

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

6 6. All admissions made by Respondent are solely for final disposition of this
7 matter and any subsequent related administrative proceedings or civil litigation involving
8 the Board and Respondent. Therefore, said admissions by Respondent are not intended
9 or made for any other use, such as in the context of another state or federal government
10 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or
11 any other state or federal court.

12 7. Upon signing this agreement, and returning this document (or a copy thereof) to
13 the Board's Executive Director, Respondent may not revoke the acceptance of the
14 Consent Agreement. Respondent may not make any modifications to the document. Any
15 modifications to this original document are ineffective and void unless mutually approved
16 by the parties.

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

20 9. This Consent Agreement, once approved and signed, is a public record that will
21 be publicly disseminated as a formal action of the Board and will be reported to the
22 National Practitioner Data Bank and to the Arizona Medical Board's website.

23 10. If any part of the Consent Agreement is later declared void or otherwise
24 unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force
25 and effect.

1 11. Any violation of this Consent Agreement constitutes unprofessional conduct
2 and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order,
3 probation, consent agreement or stipulation issued or entered into by the board or its
4 executive director under this chapter") and 32-1451.

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6 
7 _____
8 JAMES L. SAMESHIMA, M.D.

DATED: 12/13/06

1 **FINDINGS OF FACT**

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

4 2. Respondent is the holder of license number 24707 for the practice of
5 allopathic medicine in the State of Arizona.

6 3. The Board initiated case number MD-06-0235A after receiving a complaint
7 regarding Respondent's care and treatment of a ninety year-old female patient ("DS").

8 4. On January 11, 2005 DS, a resident of an adult care home, presented to
9 Respondent with Alzheimer's dementia, hypertension, and a history of subarachnoid
10 hemorrhage and chronic subdural hematomas. Respondent noted DS's medications as
11 Reminyl 8mg BID, Lasix 40mg QD, Toprol XL 50mg QD, and KC1 10mEq QD.
12 Respondent started DS on Namenda, but discontinued it on January 25, 2005 because DS
13 complained of nausea.

14 5. On November 3, 2005 DS's son contacted Respondent requesting increased
15 care for DS's dementia because in October 2005 DS was hospitalized twice after a fall and
16 loss of consciousness. DS was diagnosed with a small subarachnoid hemorrhage on her
17 first hospitalization and during the second hospitalization hospital staff noted DS had an
18 onset seizure disorder and bilateral symmetrical subdural hygromas with a resolution of
19 the hemorrhage.

20 6. On November 10, 2005 Respondent authorized the transfer of DS and her
21 husband ("TS"), also Respondent's patient, to a nursing facility. The adult care home
22 where the couple previously lived typed a list of medications taken by DS (Toprol XL,
23 Reminyl, Lasix, and KC1) and TS (Warfarin, Levothyroxine, KC1, Glipizide, Lasix, Lipitor,
24 Lisinopril and Lanoxin) and provided the list to the nursing facility. The list also contained a
25 handwritten addition to DS's list of Phenytoin sodium, an anticonvulsant to treat epilepsy.

1 The nursing facility then faxed Respondent a medication verification form purportedly for
2 DS, but it listed TS's medications and asked Respondent "How often do you want PT/INRs
3 [prothrombin time/international normalized rations]?" Respondent did not confirm the
4 medications listed, signed the form, and returned it to the nursing facility without realizing
5 the nursing facility's error of listing TS's medications under DS's name. The nursing facility
6 administered TS's medications, including Warfarin (an anticoagulant Coumadin derivative)
7 to DS. Had Respondent responded to the nursing facility's request for PT/INR studies he
8 may have realized her medication was not appropriate.

9 7. On November 26, 2005 DS was admitted to the hospital for altered mental
10 status. The on-duty physician ("Physician") noted DS had a history of seizure disorder and
11 atrial fibrillation on Coumadin. Physician also noted her medications were Reminyl, Lasix,
12 Toprol, Potassium, Digoxin, Glipizide, and Thyroxine (her husband's medications) and she
13 had an INR of 2.9. Physician ordered a computed tomography ("CT") showing bilateral
14 frontal hygromas that had not changed since DS's October 2005 hospitalization. An
15 electroencephalogram did not reveal seizure activity. Physician diagnosed DS with a
16 urinary tract infection and discharged her on Nystatin, Lisinopril, Digoxin, and three doses
17 of Ciprofloxacin. Physician did not list Coumadin as a medication, but DS's charts
18 indicated Coumadin was continued and Dilantin – used for preparation of Phenytoin
19 sodium– was not. DS continued to receive the medications ordered on the medication
20 verification form dated 11/18/2005.

21 8. On December 16, 2005 the nursing facility initiated hospice care for DS
22 because she was not eating. On December 17, 2005 DS was taken to the emergency
23 room after her family received a bill for her medications and noticed they were not the
24 correct medications. In the emergency room DS's PT was greater than 100 seconds and a
25 CT scan showed rehemorrhage into the chronic subdural hematomas.

1 9. DS died on December 18, 2005.

2 10. An autopsy report noted the cause of death as a subdural hematoma
3 secondary to inadvertent administration of Coumadin with hypertension and dementia.

4 11. The standard of care during transfer of a patient from one facility to another
5 requires a physician to review and rewrite orders, including medications.

6 12. Respondent deviated from the standard of care because he did not verify the
7 medication list with his orders at the time DS was transferred from the adult care home to
8 the nursing facility. Respondent signed a verification form resulting in administration of the
9 wrong medications to DS.

10 13. The inadvertent administration of Coumadin worsened DS's subdural
11 hematomas and contributed to her death. DS could have potentially suffered from
12 hypoglycemia from the inadvertent administration of an oral hypoglycemic that could have
13 contributed to her decreased level of consciousness.

14 **CONCLUSIONS OF LAW**

15 1. The Board possesses jurisdiction over the subject matter hereof and over
16 Respondent.

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

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

24 **ORDER**

25 IT IS HEREBY ORDERED THAT:

1 1. Respondent is issued a Letter of Reprimand for failure to verify appropriate
2 administration of medications and for failure to appropriately monitor medications for side
3 effects.

4 2. This Order is the final disposition of case number MD-06-0235A.

5 DATED AND EFFECTIVE this 9th day of February, 2008. 7

6
7 (SEAL)



ARIZONA MEDICAL BOARD

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10 By 

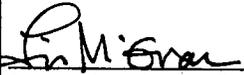
TIMOTHY C. MILLER, J.D.
Executive Director

11 ORIGINAL of the foregoing filed
12 this 9th day of February, 2008 with:

13 Arizona Medical Board
14 9545 E. Doubletree Ranch Road
15 Scottsdale, AZ 85258

16 EXECUTED COPY of the foregoing mailed
17 this 9th day of February, 2008 to:

18 James L. Sameshima, M.D.
19 Address of Record

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Investigational Review