

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **LAURA HARRINGTON-ZAUTRA, M.D.**

4 Holder of License No. **24671**
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-04-0198A

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

(Letter of Reprimand)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting
8 on April 13, 2005. Laura Harrington-Zautra, M.D., ("Respondent") appeared before the
9 Board with legal counsel Kraig Marton for a formal interview pursuant to the authority
10 vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following
11 findings of fact, conclusions of law and order after due consideration of the facts and law
12 applicable to this matter.
13

14 **FINDINGS OF FACT**

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

17 2. Respondent is the holder of License No. 24671 for the practice of allopathic
18 medicine in the State of Arizona.

19 3. The Board initiated case number MD-04-0198A after receiving a complaint
20 regarding Respondent's interactions with a 47 year-old female patient ("VS"). The
21 complaint alleged that Respondent violated physician-patient boundaries by allowing VS
22 to live in her home for a three month period. During this time Respondent filed a
23 complaint with the Chandler Police Department alleging VS assaulted Respondent's eight
24 year-old son by throwing a candle at him.

25 4. VS first presented to Respondent on April 3, 2002 and was diagnosed with
Post-Traumatic Stress Disorder and Major Depressive Disorder; Borderline Personality

1 Disorder; and a global assessment of function ranging from thirty to fifty. Respondent
2 and VS began an intensive psychotherapy program that lasted for eighteen months. In
3 September 2003, Respondent offered VS safe harbor in Respondent's home after VS
4 stated she had no family, friends or safe place to go. VS reported no shelter would
5 accept her because of her psychiatric condition. In her initial response to the Board,
6 Respondent recognized having VS stay in her home presented a significant professional
7 boundary issue, but at the time it seemed like the only humane, ethical, and moral thing
8 to do.

9 5. At the formal interview Respondent testified she regretted the apparent
10 violation of the patient-doctor boundary, however, she asked the Board to put her
11 violation in the context of compassion and humanity. Respondent testified she is a solo
12 practitioner in psychiatry in an underserved area of Phoenix. Respondent testified her
13 act was a conflict of her spiritual ethics versus the ethics of the practice of psychiatry.
14 Respondent stated circumstances were such during VS's last four visits that she had
15 come to Respondent black and blue, beat up – at one point she had a broken rib.
16 Respondent testified VS had received a death threat written on a death certificate pasted
17 to her door. Respondent stated these occurrences were happening to VS every Friday
18 night and when she saw VS as her last patient on a Friday night she felt if she sent VS
19 home, she was sending her home to another beating, if not death. Respondent testified
20 she called four different shelters to get VS housing, but none of them would accept her
21 because of her psychiatric condition. Respondent stated it was getting late in the
22 evening and she believed the only humane thing to do was offer VS shelter.

23 6. Respondent testified she had no malicious intent and she intended for VS
24 to stay only a short time until VS could get an alarm installed in her home, something VS
25 said she would do that weekend. Respondent stated she did not benefit from VS's

1 presence in her home, did not require any household responsibilities of VS, and did not
2 conduct VS's therapy in her home. Respondent stated VS's stay was extended because
3 of two serious illnesses during the course of her stay that prevented Respondent from
4 asking her to leave. Respondent testified that after she received notice from the Board of
5 the complaint, she sought counseling for herself and set up meetings to learn more about
6 medical ethics. Respondent testified she also got a primer from the American Psychiatric
7 Association on medical ethics and did an in-depth review of patient-doctor boundaries as
8 they pertain to the practice of psychiatry.

9 7. The Board noted Respondent completed her residency in 2002 and asked
10 her what exposure she had during her residency to boundary issues. Respondent
11 testified there were didactics in boundary issues, as well as in her clinical evaluations or
12 mentoring. Respondent agreed that the American Psychiatric Association has fairly
13 extensive guidelines published regarding ethical and boundary issues in patient care, but
14 noted they were usually related to sexual misconduct or interactions between the patient
15 and doctor and only one page addressed relationships outside of the therapeutic
16 relationship.

17 8. Respondent testified VS was a fairly impaired patient, with Major
18 Depressive Disorder. Respondent was asked what potential damage could have been
19 done to her ability to be effective as VS's therapist by Respondent crossing the boundary
20 between her relationship as the therapist to the interpersonal relationship where VS was
21 living in her home. Respondent testified that under normal circumstances, if VS's life
22 were not threatened, crossing the boundary could possibly impair the effectiveness of her
23 treatment of VS. Respondent noted prior to VS coming to her home she sat with her and
24 told her they were going to keep separate Respondent's providing safe haven from VS's
25

1 therapeutic treatment and she made every effort possible to continue the quality of care.
2 Respondent testified nothing impeded the quality of care at that time.

3 9. Respondent testified VS stayed in an extra bedroom. Respondent testified
4 VS was independent and Respondent went on with her structured life and VS came and
5 went independent of Respondent. Respondent stated VS had her own key. Respondent
6 testified she and VS occasionally had meals together. Respondent was asked if VS was
7 employed during this time, and if not, how she spent her days. Respondent testified VS
8 was not employed and was on disability. Respondent testified VS slept a lot of the days,
9 was ill a lot of the days she was with Respondent. Respondent stated VS did investigate
10 getting her own home fixed up and getting an alarm so she could move back home.

11 10. Respondent was asked to explain what illnesses VS had while she was
12 staying with Respondent. Respondent testified VS had kidney stones, and on a second
13 occasion, a severe urinary tract infection. Respondent stated she had to convince VS to
14 seek medical attention for these illnesses. Respondent was asked if she took on a
15 mother role for VS. Respondent testified she supposed she subconsciously had, but she
16 saw a woman suffering that needed medical care and she did her best to help her get
17 that care. Respondent was asked if VS had a primary care physician treating her
18 diabetes. Respondent testified VS did not have a primary care physician until she got
19 AHCCCS. Respondent was asked if it is part of an appropriate psychiatric practice when
20 a patient has significant medical issues to ensure the patient gets a primary care
21 physician or other physician to deal with the medical illnesses. Respondent testified it
22 was and that she attempted to do so, but VS refused. Respondent was asked if VS's
23 refusal was part of her global psychiatric illness. Respondent testified it was.

24 11. Respondent was asked to explain exactly what she did to get VS into a
25 shelter. Respondent testified she got on the Internet and looked for women's shelters in

1 Phoenix and called four different shelters. Respondent could not recall which shelters
2 she had called. Respondent was asked if she had ever successfully placed a patient in a
3 shelter. Respondent testified she had, but only about three times. Respondent testified
4 that, although VS had a case worker, the case worker was not actively involved in her life
5 and did not answer calls or desire to participate in VS's care. Respondent testified she
6 contacted VS's case worker. Respondent was asked where in her record she
7 documented doing so. Respondent testified that she did not document the contact.
8 Respondent was asked if she attempted to call Adult Protective Services. Respondent
9 testified she had not, but she had encouraged VS to call the police many times.

10 12. Respondent was asked how she was going to handle the next patient who
11 ended up in a situation similar to that of VS. Respondent testified her experience with VS
12 has taught her to separate her spiritual values from her medical practice in the sense that
13 she cannot allow her spiritual values to supersede the guidelines of the medical
14 community. Respondent testified she will put more effort into getting such a patient into a
15 women's shelter, a homeless shelter, or an alternative setting. Respondent was asked to
16 clarify why, when VS's illnesses seemed to account for two weeks of the time she spent
17 in Respondent's home, VS remained for a total of twelve weeks. Respondent testified
18 VS was preparing to move back home during this time and Respondent did not feel VS
19 would be safe if asked to leave.

20 13. The standard of care required Respondent to observe appropriate
21 boundaries with her patient.

22 14. Although intending to protect VS, Respondent deviated from the standard of
23 care by failing to observe these boundaries when she allowed her patient to live in her
24 home for a twelve week period.

25

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

3 DATED this 9th day of JUNE, 2005.

4
5 THE ARIZONA MEDICAL BOARD

6
7 By 
8 TIMOTHY C. MILLER, J.D.
9 Executive Director

10 ORIGINAL of the foregoing filed this
11 9th day of JUNE, 2005 with:

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

15 Executed copy of the foregoing
16 mailed by U.S. Certified Mail this
17 9th day of JUNE, 2005, to:

18 Kraig Marton
19 Jaburg & Wilk, P.C.
20 3200 North Central – Suite 2000
21 Phoenix, Arizona 85012-2415

22 Executed copy of the foregoing
23 mailed by U.S. Mail this
24 9th day of JUNE, 2005, to:

25 Laura Harrington-Zautra, M.D.
Address of Record

