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8 **BEFORE THE ARIZONA MEDICAL BOARD**

9 In the Matter of:

10 **ABEDON SAIZ, M.D.,**

11 Holder of License No. 24387  
12 For the Practice of Allopathic Medicine  
13 In the State of Arizona,

14 Respondent.

) Board Case No. MD-03-0166

) **CONSENT AGREEMENT FOR  
STAYED REVOCATION AND  
PROBATION**

15 **RECITALS**

16 In the interest of a prompt and judicious settlement of this case, consistent with the  
17 public interest, statutory requirements and responsibilities of the Arizona Medical Board  
18 ("Board"), and pursuant to A.R.S. §§ 32-1451(F) and 41-1092.07(F)(5), the undersigned  
19 party, Abedon Saiz, M.D., holder of License No. 24387 to practice allopathic medicine in  
20 the State of Arizona ("Respondent"), and the Board enter into the following Recitals,  
21 Findings of Fact, Conclusions of Law and Order ("Consent Agreement") as the final  
22 disposition of this matter.

23 1. Respondent has read and understands this Consent Agreement as set forth  
24 herein, and has had the opportunity to discuss this Consent Agreement with an attorney or  
25 has waived the opportunity to discuss this Consent Agreement with an attorney. Respondent  
26 voluntarily enters into this Consent Agreement for the purpose of avoiding the expense and

1 uncertainty of an administrative hearing.

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

10           3. Respondent agrees that the Board may adopt this Consent Agreement, or any  
11 part thereof, pursuant to A.R.S. §§ 32-1451(F) and 41-1092.07(F)(5). Respondent under-  
12 stands that this Consent Agreement, or any part thereof, may be considered in any future  
13 disciplinary action against him.

14           4. Respondent understands that this Consent Agreement does not constitute a  
15 dismissal or resolution of other matters currently pending before the Board, if any, and does  
16 not constitute any waiver, express or implied, of the Board's statutory authority or  
17 jurisdiction regarding any other pending or future investigation, action or proceeding.  
18 Respondent also understands that acceptance of this Consent Agreement does not preclude  
19 any other agency, subdivision or officer of this state from instituting other civil or criminal  
20 proceedings with respect to the conduct that is the subject of this Consent Agreement.

21           5. Respondent acknowledges and agrees that, upon signing this Consent  
22 Agreement and returning it to the Board's Executive Director, Respondent may not revoke  
23 his acceptance of this Consent Agreement or make any modifications to it, regardless of  
24 whether this Consent Agreement has been issued by the Executive Director. Any  
25 modification to this original document is ineffective and void unless mutually approved by  
26 the parties in writing.

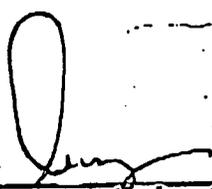
1 6. Respondent understands that the foregoing Consent Agreement shall not  
2 become effective unless and until adopted by the Board and signed by its Executive  
3 Director.

4 7. Respondent understands and agrees that if the Board does not adopt this  
5 Consent Agreement, he will not assert as a defense that the Board's consideration of this  
6 Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

7 8. Respondent understands that this Consent Agreement is a public record that  
8 may be publicly disseminated as a formal action of the Board, and shall be reported as  
9 required by law to the National Practitioner Data Bank and the Healthcare Integrity and  
10 Protection Data Bank.

11 9. Respondent understands that any violation of this Consent Agreement  
12 constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(24)(r)(violating a formal  
13 order, probation, consent agreement or stipulation issued or entered into by the board or its  
14 executive director under the provisions of this chapter) and may result in disciplinary action  
15 pursuant to A.R.S. § 32-1451.

16  
17  
18 DATED: 8/9/04

  
Abedon Saiz, M.D.

19  
20 Reviewed and Approved as to Form:

21  
22 By: Daniel P. Jantsch  
23 Dan Jantsch, Esq.

24 **FINDINGS OF FACT**

25 1. The parties stipulate that this Consent Agreement represents a compromise of  
26 a disputed matter between the Board and Respondent, and agree to the entry of this Consent

1 Order for the purpose of terminating that disputed matter.

2 2. The Board is the duly constituted authority for licensing and regulating the  
3 practice of allopathic medicine in the State of Arizona.

4 3. Respondent, is the holder of License No. 24387 for the practice of allopathic  
5 medicine in the State of Arizona.

6 4. On January 27, 2003, the Board initiated Investigation MD-03-0166A  
7 concerning Respondent's care and treatment of Patient J.M. after receiving a complaint  
8 from the patient's daughter about the quality of care rendered to her father.

9 5. Patient J.M., a 72-year old male, presented to Havasu Regional Medical  
10 Center ("HRMC") on April 25, 2001 with complaints of abdominal pain, abdominal  
11 distention and black stools. An esophagogastroduodenoscopy revealed a hiatal hernia with  
12 associated gastrointestinal bleeding. An abdominal CT scan revealed an 8cm abscess juxta-  
13 posed to the sigmoid colon, possibly secondary to ruptured diverticulitis. The abscess was  
14 treated with an intravenous antibiotic and the patient was discharged on May 1, 2001.

15 6. On May 7, 2001, the patient underwent a colonoscopy which noted extensive  
16 diverticulosis but no evidence of an abscess lesion or communication between the abscess  
17 and the colon.

18 7. On May 11, 2001, the patient again presented to HRMC with renewed com-  
19 plaints of abdominal discomfort. Respondent was asked to provide a surgical consultation.  
20 Repeat abdominal CT scans revealed little significant change in the abscess. However,  
21 Respondent did not review the results of the recent colonoscopy or order contrast radiology  
22 studies to determine whether the abscess communicated with the colon, which was negli-  
23 gent, and was or may have been harmful or dangerous to the patient's health. Furthermore,  
24 Respondent did not attempt to drain the abscess percutaneously, which was negligent, and  
25 was or may have been harmful or dangerous to the patient's health. Instead, Respondent  
26 again treated the abscess with antibiotics and discharged the patient on May 16, 2001 with

1 instructions to follow-up with him in two weeks.

2 8. On May 31, 2001, the patient had a follow-up visit with Respondent during  
3 which plans were made for the patient to undergo a colon resection.

4 9. On June 29, 2001, Respondent resected the patient's sigmoid colon and estab-  
5 lished a temporary colostomy. Before resecting the patient's colon, Respondent did not  
6 review the results of the colonoscopy or order contrast radiology studies to determine  
7 whether the abscess communicated with the colon, which was negligent, and was or may  
8 have been harmful or dangerous to the patient's health. In addition, Respondent did not  
9 attempt to drain the abscess percutaneously, which was negligent, and was or may have been  
10 harmful or dangerous to the patient's health.

11 10. Post-operative pathological examination found no evidence that the abscess  
12 communicated with the colon.

13 11. While the patient was in post-operative recovery, he experienced respiratory  
14 failure. He was emergently intubated and recovered without further incident. The patient  
15 was discharged on July 7, 2001.

16 12. Respondent's conduct resulted in actual harm to the patient, namely an  
17 unnecessary colon resection and temporary post-operative respiratory failure.

18 13. On September 20, 2001, Respondent removed a benign abdominal wall mass  
19 from the patient, which mass was thought to be a suture granuloma.

20 14. On December 20, 2001, the patient had a follow-up visit with Respondent  
21 during which plans were made for taking down the patient's colostomy. Respondent's  
22 office notes for that visit do not reflect that he discussed possible complications or alterna-  
23 tives to the surgery with the patient or the patient's family.

24 15. On February 4, 2002, Respondent performed a surgery to take down the  
25 patient's colostomy. Before performing that surgery, Respondent failed to perform or  
26 document an adequate history and physical examination of the patient, which was negligent,

1 was or may have been harmful or dangerous to the patient's health, or was inadequate  
2 record-keeping.

3 16. Following the surgery, between February 5-9, 2002, the nursing notes reflect  
4 that the patient experienced imbalanced fluid intake and output, diminished breath sounds,  
5 dyspnea, and rhonci. However, Respondent failed to adequately monitor and document the  
6 patient's fluid levels and respiratory symptoms, which was negligent, was or may have been  
7 harmful or dangerous to the patient's health, or was inadequate record-keeping.

8 17. On February 11, 2002, the patient developed respiratory failure secondary to  
9 nosocomial pneumonia and pulmonary edema. He was emergently intubated and transferred  
10 to the intensive care unit.

11 18. During the next week, the patient's condition continued to deteriorate.  
12 Eventually the patient and his family declined further artificial life support, and the patient  
13 died on February 19, 2002.

14 19. Respondent's conduct resulted in unreasonably increased risk of harm to the  
15 patient—namely the risk that the patient would develop pneumonia and respiratory distress,  
16 as well as actual harm to the patient—namely pneumonia and respiratory compromise which  
17 contributed to the patient's death.

#### 18 Previous Board Actions Against Respondent

19 20. When determining appropriate disciplinary action against a licensee, "the  
20 board shall consider all previous nondisciplinary and disciplinary actions against a  
21 licensee." A.R.S. § 32-1451(U).

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

25 22. On May 19, 2003, following an administrative hearing pursuant to A.R.S. §  
26 32-1451(D), the Board issued Respondent a stayed revocation with five-year probation for

1 his inadequate record-keeping and grossly or repeatedly negligent care and treatment of  
 2 seven patients. The Board also restricted Respondent from performing bariatric surgery and  
 3 thoracic surgery without supervision.

4 23. On June 10, 2004, following an administrative hearing pursuant to A.R.S. §  
 5 32-1451(J), the Board amended the May 19, 2003 stayed revocation to a ten-year probation  
 6 for his inadequate record-keeping and repeatedly negligent care and treatment of four  
 7 patients. The Board continued to restrict Respondent from performing bariatric surgery and  
 8 thoracic surgery without supervision.

9 CONCLUSIONS OF LAW

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

12 2. An adequate medical record is a "legible medical record" that contains "at a  
 13 minimum, sufficient information to identify the patient, support the diagnosis, justify the  
 14 treatment, accurately document the results, indicate advice and cautionary warnings provided  
 15 to the patient, and provide sufficient information for another practitioner to assume  
 16 continuity of the patient's care at any point in the course of treatment." A.R.S. § 31-1401(2).

17 3. The conduct and circumstances described above constitute unprofessional  
 18 conduct pursuant to A.R.S. § 32-1401(26)(e)(failing or refusing to maintain adequate  
 19 records on a patient).

20 4. The conduct and circumstances described above constitute unprofessional  
 21 conduct pursuant to A.R.S. § 32-1401(26)(q)(any conduct or practice that is or might be  
 22 harmful or dangerous to the health of the patient or public).

23 5. Negligence is a failure to exercise that degree of care, skill and learning  
 24 expected of a reasonable, prudent physician or specialist in Arizona in the same or similar  
 25 circumstances. A.R.S. §§ 1-215(25) and 12-563.

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6. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(26)(11)(conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or death of a patient).

ORDER

Based on the above findings of fact and conclusions of law and pursuant to the authority granted to the Board by A.R.S. § 32-1451(T),

IT IS HEREBY ORDERED that Respondent's license is placed on stayed revocation and probation, in accordance with all of the terms and conditions of the Board's previous Order of June 15, 2004.

DATED this 17<sup>th</sup> day of August, 2004.

ARIZONA MEDICAL BOARD

[SEAL]



By: Barbara J. Lane, Assistant  
for BARRY A. CASSIDY, Ph.D., P.A.-C Director  
Executive Director

1 ORIGINAL OF THE FOREGOING FILED  
this 18 day of August, 2004, with:

2 Arizona Medical Board  
3 9545 E. Doubletree Ranch Road  
4 Scottsdale, AZ 85258

5 EXECUTED COPY OF THE FOREGOING  
6 MAILED BY CERTIFIED MAIL  
this 18 day of August, 2004, to:

7 Abedon Saiz, M.D.  
8 329 Lake Havasu Avenue South  
9 Lake Havasu City, Arizona 86403-9368  
10 Respondent

11 EXECUTED COPIES OF THE FOREGOING MAILED  
12 this 18 day of August, 2004, to:

13 Dan Jantsch, Esq.  
14 OLSON JANTSCH & BAKKER, P.A.  
15 7234 North 16th Street  
16 Phoenix, Arizona 85020-7250  
17 Attorneys for Respondent

18 Stephen A. Wolf, Esq.  
19 Assistant Attorney General  
20 1275 W. Washington Street, CIV/LES  
21 Phoenix, AZ 85007  
22 Attorneys for the State of Arizona

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26  
  
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Planning & Operations