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**BEFORE THE ARIZONA MEDICAL BOARD**

In the Matter of  
**CHARLES LEW, M.D.**  
Holder of License No. **18472**  
For the Practice of Allopathic Medicine  
In the State of Arizona.

Board Case No. MD-05-0196B

**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 October 12, 2006. Charles Lew, M.D., ("Respondent") appeared before the Board without legal counsel 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. 18472 for the practice of allopathic medicine in the State of Arizona.
3. The Board initiated case number MD-05-0196B after receiving notification of a malpractice settlement paid on Respondent's behalf regarding his care and treatment of a six-month-old female patient ("KV") alleging Respondent failed to timely diagnose a small bowel obstruction leading to prolonged dehydration, shock and ultimately cardiac arrest and brain damage. KV was first seen by another physician at Mountain Park Health Center at 9:10 a.m. on October 21, 1998. KV's temperature was 97.8, pulse 110, weight twenty pounds, she had a history of emesis several times over the previous five to ten hours, her mucous membranes were

1 moist and her abdomen was soft and non-tender. The evaluating physician recommended a  
2 change in KV's diet and instructed her parents to return if KV's problems persisted.

3 4. On October 22, 1998 KV's parents returned her to Mountain Park Health Center.  
4 Respondent recorded her temperature as 99.5 and her weight as 20.9 pounds. Respondent did  
5 not record her pulse. KV's parents reported she continued to vomit since the day before.  
6 Respondent's examination revealed moist membranes and a benign non-distended abdomen.  
7 KV had no history of bilious emesis, diarrhea, or blood in stool. Respondent instructed KV's  
8 parents to return if the problems persisted. Later that same day KV's parents took her to the  
9 hospital at which time her temperature was elevated, her pulse was 178 to 220, and her white  
10 blood count was elevated at 15,600. An X-ray showed a bowel obstruction. KV's parents  
11 reported a history of diarrhea, vomiting and lethargy. An examination revealed dry mucous  
12 membranes, distended tender abdomen and fecal smelling material when aspirated from the  
13 stomach. KV required resuscitation and was transferred to Phoenix Children's Hospital where  
14 she suffered cardiac arrest and subsequent brain damage.

15 5. There are five pediatricians affiliated with Mountain Park Health Center and usually  
16 three or four are present at the same time seeing patients. Respondent saw KV when she  
17 returned on October 22 because, even though the physician who saw her on the 21<sup>st</sup> was  
18 present, Respondent was the rounding doctor for that week and when he was done rounding he  
19 returned to the clinic and his calendar was filled with walk-in patients. KV was a walk-in patient.  
20 Respondent had access to the record of the October 21 visit. KV's parents informed Respondent  
21 she had persistent vomiting for a little over one day, had no fever, no upper respiratory infection,  
22 and no other symptoms – just the vomiting since the day before.

23 6. Respondent agreed it would have been important for KV's pulse to be taken since  
24 she had been vomiting. Respondent testified he looked at the oral pharynx to see the mucous  
25 membranes and then checked the heart to see if there were any problems with tachycardia –

1 there was not. Respondent admitted to not having documented anything about tachycardia.  
2 KV's temperature was noted as 99.5 and had been 97.8 the previous day. The Board asked if  
3 this gave Respondent any pause. Respondent testified sometimes the temperature is taken in  
4 different places and he did not think her temperature was elevated. Respondent testified his  
5 examination of KV's abdomen revealed positive bowel sounds and was soft and non-tender.

6 7. The Board asked if it was important to do further work-up on a six-month-old infant  
7 who comes in with almost two days of emesis. Respondent testified it would be if KV was  
8 dehydrated or had a temperature. Respondent testified he looks at the status clinically, if KV is  
9 urinating, or if there are dry mucous membranes, or is lethargic. Respondent testified KV was  
10 none of these things. The Board noted KV could not keep anything down and kept throwing up  
11 causing the parents to bring her back. Respondent testified KV did not look dehydrated and KV  
12 gained .9 pounds. The Board asked the standard for an examination of a six-month old infant  
13 who has two days of non-stop emesis whose parents have returned to Respondent with the infant  
14 because they are concerned. Respondent testified he might do a urinalysis. The Board asked if  
15 he would check electrolytes. Respondent testified he possibly would. A high pulse would have  
16 given Respondent an indication there was some pathology going on with KV, such as marked  
17 dehydration, but he either did not do a pulse examination or did not document it. Respondent  
18 testified he did not document it, but did check the pulse.

19 8. Respondent testified that with a three-month to three-year-old child the  
20 temperature would usually be at 102 when he would start doing blood work or thinking the patient  
21 is septic and KV did not look septic. The Board asked if Respondent considered re-hydrating KV.  
22 Respondent testified he did not because she did not look dehydrated. How KV "looked" is just a  
23 perception of clinical appearance and it is very difficult to go by that with a six-month-old,  
24 especially since this infant had returned for a second time. Respondent did not check KV's urine  
25 for specific gravity when he sent it for urinalysis and he admitted doing so would have helped him.

1 Respondent's record for his examination of KV is very sparse and not very complete.  
2 Respondent agreed he did not write a lot on the chart as he should have. It was important for  
3 Respondent's record to be complete because if KV had returned a third day the physician who  
4 had to use Respondent's record would not know what KV's situation was when Respondent  
5 examined her. The Board asked what Respondent would have done differently when he saw KV  
6 now knowing the outcome. Respondent testified maybe he would have taken a UA or  
7 electrolytes and documented more.

8           9.       The Board asked Respondent's experience in seeing young children with bowel  
9 obstruction, intussusception or other forms of bowel obstruction. Respondent testified he saw one  
10 case when he was a resident, but he did not diagnose it and when he was at a Phoenix Hospital  
11 he saw an older child, a nine year-old. A bowel obstruction is a common concern in a child who  
12 comes back for repeat visits. The Board asked how often Respondent saw patients that are  
13 really ill and do not have particularly elevated temperatures. Respondent testified it is very  
14 seldom that they do not have elevated temperatures. The lack of a temperature can be a bit  
15 deceiving.

16           10.       The leading cause of death worldwide in pediatric patients under six years-old is  
17 dehydration and gastroenteritis – vomiting and diarrhea. The Board confirmed Respondent's  
18 diagnosis in KV was gastroenteritis and asked Respondent to explain what gastroenteritis is.  
19 Respondent testified it was an infection in the gastrointestinal tract. The Board asked  
20 Respondent to elaborate – what does gastroenteritis mean. Respondent testified it meant  
21 inflammation in the intestine and stomach. The Board asked when Respondent diagnoses  
22 gastroenteritis what his theory is as to what causes the inflammation in the gastrointestinal tract.  
23 Respondent testified it is probably a viral infection, which is common and the signs are diarrhea  
24 and vomiting. Respondent made this diagnosis even though KV did not have diarrhea.

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1           11.     The Board asked if the Phenergan suppository is a standard treatment for acute  
2 gastroenteritis in a six-month-old. Respondent testified it was not standard. In 1998 Phenergan  
3 was relatively contraindicated in children less than two years old yet Respondent gave it to a six-  
4 month-old for an illness that, in retrospect, did not exist. Respondent was asked to explain.  
5 Respondent testified a contraindicated drug can sometimes be used in a child. The Board asked  
6 if Respondent thought it was incumbent upon him when he was using a contraindicated drug to  
7 write in the medical record why he was using such a drug in a child. Respondent testified he did  
8 not. Respondent admitted his chart did not in any way meet the standard he was taught in  
9 residency.

10           12.     The Board directed Respondent to the emergency department record for KV and  
11 asked him to read the present illness. Respondent read "[s]ix month old who has been vomiting  
12 for last two days. Fever today. Started with some diarrhea today. Treated at a doctor's office  
13 and given some Phenergan suppositories. The child apparently, per mother, has had some  
14 altered level of sleep today." This record mentions diarrhea and vomiting, but Respondent's  
15 record says there was none. The Board asked which record the Board was to believe.  
16 Respondent stated his record reflects what KV's mother told him. The hospital chart shows KV's  
17 temperature was 105.9, pulse 178 and respiratory rate was 45. The general examination reports  
18 KV as lethargic, that she did open her eyes and maintained some eye contact, that her tympanic  
19 membranes were clear, her conjunctivae were clear, and her mucous membranes were dry. In  
20 comparison to Respondent's chart, this description seems to be of a totally different infant. The  
21 Board asked Respondent which chart the Board, not having seen the infant, should believe.  
22 Respondent testified the Board should believe the emergency room chart because KV probably  
23 got worse and had more of a complete obstruction. The Board asked if Respondent expected it  
24 to believe KV was perfectly benign looking when he saw her at an unknown time earlier in the day  
25 and then suddenly de-compensated. Respondent testified sometimes a patient can go shock-

1 like. The Board asked Respondent if he were on a desert island and could have only one vital  
2 sign on a six-month-old which would he choose. Respondent testified he would choose heart  
3 rate.

4 13. The standard of care for a child who returns to a physician within 24 hours with  
5 persistent vomiting and fever is to conduct a complete physical examination, including taking and  
6 recording a pulse, documenting a CNS examination, obtaining a white blood cell count, blood  
7 culture, serum electrolytes, urine culture and urine specific gravity, a spinal tap, and X-ray  
8 assessment of the abdomen. The standard of care also required institution of re-hydration (IV or  
9 oral) in the presence of medical personnel.

10 14. Respondent deviated from the standard of care because he did not conduct a  
11 complete physical examination, including taking and recording a pulse, documenting a CNS  
12 examination, obtaining a white blood cell count, blood culture, serum electrolytes, urine culture  
13 and urine specific gravity, a spinal tap, and X-ray assessment of the abdomen and because he  
14 did not institute re-hydration (IV or oral) in the presence of medical personnel.

15 15. The delay in recognizing bowel obstruction and instituting treatment resulted in  
16 bowel necrosis leading to cardiac arrest and brain damage.

17 **CONCLUSIONS OF LAW**

18 1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof  
19 and over Respondent.

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

23 3. The conduct and circumstances described above constitutes unprofessional  
24 conduct pursuant to A.R.S. § 32-1401(27)(II) (“[c]onduct that the board determines is gross  
25 negligence, repeated negligence or negligence resulting in harm to or the death of the patient”).

1 **ORDER**

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

3 IT IS HEREBY ORDERED:

4 1. Respondent is issued a Letter of Reprimand for failure to diagnose and treat bowel  
5 obstruction in a timely manner in an infant presenting with continued emesis.

6 2. Respondent is placed on probation for one year with the following terms and  
7 conditions:

8 a. Respondent shall obtain 20 hours of Board Staff pre-approved Category I  
9 Continuing Medical Education ("CME") in management of acutely ill pediatric patients.

10 3. Respondent shall obey all federal, state, and local laws and all rules governing the  
11 practice of medicine in Arizona.

12 4. In the event Respondent should leave Arizona to reside or practice outside the  
13 State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall  
14 notify the Executive Director in writing within ten days of departure and return or the dates of non-  
15 practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during  
16 which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent  
17 residence or practice outside Arizona or of non-practice within Arizona, will not apply to the  
18 reduction of the probationary period.

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

20 Respondent is hereby notified that he has the right to petition for a rehearing or review.  
21 The petition for rehearing or review must be filed with the Board's Executive Director within thirty  
22 (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review  
23 must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103.  
24 Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a  
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1 petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35)  
2 days after it is mailed to Respondent.

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

5 DATED this 7<sup>th</sup> day of December 2006.



THE ARIZONA MEDICAL BOARD

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

11 ORIGINAL of the foregoing filed this  
12 8<sup>th</sup> day of December, 2006 with:

13 Arizona Medical Board  
14 9545 East Doubletree Ranch Road  
15 Scottsdale, Arizona 85258

16 Executed copy of the foregoing  
17 mailed by U.S. Certified Mail this  
18 8<sup>th</sup> day of December, 2006, to:

19 Charles Lew, M.D.  
20 Address of Record

21 *Fin M. Gray*

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