:

15 J. Michael Kassenbrock, M.D.
16 539 W Vista Ave
17 Phoenix AZ 85021-7257

18 Copy of the foregoing hand-delivered this
3rd day of OCTOBER, 2002, to:

19 Christine Cassetta
20 Assistant Attorney General
21 Sandra Waitt, Management Analyst
22 Lynda Mottram, Senior Compliance Officer
23 Investigations (Investigation File)
24 Arizona Medical Board
25 9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Joan Ferguson