

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **DERYL ROBERT LAMB, M.D.**

4 Holder of License No. 21010
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Case No. MD-05-0782A

**CONSENT AGREEMENT FOR
DECREE OF CENSURE AND
PROBATION**

7 **CONSENT AGREEMENT**

8 By mutual agreement and understanding, between the Arizona Medical Board
9 ("Board") and Deryl Robert Lamb, 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.
23 This 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

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

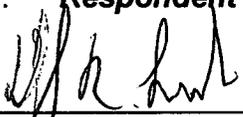
17 8. If the Board does not adopt this Consent Agreement, Respondent will not
18 assert as a defense that the Board's consideration of this Consent Agreement constitutes
19 bias, prejudice, prejudgment or other similar defense.

20 9. This Consent Agreement, once approved and signed, is a public record that
21 will 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.

5 12. ***Respondent has read and understands the condition(s) of probation.***

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DATED: 8-2-2006

7 DERYL ROBERT LAMB, M.D.

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1 **FINDINGS OF FACT**

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 21010 for the practice of
5 allopathic medicine in the State of Arizona.

6 3. The Board initiated case number MD-05-0782A after receiving notification
7 that Respondent, a family practice physician, was suspended from a hospital due to
8 substandard care in two cases involving prenatal treatment.

9 4. A Board medical consultant ("Consultant") reviewed of five of Respondent's
10 patient charts and found the charts only document basic obstetrical visits in low risk
11 patients. Respondent's records for patients with complications such as diabetes mellitus,
12 pre-eclampsia and hydrocephaly do not document his discussions with the patients about
13 potential problems, treatment and possible complications, and do not document a
14 treatment plan. Additionally, Consultant opined that the records demonstrated
15 Respondent's lack of understanding of the nature of high risk pregnancy.

16 **Patient MC**

17 5. Respondent provided care to MC, a thirty-five year-old female, gravida 3,
18 para 2, with a history of diabetes since the age of twenty-five. Respondent recorded in
19 MC's chart his difficulties with her insurance carrier and the difficulties he encountered
20 while trying to find a referring physician; however there is no note that Respondent made a
21 referral.

22 6. Respondent noted that MC's blood sugar level was high and indicated he
23 would start her on insulin therapy on March 8, 2005. However, MC's documented blood
24 sugar levels remained elevated after that date and Respondent did not note any indication
25 for further treatment. In addition, there is no documentation that Respondent had a plan for

1 serial ultrasounds, non-stress/stress testing, and monitoring of blood glucose levels. There
2 was also no indication in the record that Respondent performed venous draws, which is
3 the standard for diabetic patients.

4 7. On June 3, 2005 MC was admitted to the hospital with fetal demise. The
5 weight of the deceased infant was noted to be eight pounds, nine ounces. A high birth
6 weight is consistent with gestational diabetes. Respondent failed to appropriately manage
7 a diabetic patient with subsequent fetal demise.

8 **Patient BR**

9 8. Respondent provided care to BR, a twenty-two year-old female patient,
10 gravida 3, para 2. At thirty weeks gestation, an ultrasound of BR's fetus revealed
11 hydrocephalus. This condition made BR a high risk patient. Respondent did not keep the
12 ultrasound report with his records. The report was later found in hospital records.

13 9. There was no evidence in the record that Respondent sought consultation for
14 this high-risk patient or that he discussed the complications of delivering an infant with
15 hydrocephalus with her.

16 10. BR delivered an infant by Cesarean Section at thirty-seven weeks gestation.
17 Although there were no complications, there was the potential for numerous complications
18 during delivery including Cephalopelvic Disproportion (CPD) or breech presentation.

19 **Patient AD**

20 11. Respondent provided care to AD, a thirty-three year-old female patient,
21 gravida 3, para 2. Respondent's records indicated that beginning at thirty-one weeks of the
22 pregnancy AD had an elevated blood pressure and an abnormal 1 hour glucola (screening
23 test for gestational diabetes). However, there is no documentation in the record
24 Respondent further evaluated these abnormal findings by ordering a follow-up glucose
25 tolerance test or testing for possible pre-eclampsia.

1 12. AD delivered her baby at term. At the time of delivery, AD was noted to have
2 significantly elevated blood pressures at 178/101 and a 3+ proteinuria. She was treated
3 with MgSO4 following delivery and discharged without complications following her
4 hospitalization.

5 13. AD's unrecognized pre-eclampsia could have turned into eclampsia and could
6 have resulted in maternal or fetal demise.

7 **Patient JT**

8 14. JT, a twenty-nine year-old female patient, gravida 2, para 1, presented to
9 Respondent's office at thirty-one weeks gestation for obstetrical care. JT had a previous
10 Cesarean Section and desired a vaginal birth after Cesarean ("VBAC").

11 15. Although Respondent obtained a consultation for JT, there is no evidence in
12 the record of a discussion with JT about the complications of her preferred delivery
13 method. Additionally, Respondent did not record a discussion regarding the type of scar JT
14 had from her previous Cesarean section. Patients with prior vertical incisions are not
15 eligible for VBAC and should be so informed.

16 16. JT declined a Cesarean section when she was at term and later went on to
17 deliver vaginally at 41+ week's gestation.

18 17. A patient with a previous history of Cesarean Section has the potential for
19 rupture that could necessitate an immediate Cesarean Section. Although Respondent had
20 access to a 24 hour obstetrician group he should not have agreed to a vaginal delivery
21 after Cesarean under any circumstances because of the high potential uterine rupture.

22 **Patient TS**

23 18. Respondent treated TS, a nineteen year-old female patient, gravida 1, para 0,
24 with a history of spina bifida. Respondent's records do not document he counseled TS
25 regarding her spina bifida and the possible risks of spina bifida occurring in her infant.

1 Additionally, Respondent did not order an ultrasound or alpha-fetoprotein examination to
2 rule out the possibility of potential fetal problems.

3 19. TS delivered at term with no complications. However, a patient with spina
4 bifida is at increased risk of delivering an infant with the same condition. Fetal compromise
5 can occur in an infant born with spina bifida, especially if a tertiary care unit is not prepared
6 to immediately care for this complication.

7 20. A physician is required to maintain adequate legible medical records
8 containing, at a minimum, sufficient information to identify the patient, support the
9 diagnosis, justify the treatment, accurately document the results, indicate advice and
10 cautionary warnings provided to the patient and provide sufficient information for another
11 practitioner to assume continuity of the patient's care at any point in the course of
12 treatment. A.R.S. §32-1401(2). Respondent's records were inadequate because they
13 lacked documentation for referrals made to treating obstetricians (Patient MC), lacked test
14 results (Patient BR), did not include documentation of further testing following abnormal
15 test results (Patient AD), did not provide evidence of a discussion regarding the patient's
16 preferred delivery method (Patient JT) and did not reveal evidence of counseling for
17 potential fetal complications (Patient TS).

18 21. The standard of care required Respondent, as a family physician caring for
19 obstetrical patients, to evaluate, document and discuss the potential risk factors for
20 pregnancy. If risk factors are identified, the standard of care requires Respondent to refer
21 the patient to an obstetrician for care.

22 22. Respondent deviated from the standard of care because he did not evaluate,
23 document and discuss the potential risk factors for pregnancy and because he did not
24 refer patients with those identified risk factors to an obstetrician. Respondent's patients
25 were subject to actual and potential harm as discussed above.

1 23. Effective October 31, 2005 Respondent ceased the practice of obstetrics.

2 **CONCLUSIONS OF LAW**

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

5 2. The conduct and circumstances described above constitute unprofessional
6 conduct pursuant to A.R.S. § 32-1401(27)(e) - ("[f]ailing or refusing to maintain adequate
7 records on a patient").

8 3. The conduct and circumstances described above constitute unprofessional
9 conduct pursuant to A.R.S. § 32-1401(27)(q) - ("[a]ny conduct or practice that is or might
10 be harmful or dangerous to the health of the patient or the public").

11 4. The conduct and circumstances described above constitute unprofessional
12 conduct pursuant to A.R.S. § 32-1401 (27)(ll) - ("[c]onduct that the board determines is
13 gross negligence, repeated negligence or negligence resulting in harm to or the death of a
14 patient.")

15 **ORDER**

16 IT IS HEREBY ORDERED THAT:

17 1. Respondent is issued a Decree of Censure for negligent obstetric care in
18 numerous patients resulting in fetal demise in one patient and for poor medical record
19 keeping.

20 2. Respondent is permanently restricted from the practice of obstetrics.

21 3. This Order is the final disposition of case number MD-05-0782A.

22 DATED AND EFFECTIVE this 11th day of August, 2006.

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(SEAL)



ARIZONA MEDICAL BOARD

By 
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this
11th day of August, 2006 with:

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

EXECUTED COPY of the foregoing mailed
this 11th day of August, 2006 to:

Mr. Stephen Myers
Myers & Jenkins
Phoenix Corporate Center
3003 N Central Avenue, Suite 1900
Phoenix, AZ 85012-2910

EXECUTED COPY of the foregoing mailed
this 11th day of August, 2006 to:

Deryl Robert Lamb, M.D.
Address of Record


Investigative Review