

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **WILLIAM R. BURKS, M.D.**

4 Holder of License No. 18669
5 For the Practice of Allopathic Medicine
6 In the State of Arizona

Case No. MD-05-0524A

**CONSENT AGREEMENT FOR
LETTER OF REPRIMAND**

7 **CONSENT AGREEMENT**

8 By mutual agreement and understanding, between the Arizona Medical Board
9 ("Board") and William R. Burks, M.D. ("Respondent"), the parties agreed to the following
10 disposition of this matter.

11 1. Respondent has read and understands this Consent Agreement and the
12 stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement").
13 Respondent acknowledges that he has the right to consult with legal counsel regarding
14 this matter.

15 2. By entering into this Consent Agreement, Respondent voluntarily
16 relinquishes any rights to a hearing or judicial review in state or federal court on the
17 matters alleged, or to challenge this Consent Agreement in its entirety as issued by the
18 Board, and waives any other cause of action related thereto or arising from said Consent
19 Agreement.

20 3. This Consent Agreement is not effective until approved by the Board and
21 signed by its Executive Director.

22 4. The Board may adopt this Consent Agreement of any part thereof. This
23 Consent Agreement, or any part thereof, may be considered in any future disciplinary
24 action against Respondent.

25 5. This Consent Agreement does not constitute a dismissal or resolution of other
matters currently pending before the Board, if any, and does not constitute any waiver,

1 express or implied, of the Board's statutory authority or jurisdiction regarding any other
2 pending or future investigation, action or proceeding. The acceptance of this Consent
3 Agreement does not preclude any other agency, subdivision or officer of this State from
4 instituting other civil or criminal proceedings with respect to the conduct that is the subject
5 of this Consent Agreement.

6 6. All admissions made by Respondent are solely for final disposition of this
7 matter and any subsequent related administrative proceedings or civil litigation involving
8 the Board and Respondent. Therefore, said admissions by Respondent are not intended
9 or made for any other use, such as in the context of another state or federal government
10 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or
11 any other state or federal court.

12 7. Upon signing this agreement, and returning this document (or a copy thereof) to
13 the Board's Executive Director, Respondent may not revoke the acceptance of the
14 Consent Agreement. Respondent may not make any modifications to the document. Any
15 modifications to this original document are ineffective and void unless mutually approved
16 by the parties.

17 8. If the Board does not adopt this Consent Agreement, Respondent will not
18 assert as a defense that the Board's consideration of this Consent Agreement constitutes
19 bias, prejudice, prejudgment or other similar defense.

20 9. This Consent Agreement, once approved and signed, is a public record that will
21 be publicly disseminated as a formal action of the Board and will be reported to the
22 National Practitioner Data Bank and to the Arizona Medical Board's website.

23 10. If any part of the Consent Agreement is later declared void or otherwise
24 unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force
25 and effect.

1 11. Any violation of this Consent Agreement constitutes unprofessional conduct
2 and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order,
3 probation, consent agreement or stipulation issued or entered into by the board or its
4 executive director under this chapter") and 32-1451.

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WILLIAM R. BURKS, M.D.

DATED: 10-12-06

FINDINGS OF FACT

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2 1. The Board is the duly constituted authority for the regulation and control of
3 the practice of allopathic medicine in the State of Arizona.

4 2. Respondent is the holder of license number 18669 for the practice of
5 allopathic medicine in the State of Arizona.

6 3. The Board initiated case number MD-05-0524A after receiving Respondent's
7 2005 biennial renewal application for his Arizona Medical license. Respondent answered
8 "yes" to question #1 indicating he was under investigation by another medical board. On
9 January 25, 2005 an administrative complaint was filed by the Florida Medical Board
10 ("FMB") regarding Respondent's care and treatment of an eighty-three year-old female
11 ("MN") and a seventy-four year-old female ("HR").

12 4. On March 2, 2004 Respondent faxed a surgical planning sheet to the
13 hospital where he would perform intraocular lens surgery on MN and HR on March 16,
14 2004. As part of Respondent's routine he requested four different types of lenses for each
15 patient so he would be prepared if a surgical situation favored one type of lens or another.
16 The planning sheet contained lens types with corresponding powers and indicated which
17 lens was for MN and which lens was for HR. Respondent wrote legibly and clearly stated
18 all information on the surgical planning sheet. A hospital staff member ("Hospital Staff")
19 removed the lenses from stock and wrapped the corresponding lenses in each patient's
20 faxed surgical planning sheet. However, Hospital Staff wrapped the lenses for MN in HR's
21 surgical planning sheet and vice versa.

22 5. As a second line of security, Respondent also posted a list in the operating
23 room with each patient and their corresponding lenses. The circulating nurse and scrub
24 technician were to confirm the lenses, lens power, and lens correspondence with each
25 patient prior to Respondent requesting the lenses for surgery. Respondent routinely

1 delegated removing the lenses from stock, but he double checked the lens power against
2 the list before the lenses were unwrapped and placed on the surgical field. However,
3 Respondent did not do this for either patient.

4 6. Respondent performed the surgery on MN and HR on March 16, 2004. The
5 corrective vision was good in both patients, but the refractive error was very high (MN was
6 nearsighted and HR was farsighted). Respondent realized the error a few days after the
7 surgery and obtained permission from MN and HR to correct the error. On March 30, 2004
8 Respondent performed the lens exchanges in both patients at no charge.

9 7. As a result of this error Respondent entered into an agreement with FMB,
10 effective May 3, 2005 requiring he pay an administrative fine, reimburse administrative
11 costs, perform community service hours, submit a quality assurance review for medical
12 practice and submit an article suitable for publication or a letter to an ophthalmologic
13 publication periodical addressing practices instituted to reduce the implantation of the
14 wrong lens in a patient. Respondent complied with the terms of the FMB agreement.

15 8. On December 9, 2005 Respondent entered into an Order with the Texas
16 Medical Board (TMB) regarding the same incident. The Order reflected that Respondent
17 was required to pay an administrative penalty within 180 days from the Order. Respondent
18 complied with the Order.

19 9. The standard of care required Respondent to ensure the correct lenses were
20 implanted in each patient.

21 10. Respondent deviated from the standard of care because he failed to ensure
22 the correct lenses were implanted in each patient.

23 11. MN and HR each received the wrong lens and were required to undergo
24 additional surgery to correct the error.

25

1 CONCLUSIONS OF LAW

2 1. The Board possesses jurisdiction over the subject matter hereof and over
3 Respondent.

4 2. The conduct and circumstances described above constitute unprofessional
5 conduct pursuant to A.R.S. § 32-1401(27)(o) (“[a]ction that is taken against a doctor of
6 medicine by another licensing or regulatory jurisdiction due to that doctor’s mental or
7 physical inability to engage safely in the practice of medicine, the doctor’s medical
8 incompetence or for unprofessional conduct as defined by that jurisdiction and that
9 corresponds directly or indirectly to an act of unprofessional conduct prescribed by this
10 paragraph. . . .”; specifically, A.R.S. § 32-1401(27)(q) (“[a]ny conduct or practice that is or
11 might be harmful or dangerous to the health of the patient or the public”); and A.R.S. § 32-
12 1401 (27)(ll) (“[c]onduct that the board determines is gross negligence, repeated
13 negligence or negligence resulting in harm to or the death of a patient.”).

14 ORDER

15 IT IS HEREBY ORDERED THAT:

16 1. Respondent is issued a Letter of Reprimand for failure to implant the correct
17 intraocular lens in two patients.

18 2. This Order is the final disposition of case number MD-05-0524A.

19 DATED AND EFFECTIVE this 7th day of December, 2006.

20
21 (SEAL)



ARIZONA MEDICAL BOARD

22
23 By *Timothy C. Miller*
24 TIMOTHY C. MILLER, J.D.
Executive Director

25 ORIGINAL of the foregoing filed
this 8th day of December, 2006 with:

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Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed
this 8th day of December, 2006 to:

William R. Burks, M.D.
Address of Record


Investigational Review