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12 **BEFORE THE ARIZONA MEDICAL BOARD**

13 In the Matter of

14 **OLE G. TORJUSEN, M.D.**

15 **Holder of License No. 19487**  
16 For the Practice of Medicine  
17 In the State of Arizona

18 **Case No. MD-01-0775**

19 **CONSENT AGREEMENT AND ORDER**  
20 **FOR DECREE OF CENSURE AND**  
21 **PROBATION**

22 **CONSENT AGREEMENT**

23 In the interest of a prompt and judicious settlement of the above-captioned matter before  
24 the Arizona Medical Board ("Board") and consistent with the public interest, statutory requirements  
25 and responsibilities of the Board and pursuant to A.R.S. § 41-1092.07(F)(5) and A.R.S. § 32-1401  
*et seq.*, Ole G. Torjusen, M.D., holder of license number 19487 ("Respondent") and the Board enter  
into the following Recitals, Findings of Fact, Conclusions of Law and Order ("Consent  
Agreement") as the final disposition of this matter.

1. Respondent acknowledges that he has read and understands this Consent Agreement  
and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement").  
Respondent acknowledges that he has the right to consult with legal counsel regarding this matter  
and has done so or chooses not to do so. Respondent neither admits nor denies the Findings of Fact  
and Conclusions of Law set forth in this Consent Agreement. Respondent consents to the entry of

1 the Order set forth below as a compromise of a disputed matter between Respondent and the Board,  
2 and does so only for the purpose of terminating this disputed matter by agreement.

3 2. Respondent understands that he has a right to a public administrative hearing  
4 concerning each allegation set forth in the above-captioned matter, at which administrative hearing  
5 he could present evidence and cross-examine witnesses. By entering into this Consent Agreement,  
6 Respondent freely and voluntarily relinquishes all rights to such an administrative hearing, as well  
7 as all rights of rehearing, review, reconsideration, appeal, judicial review or any other  
8 administrative and/or judicial action, concerning the matters set forth herein.

9 3. Respondent understands that by entering into this Consent Agreement, he voluntarily  
10 relinquishes any rights to a hearing or judicial review in state or federal court on the matters  
11 alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives  
12 any other cause of action related thereto or arising from said Consent Agreement.

13 4. Respondent acknowledges and understands that this Consent Agreement is not  
14 effective until approved by the Board and signed by its Executive Director or designee.

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

20 6. Respondent understands that this Consent Agreement deals with Board  
21 Investigations **Case No. MD-01-0775** involving allegations of unprofessional conduct against  
22 Respondent. The investigation into these allegations against Respondent shall be concluded upon  
23 the Board's adoption of this Consent Agreement.

24 7. Respondent understands that this Consent Agreement does not constitute a dismissal  
25 or resolution of other matters currently pending before the Board, if any, and does not constitute

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

6 8. Respondent acknowledges and agrees upon signing this Consent Agreement and  
7 returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not  
8 revoke acceptance of the Consent Agreement. Respondent may not make any modifications to the  
9 document. Any modifications to this original document are ineffective and void unless mutually  
10 approved by the parties.

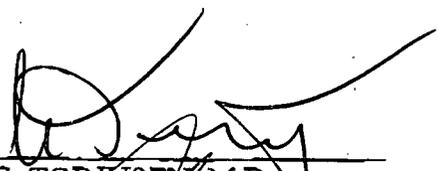
11 9. Respondent further understands that this Consent Agreement, once approved and  
12 signed, is a public record that may be publicly disseminated as a formal action of the Board and will  
13 be reported to the National Practitioner Data Bank, the Healthcare Integrity and Protection Data  
14 Bank and the Arizona Medical Board's website.

15 10. Respondent understands that any violation of this Consent Agreement constitutes  
16 unprofessional conduct under A.R.S. § 32-1401(27)(r) ([v]iolating a formal order, probation,  
17 consent agreement or stipulation issued or entered into by the board or its executive director under  
18 the provisions of this chapter) and shall result in disciplinary action under A.R.S. § 32-1451 *et seq.*

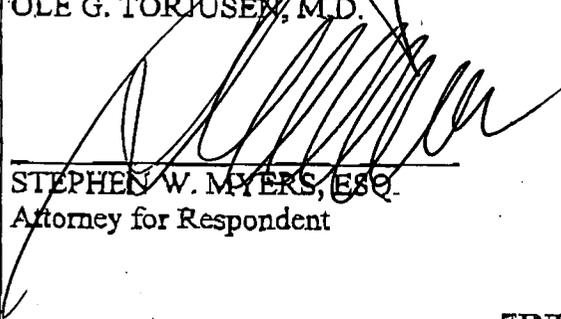
19 11. If any part of the Consent Agreement is later declared void or otherwise  
20 unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and  
21 effect.

22 12. The parties mutually understand and agree that this order constitutes a final binding  
23 decision of this matter under investigation by the Board and referenced above and throughout this  
24 Consent Agreement.

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3 OLE G. TORJUSEN, M.D.

DATED: 01/11/05

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5   
6 STEPHEN W. MYERS, ESQ.  
7 Attorney for Respondent

DATED: 01/11/05

8 **FINDINGS OF FACT**

9  
10 1. The Board is the duly constituted authority for regulating and controlling the practice  
11 of allopathic medicine in the State of Arizona.

12 2. Respondent is the holder of license number 19487 for the practice of allopathic  
13 medicine in the State of Arizona.

14 3. The Board initiated case number MD-01-0775 after the Board was notified that  
15 Respondent failed to provide requested information to Desert Samaritan Medical Center regarding  
16 prior adverse actions taken by Chandler Regional Hospital.

17 **PATIENT G.C.**

18 4. On March 17, 1998, at 10:30 p.m., Respondent's partner ("Partner") admitted a  
19 pregnant patient ("G.C.") at twenty-five (25) weeks, two (2) days, gestation to Chandler Regional  
20 Hospital ("Hospital") for severe urinary tract infection and mild contractions. A magnesium level  
21 drawn approximately six (6) hours later indicated that G.C.'s magnesium level was 6.4.

22 5. On March 18, 1998, at approximately 9:30 a.m., the Hospital first notified  
23 Respondent by telephone of G.C.'s magnesium level and Respondent discontinued the magnesium  
24 sulfate because of the side effects and started G.C. on Indocin.  
25

1           6.       At 1:42 p.m., Respondent examined G.C. and noted that she had signs of pre-term  
2 labor. Respondent ordered Terbutaline that was started at 2:05 p.m. and one (1) gram of Ancef was  
3 administered at 2:32 P.M. At 5:45 p.m. Terbutaline was give to G.C., again.

4           7.       At 6:30 p.m., the Hospital called Respondent because G.C. was complaining of right  
5 flank pain, although she denied feeling any contractions. Respondent gave orders for a complete  
6 blood count ("CBC") and other laboratory tests.

7           8.       The result of the CBC showed that G.C. had severe anemia with a hemoglobin level  
8 of 4.8 and a hematic level of 14.8.

9           9.       The duty nurse had G.C.'s blood redrawn and a second CBC was performed. The  
10 second CBC result was, again, significant for anemia with a critical hemoglobin level of 4.7 and  
11 hematocrit level of 13.8.

12          10.      At 9:05 p.m., the second CVC result was given to Respondent along with partial  
13 laboratory test results. Respondent issued orders for an obstetric ultrasound, blood type and screen  
14 test, and instructed Hospital staff to contact him with the results.

15          11.      At 9:13 p.m., when Respondent was given G.C.'s ultrasound reports confirming a  
16 placental abruption, he ordered an immediate CBC type and cross-match for four units of packed  
17 red blood cells. Respondent advised the Hospital that he was going to arrange for maternal  
18 transport and he would call the Hospital back.

19          12.      At 9:19 p.m., Respondent called the Hospital and advised that an Air Evac Services,  
20 Inc. helicopter ("Air Evac") was going to arrive and take G.C. to St. Joseph's Hospital. ("St.  
21 Joseph's").

22          13.      During the six (6) minute time frame, Respondent called the Director of Maternal-  
23 Fetal Medicine at St. Joseph's to ensure that G.C. would be accepted as a transfer patient and called  
24 Air Evac to arrange transport.

25

1           14.     At 9:32 p.m., Air Evac arrived at the Hospital to transport G.C. to St. Joseph's. Air  
2 Evac was given a report that contained the fetal heart tones at 140 to 150 beats per minute. At 9:45  
3 p.m., G.C. was transported to St. Joseph's before the blood could be cross-matched.

4           15.     A cesarean section ("C-section") was performed at St. Joseph's soon after G.C.  
5 arrived. G.C. and her infant both left the hospital in good health.

6           16.     A fair hearing panel of the Hospital reviewed G.C.'s case because the Hospital was  
7 critical of Respondent's decision to not immediately leave for the Hospital to examine G.C.

8           17.     Respondent's home was approximately twenty (20) minutes away from the Hospital.  
9 Respondent determined that he could make the telephone calls from home, keep informed of G.C.'s  
10 condition and arrange for transport, rather than try to return to the hospital while making telephone  
11 calls via his cell phone.

12           18.     At no time was there fetal distress and G.C. was not immediately taken to have a C-  
13 section performed upon arrival at St. Joseph's.

14           19.     A Board Medical Consultant reviewed this case and opined that Respondent did not  
15 meet the accepted standard of care. Specifically, Respondent deviated from the accepted standard  
16 of care when he did not timely evaluate G.C.'s critical lab values.

17           20.     The standard of care required Respondent to go to the Hospital to evaluate G.C.'s  
18 stability for transfer because if a placental abruption was occurring, a decision had to be made  
19 quickly regarding the transfer of G.C. and/or a possible immediate C-section.

20           21.     Respondent failed to meet the accepted standard of care because he failed to return  
21 to the Hospital to evaluate G.C.'s ability to transfer. If Respondent had gone to the Hospital, he  
22 might have decided that G.C.'s condition could well be managed where she was and thereby avoid  
23 a possible catastrophe during the transport.

24           22.     G.C. and her infant were exposed to potential harm and possible death had the  
25 abruption progressed during transfer.

**PATIENT T.R.**

1  
2           23.    On August 18, 1997, Respondent admitted a 25-year-old patient ("T.R.") to  
3 the Hospital for a total hysterectomy.

4           24.    T.R. had a history of dysmenorrhea and dyspareunia as well as a previous  
5 laparoscopy and diagnostic laparotomy for a seven centimeter hemorrhagic cyst.

6           25.    Respondent performed surgery and T.R. experienced an  
7 estimated blood lost of 50 ccs. T.R.'s pre-operative hematocrit was 31.9 and the hemoglobin was  
8 14.5.

9           26.    At 4:45 p.m., on August 18, 1997 (approximately three (3) hours after T.R.  
10 returned to her hospital room), Respondent was called because a nurse noted that T.R.'s blood  
11 pressure was 81/40 with a pulse of 75. T.R. was also complaining of abdominal pain although she  
12 denied any shortness of breath.

13           27.    At 5:20 p.m., when Respondent was, again, advised that T.R.'s blood  
14 pressure was falling, Respondent ordered an ultravenous infusion of lactated Ringers as well as  
15 immediate hemoglobin and hematocrit ("H&H"). At 5:30 p.m., T.R.'s blood pressure was 76/39.

16           28.    At 6:00 p.m., Respondent was called and told that the hemoglobin was 10  
17 and hematocrit was 29, essentially an expected laboratory level and within normal limits for a  
18 postoperative patient if the patient did not have a history of decreasing blood pressure. At 6:30  
19 p.m., T.R.'s blood pressure was 91/42.

20           29.    At 9:45 p.m., Respondent called the Hospital because he was concerned  
21 about T.R.'s status and was told that blood had not been redrawn. Respondent ordered another  
22 H&H.

23           30.    At 10:00 p.m., Respondent left for the Hospital because he was told that  
24 T.R.'s blood report showed a hematocrit of 23 and hemoglobin of 8.

25           31.    When Respondent arrived at the Hospital, T.R.'s abdomen was distended

1 and she was taken to surgery where she was found to be bleeding from the right infundibulopelvic  
2 ligament.

3 32. Respondent repaired the bleed site. T.R. experienced an estimated blood  
4 loss of 1500 ccs. The intraoperative blood drawn showed an H&H of 13.6 and 4.6. According to  
5 Respondent, this result was inaccurate because T.R. had been transfused with 500 ccs of fluid bolus  
6 starting at 5:20 p.m. T.R. continued to improve after the bleeding was stopped and she was  
7 transfused, again.

8 33. A Board Medical Consultant reviewed this case and opined that Respondent  
9 did not meet the standard of care. Specifically, Respondent failed to evaluate T.R. personally based  
10 upon symptoms and laboratory values. Respondent received two (2) telephone calls stating that  
11 T.R.'s clinical status was questionable and Respondent tried to manage a postoperative patient in  
12 shock by telephone. Respondent should have gone to Chandler Regional to address T.R. directly  
13 especially in light of the fact that he had ordered STAT laboratory tests. Respondent should have  
14 evaluated T.R. personally on site and not just by telephone.

15 34. The standard of care required Respondent to return to the hospital immediately to  
16 attend to T.R. personally when he was notified she was in postoperative shock.

17 35. Respondent failed to meet the accepted standard of care because he tried to  
18 evaluate T.R.'s condition over the telephone instead of going to the hospital to personally evaluate  
19 T.R., especially after he had ordered STAT laboratories.

20 36. The actual and potential harm suffered by T.R. was increased blood loss and  
21 increased need for blood replacement.

22 **PATIENT B.L.**

23 37. On December 15, 1997, at 5:00 a.m., patient ("B.L.") was presented to the  
24 Hospital for spontaneous onset of labor.

25 38. B.L.'s cervix was 3 to 4 centimeters dilated and 95% effaced. Her amniotic

1 fluid was clear with no odor, fetal heart rate was 130 to 140 beats per minute with good long and  
2 short-term variability, with -1 station and contractions that were moderate.

3 39. At 7:30 a.m., Respondent saw B.L. and noted a 5 centimeter dilation with  
4 100% effacement and +1 station. Mild variable decelerations remained, but they returned to the  
5 baseline by the end of each contraction and the fetal heart rate baseline remained at 140 to 150 beats  
6 per minute.

7 40. At 9:00 a.m., Respondent was notified that B.L. was 9 centimeters dilated,  
8 100% effaced and +1/+2 station. Respondent was in surgery with another patient at the Hospital.

9 41. At 10:32 a.m., B.L.'s cervix was 9 centimeters, 100% effaced and a +2  
10 station. A small anterior lip remained and attempts to resolve this by pushing were unsuccessful.

11 42. At 10:45 a.m., Respondent was called and advised of B.L.'s condition.  
12 Respondent ordered B.L. to rest and labor with an epidural that had been previously placed. At  
13 12:14 p.m., B.L.'s cervix was 9.5 centimeters, 90% effaced, station of 0/+1.

14 43. At 1:10 p.m., Respondent examined B.L. and noted the persistent anterior  
15 lip of the cervix. At that time, the baseline fetal heart rate was in the 150s with short and long term  
16 variability along with accelerations. B.L. had contractions every two (2) minutes of forty (40) to  
17 sixty (60) second durations.

18 44. At 1:50 p.m., B.L. was placed in a semi-Fowlers position and began pushing.  
19 The fetal heart rate was in the 150s with short and long term variability and accelerations with  
20 contractions every two (2) minutes which were of forty (40) to sixty (60) seconds in duration.

21 45. At 2:40 p.m., Respondent examined B.L., reviewed the fetal monitor strips  
22 and ordered Pitocin. Respondent discussed a cesarean section ("C-section") with B.L., but she was  
23 unwilling to discuss the possibility.

24 46. At 4:45 p.m., Respondent received a telephone call and was advised of  
25

1 B.L.'s condition. The fetal heart rate was in the 160s with minimal long-term variability and short-  
2 term variability present. B.L. continued to push intermittently with contractions, but not on a  
3 regular basis.

4 47. At 6:00 p.m., B.L. developed an elevated temperature of 101 degrees. The  
5 Fetal heart rate continued in the 160s with short-term variability present. At 6:09 p.m., Respondent  
6 was advised of B.L.'s condition and intravenous antibiotics were ordered.

7 48. At 6:54 p.m., Respondent was advised that B.L. was complete and pushing,  
8 but at +1 stations with a fetal heart rate of 179 to 180 with variable deceleration and decreased  
9 variability. Respondent left for Chandler Regional.

10 49. At 7:26 p.m., Respondent attempted vacuum extraction as the fetal heart  
11 rate remained in the 180s with variable decelerations, late decelerations and absent long term  
12 variability. Respondent attempted a manual rotation of the fetus, which became occiput anterior.  
13 The fetal heart rate remained in the 170s to 190s with short-term variability present with variable  
14 and late decelerations. B.L. continued to push and Respondent continued to apply intermittent  
15 vacuum extraction and front pressure for another 15 to 20 minutes after advising B.L. that at C-  
16 section should be performed. B. L. adamantly refused a C-section.

17 50. At 7:55 p.m., Respondent repeated to B.L. that a C-section should be  
18 performed and, again, B.L. refused to have a C-section. Respondent extended an episiotomy in  
19 order to assist with the vacuum extraction.

20 51. At 8:12 p.m., B. L. finally gave consent for a C-section and at 8:40 p.m., a  
21 viable male infant was delivered.

22 52. Respondent stated that he did not believe the infant was in fetal distress  
23 nor did he delay the C-section. Respondent admitted he poorly documented his advice to B.L. that  
24 she needed to have a C-section and her adamant refusals each time it was presented to her.

25 53. A Board Medical Consultant reviewed this case and opined that Respondent did not

1 meet the standard of care because Respondent did not personally examine B.L. from 2:40 p.m. to  
2 7:26 p.m. and that due to B.L.'s history, in addition to being completely dilated, the five (5) hour  
3 gap fell below the standard of care.

4 54. The standard of care required Respondent to perform a hands-on evaluation  
5 when B.L. failed to progress with labor for two (2) hours.

6 55. Respondent failed to meet the accepted standard of care because he did  
7 not perform a hands-on evaluation of B.L. for twelve (12) hours particularly in light of the fact that  
8 B.L. had a fetal monitor showing poor variability.

9 56. Although there was not actual harm to B.L., the fetal monitor strips showed  
10 poor variability and her infant did develop cerebral palsy. There is considerable evidence that  
11 cerebral palsy is more likely to result from a prenatal hypoxic insult rather than hypoxia during  
12 labor and delivery.

### 13 14 **CONCLUSIONS OF LAW**

15 1. The Board possesses jurisdiction over the subject matter hereof and over  
16 Respondent.

17 2. The conduct and circumstances described above constitute unprofessional conduct  
18 pursuant to A.R.S. § 32-1401(27)(q) - (“[a]ny conduct or practice that is or might be harmful or  
19 dangerous to the health of the patient or the public.”).

20 3. The conduct and circumstances described above constitute unprofessional conduct  
21 pursuant to A.R.S. § 32-1401(27)(ll) - (“Conduct that the Board determines is gross negligence,  
22 repeated negligence or negligence resulting in harm to or the death of a patient.”)

1  
2 **ORDER**

3 **IT IS HEREBY ORDERED THAT:**

4 1. That a **Decree of Censure** is imposed upon **Ole G. Torjusen, M.D.**, holder of license  
5 **number 19487**, for his unprofessional conduct, including the following: (i) Failing to return to the  
6 hospital to properly evaluate the stability for transfer via Air Evac Services helicopter of patient  
7 G.C. and patient G.C.'s fetus; (ii) Failing to return to the hospital in a timely manner to attend to  
8 patient T.R. when notified that patient T.R. is in post-operative shock following a hysterectomy;  
9 and (iii) Failing to return to the hospital to perform a personal evaluation of patient B.L. who was in  
10 labor for twelve (12) hours, particularly in light of the fact that B.L.'s fetus showed poor variability.

11 2. The Board further orders that **Respondent shall be placed on Probation** from the  
12 effective date of this Order ("Effective Date") until Respondent has submitted evidence of  
13 completion of **Twenty (20) hours** of Board staff pre-approved Continuing Medical Education  
14 ("CME") in the area of **Diagnosis and Management of Obstetric Complications**, and such  
15 evidence must be satisfactory to the Board. This CME requirement is in *addition* to Respondent's  
16 statutorily mandated biennial CME requirement. Respondent must complete the above-described  
17 CME within one (1) year of the Effective Date. Upon completion of the above-described CME  
18 requirement, and such evidence is satisfactory to the Board, the Board's Executive Director is  
19 authorized to terminate the probationary provision of this Order.

20 This Order is the final disposition of case number **MD-01-0775**.

21  
22 DATED AND EFFECTIVE this 12 day of January, 2005.  
23  
24  
25



ARIZONA MEDICAL BOARD

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

6 EXECUTED ORIGINAL of the foregoing filed this 12 day of January, 2005 with:

7 Arizona Medical Board  
8 9545 East Doubletree Ranch Road  
9 Scottsdale, Arizona 85258

10 EXECUTED COPY of the foregoing mailed  
11 this 21 day of January, 2005 to:

12 Ole G. Torjusen, M.D.  
13 4545 East Chandler Boulevard, Suite 208  
14 Phoenix, Arizona 85048-7645

15 EXECUTED COPY of the foregoing  
16 mailed this 21 day of January, 2005, to:

17 Stephen W. Myers, Esq.  
18 Myers & Jenkins  
19 3003 North Central Avenue, Suite 1900  
20 Phoenix, Arizona 85012  
21 Respondent's Counsel

22 EXECUTED COPY of the foregoing mailed this 21 day of  
23 January, 2005, to:

24 Ann-Marie Anderson, Esq.  
25 Assistant Attorney General  
1275 West Washington  
Phoenix, Arizona 85007  
Attorneys for the State of Arizona

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