BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **ABEDON SAIZ, M.D.** Holder of License No. 24387 For the Practice of Allopathic Medicine in the State of Arizona	Docket No. **03F-24387B-MDX** **Case No. MD-02-0216** **MD-02-0764** **MD-02-0765** **MD-03-0504** **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR LICENSE REVOCATION, STAYED AND PROBATION**

On June 10, 2004 this matter came before the Arizona Medical Board ("Board") for oral argument and consideration of Administrative Law Judge ("ALJ") Brian Brendan Tully's proposed Findings of Fact and Conclusions of Law and Recommended Order. Abedon Saiz, M.D. ("Respondent") was notified of the Board's intent to consider this matter on the aforementioned date at the Board's public meeting. Respondent appeared personally and was represented by his attorney, Daniel P. Jantsch. Assistant Attorney General Stephen A. Wolf represented the State. Assistant Attorney General Christine Cassetta, with the Solicitor General's Section of the Attorney General's Office, was present and available to provide independent legal advice to the Board.

The Board, having considered the ALJ's report and the entire record in this matter hereby issues the following Findings of Fact, Conclusion of Law and Order.

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. He also holds a medical license

issued by the State of Florida, although he does not currently practice there. Dr. Saiz is board certified in general surgery.

3. The Board instituted these proceedings against Dr. Saiz pursuant to A.R.S. §§ 32-1451 and 41-1092 *et seq.*, concerning his care and treatment of Patients R.C., W.G., D.L. and D.E.

PATIENT R.C.

4. In April 2002, the Board initiated Investigation MD-02-0216 concerning Dr. Saiz's care and treatment of Patient R.C. after receiving a notice from the Health Services Advisory Group ("HSAG") expressing concerns about the quality of care Dr. Saiz provided to this patient.

5. HSAG is a quality improvement organization authorized to review medical services provided to Medicare patients in the State of Arizona.

6. On September 9, 2002, Havasu Regional Medical Center ("HRMC") advised the Board that Dr. Saiz had entered into a voluntary agreement with the HSAG to restrict his ability to perform thoracic surgeries without supervision.

7. In August 2003, the Board conducted a formal interview with Dr. Saiz concerning this patient and referred the matter for formal administrative hearing before the Office of Administrative Hearings, an independent state agency.

8. Dr. Robert Rosenberg, a pulmonologist, initially evaluated Patient R.C., at the time a 70-year old female, on February 16, 2001.

9. Dr. Rosenberg had treated R.C. from 1994-1998 for a mycobacterium avium infection. She had also undergone a mastectomy and radiation therapy.

10. Fungus and acid-fast bacterium sputum cultures taken on February 19, 2001 were negative.

11. Dr. Rosenberg performed Bronchoscopies and transbronchial biopsies (or bronchial washings) on February 20 and 28, 2001. Cultures from those washings ruled out a typical tuberculosis infection or a mycobacterium avium re-infection, but suggested the presence of mycobacterium chelonae.

12. Dr. Rosenberg admitted Patient R.C. to HRMC on April 3, 2001 for evaluation of "non-resolving, progressive right pneumonitis of unknown etiology." He recommended a "thoracic consult...for probable tissue diagnosis."

13. She was referred to Dr. Saiz by Dr. Rosenberg.

14. The records maintained by Dr. Rosenberg and Dr. Saiz do not reflect that they discussed or considered additional measures other than surgical biopsy, such as a repeated bronchoscopy, a CT-guided needle biopsy, or a course of antibiotic treatment, to assist them in making a definitive diagnosis.

15. At the hearing, Dr. Rosenberg testified that he decided not to repeat the bronchoscopy because he did not believe it would provide a large enough tissue sample to assist in making a definitive diagnosis.

16. Dr. Rosenberg also testified that he decided not to order a CT-guided needle biopsy because he strongly suspected that the patient was experiencing an infectious disease process and he was concerned that a needle biopsy might spread that infection into the pleural space.

17. Dr. Rosenberg testified that he decided not to attempt to treat the patient with antibiotic medications because without knowing which infectious disease process was afflicting the patient's lung he did not know which antibiotic to use.

18. Dr. Rosenberg testified that he left the decision of whether to perform an open or laparoscopic procedure "in the hand of the surgeon."

19. An x-ray study on April 3, 2001 showed: "extensive right lung consolidation with shift of the mediastinum to the right consistent with pneumonia and atelectasis."

20. That same day Dr. Saiz provided a surgical consultation and recommended a video-assisted thoracoscopy.

21. Dr. Saiz's written progress note and dictated consultation report do not reflect whether he reviewed the patient's CT scan or x-ray studies.

22. Dr. Saiz testified at the hearing that he did not review the April 3, 2001 x-ray report when he was evaluating the patient for surgery, but did review the actual x-ray and CT scans.

23. Dr. Saiz did not appreciate the patient's history of previous radiation therapy, previous pleural infection, and radiological evidence of pleural adhesions and thickening were relative contraindications for attempting to perform a video-assisted thoracoscopy on R.C.

24. Dr. Saiz lacked sufficient thoracic and thoracoscopic training and experience both to evaluate whether the patient was an appropriate candidate for a video-assisted thoracoscopy and to attempt to perform one on her.

25. For a patient who had previously undergone radiation therapy following a mastectomy, who had previously suffered a mycobacterium avium infection of the right lung, and who now presented with "marked cavitation destruction of most of her right lung", the standard of care requires a reasonably prudent surgeon to perform an open thoracotomy when attempting to obtain a tissue sample of that lung. Pleural adhesions and thickenings are a relative contraindication for attempting to perform a video-assisted thoracoscopy on such a patient. An open thoracotomy gives the surgeon a better opportunity to control the bleeding and air leaks one would reasonably anticipate happening when operating on such a patient.

26. Dr. Saiz deviated from the standard of care by attempting to perform a video-assisted thoracoscopy on R.C.

27. Before proceeding with a video-assisted thoracoscopy, the standard of care requires a reasonably prudent surgeon to ensure that proper cardiopulmonary safeguards are in place, including a double-lumen or bronchial blocker endotracheal tube to assist in ventilating the patient and an arterial line to monitor the patient's arterial blood pressure and serial blood gases.

28. Dr. Saiz deviated from the standard of care by proceeding with the video-assisted thoracoscopy without ensuring that proper cardiovascular safeguards were in place. R.C. was intubated with a single lumen endotracheal tube and was monitored by a pulse oximeter and blood pressure cuffs by the attending anesthesiologist, Dr. Munoz. Also present at that time was the Chief of Anesthesiology, Dr. Rosenthal.

29. Dr. Saiz initiated the video-assisted thoracoscopy on April 5, 2001 at approximately 2100 hours. During the procedure, blood was found in the endotracheal tube and R.C. became hypotensive and hypoxic. Dr. Saiz converted the video-assisted thoracoscopy into an open thoracotomy to determine the cause of the patient's bleeding and decompensation.

30. Efforts to resuscitate R.C. were unsuccessful and she was pronounced dead at 2233 hours.

31. Dr. Saiz's deviations from the standard of care in his pre-operative evaluation and intra-operative management of the patient unreasonably increased the risk of harm to R.C. and contributed to her death during the video-assisted thoracoscopy.

Patient W.G.

32. In December 2002, the Board initiated an investigation MD-02-0764 concerning Dr. Saiz's care and treatment of patient W.G. after receiving a complaint from C.O., the patient's daughter.

33. During the administrative hearing, Dr. Saiz admitted to all of the allegations concerning W.G contained in the Board's complaint.

34. In August 2003, the Board conducted a formal interview of Dr. Saiz concerning this matter and referred the case to the Office of Administrative Hearings for a formal administrative hearing.

35. Patient W.G., at the time in question a 79-year old male, lived at the Havasu Nursing Center having been transferred there from a similar facility in California in July 1999 after the death of his wife.

36. W.G. had a history of Parkinson's disease and COPD. In addition to those conditions, W.G. had suffered a complete obstruction of the sigmoid colon and had undergone a colon resection and colonoscopy in September 1995.

37. After experiencing significant post-operative complications from dehiscence of the surgical incision, the colostomy was taken down in March 1996.

38. In September, W.G. was referred by Dr. Kazmi, a neurologist, to Dr. Saiz for evaluation of "[an] unknown gastrointestinal problem." Dr. Saiz diagnosed the patient as having recurrent ventral incisional hernias and multiple fistulous tracts associated with what Dr. Saiz thought was a previous ventral hernia repair with mesh in 1996.

39. The patient was originally scheduled for surgery to repair recurrent ventral incisional hernias and remove multiple fistulous tracts in January 2000, but that surgery was postponed when the anesthesiologist became concerned about the patient's pulmonary status. A chest x-ray taken on December 29, 1999 showed "[m]ild elevation of

the right hemidiaphragm with Chilaiditi's [syndrome] incidentally noted." A follow-up chest x-ray on January 6, 2000 also showed "slight elevation of the right hemidiaphragm [with] interposed colon...beneath [it]." Significantly, a previous x-ray taken in California six months earlier had also shown "interposition of bowel between the right diaphragm and liver, an anatomic variant."

40. Surgery to repair recurrent ventral incisional hernias and remove multiple fistulous tracts was re-scheduled for February 7, 2000.

41. Before performing the surgery, Dr. Saiz failed to perform or document an adequate history and physical examination of the patient, which was below the standard of care, was or may have been harmful or dangerous to the patient's health, or was inadequate.

42. Dr. Saiz also failed to perform or document an adequate pre-operative evaluation of the source and cause of the abdominal fistulous tracts, which was below the standard of care, was or may have been harmful or dangerous to the patient's health, or was inadequate.

43. Upon exploring several of the abdominal tracts during the surgery, Dr. Saiz was surprised to find that the tracts penetrated the peritoneal cavity into the small bowel. Dr. Saiz performed a laparotomy and found "massive" adhesion, dilatation, dislocation and obstruction of the small and large bowels. He then performed a right hemicolectomy and sigmoid colectomy with colostomy. He also resected the enterocutaneous fistulas from the small bowel.

44. Following a difficult post-operative recovery period during which he developed a left pneumothorax and methicillin-resistant staphylococcus aureus ("MSRA") pneumonia, the patient was discharged to the Havasu Nursing Center on March 1, 2000. He died there on March 5, 2000 at approximately 0400 hours.

45. The report of the Board's expert, Dr. Kennell, was disclosed to Dr. Saiz prior to the administrative hearing. The report, Exhibit 31, was admitted into evidence. Dr. Kennell's report limited his criticisms of Dr. Saiz to failure to properly evaluate the patient pre-operatively and failure to inform the patient of the magnitude of the surgery had his true condition been known.

46. Dr. Saiz's deviations from the standard of care resulted in actual harm to the patient. By failing to review the records of the previous colon resection and colostomy that were in his office chart, and by failing to properly evaluate pre-operatively the source and cause of the patient's fistula tracts, Dr. Saiz did not have a sufficient understanding of the patient's pre-operative condition. If he had had a sufficient understanding of the patient's pre-operative condition, he would have offered the patient the option of treating the fistula tracts either non-surgically or surgically. The patient was harmed because he was denied the opportunity to knowingly elect either a non-surgical or a surgical option that included resection of the small bowel and colon. The unplanned right hemicolectomy, sigmoid colectomy with colostomy, and small bowel resection hastened the patient's death.

Patient D.L.

47. In December 2002, the Board initiated investigation MD-02-0765 concerning Dr. Saiz's care and treatment of Patient D.L. after receiving a complaint from R.L., the patient's wife.

48. In August 2003, the Board conducted a formal interview with Dr. Saiz concerning this matter and referred the case to the Office of Administrative Hearings for an administrative hearing.

49. Patient D.L., who at the time in question was a 77-year old male, had numerous long-standing medical conditions including spinal stenosis and chronic back problems

that required surgeries in 1988-89, a laparoscopic cholecystectomy in 1999, and arteriosclerotic heart disease that required cardiac stenting in April 2001. He also had well-controlled, type II diabetes mellitus, benign prostatic hypertrophy, multiple gastric ulcers, a hiatal hernia, and a history of syncopal episodes.

50. The patient initially referred himself to Dr. Saiz for evaluation of possible circulatory problems.

51. During an examination of the patient on March 21, 2000, Dr. Saiz reported in his progress note: "Exam-no weakness; large 14 x 8 cm. right flank hernia. Plan-CT scan…follow-up after."

52. A CT scan performed on March 24, 2000 did not provide any evidence of a large right flank incisional hernia.

53. During a follow-up examination of the patient on May 3, 2000, Dr. Saiz reported in his progress note: "Still has a large right flank hernia reducible at site of old laparoscopic cholecsystectomy trocar incision. Plan-right flank hernia repair with mesh. Risks/benefits reviewed with patient. Agrees to proceed."

54. Dr. Saiz examined the patient again on September 29, 2001. In his progress note, Dr. Saiz reported: "Seen in follow-up. Recent stints cardiac. Exam-large right and swollen left flank hernia. Multiple skin lesions (Dr. Anderson attending). Plan-evaluate [cardiac condition] with Dr. Sadeeh. If okay, right flank hernia."

55. The patient's cardiac condition was cleared by Dr. Sadeeh on November 11, 2001 and Dr. Saiz scheduled the patient for surgery to repair what he thought was a right flank incisional hernia on November 19, 2001.

56. On November 19, 2001, Dr. Saiz performed a laparoscopy to visualize and repair the right flank incisional hernia.

57. Before performing that surgery, Dr. Saiz failed to perform or document an adequate history and physical examination of the patient, which was below the standard of care, was or may have been harmful or dangerous to the patient's health, or was inadequate.

58. Before proceeding with surgery to repair a large right flank incisional hernia, the standard of care requires a reasonably prudent surgeon to confirm the presence of such a hernia by physical examination, radiological study or laparoscopic visualization.

59. Dr. Saiz deviated from the standard of care by failing to establish the presence of an actual large right flank incisional hernia before he proceeded with the surgical repair.

60. Pre-operatively, Dr. Saiz did not establish the presence of a right flank incisional hernia by physical examination or radiological study.

61. Dr. Kennell, the Board's expert witness, testified that it was "incredulous" to believe that a 5-10 mm. trocar incision site could produce a 14 x 8 cm. incisional hernia.

62. Dr. Tieman, Dr. Saiz's expert witness, agreed that the patient did not have a large right flank incisional hernia caused by a 5-10 mm. trocar incision site.

63. Drs. Tieman and Kennell opined that when the patient presented to Dr. Saiz with a large bulge on his right flank, D.L. was suffering from a diffuse lumbar hernia.

64. During the laparoscopy, Dr. Saiz found "no evidence of any direct hole here we could actually see." He summarized his intra-operative findings in the operative report as follows: "Right flank attenuation with no frank puncture site noted."

65. Despite finding no evidence of a right flank incisional hernia, Dr. Saiz converted the laparoscopic procedure to an open laparotomy and placed a large piece of Mersilene mesh over the area of a presumed fascial defect.

66. Dr. Saiz's improvised surgical procedure using Mersilene mesh to repair abdominal fascial attenuation is not recognized in the surgical literature.

67. Dr. Saiz's deviations from the standard of care resulted in actual harm to the patient who was subjected to an unnecessary and unrecognized surgical procedure, and experienced chronic severe pain in the area after the surgery.

68. When Dr. Saiz recommended another operation to explore and repair what he continued to call a recurrent right flank hernia, the patient sought a second opinion from Dr. Daniel Para, who had performed the laparoscopic cholecystectomy on him in July 1999.

69. After obtaining a CT study that "suggests a recurrence of his hernia" and explaining the various treatment options to the patient, Dr. Para explored the patient's right flank laparoscopically.

70. During the procedure, Dr. Para noted "multiple adhesions...to the anterior wall" which he took down by blunt dissection and electrocautery. He did not find any evidence of "gross herniation" or "hernia recurrence." Dr. Para also noted an abnormality of the liver consistent with Chilaiditi syndrome, but "no other abnormalities."

71. In a follow-up office visit, Dr. Para noted that the patient "notices the weakness or bulge to his right side of his abdomen but there were no true hernia defects intra-abdominally."

72. Later, Dr. Para explained to the patient that he could not offer him any further surgical options for his chronic severe right flank pain and discharged the patient from his care.

Patient D.E.

73. At the hearing, Dr. Saiz admitted to all of the allegations concerning Patient D.E. in the State's complaint.

74. In July 2003, the Board initiated investigation number MD-03-0504 concerning Dr. Saiz's care and treatment of Patient D.E. after receiving notice pursuant to A.R.S.

§ 12-570 of the payment of a medical malpractice settlement. In December 2003 the Board's Executive Director referred the matter to the Office of Administrative Hearings for formal hearing.

75. Patient D.E., at the time a 57-year old male, was referred to Dr. Saiz in May 2001 for a surgical consultation. The patient had a history of hypertension, diabetes mellitus, hyperlipidemia and exogenous obesity.

76. A CAT scan on April 12, 2001 showed "[a] small asymmetrical enlargement of the left adrenal gland which most likely represents small left adrenal cyst."

77. A 24-hour urine study on May 14, 2001 showed normal levels of metanephrine, normetanephrine and total metanephrine.

78. Dr. Saiz recommended a laparoscopic left adrenalectomy.

79. Before performing the laparoscopic adrenalectomy, Dr. Saiz failed to perform or document an adequate history and physical examination of the patient, which was below the standard of care, was or may have been harmful or dangerous to the patient's health, or was inadequate.

80. On June 22, 2001, Dr. Saiz performed a laparoscopic left adrenalectomy, which was below the standard of care, was or may have been harmful or dangerous to the patient's health, or was inadequate. A post-operative pathological examination found "an essentially unremarkable adrenal gland."

81. During the laparoscopic procedure, Dr. Saiz perforated the patient's colon.

82. For a patient who presents with a mildly enlarged left adrenal gland that is proven to be chemically inactive and has no characteristics to suggest malignancy, such as was found with this patient, the standard of care requires a reasonably prudent surgeon to simply follow up with a repeat CT scan of the adrenal gland in three months.

83. Dr. Saiz acknowledged that if he had known there was only an adrenal cyst or non-functional adrenal adenoma, he would not have removed the patient's adrenal gland.

84. Dr. Saiz deviated from the standard of care by performing a laparoscopic adrenalectomy on the patient.

85. Following the laparoscopic adrenalectomy, the patient had a difficult post-operative course. Post-operative diagnostic studies performed between June 27 and July 1, 2001 showed the presence of free air in the abdomen beneath the diaphragm, indicating a perforated colon.

86. On July 2, 2001, Dr. Saiz performed an exploratory laparotomy to repair the perforated colon and cleanse the sepsis that had developed in the patient's abdominal cavity. He completed a small bowel resection with colostomy, appendectomy and omentectomy.

87. On July 7, 2001, Dr. Saiz performed a second exploratory laparoctomy to repair the colostomy and re-cleans abdominal cavity. He completed a colostomy repair, cholecystectomy and omentectomy.

88. On July 8, 2001, the patient was discharged from HRMC and transferred to a hospital in Phoenix for further intensive care management and later take down of the colostomy.

89. Dr. Saiz admitted that his deviations from the standard of care caused actual harm to the patient who was subjected to an unnecessary laparoscopic left adrenalectomy, a perforated colon, and subsequent surgeries to repair the perforation and cleanse the sepsis that developed in the patient's abdomen.

Medical Incompetence

90. The evidence of record supports a finding that Dr. Saiz's care and treatment of these four patients demonstrated medical incompetence as defined by law.

Previous Board Actions Against Dr. Saiz

91. When determining appropriate disciplinary action against a licensee, "the board shall consider all previous non-disciplinary and disciplinary actions against a licensee."

92. On December 10, 2001, following a formal interview with the Board pursuant to A.R.S. § 32-1451(H) and (I), the Board issued Dr. Saiz a non-disciplinary advisory letter for "improper management of a patient with suspected small bowel obstruction."

93. On May 19, 2003, following an administrative hearing pursuant to A.R.S. § 32-1451(J), the Board issued Dr. Saiz a stayed revocation with five-year probation for his inadequate record-keeping and grossly or repeatedly negligent care and treatment of seven patients. The Board also restricted Dr. Saiz from performing bariatric surgery and thoracic surgery without supervision.

Dr. Saiz's Privileges

94. Dr. Saiz testified at the hearing that he does not currently have active privileges at HRMC.[1]

95. The testimony at formal hearing demonstrated that Dr. Saiz is in compliance with the CPEP recommendations.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter and over Dr. Saiz pursuant to A.R.S. § 32-1401 *et seq.*

2. Pursuant to A.A.C. R2-19-119, the Board has the burden of proving the allegations against Dr. Saiz by a preponderance of the evidence.

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[1] Exhibit 66, admitted over the objection of the Respondent, corroborates Dr. Saiz's testimony that his privileges were not renewed by the hospital. With respect to the actual allegations set forth therein giving rise to the hospital's non-renewal of Dr. Saiz's privileges, said allegations were not considered by this tribunal in reaching its decision.

3. Dr. Saiz failed to maintain adequate medical records as defined by A.R.S. § 32-1401(2)[2] with respect to patients R.C., W.G., D.L. and D.E.

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(26)(e) (failing or refusing to maintain adequate records on a patient).

5. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Dr. Saiz pursuant to A.R.S. § 32-1401(26)(q) (any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public).

6. 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.

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(26)(ll) (conduct the board determines is gross negligence, repeated negligence or negligence resulting in harm to or death of a patient). It is further concluded that Dr. Saiz's actions described in the above Findings of Fact constitute repeated negligence but does not rise to the level of gross negligence as set forth in *Caldwell v. Arizona Board of Dental Examiners*, 137 Ariz. 396, 670 P2d 120 (App. 1983).

8. Medical incompetence is a lack of sufficient medical knowledge or skills, or both, to a degree likely to endanger the health of patients. A.R.S. 32-1401(18); *Board of*

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[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 continuity of the patient's care at any point in the course of treatment." A.R.S. § 32-1401(2).

Dental Examiners v. Brown, 448 A.2d 881 (Me. 1982) ("In common parlance, 'incompetence' means a lack of the learning or skill necessary to perform, day in and day out, the characteristic tasks of a given calling in at least a reasonably effective way. Competency does not mean perfection, and incompetence is not ordinarily established by the showing merely of an isolated instance in which performance has been inadequate....Unlike the comparison that is made in an action for malpractice, the comparison is made for the purpose of determining defendant's professional competence and skill in general, not merely his competence in the treatment of one particular patient.")

9. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Dr. Saiz pursuant to A.R.S. §§ 32-1401(18)(a) ("Medically incompetent" means a person who the board determines is incompetent based upon a variety of factors including: (a) A lack of sufficient medical knowledge or skills, or both, to a degree likely to endanger the health of patients) and 32-1451(M) (Any doctor of medicine who after a formal hearing is found by the board to be guilty of unprofessional conduct, to be physically or mentally unable safely to engage in the practice of medicine or to be medically incompetent is subject to censure, probation as provided in this section, suspension of license or revocation of license or any combination of these, including a stay of action, and for a period of time or permanently and under conditions as the board deems appropriate for the protection of the public health and safety and just in the circumstance.).

10. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Dr. Saiz pursuant to A.R.S. § 32-1401(26)(s) (violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision of this chapter.).

11. It is concluded, based upon the evidence of record, that Dr. Saiz should be charged the costs of the formal hearing in this matter, pursuant to A.R.S. § 32-1451(M).

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 ten years subject to the terms and conditions enumerated below. After the expiration of five years of the probationary period Dr. Saiz may petition the Board to have the remaining five years of the probationary period lifted. Upon any alleged violation of a probationary term, Dr. Saiz 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. The Board Order for Stayed Revocation dated April 14, 2003, effective May 19, 2004, remains in effect.

1. 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.

2. Dr. Saiz shall not perform any bariatric surgery, including "gut shortening" and excision of omentum for weight loss purposes.

3. Dr. Saiz shall not perform thoracic surgery without supervision.

4. Board staff shall conduct chart reviews of Dr. Saiz's charts every six months.

5. Dr. Saiz shall notify the Board within five business-days of his notification of any pending malpractice action or restriction in his privileges by any hospital or free-standing surgery center.

6. 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.

7. Dr. Saiz shall obey all federal, state and local laws, and all rules governing the practice of medicine in Arizona.

8. 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.

9. 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.

10. 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.

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.C.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 15th day of June 2004.

(SEAL)

ARIZONA MEDICAL BOARD

By: Barry A. Cassidy
Barry A. Cassidy, Ph.D., P.A.-C
Executive Director

Original of the foregoing filed this 15th day of June, 2004, with:

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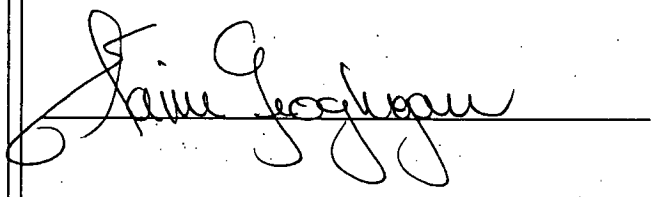
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