ARIZONA MEDICAL BOARD

IN THE MATTER OF : ABEDON SAIZ, M.D., Holder of License No. 24387 For the Practice of Medicine In the State of Arizona.	**No. 03F-24387-MDX** **Case No. MD-01-0604** **MD-02-0623** **AMENDED** **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR STAYED REVOCATION AND PROBATION**

On April 14, 2003 the Arizona Medical Board ("Board") held a special meeting to review its Findings of Fact, Conclusions of Law and Order for Stayed Revocation and Probation ("Order") to clarify the restriction on bariatric surgery contained in Paragraph 3 of Order as issued after the Board's April 2, 2003 meeting when the case came before the Arizona Medical Board for oral argument and consideration of the Recommended Decision of the Administrative Law Judge ("ALJ"). Abedon Saiz, M.D. was represented by counsel, Dan Jantsch. Assistant Attorney General Stephen A. Wolf represented the State. Christine Cassetta, Assistant Attorney General was legal advisor to the Board.

FINDINGS OF FACT

1. The Arizona Medical Board ("Board") is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.
2. The Respondent, Abedon Saiz, M.D., is the holder of License No. 24387 for the practice of allopathic medicine in the State of Arizona.
3. Dr. Saiz is a vascular surgeon who has practiced in Lake Havasu City, Arizona, since 1996.
4. Dr. Saiz graduated from Arizona State University in 1984 with an earned degree in Chemistry.
5. Dr. Saiz earned his Medical Degree in 1989 from the University of Arizona.

6. In 1994, Dr. Saiz completed his residency training in general surgery at Mount Sinai Medical Center in Miami, Florida. In his third year of residency, Dr. Saiz did an oncology fellowship within the residency. Dr. Saiz still had all the responsibilities of a third year surgical resident in addition to the requirements of his oncology fellowship.
7. After completing his residency, Dr. Saiz did a year of vascular fellowship at Mount Sinai. As part of his vascular fellowship, Dr. Saiz studied peripheral vascular from the heart away.
8. After his vascular fellowship, Dr. Saiz stayed in Miami Beach for another year and a half working with one of the other attendings to gain more surgical experience. He then moved to Lake Havasu City.
9. The nature and scope of Dr. Saiz's practice in Lake Havasu City includes pediatrics up to geriatric patients with all sorts of problems, both chronic and acute. His practice also includes general surgical, vascular and thoracic problems as well.
10. Dr. Saiz practiced in Lake Havasu City until October 29, 2002 when the Board summarily restricted his ability to perform major surgical procedures pending an administrative hearing.

THE BOARD'S SUMMARY PRACTICE RESTRICTION

11. On August 27, 2001, Board staff notified Dr. Saiz that it had initiated Investigation No. MD-01-0604 to review his care and treatment of Patient D.F. Board staff asked him to provide a copy of the patient's medical records and to prepare a narrative statement concerning his care and treatment of the patient.
12. Dr. Saiz provided approximately 86 pages of medical records and his narrative statement to the Board on September 11, 2001. In that statement, Dr. Saiz described a "procedure that is normally done here at our hospital [;] namely, we perform a Vertical Banded Gastroplasy to decrease intake, Small Bowel Resection to limit absorption, and removal of excess fat, i.e. Omentectomy."
13. William Kennell, M.D., is a senior medical consultant for the Board. He did his pre-medical studies from 1957 to 1960 at the University of Illinois, Urbana, Illinois. Dr. Kennell completed his medical education at the University of Illinois, Chicago which

is now known as Abraham Lincoln School of Medicine. He completed his rotating internship at Iowa Methodist Hospital in 1965. Dr. Kennell did a general surgical residency from 1965-1969 at Marquette School of Medicine in Milwaukee, Wisconsin. From 1969 to 1971 Dr. Kennell was Chief Surgeon and Chief of Professional Services as an officer in the U.S. Air Force assigned to Luke Air Force Base in Glendale, Arizona. He was in private practice of General and Vascular Surgery from 1971 to 1998 in Sun City and Sun City West, Arizona. Dr. Kennell has served as a medical consultant for the Board from 1998 to the present. He recently opened a part-time non-surgical medical practice.

14. Dr. Kennell reviewed 2,130 pages of medical records concerning Patient D.F.'s treatment at Havasu Regional Medical Center ("HRMC") and Good Samaritan Regional Medical Center ("GSRMC") in Phoenix between April 23, 2001 and July 26, 2001. Dr. Kennell prepared a report which outlined his criticisms of Dr. Saiz's treatment of Patient D.F.

15. In that report, Dr. Kennell concluded that:

a) "There is extremely poor documentation present by Dr. Saiz of an adequate preoperative consultation, evaluations and discussions with the patient."
b) "The hospital documentation is equally lacking."
c) "The surgical procedure of resecting massive amounts of small bowel for obesity is below the standard of care for weight control surgery in 2001."
d) "The poor clinical judgment involved in submitting a patient with this amount of comorbid disease to an unrecognized surgical procedure represents a danger to the public."

16. Dr. Kennell also asked Alan Yale Newhoff, M.D., a specialist in bariatric surgery, to review portions of the medical record and offer opinions about whether Patient D.F. was an appropriate candidate for bariatric surgery and whether the specific bariatric procedures used by Dr. Saiz were acceptable surgical procedures for obesity.

17. Dr. Newhoff earned a B.A. in Chemistry from the University of Pennsylvania in 1957. He earned his Medical Degree from that academic institution in 1961. Dr. Newhoff completed his surgical internship at the University of California-San Francisco in 1962. From 1962-67, Dr. Newhoff was a resident and ultimately Chief Resident-

Surgery at the Albert Einstein Medical Center in Philadelphia. He had a fellowship in Organ Transplantation at the Medical College of Virginia at Richmond from 1966-67. Dr. Newhoff was certified by the American Board of Surgery in 1967. From 1968-70, Dr. Newhoff was an officer in the U.S. Air Force achieving the position of Chief of Surgery at Luke Air Force Base. From 1967 to the present, Dr. Newhoff has been in private practice in Phoenix, Arizona.

18. In 1977, Dr. Newhoff received gastric stapling training at the University of Iowa under Edward Mason, M.D. In June 1977, Dr. Newhoff performed his first gastric stapling. In 1989, Dr. Newhoff founded the Center for the Treatment of Obesity in Phoenix. Since 1989, Dr. Newhoff has personally performed 2,500 plus gastric stapling procedures in Phoenix, approximately 1,000 plus gastric bypasses, and 50 plus take-downs of Jejunoileal bypasses with simultaneous gastric staplings and the rest gastroplasties.

19. After completing his review of the medical records for Patient D.F. Dr. Newhoff prepared a report which outlined his criticisms of Dr. Saiz's care and treatment of the patient.

20. In that report, Dr. Newhoff opined that the procedures Dr. Saiz performed on the patient were not accepted surgical procedures for obesity. First, he stated that "the omentum was resected for no reason which I can understand unless it was felt that several pounds could be removed from this patient in this way, although by taking out the omentum its ability to separate the bowel from the subsequent abdominal closure is lost, and seems to be a very poor trade off to me." Secondly, Dr. Newhoff stated that "by far the most glaring discrepancy in my mind is the small bowel resection, which is apparently added because of the surgeon's impression that the bowel was large and long...The thing that is so particularly bad about it is that this is now an irreversible mal-absorption procedure" which is "an unacceptable on at this time and in this country." He further opined that an irreversible mal-absorption procedure has "the potential for producing a gastro-intestinal cripple with no prospect of ever getting better." Thirdly, Dr. Newhoff stated that Patient D.F. was not an appropriate candidate for bariatric surgery. He stated "this man obviously had a great many medical problems, including badly compromised renal function, and should have

been under the close supervision of a competent internist who was familiar with his case and was making adjustments to his various medical therapies as were appropriate before and after surgery."

21. On September 27, 2002, Board staff notified Dr. Saiz that it had initiated Investigation No. MD-02-0623 to review his care and treatment of Patients F.P., D.D., A.L., F.N., J.T. and J.N. Board staff asked him to provide a copy of the patients' medical records and to prepare a narrative statement concerning his care and treatment of those patients by October 15, 2002. Dr. Saiz requested and received an extension of time to provide that information. Dr. Saiz provided 456 pages of medical records and his narrative statement to the Board on October 31, 2002.

22. Dr. Kennell reviewed 2,250 pages of medical records concerning the treatment of Patients F.P., D.D., A.L., F.N., J.T. and J.N. by Dr. Saiz. He prepared a report which outlined his criticisms of Dr. Saiz's care and treatment of those patients.

23. In that report, Dr. Kennell concluded that "there are numerous examples of poor surgical judgment, a rush to take patients to surgery without an appropriate thoughtful workup, and some questions about his accuracy in describing intra-operative complications. The record-keeping that is carried out in his progress notes are uniformly poor, and fail to meet the criteria of a reasonable medical record in many respects." On October 29, 2002, the Board conducted an emergency teleconference to consider the summary suspension of Dr. Saiz's license after investigating cases MD-01-0604 and MD-02-0623 involving Dr. Saiz's care and treatment of a total of eight patients, all of whom are deceased.

24. The minutes of that emergency teleconference reflect that Dr. Saiz appeared in person and was represented by his counsel, Daniel P. Jantsch, Esq. Dr. Saiz and Mr. Jantsch both addressed the Board during the fifty-minute meeting.

25. After receiving testimony from Dr. Kennell, Dr. Saiz and Mr. Jantsch, the Board found that the public health, safety and welfare imperatively required emergency action and entered the following Order restricting Dr. Saiz's medical license pending a formal hearing before the Office of Administrative Hearings, an independent state agency:

"1. Respondent's license to practice allopathic medicine in the State of Arizona, License No. 24387, is restricted in that Respondent may not perform major surgical procedures. `Major Surgical Procedure' is defined using the common working definition of practicing surgeons and prohibits Respondent from performing any procedure that requires conscious or unconscious sedation of a patient or any procedure within any major body cavity of a patient. Respondent may perform minor surgery that requires a local anesthetic, not including for example, a hernia repair that necessitates an anesthesia stand-by."

PATIENT D .F.

26. Patient D.F. tried to lose weight for years with diets and exercise, but without lasting effect.

27. At the time he presented to the following physicians, Patient D.F. was a 62-year old man weighting approximately 330 pounds.

28. On March 8, 2001, the patient visited with Dr. Faibisoff, a plastic surgeon, concerning his leg ulcer. In a six-line progress note of that visit, Dr. Faibisoff simply notes: "I am going to speak to Dr. Saba regarding possible Bypass surgery given his inability to maintain weight and control his diet." That note is the first one to mention the possibility of bariatric surgery for this patient.

29. On the same day, the patient also visited Dr. Saba, a cardiologist, who noted that the patient presented "a rather challenging and complex case" and had a "multitude of medical problems," including diabetes, hypertension, renal insufficiency and exogenous obesity. Dr. Saba noted that Dr. Faibisoff was asking him whether the patient would be "an acceptable operative candidate" for gastric stapling. In his office note Dr. Saba stated:

> "I discussed his case, in detail, with Dr. Faibisoff. He will be referred to Dr. Saiz for consideration of gastric stapling. I could not overemphasize to [the patient] the importance of adequate control of his risk factors; the risk of deterioration of his renal function is very clear. I also asked him on multiple occasions in the past to establish with a primary care physician. He has not established with one and I explained to him that the magnitude of his problems will require a primary care physician.
>
> At this stage, I will refer him to Dr. Sabowitz. As far as his cardiac status, he is definitely a higher than average risk for gastric stapling due to his multiple risk factors, but the risks are still acceptable as these are non-modifiable factors and I doubt he will be in any better shape for surgery."

30. On March 13, 2001, the patient visited with Dr. Saiz. His handwritten office note of that visit is illegible to all but Dr. Saiz. Dr. Saiz testified that the note says: "Wants help with reduction. Tried diets and activity without help. Exam. Very large question of diastasis. Positive pannus. Plan is our procedure or modification. Discussed risks and benefits with patient. Consult with Dr. Faibisoff."

31. On March 15, 2001, the patient visited again with Dr. Faibisoff. In his four-line note of that visit, Dr. Faibisoff states: "We discussed his desires for stomach stapling at length today including diagramming the procedure, discussing bowel removal and hope to control diabetes, anticipated weight loss."

32. On March 20, 2001, the patient established with Dr. Sabowitz to manage his diabetes and hypertension. The patient reported that he was considering undergoing stomach stapling surgery with Drs. Saiz and Faibisoff. At that time, Dr. Sabowitz recommended that the patient "get on weight watchers" and offered to "start him on orlistat." Dr. Sabowitz also noted that he was "going to look at the literature to evaluate the patient's risk." Dr. Sabowitz testified that he reviewed three articles concerning the potential risks and benefits of any surgical procedure for the patient's hypertension, diabetes and nutrition.

33. Since October 2000, Patient D.F. had been receiving periodically adjusted dosages of Coumadin, an anti-coagulation medication. A nurse's note dated April 9, 2001, recorded that the patient's INR value had elevated from 1.8 a week earlier to 5.6.

The note stated: "Will be having surgery 4/23. Quit Coumadin." Another nurse's note dated April 16, 2001 recorded that the patient's INR value had decreased to 2.1. Again the note stated: "Will go off Coumadin 4/19 for stomach surgery."

34. On April 17, 2001, Dr. Sabowitz discussed certain risks of surgery with the patient, including "the fact that his is increased by his hypertension, diabetes and anemia." Dr. Sabowitz noted that the patient "understands the risk and feels that the benefit is [worth] the risk."

35. The patient visited with Dr. Faibisoff nine times between March 22, 2001 and April 23, 2001. The records provided by Dr. Faibisoff concerning those visits only reflect his treatment of the ulcer on the patient's left lower extremity.

36. On April 23, 2001, Patient D.F. was admitted to HRMC for bariatric surgery to treat his morbid obesity.

37. The record contains an undated handwritten history and physical examination of the patient written by someone other than Dr. Saiz.

38. In that handwritten report, it is noted that Patient D.F. had a history of diabetes mellitus, hypertension, hypothyroidism, deep vein thrombosis of the legs and chronic renal insufficiency. It also noted that the patient's Creatinine level was 2.3.

39. To treat those conditions, the handwritten report notes that the patient was receiving some fifteen different medications prior to his admission. The note did not reflect that the patient had been receiving adjusted dosages of Coumadin.

40. The handwritten report states the assessment is simply "morbid obesity" and the plan is "vertical gastroplasty, omentectomy, entero-entero bypass, appendectomy, cholecystectomy, abdominoplasty, panniculectomy, resection by Dr. Saiz."

41. Dr. Saiz failed to maintain an adequate medical record for Patient D.F. because his March 23, 2001 office note and undated history and physical examination report did not provide sufficient information to support the diagnosis, justify the treatment, indicate advice and cautionary warnings provided to the patient, or provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment.

42. The standard of care requires a reasonably prudent general surgeon to perform an appropriate pre-operative surgical evaluation and consultation with the patient to

determine whether the patient is an appropriate candidate for the anticipated surgical procedure.

43. Dr. Saiz deviated from the standard of care by failing to perform an appropriate pre-operative surgical evaluation and consultation with the patient to determine whether he was an appropriate candidate for Dr. Saiz's unique bariatric procedure.

44. Dr. Saiz's deviation from the standard of care resulted in actual harm to Patient D.F. because he did not evaluate the patient's anti-coagulation medication, diet and renal insufficiency, which caused the patient to experience prolonged post-operative complications that required repeated hospitalizations.

45. On April 24, 2001, Dr. Saiz performed a vertical-banded gastroplasty and removed a sizable portion of Patient D.F.'s small bowel as well as the entire omentum. In addition, he removed the patient's appendix and gall bladder.

46. Dr. Faibisoff performed a panniculectomy and abdominoplasty to remove excess skin and fatty tissue from the patient's abdomen.

47. The pathology report found no evidence to support the resection of the portions of the small bowel and omentum submitted for review. The estimated size of the small bowel specimen measured approximately 150 cm. or 5 feet in length.

48. Dr. Saiz and Dr. Faibisoff devised a unique type of bariatric procedure that "affect[s] the amount of food [a patient] can eat at one time and then affect[s] absorption by removing some of the small intestines." The procedure combines a vertical-banded gastroplasty and small bowel resection.

49. Dr. Faibisoff admittedly has only a very general knowledge of that bariatric procedure.

50. Dr. Saiz developed the idea of combining a vertical-banded gastroplasty or intake restriction procedure with a small bowel resection or absorption reduction procedure by reading about various bariatric procedures in the medical literature and talking about those procedures with some bariatric surgeons.

51. Dr. Saiz testified that he resects a portion of the small bowel to limit or affect absorption.

52. Dr. Saiz also testified that he removes the omentum in some patients to make it easier to access the surgical field and close the surgical incision in the abdomen without tension.

53. The standard of care does not recognize the combination of a vertical-banded gastroplasty to limit intake with a small bowel resection to limit absorption as an acceptable bariatric procedure.

54. The standard of care does not recognize the removal of the omentum as part of an acceptable bariatric procedure.

55. Dr. Saiz grossly deviated from the standard of care by resecting an estimated 150 cm. of Patient D.F.'s small bowel and the patient's omentum without appropriate medical indications.

56. Dr. Saiz's gross deviations from the standard of care resulted in actual harm to the patient because he inappropriately removed a sizable portion of the patient's small bowel and the patient's omentum, and caused the patient to experience prolonged post-operative hydrational and nutritional complications that required repeated hospitalizations.

57. Patient D.F. initially appeared to recover from these multiple and extensive surgical procedures and was discharged on May 2, 2001.

58. In his discharge summary, Dr. Saiz notes that the patient had been told to "continue his regular medications at home," but the note did not reflect that the patient had been receiving adjusted dosages of Coumadin.

59. Patient D.F. was emergently re-admitted to HRMC on May 8, 2001 with complaints of weakness, vomiting, diarrhea and syncopal episodes thought to be due to dehydration.

60. Patient D.F. was re-hydrated and discharged on May 11, 2001.

61. On May 13, 2001, D.F. was again emergently admitted to HRMC for upper gastrointestinal bleeding.

62. D.F. received four units of blood and four units of fresh frozen plasma to correct a coagulapathy resulting from anti-coagulation medication he continued to take for deep vein thrombosis.

63. On May 14, 2001, an esophagogatroduodenoscopy found an hourglass deformity of the fundus, gastritis and esphagitis, indicating a surgically-induced gastric outlet obstruction. Those findings were confirmed by an upper GI series on May 21, 2001.

64. Dr. Saiz testified that D.F. disrupted the size of the stomach pouch created by vertical-banded gastroplasty by "eating French bread dipped in coffee" contrary to his post-operative instructions.

65. D.F.'s surviving spouse gave credible testimony that she personally prepared the patient's meals after the surgery and the patient did not consume "French bread dipped in coffee." In fact, D.F. did not drink coffee; he was a tea drinker.

66. During this hospitalization, D.F. also developed a methicillin-resistant staph infection and was treated with Vancomycin.

67. D.F. was discharged from the hospital on May 30, 2001.

68. On June 9, 2001, D.F. was again emergently admitted to HRMC with complaints of vomiting, diarrhea, inability to urinate and emesis of bloody material.

69. D.F. was diagnosed as suffering from dehydration and acute renal failure.

70. D.F. was aggressively rehydrated, but when his renal condition did not improve, he was emergently transferred by helicopter to GSRMC in Phoenix on June 11, 2001.

71. At GSRMC, D.F. required intubation, respiratory therapy, intensive metabolic replacements and hydration.

72. Dr. Alan Newhoff consulted on the case at GSRMC and formed the clinical impression that D.F. suffered from a surgically-induced gastric outlet obstruction and possible short bowel syndrome.

73. D.F. was stabilized and eventually discharged to a skilled nursing facility in Lake Havasu City on July 26, 2001.

74. After his discharge from GSRMC, the patient continued to experience significant nutritional complications and was unable to eat solid foods.

75. D.F. remained in the care of the skilled nursing facility until his death in October 2002 from acute renal failure.

76. Dr. Saiz estimated that he has performed approximately twenty bariatric procedures during his career, five to ten of which involved his unique type of procedure.

77. Dr. Saiz testified that he and Dr. Faibisoff "have a series of these patients going" and their "intent...is to present this at a national or international conference. Here's another way of dealing with the obese patient and we just have never gotten that far."

78. No protocols have been developed for performing Dr. Saiz's unique bariatric procedure.

79. Dr. Saiz admitted that there is no Investigational Review Board reviewing the use of his unique bariatric procedure to determine whether it is safe and effective.

80. Dr. Saiz has not been designated as a clinical investigator for any studies involving the experimental use of his unique procedure.

81. Dr. William Binder, the chief of staff at HRMC, testified that there has been no ethics committee formed at the hospital to review the patients selected to undergo Dr. Saiz's unique bariatric procedure.

82. Dr. Terry Simpson, M.D., a general surgeon, testified that the removal of small bowel measuring between 150 and 300 centimeters is not a recognized bariatric procedure.

83. Dr. Saiz has agreed not to practice his unique bariatric procedure, involving a vertical-banded gastroplasty combined with a resection of the small bowel and possible omentectomy, pending further Board investigation of that potentially experimental procedure.

PATIENT F.P.

84. On June 1, 2001 at 1659 hours, Patient F.P presented to the HRMC Emergency Room complaining of abdominal pain, and was examined by Dr. Sam Urso, the emergency room physician.

85. Patient F.P. was admitted to the hospital.

86. There were conflicting reports about the duration of F.P.'s abdominal pain. The ER staff noted lower abdominal pain for 3-4 days. Dr. Kalin, a treating internist, noted that the patient "had about a week of abdominal pain." On the other hand, Dr. Saiz

stated that "[t]he patient present[ed] with one day of abdominal pain. He was normal yesterday."

87. There were also conflicting statements about the acuity of that pain. Dr. Kalin noted that the patient was "brought in with progressive weakness, substantial abdominal pain, but the details and characteristics are difficult for the patient to describe." Upon examination, Dr. Kalin found the patient "in moderate to severe distress with some abdominal pain" and his abdomen "somewhat tense with reduced bowel sounds" and "tender in all four quadrants without rebound or masses." Dr. Kalin assessed "subacute abdominal pain." On the other hand, Dr. Saiz found the patient's abdomen "a little tender in the epigastrium; otherwise unremarkable."

88. In addition to the complaint of abdominal pain, the 88-year old male patient had a history of severe chronic obstructive pulmonary disease ("COPD") with steroid and home oxygen therapy, gastroesophageal reflux disease ("GERD"), hiatal hernia, purported appendectomy, urinary tract infections, and probable prostate cancer.

89. Dr. Kennell credibly testified that patients with COPD are poor surgical candidates because they frequently require post-operative intubation and respiratory care for some time, and may become respirator-dependent.

90. Dr. Kennell also testified that the steroids used to treat severe COPD, like Prednisone, "complicate the evaluation of a patient" by "block[ing] the body's ability to form an inflammatory reaction [to an infection]" and "hid[ing] an inflammation."

91. Dr. Kalin noted that F.P.'s COPD "has been rather stable at this time. He has been off the prednisone for the last week or so, and there is no apparent cough, chest pain, shortness of breath or fever." Given that information, Dr. Kennell testified that the Prednisone was not "a major factor in hiding something" in this patient.

92. Dr. Urso ordered the administration of 25 mg. of Demerol intravenously every four hours. The nursing notes reflect that F.P. received the prescribed dosage of Demerol on June 1, 2001 at 1825 and 2200 hours.

93. On June 1, 2001, at 1835 hours, F.P.'s white blood cell count was mildly elevated at 11.4, with normal lab values between 4.8 and 10.8.

94. An abdominal x-ray taken on June 1, 2001 between 1855 and 2000 hours showed "no evidence of free peritoneal air or obstructed bowel gas pattern" and "no acute

intra-abdominal pathology." Free peritoneal air would indicate a possible bowel perforation. Obstructed bowel gas pattern would indicate a possible bowel obstruction.

95. Dr. Kalin asked Dr. Saiz to consult on the case. Dr. Saiz examined F.P. after the x-ray results were available.

96. In his consultation report dictated on June 1, 2001, at 2249 hours, Dr. Saiz stated: "I believe this is an ileus; other possibilities include urinary tract infection, electrolyte disturbance or adhesions. Obviously neoplastic process must be considered as well. Will follow up with CT scan when that is available."

97. Dr. Saiz testified that he was "not overly impressed" during his initial examination of the patient.

98. A CT scan taken sometime after June 1. 2001 at 2350 hours found: "A large hiatus hernia is present. Liver, spleen, pancreas, gallbladder, adrenal glands, and kidneys are unremarkable. The urinary bladder demonstrates a prominent extrinsic impression from a very enlarged prostate, and contains a Foley catheter balloon. There is mild bladder wall thickening...There is a moderate degree of sigmoid diverticulosis but without evidence of acute diverticulitis. Remaining small bowel, large bowel, and mesenteric fat are unremarkable."

99. Dr. Kennell testified that the CT scan findings ruled out any significant acute diverticulitis.

100. Dr. Saiz agreed that the CT scan "was not very specific" and "didn't show anything horrible" only "some diverticulum on the left side."

101. In his Answer, Dr. Saiz affirmatively alleges that "ischemic bowel was considered, which would not appear on a CT."

102. There is no evidence in the medical records that Dr. Saiz considered ischemic bowel prior to surgery.

103. Dr. Saiz did not testify that he considered ischemic bowel at that time.

104. Dr. Saiz testified that F.P. "had been on antibiotic with a presumed diagnosis of diverticulitis." That testimony is not supported by any evidence in the medical records.

105. In his Answer, Dr. Saiz admits that the CT scan was negative, but states that F.P.'s pain was worsening.

106. Dr. Saiz also testified that he took F.P. to surgery because his pain was worsening and localizing to the left side.

107. There is no evidence in the medical records pre-operatively that F.P.'s pain was worsening and localizing to the left side.

108. On the contrary, the nurses' notes reflect that F.P.'s pain remained generalized and had stabilized. F.P. received the prescribed dosage of Demerol on June 2, 2001, at 0825 and 1200 hours and each time, within 45-50 minutes after receiving the prescribed pain medication, F.P. was sleeping undisturbed.

109. Dr. Kennell testified that the nurses' notes "[did] not present a picture of severe pain."

110. Following his initial examination of F.P. sometime between 2000 and 2249 hours on June 1, 2001, Dr. Saiz only examined the patient once more before deciding to take him to surgery.

111. In his progress note of that second examination dated June 2, 2001, at 1140 hours, Dr. Saiz simply noted "febrile[;] still lots of pain."

112. On June 2, 2001, at 1700 hours, Dr. Saiz performed an exploratory laparotomy on F.P.

113. In an operative note dated June 2, 2001 but dictated on June 5, 2001, Dr. Saiz stated that the indication for surgery was a "frank acute abdomen."

114. Dr. Saiz failed to maintain an adequate medical record because his pre-operative progress notes and operative report did not provide sufficient information to support his diagnosis of a "frank acute abdomen" and justify his treatment of an exploratory laparotomy.

115. The standard of care requires a reasonably prudent general surgeon to find appropriate evidence of an acute abdomen, such as tenderness, guarding and rebound, before performing an exploratory laparotomy on a patient.

116. Dr. Saiz admitted during his testimony that his pre-operative progress notes did not record any findings of tenderness, guarding or rebound.

117. Dr. Simpson also testified that he did not find any evidence of tenderness, guarding or rebound in F.P.'s medical record.

118. Dr. Saiz deviated from the standard of care by performing an exploratory laparotomy on F.P. without finding appropriate evidence of an acute abdomen, such as tenderness, guarding or rebound.

119. During the exploratory laparotomy, Dr. Saiz purportedly encountered diverticulitis in the sigmoid colon. He performed a Hartman's procedure to resect a 115 mm. portion of the sigmoid colon and establish a temporary colostomy. Dr. Saiz also resected a 25 mm. x 20 mm. Meckel's diverticulum from F.P.'s small bowel and removed the patient's appendix and gallbladder.

120. The standard of care requires a reasonably prudent general surgeon to find appropriate intra-operative indications for resecting a portion of a patient's small or large bowel or removing the patient's appendix or gallbladder during an exploratory laparotomy.

121. The pathology report did not find any evidence of significant acute diverticulitis in the colon specimen or significant pathological alteration in the appendix specimen. The gall bladder specimen exhibited focal areas of chronic inflammation but not gall stones.

122. Dr. Saiz deviated from the standard of care by resecting portions of F.P.'s small and large bowel and removing the patient's appendix and gall bladder during an exploratory laparotomy without appropriate intra-operative indications.

123. Following the unnecessary surgery, F.P. developed renal insufficiency as well as bilateral infiltrates in his lungs that did not respond to antibiotics, and was unable to be weaned permanently from ventilator support.

124. F.P.'s family agreed to establish a do not resuscitate ("DNR") order.

125. F.P. died at 0850 hours on June 27, 2001.

126. Dr. Saiz's deviations from the standard of care resulted in actual harm to F.P. because he unnecessarily performed an exploratory laparotomy on an elderly patient with a history of severe COPD. During that unnecessary exploratory laparotomy, Dr. Saiz also unnecessarily resected portions of F.P.'s small and large bowel and unnecessarily removed the patient's gall bladder and appendix.

As result of that unnecessary surgery, F.P. developed foreseeable post-operative pulmonary and renal complications that either caused or significantly contributed to F.P.'s death.

PATIENT D.D.

127. On May 18, 2001, Patient D.D. was emergently admitted by her primary care physician, Dr. Hade, to HRMC with complaints of the sudden onset of nausea, vomiting and abdominal pain and distention.

128. In addition to her presenting complaints, the 81-year old female patient had a history of appendectomy, cholecystectomy, partial gastric resection, abdominal aortic aneurysm resection and hysterectomy.

129. Diagnostic studies and laboratory results obtained prior to her admission indicated a small bowel obstruction and urinary tract infection.

130. On May 19, 2001, Dr. Hade requested a surgical consult by Dr. Saiz. Dr. Saiz diagnosed a partial small bowel obstruction probably secondary to adhesions from D.D.'s previous surgeries. Dr. Saiz endorsed the placement of a nasogastric tube and use of enemas in an effort to alleviate the obstruction without surgical intervention.

131. Intake and output records for D.D. reflect that the following amounts of fluid were aspirated from the patient via the nasogastric tube between May 18 and 23, 2001: 475 cc. (May 18); 825 cc. (May 19); 875 cc. (May 20); 150 cc. (May 21); none-clamped (May 22); and 475 cc. (May 23).

132. Dr. Kennell testified that those amounts of fluid indicated that D.D.'s partial bowel obstruction was resolving.

133. In his Answer, Dr. Saiz admits that he failed to record or discuss appropriate physical findings and laboratory results in his daily progress notes.

134. In a patient with a suspected distal small bowel obstruction, the standard of care requires a reasonably prudent general surgeon first to evaluate the colon from below with a colonoscopy to rule out any possible sources of obstruction in the colon, and then to evaluate the small bowel from above with an upper

gastrointestinal ("GI") study using gastrografin contrast material to avoid the risk of compounding any bowel obstruction.

135. During his testimony, Dr. Saiz did not explain why he did not evaluate D.D.'s colon first.

136. Dr. Saiz ordered an upper GI study for D.D. Barium contrast material was used to perform that study. Dr. Saiz failed to order that gastrografin contrast material be used in that study.

137. Dr. Kennell testified that using barium contrast material for an upper GI study of a patient with a suspected distal small bowel obstruction could produce a complete bowel obstruction

138. In his Answer and during his testimony, Dr. Saiz stated that it was the radiologist's decision to use the barium contrast material, and he agreed with that decision.

139. Dr. Kennell testified that the surgeon who orders a study is responsible for selecting the contrast material to be used in that study.

140. Dr. Saiz deviated from the standard of care by evaluating the small bowel from above with an upper GI study before first evaluating the colon. Dr. Saiz also deviated from the standard of care by allowing barium contrast material to be used in the upper GI study.

141. The upper GI study showed "no evidence of small bowel structuring, dilation or fold thickening [but] there appears to be an apple core lesion involving the colon adjacent to the cecum."

142. The radiologist recommended a barium enema or colonoscopy to confirm the presence of the apple-core lesion.

143. Dr. Kennell testified that the overall incidence of small bowel cancer in people of all ages is 9.1 per million people. However, the incidence of small bowel cancers in elderly people is even lower, at 3.8-5.0 per million people.

144. In his initial response to the Board, Dr. Saiz stated that he was not able to perform a second study to confirm the presence of an apple-core lesion because it would have taken several days for the barium residue to clear D.D.'s bowel.

145. Dr. Saiz's deviation from the standard of care resulted in actual harm to D.D. because the presence of barium residue in her bowel after the upper GI study led

Dr. Saiz not to perform or order a barium enema or colonoscopy to ascertain whether there was an apple-core lesion, which in turn led him to later perform an unnecessary right hemicolectomy.

146. In a second response letter to the Board and in his testimony, Dr. Saiz stated that the written report on the upper GI series was not available to him before D.D. was taken to surgery on May 23, 2001 at 1825 hours.

147. However, the written report on the upper GI series was dictated on May 22, 2001 at 1459 hours, transcribed at 2318 hours, and printed on May 23, 2001 at 0601 hours. In addition, the radiologist's written progress note discussing the finding of a possible apple-core lesion near the cecum and recommending a follow-up colonoscopy was recorded on May 23, 2001 at 0710 hours, approximately three hours before Dr. Saiz recorded a subsequent written progress note and approximately eleven hours before the surgery.

148. Dr. Saiz also testified that he reviewed the upper GI films himself, without the radiologist or his report.

149. There is considerable confusion in the record about the location of the suspected apple-core lesion. The radiologist stated that it "appear[ed] to involv[e] the colon adjacent to the cecum." Dr. Saiz stated that he palpated "a circular type mass right just past the terminal ileum in the cecum." The pathologist stated that "the ileocecal valve appears fatty and somewhat firm." However, Dr. Saiz testified that the upper GI film showed "a lesion just before the last end of the small bowel just before the ileocecal valve. Just before the small valve goes into the cecum."

150. Having received radiological evidence of a possible apple-core lesion, the standard of care requires a reasonably prudent general surgeon to perform or order a colonoscopy or barium enema to further evaluate whether such a lesion existed.

151. Dr. Saiz admits that he did not perform or order a colonoscopy or barium enema before taking D.D. to surgery.

152. On May 23, 2001, at 1008 hours, Dr. Saiz ordered the preparation of a patient consent form for a right hemicolectomy.

153. On May 23, 2001, at 1030 hours, D.D. signed a consent form for a right hemicolectomy.

154. In his operative report, Dr. Saiz stated that "the small bowel was run from the ligament of Treitz all the way to the ileocecal valve. Here, the ileocecal valve could be felt with what was described as a previously noted radiographic change from her upper GI. A circular type mass right just past the terminal ileum in the cecum was noted. A standard right hemicolectomy was performed.

155. Following the right hemicolectomy, the pathologist noted the presence of a "putty-like yellow-white substance consistent with barium used in radiography studies" in the cecum and the ascending colon specimen.

156. The pathology report failed to confirm the presence of an apple-core lesion in the cecum specimen submitted for review.

157. Dr. Saiz's deviation from the standard of care resulted in actual harm to D.D. because he unnecessarily removed portions of her distal small bowel, cecum and ascending colon.

158. D.D. was recovering well from surgery when three days later she had a sudden onset of abdominal pain and hypotension.

159. On May 27, 2001, at approximately 1140 hours, Dr. Saiz emergently and appropriately performed an exploratory laparotomy on D.D. during which he encountered "dead small bowel" and performed a "massive" small bowel resection involving a 118 cm. portion of the small bowel.

160. During the surgery, D.D. suffered cardiopulmonary failure and did not respond to efforts to resuscitate her.

161. D.D. was pronounced dead on May 27, 2001 at 1226 hours.

162. Dr. Saiz's care and treatment of D.D. through the first surgery on May 23, 2001 did not cause the complication in D.D.'s small bowel that resulted in her death.

PATIENT A.L.

163. On July 9, 200, Patient A.L. was admitted to HRMC to take down a colostomy that Dr. Saiz had established during a Hartman's procedure in September 16, 1999.

164. At the time of the colostomy procedure, A.L. was diagnosed as having Duke's C colon cancer and was treated with chemoradiation therapy.

165. At the time of his admission, A.L. was cancer free as evidenced by CT scans and serial CEA measurements performed by his oncologist.

166. In addition to those conditions, the 82-year old male patient had a history of myocardial infarction, COPD, arthritis, total right hip arthroplasty, appendectomy and hernia repair.

167. On July 10, 2000, Dr. Saiz took down the colostomy and restored the continuity of A.L.'s colon with hand-sewn anastomosis.

168. Before taking down a colostomy, the standard of care requires a reasonably prudent general surgeon to evaluate pre-operatively the residual portions of the colon proximal and distal to the area of the previous resection to determine whether that residual portion contains any further cancer and whether it is viable for anastamosis.

169. Dr. Saiz deviated from the standard of care by failing to evaluate pre-operatively the residual portions of A.L.'s colon proximal and distal to the area of the previous resection.

170. Dr. Saiz's deviation from the standard of care did not result in any actual harm to A.L., but it unreasonably exposed the patient to an increased risk of potential harm that the anastamosis might fail.

171. There is conflicting evidence in the record about whether A.L. either passed gas or had a bowel movement between July 10 and July 28, 2000. The nurses' notes and daily patient care records reflect that A.L. did not pass gas or have a bowel movement during that period of time. Dr. Saiz's operative note for the rigid sigmoidoscopy procedure performed on July 26, 2000 states as the indication for that procedure that A.L. had had "no bowel movements for greater than two weeks." Dr. Hitendra Chauhan's notes concerning the flexible sigmoidoscopy procedure on July 27, 2000 also reflect that A.L. had not had a bowel movement following the colostomy takedown on July 10, 2000. However, Dr. Saiz's progress notes stated that the patient sometimes had flatus and once had a bowel movement.

172. Dr. Kennell testified that there was no documentation in the record that persuaded him that A.L. had had a bowel movement between July 10 and July 28, 2000.

173. From July 19-27, 2000, A.L.'s Foley catheter drained feculent urine which indicated the possible formation of a colovesical fistula between the bowel and bladder.

174. On July 20, 2000, a CT scan of the pelvis was performed but it did not find any evidence of an obstructed colon or colovesical fistula.

175. On July 22, 2000, an abdominal x-ray was performed which showed "gas present within the non-dilated colon and several small bowel loops, consistent with a mild ileus."

176. On July 24, 2000, a gastrografin enema study showed A.L.'s "lower colon totally obstructed to retrograde flow [of] water soluble contrast material as demonstrated on multiple examinations. No fistula tract was identified. Site of obstruction is presumed to be the anastomotic site."

177. When presented with clinical evidence of a complete bowel obstruction and a possible colovesical fistula, the standard of care requires a reasonably prudent general surgeon to promptly perform a sigmoidoscopy or laparotomy to diagnose and treat the bowel obstruction.

178. Dr. Saiz deviated from the standard of care by delaying until July 26, 2000 before performing a rigid sigmoidoscopy on A.L.

179. During the rigid sigmoidoscopy procedure, Dr. Saiz was able to visualize the patient's colon to approximately 18 cm. but found no evidence of any fistula.

180. Dr. Saiz also deviated from the standard of care by delaying until July 27, 2000 for another physician, Dr. Chauhan, to perform a flexible sigmoidoscopy on A.L.

181. Dr. Chauhan was able to visualize the colon to approximately 20 cm. where he encountered "a totally obliterated lumen" through which "no passage could be identified."

182. Dr. Saiz deviated from the standard of care by delaying until July 28, 2000 before performing an exploratory laparotomy to resect a 3 cm. portion of the colon that was purportedly involved with a colovesical fistula and to re-establish a temporary colostomy.

183. In his operative note, Dr. Saiz stated: "[The old anastomosis] was completely intact. There was no leak noted. Dissection distal to this, however, revealed a few cm. away that, in fact, he had a near occluding fistula there. This was taken down and a segment of bowel resected."

184. Dr. Saiz failed to maintain an adequate medical record because his operative note did not provide sufficient information to accurately describe the location and cause of the colovesical fistula.

185. The pathology did not confirm the presence of a colovesical fistula in the resected colon specimen submitted for evaluation.

186. Dr. Saiz testified that the colovesical fistula was not caused by the original anastamosis, and must have been present before that anastamosis was performed. However, Dr. Saiz also testified that he manually examined the residual portions of the colon before he performed that anastamosis, but his operative report does not record that he found any fistula. Dr. Saiz's testimony on these points is contradictory and not credible.

187. During the exploratory laparotomy, Dr. Saiz also removed A.L.'s gall bladder and resected a 15 cm. portion of his small bowel.

188. The pathology report confirmed chronic cholecystitis and cholelithiasis in the gall bladder specimen as well as areas of fibrosis, chronic inflammation and fat necrosis in the small bowel specimen.

189. Dr. Saiz's deviation from the standard of care did not result in any actual harm to A.L., but it unreasonably exposed A.L. to an increased risk of potential harm that a urinary tract infection or septicemia would develop from the colovesical fistula.

190. On July 31, 2000, A.L. developed acute atrial fibrillation.

191. A second surgeon, Dr. Rankel, followed the patient from August 4-13, 2000, during Dr. Saiz's absence.

192. On August 5, 2000, A.L. aspirated vomit after he improperly removed a nasogastric tube.

193. Patient A.L. suffered pulmonary compromise, developed aspirational pneumonia, and required ventilator support.

194. On August 13, 2000, Dr. Rankel entered a progress note stating that he "will sign off care" for A.L.

195. A.L. was extubated on August 17, 2001, but on August 19, 2000 he was found unresponsive and pronounced dead at 0315 hours.

196. Dr. Kennell testified that Dr. Saiz's care and treatment of A.L. through July 28, 2000 did not directly cause the myocardial infarction or aspirational pneumonia that resulted in the patient's death.

197. Dr. Saiz's discharge summary was dictated on January 9, 2001, approximately five months after A.L. died.

198. Dr. Lang, a consultant in medical staff management and quality assessments for HRMC, credibly testified that under state laws and regulations a physician is required to submit a discharge summary within 30 days of the patient's discharge.

199. Dr. Saiz's discharge summary for A.L. fell below the standard of care because it was submitted approximately five months after A.L.'s death.

200. In the discharge summary, Dr. Saiz stated that A.L. "had a previous history of fistula to the region." There is no evidence in the medical records that the patient had a previous history of fistula to the region. Dr. Saiz failed to maintain an adequate medical record because his discharge summary did not accurately document the patient's history.

PATIENT F.N.:

201. On December 22, 2000, Patient F.N. underwent an elective ultrasound examination by Life Line Screening in Phoenix.

202. The ultrasound examination found narrowing of the right internal carotid artery of greater than 60% and a 4.1 x 4.4 cum. aneurysm of the abdominal aorta ("AAA"). The examiner recommended a neurology consultation for the carotid artery and a six- month follow-up study for the abdominal aorta.

203. After receiving those results, F.N. established with Dr. Walter Sorey, an internist.

204. During an initial visit on January 12, 2001, Dr. Sosey noted that the abdominal aortic aneurysm was "barely palpable" and heard "no bruits over aorta."

205. On February 21, 2001, an abdominal and pelvic CT scan found an "infrarenal abdominal aortic aneurysm with peripheral thrombus and arteriosclerotic calcifications noted. This extends through virtually the level of bifurcation. It measures maximally 4.4 x 4.6 cm." The study also found the presence of multiple gallstones, but "no evidence of pericholecystic fat to suggest acute inflammatory change associated with cholecystitis.

206. On February 22, 2001, an ultrasound study of the right carotid artery found "a significant amount of calcified irregular and heterogeneous plaque involving the bulb of the internal carotid artery, common carotid artery bifurcation, and involving the origin and proximal external artery as well. Velocities within the internal carotid artery are elevated, and peak ICA:CCA ration is 2.13. Mild spectral broadening is noted."

207. Based upon those studies, Dr. Sosey referred the patient to Dr. Saiz for a vascular surgical consultation of the carotid artery, but recommended observation and a 6-12 month follow-up study of the abdominal aortic aneurysm. He also noted that F.N. had asymptomatic cholelithiasis.

208. On March 12, 2001, Dr. Sosey noted that the patient was scheduled for a right carotid endarterectomy with Dr. Saiz on March 26, 2001. He also stated: "At present time AAA will be observed." Finally, he noted that Dr. Saiz had recommended the patient receive a laparoscopic cholecystectomy even though his cholelithiasis was "currently asympt[omatic]."

209. On March 26, 2001, Dr. Saiz performed a right carotid endarterectomy on the patient.

210. After an initial follow-up visit with the patient on May 3, 2001, Dr. Saiz stated that his plan for the patient was an abdominal aortic aneurysm resection and then gallbladder surgery.

211. On May 8, 2001, Dr. Saiz notified Dr. Sosey that F.N. was scheduled for an abdominal aortic aneurysm resection on May 21, 2001.

212. On May 21, 2001, F.N. was admitted to HRMC for what Dr. Saiz described as a "semi-elective" resection of an abdominal aortic aneurysm.

213. F.N., a 79-year old male, had a history of hypertension, vascular disease and COPD.

214. In his operative note, Dr. Saiz stated that the aneurysm was "symptomatic."

215. Prior to the abdominal aortic aneurysm resection, there is no evidence in the medical records that the aneurysm was either painful or acutely enlarged.

216. In his Answer, Dr. Saiz states that when he operated on F.N. he found that the aneurysm had ruptured. In his discharge summary, Dr. Saiz made a similar statement.

217. However, those statements are not consistent with the medical records, including Dr. Saiz's operative report.

218. Dr. Saiz failed to maintain an adequate medical record because his office notes and pre-operative history and physical examination did not provide sufficient information to support his diagnosis of a "symptomatic" abdominal aortic aneurysm and justify his treatment of a "semi-elective" abdominal aortic aneurysm resection.

219. The standard of care requires a reasonably prudent vascular surgeon to find evidence of a tender, painful or acutely expanding abdominal aortic aneurysm before resecting a "symptomatic" abdominal aortic aneurysm smaller than 5 cm.

220. Dr. Saiz deviated from the standard of care by resecting an asymptomatic abdominal aortic aneurysm smaller than 5 cm.

221. Dr. Saiz's deviation from the standard of care resulted in actual harm to F.N. because he subjected the patient to an inappropriate elective surgery which resulted in the patient's death.

222. Following the surgery, F.N. became significantly hypotensive and had to be resuscitated with large amounts of blood, blood products and fluids.

223. When Dr. Saiz was not able to properly manage F.N.'s blood volume after the surgery, the patient became hypovolemic and developed multi-system organ failure.

224. When a patient becomes significantly hypotensive after surgery, the standard of care requires a reasonably prudent physician to place a Swan-Ganz catheter in the patient to monitor his/her blood volume.

225. Dr. Saiz deviated from the standard of care by failing to place a Swan-Ganz catheter in F.N. when he became significantly hypotensive after surgery.

226. F.N.'s family agreed to establish a DNR order on May 24, 2001 at 0020 hours.

227. F.N. died on May 24, 2001 at 0135 hours.

228. Dr. Saiz's deviation from the standard of care resulted in actual harm to F.N. because Dr. Saiz was not able to properly manage the patient's blood volume after the surgery which caused the patient's death.

PATIENT J.T.

229. In March 1999, Dr. Thomas Wrona, an internist, evaluated Patient J.T. at HRMC for severe vascular insufficiency in both lower extremities, but transferred her to GSRMC in Phoenix for the axillofemoral femoral bypass graft. The records of that bypass procedure were not available in medical records provided by Drs. Saiz or Wrona and they were not subpoenaed by Dr. Saiz for this hearing.

230. On June 5, 2000, J.T. was admitted to HRMC for the exploration of a mass in her right groin area and the possible revision of the axillofemoral femoral bypass that had been performed in March 1999.

231. J.T. presented in consultation to Dr. Saiz from Dr. Wrona.

232. In addition to the history of peripheral vascular disease, J.T., a 68-year old female, had a history of COPD, emphysema, arteriosclerotic cardiovascular disease, hypertension and osteoporosis.

233. In his Answer, Dr. Saiz states that J.T. was admitted for a painful right groin mass. He also states that he performed surgery on J.T. to relieve the source of that pain which was an incisional hernia.

234. However, Dr. Saiz testified that J.T. presented with a mass in the right groin area that was simply "getting larger [and more] uncomfortable for her."

235. Although he testified that he successfully repaired an incisional hernia during the exploratory procedure, Dr. Saiz could not explain the nature of the incisional hernia he purportedly found and repaired.

236. Dr. Tieman, an expert medical witness for Dr. Saiz, based his opinions about this case on his conversations with Dr. Saiz and not on a detailed review of the medical records. Dr. Tieman had not seen Dr. Saiz's operative note in this case.

237. Dr. Tieman stated that his opinions would be affected if there was no evidence in the record prior to surgery that J.T. had symptoms of an incisional hernia.

238. There is no evidence in the medical records prior to surgery that J.T. had symptoms of an incisional hernia, or that Dr. Saiz planned to repair an incisional hernia.

239. In fact, the medical records prior to surgery clearly reflect that Dr. Saiz planned to explore the mass in J.T.'s right groin area and possibly revise the axillofemoral femoral bypass graft due to the presence of a suspected pseudo-aneurysm.

240. Dr. Kennell testified that he had doubts about whether Dr. Saiz actually found and repaired an incisional hernia.

241. The standard of care requires a reasonably prudent vascular surgeon to perform a pre-operative ultrasound examination of that type of right groin mass to determine whether the mass is pseudo-aneurysm which would necessitate an operation under general anesthesia to possibly revise the previous graft, or a seroma which could be aspirated under local anesthesia in an office setting.

242. If it was determined that the groin mass was a pseudo-aneurysm, the standard of care requires a reasonably prudent vascular surgeon to perform an adequate pre-operative vascular evaluation of the patient's peripheral vascular run-off below the axillofemoral femoral bypass.

243. Dr. Saiz deviated from the standard of care by performing a surgical exploration of the right groin mass before he performed a pre-operative ultrasound examination of the mass to determine whether it was a pseudo-aneurysm or a seroma.

244. On June 5, 2000, Dr. Saiz surgically explored J.T.'s right groin mass during which he drained a large seroma and purportedly repaired an incisional hernia.

245. Dr. Saiz's deviation from the standard of care resulted in actual harm to Patient J.T. because he performed an unnecessary surgical procedure on her.

246. Dr. Saiz's deviation from the standard of care also unreasonably exposed J.T. to an increased risk of potential harm from unnecessary spinal anesthesia.

247. Two days after the unnecessary surgery, J.T. suffered a myocardial infarction.

248. Despite aggressive efforts, J.T.'s hemodynamic status deteriorated and she developed respiratory failure requiring ventilator support.

249. J.T.'s family agreed to a DNR order.

250. J.T. died on June 15, 2000 at 1925 hours.

251. Dr. Kennell testified that Dr. Saiz's care and treatment of Patient J.T. did not directly cause the myocardial infarction that resulted in her death.

PATIENT J.N.

252. Patient J.N. was a patient well known to Dr. Saiz having been a vascular patient under his care for years.

253. J.N. presented to Dr. Saiz on November 13, 2000 with painful changes and odor to his right second toe, a problem for which Dr. Saiz had been following the patient for a number of months.

254. Dr. Saiz had followed this patient regarding his peripheral vascular disease for a number of years and had done a number of vascular procedures, as well as a number of diagnostic procedures.

255. On November 13, 2000, J.N. was admitted to HRMC for the amputation of an ischemic gangrenous right second toe.

256. The 86-year old patient had a history of diabetes mellitus, peripheral vascular disease, coronary artery disease with a four-vessel bypass graft approximately two years earlier, myocardial infarctions and congestive heart failure.

257. During the previous three-and-a-half years, Dr. Saiz had performed four separate bypass grafts to revascularize the right lower leg.

258. Dr. Saiz failed to maintain an adequate medical record because his admitting history and physical examination report dated November 13, 2000 failed to adequately document J.N.'s past medical and surgical history.

259. In a patient with a history of diabetes mellitus and advanced peripheral vascular disease, the standard of care requires a reasonably prudent general or vascular surgeon to perform or order an adequate pre-operative vascular evaluation, such

as a Doppler study of the perfusion pressures in the foot and ankle, to determine whether there was a sufficient supply of blood to the proposed amputation site.

260. Dr. Saiz removed J.N.'s right second toe on November 13, 2000.

261. Dr. Saiz testified that the gangrene in J.N.'s right second toe was "wet" gangrene, which required him to emergently remove that toe to avoid the spread of infection.

262. Dr. Saiz's admitting history and physical examination does not reflect any determination whether the gangrene was "wet."

263. In addition, the medical records do not reflect that a culture was taken to determine whether the gangrene was "wet."

264. J.N. had a known history of high level of activity, notwithstanding being 86 years of age, and also had a strong desire to maintain as much mobility as possible, which was a goal respected by Dr. Saiz.

265. Dr. Saiz also testified that the amputation site was selected in accordance with the patient's wishes after appropriate discussion of the risks and benefits.

266. Dr. Saiz's admitting history and physical examination note states: "PLAN: Removal. The risks and benefits including bleeding, infection have been explained to him and he agrees at this point to have this done, as it is extremely painful."

267. Dr. Saiz deviated from the standard of care by removing J.N.'s right second toe without first performing an adequate pre-operative vascular evaluation to determine whether there was a sufficient supply of blood to the amputation site.

268. When J.N. developed further ischemic gangrene in his right foot and lower leg following the amputation, Dr. Saiz removed the patient's right lower leg below the knee on November 20, 2000.

269. Dr. Saiz also deviated from the standard of care by removing J.N.'s right leg below the knee without first performing an adequate pre-operative vascular evaluation to determine whether there was a sufficient supply of blood to the amputation site.

270. Dr. Saiz's deviations from the standard of care did not result in any actual harm to Patient J.N., but they unreasonably exposed the patient to increased risks of potential harms that the amputation site would not heal properly and further amputation would be necessary, requiring prolonged hospitalization.

271. Following the second surgery, J.N. developed respiratory failure, myocardial infarction and renal failure.

272. Thereafter, the family indicated that J.N. was to be kept comfortable but no heroic measures were to be pursued.. J.N.'s family agreed to establish a DNR order.

273. J.N. died at 1000 hours on November 25, 2000.

274. Dr. Kennell testified that Dr. Saiz's care and treatment of Patient J.N. did not directly cause the respiratory failure, myocardial infarction and renal failure that resulted in his death.

THE CENTER FOR PERSONALIZED EDUCATION FOR PHYSICIANS REPORT

275. Administrators at HRMC referred Dr. Saiz for evaluation by the Center for Personalized Education for Physicians ("CPEP") after an external quality review organization "became aware of a patient who died while undergoing a video-assisted thoracotomy performed by Dr. Saiz" and "raised questions about Dr. Saiz's documentation, patient selection, and choice of procedures."

276. CPEP evaluated Dr. Saiz on July 31, 2002 and August 1, 2002.

277. As a result of its evaluation, CPEP assessed Dr. Saiz as follows:

> "During this Assessment, Dr. Saiz demonstrated *medical knowledge* that was good in vascular surgery and acceptable with some areas of deficit in general surgery. His stated and documented indications for surgery and recommendations for vascular procedures were appropriate and correct. Knowledge of general surgery was good regarding most topics, but he showed deficits in the areas of diagnosis of acalculous cholecystitis, and the management of complications of laparoscopic cholecystectomy (such as transection of the common bile duct), recommended margins for breast biopsy, hernia repair, and reflux esophagitis.
>
> Dr. Saiz'[s] *judgment and reasoning* were largely sound, though not invariably. He voiced an awareness of his limitations and the circumstances in which he practices. However, at times he demonstrated decision-making that was inconsistent with his stated knowledge and currently recommended practices. Dr. Saiz has integrated variation in certain surgical techniques that are not generally recognized. Although the consultants thought that most of the variations were minor, this may

represent a tendency to modify his practice for reasons that are not well substantiated or not critically evaluated by Dr. Saiz.

One of the two instances where Dr. Saiz's judgment appeared to deviate more significantly included his recommendation for early surgery in the case of abscessed diverticulitis. Another concern was raised by Dr. Saiz'[s] dictation indicating that an obstructing malignancy was present during a colonoscopy, when, in fact, there was no pathology available at the time of the colonoscopy and the lesion was later noted to be a benign condition. Although there were no actual adverse outcomes, documenting a presumption in a way that could be understood as factual information can clearly invite errors in judgment and may be related to some of the issues prompting referral.

The information regarding patient and procedure volume provided by Dr. Saiz differed from that recalled by the administrator of Dr. Saiz'[s] hospital. The actual volume is relevant because, certainly, a physician over-burdened by excessive volume would not perform at his best judgment and documentation.

Dr. Saiz'[s] *patient care documentation* in notes composed at CPEP was good with the exception of some difficulty in legibility. In review of notes from Dr. Saiz'[s] actual patient charts, his handwriting was nearly illegible at times. The quality of the content in the notes varied. General surgery notes were not always as complete and detailed as necessary. Vascular surgery notes appeared thorough and logical. The busy pace of Dr. Saiz'[s] practice might be negatively impacting the quality of his documentation.

Dr. Saiz demonstrated good *communication skills* with simulated patients and peers alike.

The cognitive function screen was within normal limits. Dr. Saiz failed to submit the results of a recent physical examination, so CPEP was not able to review *health information…*

An Assessment such as that done by CPEP does not involve direct observation of the participant-physician at work. Our conclusions, therefore, can address only whether the physician possesses the knowledge and judgment necessary to perform. We cannot predict actual behavior."

278. Dr. Kennell testified that he reviewed the CPEP report and thought that 'they're very much on line with what I have observed."

DR. SAIZ'S WORKLOAD

279. During the CPEP evaluation, Dr. Saiz reported that he works "six days a week and sees about 30 patients a day. He also reported that he performs "40 inpatient and 30 outpatient procedures each month," or approximately 840 cases a year.

280. An HRMC administrator told CPEP that Dr. Saiz performs "1100 to 1200 cases per year."

281. When asked to explain the discrepancy between the two workload figures, Dr. Saiz "postulated that the cases quoted by the administrator might include endoscopies and line placement procedures."

282. CPEP also noted that Dr. Saiz "seemed to be either unaware or in denial about concerns other than his patient care documentation."

283. According to figures provided by Dr. Saiz during the administrative hearing, his workload for the years 2000-2002 was as follows:

- In 2000, 2,491 office visits; 522 in-patient consults; and 989 surgical procedures.
- In 2001, 4,455 office visits; 438 in-patient consults; and 1,183 surgical procedures.
- In 2002, 4,274 office visits; no data available for in-patient consults; and 893 surgical procedures.

284. Dr. Saiz testified that he did not consider that volume of office visits, in-patient consultations and surgical procedures to be a heavy workload.

285. Dr. Kennell testified that those workload figures represented the volume of a two or three person surgical practice. He believed Dr. Saiz was "in a position where the practice is running him."

286. Dr. Kennell also testified that Dr. Saiz's excessive workload affected his judgment of cases and the work-ups leading to those record-keeping.

287. Dr. Lang, the consultant in medical staff management and quality assurance for HRMC, testified that in his professional judgment Dr. Saiz's workload was "excessive."

288. When presented with the workload figures described above, Dr. Lang testified that they represented "a terrible workload...[I]t's hard to see how that fits in with the time available. So it's obvious that he is working day and night."

289. Dr. Lang also testified that he has and would continue to counsel Dr. Saiz to "limit his activities to a more workable schedule."

290. Dr. Saiz's colleagues testifying on his behalf at the hearing all readily and frankly opined that Dr. Saiz's workload is excessive.

291. The evidence of record supports a finding that Dr. Saiz's workload has been excessive and negatively impacted his surgical practice and, at least equally important, his family life. Dr. Saiz should not be permitted to continue to maintain such an excessive workload.

DR. SAIZ'S VOLUNTARY AGREEMENT TO RESTRICT THORACIC SURGERIES

292. On September 9, 2002, HRMC advised the Board that Dr. Saiz had entered into a voluntary agreement with the Health Services Advisory Group ("HSAG") to restrict his ability to perform thoracic surgeries without supervision.

293. Dr. Lang testified that it would be "a practical impossibility" to provide concurrent practice monitoring of any elective thoracic procedures that Dr. Saiz might perform. Dr. Lang suggested that HRMC might simply retain an outside thoracic surgeon for several cases to reassure the hospital that Dr. Saiz had not lost his technical thoracic surgical skills during the suspension of his surgical privileges.

294. During his testimony, Dr. Saiz reiterated his agreement not to practice elective thoracic surgery at HRMC without the supervision of another staff thoracic surgeon.

PREVIOUS BOARD ACTION

295. On December 10, 2001, following a Formal Interview with the Board pursuant to A.R.S. § 32-1451, the Board issued Dr. Saiz a non-disciplinary advisory letter for "improper management of a patient with suspected small bowel obstruction."

MATTERS IN MITIGATION

296. Although he has made significant errors in judgment, there is evidence in the record that Dr. Saiz is a technically proficient surgeon who is well-respected by his colleagues, his patients and the Lake Havasu City community.

297. There is also evidence in the record that Dr. Saiz's errors in judgment are probably the result of an exceedingly busy practice, and not the result of incompetence or greed.

298. There is reason to expect that with the proper education, supervision and mentoring, Dr. Saiz may reform the bad habits that led him to commit the acts of unprofessional conduct described above.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter of this disciplinary action and over Dr. Saiz, pursuant to A.R.S. § 32-1401 *et seq.*
2. Pursuant to the provisions of A.R.S. § 32-1401(2), an adequate medical record is a "legible medical record" that contains "at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient, and provide sufficient information for another practitioner to assume the continuity of the patient's care at any point in the course of treatment.

3. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Dr. Saiz pursuant to A.R.S. § 32-1401(24)(e) (failing or refusing to maintain adequate records on a patient).
4. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Dr. Saiz pursuant to A.R.S. § 32-1401(24)(q) (any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public).
5. Negligence is a failure to exercise that degree of care, skill and learning expected of a reasonable, prudent physician or specialist in Arizona in the same or similar circumstances. A.R.S. §§ 1-215 (25) and 12-563.
6. Gross negligence is negligence that creates an unreasonable risk of bodily harm and involves a high degree of probability that substantial bodily harm will result. It implies a reckless indifference to the results of an act. *Caldwell v. Arizona Board of Dental Examiners*, 137 Ariz. 396, 400, 670 P.2d 1220, 1224 (App. 1983).
7. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Dr. Saiz pursuant to A.R.S. § 32-1401(24)(ll) (conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or death of the patient).
8. With respect to the emergency action taken by the Board on October 29, 2002, the public health, safety or welfare did imperatively require emergency action pursuant to A.R.S § 32-1451(D).
9. When determining appropriate disciplinary action against a licensee, "the board shall consider all previous non-disciplinary and disciplinary actions against a licensee." A.R.S. § 32-1451(U).
10. Pursuant to the provisions of A.R.S. § 32-1451(M), Dr. Saiz should be assessed the costs of the formal hearing in this matter.

ORDER

In view of the foregoing, it is Ordered that Dr. Saiz's License No. 24387 is Revoked. However, revocation is stayed and Dr. Saiz is placed on probation for a period of five years subject to the terms and conditions enumerated below. Upon any alleged violation of a probationary term, Respondent shall be given notice and an opportunity to be heard on the alleged violation. Thereafter the Board shall terminate the probation and revoke Dr. Saiz's license. If an investigation involving an alleged violation of the probation is initiated, but not resolved, prior to the termination of the probation, the Board shall have continuing jurisdiction and the period of probation shall extend until the matter is final.

1. Dr. Saiz shall successfully complete an Educational Intervention plan recommended by CPEP. Such a plan shall include education and review of Dr. Saiz's record-keeping skills. Dr. Saiz shall pay the costs of developing and successfully completing that plan.
2. Dr. Saiz shall maintain a log of all operative procedures he performs. The log shall include the identity of the patient; the indications for the procedure performed; the outcome of the procedure; and any complications experienced. Dr. Saiz shall submit the log to the Board each month. The Board shall review the log and may open any investigations based on that review.
3. Dr. Saiz shall not perform any bariatric surgery, including "gut shortening" and excision of omentum for weight loss purposes.
4. Dr. Saiz shall not perform thoracic surgery without supervision.
5. Dr. Saiz shall be subjected to periodic chart reviews by Board staff.
6. Dr. Saiz shall pay the costs of the administrative hearing. Board Staff will notify Dr. Saiz of the amount due. Dr. Saiz shall pay the costs within 60 days of receiving the notification of the amount due.

7. Dr. Saiz shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all conditions of probation. The declarations must be submitted on or before the 15th of March, June, September and December of each year.
8. Dr. Saiz shall obey all federal, state and local laws, and all rules governing the practice of medicine in Arizona.
9. In the event Dr. Saiz should leave Arizona to reside or to practice medicine outside the State or for any reason should Dr. Saiz stop practicing medicine in Arizona, Dr. Saiz shall notify the Executive Director in writing within 10 days of departure and return or the dates of non-practice in Arizona. Non-practice is any period of time exceeding 30 days during which Dr. Saiz is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside of Arizona or of non-practice within Arizona do not apply to the reduction of the probationary period.
10. Dr. Saiz shall pay the costs associated with monitoring his probation as designated by the Board each and every year of probation. Such costs may be adjusted on an annual basis. Costs are payable to the Board no later than 60 days after invoice is sent to Respondent and thereafter on an annual basis. Failure to pay these costs within 30 days of the due date constitutes a violation of probation.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review by filing a petition with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09. The petition must set forth legally sufficient reasons for granting a rehearing. A.A.C. R4-16-102. Service of this order is effective

five (5) days after date of mailing. If a motion for rehearing is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

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

DATED this 14th day of April, 2003.

ARIZONA MEDICAL BOARD

(SEAL)

By: Amanda Diehl
Barry A. Cassidy, Ph.D., PA-C
Executive Director
Amanda Diehl
Assistant Director

Original of the foregoing filed this
14th day of April, 2003 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Copy of the foregoing filed this
14th day of April, 2003 with:

Cliff J. Vanell, Director
Office of Administrative Hearings
1400 West Washington, Suite 101
Phoenix, Arizona 85007

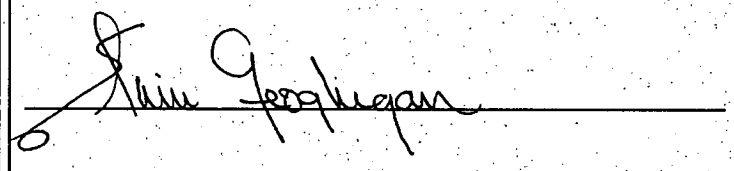
Executed copy of the foregoing
mailed by US CERTIFIED MAIL
this 14th day of April, 2003 to:

Dan Jantsch
Olson Jantsch & Bakker, PA
7243 North 16th Street
Phoenix, Arizona 85020-7250

Executed copy of the foregoing
mailed by US MAIL
this 14th day of April, 2003 to:

Abedon Saiz, M.D.
329 Lake Havasu Avenue South
Lake Havasu City, Arizona 86403-9368

Stephen Wolf
Assistant Attorney General
Office of the Attorney General
1275 West Washington
Phoenix, Arizona 85007

Executed copy of the foregoing hand-delivered
this 14th day of April, 2003 to:

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