

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **MILUSE VITKOVA, M.D.**

4 Holder of License No. 20176  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona.

Board Case No. MD-04-0991A

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

(Letter of Reprimand)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on April  
8 6, 2006. Miluse Vitkova, M.D., ("Respondent") appeared before the Board with legal counsel  
9 Kraig J. Marton for a formal interview pursuant to the authority vested in the Board by A.R.S.  
10 § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and  
11 Order after due consideration of the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

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

15 2. Respondent is the holder of License No. 20176 for the practice of allopathic  
16 medicine in the State of Arizona.

17 3. GM, a seventy-seven year-old female, died following shoulder surgery and her  
18 family retained Respondent to perform a private autopsy. The family requested Respondent  
19 answer certain specific questions related to GM's demise. The Board initiated case number MD-  
20 04-0991A after receiving a complaint alleging Respondent failed to provide complete and  
21 accurate results of the autopsy and that she improperly changed three separate and inaccurate  
22 autopsy reports. The complaint also alleged Respondent failed to disclose the participation in the  
23 autopsy of an organ and tissue harvester, failed to properly supervise this person's participation  
24 in the autopsy, and granted him improper access to the body of the deceased.

25

1           4.       Respondent testified she was a board certified pathologist who has been doing  
2 autopsies since 1986 and, at the time of GM's autopsy, she was working at Phoenix Indian  
3 Hospital, but doing private autopsies on the side through referrals from mortuaries. Respondent  
4 testified sometimes she was retained to do an autopsy to ascertain cause of death or the primary  
5 origin of cancer.

6           5.       The Board asked what Respondent felt was her obligation to families that request  
7 autopsies. Respondent testified it was to give them answers. The Board asked if that meant  
8 accurate answers. Respondent testified it did. The Board then directed Respondent to the  
9 autopsy reports she prepared regarding GM. The Board noted the first report says "[t]his is an  
10 elderly well-nourished and well-developed Caucasian man, 170 pounds and 71 inches, balding;  
11 the external genitals are those of an adult male; heart is 520 grams, liver 1800 grams; both  
12 kidneys show finely granular systems, capsules strip easily; right kidney is 120, left is 130;  
13 collecting system, urinary bladder and ureters. Uterus is absent. Ovaries are atrophic." The Board  
14 asked Respondent to explain the discrepancies within the report, even without considering the  
15 patient she was to perform the autopsy on was a female. Respondent testified at the time she  
16 was working on two autopsies and she did not have access to a computer so as she was working  
17 she was using one autopsy as a template and she was changing everything. Respondent  
18 testified she did not change it appropriately.

19           6.       The Board noted the complainant stated his family contacted Respondent and told  
20 her the autopsy report was for a man. The Board asked what corrections Respondent made  
21 when she received that information. Respondent testified that was not what happened – that she  
22 sent the autopsy report and the family contacted her around the holidays and said they did not  
23 receive it. Respondent testified she then told the family she would send another copy and she  
24 printed it, signed it, and sent it without checking it. Respondent testified she then received the  
25 phone call from the family that the report was for a male and she was really surprised.

1 Respondent testified she told the family to disregard the report, it was a mistake, she probably  
2 mixed two reports together and she would send a new, correct report. Respondent testified she  
3 apologized a number of times, sent a refund and then issued a new third report. The Board  
4 asked if Respondent's testimony was that the first and second autopsy reports are identical.  
5 Respondent testified it was.

6 7. The Board asked if the third autopsy report was separate completely from the  
7 other two. Respondent testified it was. The Board asked Respondent the normal size of a liver.  
8 Respondent testified it was between 1200 and 1600 grams. The Board noted that on all three  
9 autopsy reports, two for a 175 pound man and one for a 135 pound woman, she reported the liver  
10 at 1800 grams. The Board asked how a 135 pound woman and 175 pound man could have the  
11 same size liver. Respondent testified it could be the same if the woman has heart failure. The  
12 Board asked if GM had heart failure. Respondent testified GM died and she can just have  
13 congestion of the liver and it will increase. The Board asked if Respondent reported this. The  
14 Board noted that when Respondent realized her error and mailed the amended report she only  
15 amended it in certain sections and that it understood the family's concern that they are uncertain  
16 this is even GM's autopsy.

17 8. The Board asked if Respondent answered the questions the family posed to her  
18 when they asked her to perform the autopsy. Respondent testified she did. The Board noted in  
19 one report Respondent said the person died of a left ventricular infarct due to a right coronary  
20 thrombosis. The Board noted this was structurally not correct because the RCA supplies the right  
21 ventricle. The Board noted Respondent's third autopsy said the patient had an LAD thrombus  
22 and LV transmural infarct. The Board noted a number of inconsistencies and asked if  
23 Respondent answered the family's question of whether intubation contributed to GM's death.  
24 Respondent testified that when a pathologist performs an autopsy all organs are opened and, if  
25 there would be a rupture or even mucosal damage to the esophagus, to the trachea, she would

1 see it. The Board again asked if Respondent answered the question for the family. Respondent  
2 testified when she talked to Mr. M after his wife died he told her his wife had shoulder surgery that  
3 was supposed to be minor and then she was on a respirator and died and he wanted to know the  
4 cause of death. Respondent testified Mr. M did not mention anything about a ruptured  
5 esophagus, so if she saw anything abnormal in the esophagus, she would report it and she put in  
6 the report that the mucosa is small. Respondent read from the report "esophagus shows smooth  
7 gray mucosa and well-delineated GE junction. Stomach shows preserved architecture of gastric  
8 folds and there is no evidence of hemorrhage, ulcer, or masses." The Board noted another  
9 question the family asked was whether GM had heart disease, something the family should be  
10 concerned about genetically. The Board noted GM died of a heart attack. Respondent agreed.

11 9. The Board asked how Respondent's practice changed since she was last before  
12 the Board and received an advisory letter for amending an autopsy report without indicating it was  
13 an amendment. Respondent noted this autopsy was done before the advisory letter was issued,  
14 but noted her practice had changed very much. Respondent noted in GM's case she issued a  
15 new report because she made a terrible mistake and she completely understands how GM's  
16 husband felt and when she spoke to him she could not say enough about how sorry she was.  
17 Respondent testified she believed her apology was accepted because she did not hear from Mr.  
18 M for two years. Respondent testified whenever she did an autopsy she talked to the family  
19 repeatedly to explain any findings and answer any questions they may have. Respondent  
20 testified she did not have the feeling she did not respond to the questions posed by GM's family  
21 and she believes the question regarding damage to the esophagus or hereditary heart disease  
22 was not part of the original request.

23 10. The Board again reiterated the concern that would arise from a family receiving  
24 three edited autopsy reports, specifically the concern whether the autopsy was really the autopsy  
25 of their loved one. Respondent testified she had the autopsy notes and when she was writing the

1 third report she went through the notes and was putting things down. Respondent testified the  
2 first page of the report is inaccurate and the second and the third are the numbers that were  
3 already correct.

4 11. The Board asked if Respondent was currently employed as a pathologist in  
5 Arizona and, if not, was she currently working as a physician. Respondent testified she was not  
6 employed as a pathologist in Arizona and was working at Kaiser Hospital in the Bay Area as a  
7 pool pathologist. The Board asked what a "pool pathologist" was. Respondent testified a pool  
8 pathologist goes to different hospitals to cover for pathologists who may be ill or on leave. The  
9 Board asked if when Respondent performed private autopsies in Phoenix she was employed by  
10 the mortuary that referred GM's case. Respondent testified she was not and was reimbursed by  
11 GM's family. The Board asked if Respondent paid any money to the mortuary for referring GM's  
12 family. Respondent testified she did not. The Board asked if the mortuary received any money  
13 from Respondent. Respondent testified she paid the mortuary \$200.00 for using the premises.  
14 Respondent testified she charged between \$1,700 and \$2,400.00 for an autopsy depending on  
15 the case. Respondent testified other mortuaries also referred to her and she just paid them if she  
16 used their premises.

17 12. The Board asked whether Respondent had any ownership interest in the  
18 transportation vehicle that brought the deceased to the mortuary. Respondent testified she used  
19 the transportation company when she performed autopsies at John C. Lincoln Hospital and she  
20 would pay for the transport between \$50 and \$150.00 per trip. Respondent testified she had no  
21 financial interest in the transportation company and did not receive any kickbacks from the  
22 company. The Board asked Respondent who Larry Pohorily was. Respondent testified he was a  
23 pathology assistant who assisted during autopsies for a number of years for a number of Valley  
24 pathologists. Respondent testified she employed him to help her do the autopsies and paid him  
25 \$600.00 per autopsy. The Board asked if Mr. Pohorily ever harvested any organs from the

1 autopsies he performed with Respondent. Respondent testified he never did and as far as she  
2 knew he, nor anyone else, ever harvested organs during or following the autopsies.

3 13. The Board asked Respondent to explain her system for recording findings of the  
4 autopsy as she went along with the autopsy. Respondent testified during the autopsy she has a  
5 separate piece of paper where she put weights down or her assistant would. Respondent  
6 testified as the assistant hands her the organs, she weighs them and the assistant writes down  
7 the weight. Respondent testified at the end of the autopsy she makes her general notes and  
8 transfers the weight of the organs to the original piece of paper. The Board asked what  
9 Respondent would do with the original piece of paper where she collected her findings.  
10 Respondent testified she would put it in a folder containing the autopsy authorization form and the  
11 notes and would file them. The Board asked what action Respondent took to make sure when  
12 she revised the report that it was accurate. Respondent testified she went to the original notes  
13 and started to do it all over again.

14 14. The Board asked Respondent what she did with the organs after the autopsy.  
15 Respondent testified she put them back in the body. Respondent testified that during the autopsy  
16 she takes sections of all organs that go for processing and microscopic examination, but the  
17 remainder go back in the body. Respondent testified she was thorough in the autopsies and was  
18 trying to give the answers she could. Respondent testified she is extremely careful about signing  
19 reports because many times mistakes can be made. Respondent testified her practice has  
20 changed a lot because she is really careful about the wording, about not overlooking something  
21 because this case would not have happened if she read the report more carefully.

22 15. The Board asked if it ever occurred to Respondent to send a letter to GM's family  
23 answering the four questions they posed to her because it is awfully difficult for a family to look  
24 through an autopsy report and decipher the medical terminology and figure out the esophagus is  
25 normal. Respondent testified after she sent the second report she called Mr. M. and asked if

1 there was anything they could discuss and she understands that he did not want to talk to her, but  
2 she told him if he had any questions she would be willing to talk to him.

3 16. The Board asked Respondent how many autopsies she was doing in a month at  
4 the time she performed GM's autopsy. Respondent testified she was doing one or two per  
5 month. The Board asked how then, with such a small volume, it was possible she got reports  
6 mixed up between a 170 pound male and 135 pound female. Respondent testified she did go  
7 back and check and make sure she did not send an incorrect report to the family of the 170  
8 pound male and she did not. Respondent testified what happened was that she did not have  
9 access to a computer and she was working on two autopsies and when she finished the first she  
10 used it as a template for the second and that is why one report is correct and the other is not.  
11 Respondent testified she was physically present and always did her own autopsies. The Board  
12 noted the male's autopsy was done on November 9 and GM's on November 27, 2001.

13 17. The Board again directed Respondent to the liver weights in the reports and noted  
14 the liver and esophagus weights were the same and noted it was remarkable that Respondent  
15 would have the same findings on two different people in autopsies conducted eighteen days  
16 apart. Respondent testified about ninety percent of patients have the same findings in different  
17 organs. The Board asked if this is why Respondent used a template. Respondent testified it was  
18 not and she used the template so she did not forget or omit something. The Board noted the  
19 family has three reports and cannot know the third report is truly that of GM.

20 18. The Board noted it found on pages beyond the first three paragraphs of the report  
21 identical words in all three autopsy reports. For example, in the hematopoetic system the spleen  
22 weighed the same in all three. The Board asked Respondent if she could state without question  
23 that she was confident the only mistakes were made in the first three items of the gross  
24 examination. Respondent testified she could and that she has the reports on both patients and  
25 can say that only the beginning is where the mistakes were. The Board asked if Respondent

1 could state with confidence that beyond that point, the typed results on all three autopsy reports  
2 are those of patient GM. Respondent testified she could.

3 **CONCLUSIONS OF LAW**

4 1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof  
5 and over Respondent.

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

9 3. The conduct and circumstances described above constitutes unprofessional  
10 conduct pursuant to A.R.S. § 32-1401(27)(e) (“[f]ailing or refusing to maintain adequate records  
11 on a patient”).

12 **ORDER**

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

14 IT IS HEREBY ORDERED:

15 Respondent is issued a Letter of Reprimand for failing or refusing to maintain adequate  
16 records, specifically amending an autopsy report without indicating it was amended.

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

18 Respondent is hereby notified that she has the right to petition for a rehearing or review.  
19 The petition for rehearing or review must be filed with the Board’s Executive Director within thirty  
20 (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review  
21 must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102.  
22 Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a  
23 petition for rehearing or review is not filed, the Board’s Order becomes effective thirty-five (35)  
24 days after it is mailed to Respondent.

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

3 DATED this 9th day of June, 2006.



4 THE ARIZONA MEDICAL BOARD

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6  
7 By *Timothy C. Miller*  
8 TIMOTHY C. MILLER, J.D.  
Executive Director

9 ORIGINAL of the foregoing filed this  
10 9th day of June, 2006 with:

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

14 Executed copy of the foregoing  
15 mailed by U.S. Mail this  
16 9th day of June, 2006, to:

17 Kraig J. Marton  
18 Jaburg & Wilk, PC  
19 3200 North Central Avenue – Suite 2000  
20 Phoenix, Arizona 85012

21 Miluse Vitkova, M.D.  
22 Address of Record

23  
24 *Miluse Vitkova*  
25