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**BEFORE THE ARIZONA MEDICAL BOARD**

In the Matter of  
**ZULFIQAR FAROOQUI, M.D.**  
Holder of License No. **24737**  
For the Practice of Allopathic Medicine  
In the State of Arizona.

Board Case No. MD-05-0124B

**FINDINGS OF FACT,  
CONCLUSIONS OF LAW AND ORDER**  
(Letter of Reprimand and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on October 11, 2006. Zulfiqar Farooqui, M.D., ("Respondent") appeared before the Board with legal counsel Edwin M. Gaines, Jr. for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

**FINDINGS OF FACT**

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
2. Respondent is the holder of License No. 24737 for the practice of allopathic medicine in the State of Arizona.
3. The Board initiated case number MD-05-0124B after receiving a complaint from a thirty-five year-old female patient ("MM") alleging Respondent failed to notify her of abnormal laboratory tests and failed to follow-up and conduct repeat tests. MM presented to Respondent on February 22, 2003 when she was thirty years-old for a complete checkup prior to going through a fertilization process. The Board is in possession of two different medical records of this visit – one provided by MM and one by Respondent. There are also two different urinalyses from February 22, 2003. During the February 22, 2003 visit Respondent ordered a complete blood count ("CBC") as part of his workup. The CBC was abnormal and showed a low white count and

1 macrocytic indices. During the course of the Board's investigation medical records trickled into  
2 the Board for review. Ultimately the Board received four copies of the February 22, 2003 CBC,  
3 none of which was the original report and instead were generated on either November 5, 2003 or  
4 January 23, 2004. A careful review of the four copies shows each has a different notation.  
5 Respondent had two prior CBCs in MM's chart – one from February 3, 2000 and another from  
6 November 5, 2002 – both of which were abnormal with low white blood counts and macrocytic  
7 indices.

8 4. MM saw an obstetrician-gynecologist and reproductive specialist and underwent  
9 assisted fertilization in the fall of 2003. In January 2004 she became critically ill with severe blood  
10 disorders and required a therapeutic abortion as part of her treatment. In 2004, a hematologist,  
11 after reviewing all of MM's past CBCs and the then-current medical data, diagnosed her with  
12 hereditary spherocytosis and ITP. During interviews with Board Staff during the investigation of  
13 this case Staff found Respondent less than clear regarding the discrepancies within his medical  
14 record.

15 5. Respondent testified he first saw MM for the general checkup and a CBC was  
16 drawn that showed MM's red blood count was 137,000, but the complication that required the  
17 termination of her pregnancy was low red blood cell counts, TTP, and she had low white blood  
18 cell counts and cyclic neutropenia. Respondent testified MM had two previous white blood cell  
19 counts done by another physician and they were low. Respondent stated MM had a history of  
20 low white blood cell count for years, but she never had low red blood count in her life.  
21 Respondent testified he never cleared MM on February 22 for an infertility workup and she had  
22 been treated with infertility drugs by other physicians. Respondent noted he had experts review  
23 the case and they found there was absolutely no clinical relationship, direct or indirect, between  
24 the blood values drawn February 22, 2003 and the determination of TTP diagnosed one year  
25 later and resulting in the termination of pregnancy.

1           6.       Respondent testified he made a new record for MM at a later date, but did not  
2 post-date the record. The Board asked if the new record was made to clarify thoughts in his mind  
3 or to cover his tracks in a fraudulent manner. Respondent testified he did not have the older  
4 record and he created the new record from his memory and did not identify non-  
5 contemporaneous entries. The Board clarified the record MM supplied was the original one and  
6 the one Respondent supplied was created from his recollection. Respondent testified when he  
7 sent all his records to storage this record was missing from the chart so it was made  
8 approximately eight months later. The Board asked how often Respondent does something like  
9 this with a record. Respondent testified it was the first time and probably the last time. There  
10 were approximately four different lab values or print-outs for the same set of lab values and on  
11 one set there is no notation other than circling and on another there is a notation of "SWTP," that  
12 the Board assumed meant "spoke with the patient" and this note was added at a later time.  
13 Respondent testified he added this before he sent the record to storage. The Board asked if  
14 Respondent actually spoke with MM about the lab values. Respondent testified he did not speak  
15 with her on the same day, but his recollection was that he spoke to MM before then. Respondent  
16 had no log record of that conversation and MM denied any conversation took place.

17           7.       When Respondent saw MM he did not have a practice of logging patient calls  
18 either in-coming or out-going. Respondent testified he documented conversations in his chart.  
19 The Board noted it already discussed this issue and determined what he documented in the chart  
20 was postdated and not documented contemporaneously. MM's lab results show a low white  
21 count and enlarged cells and the platelets were normal. The Board asked if Respondent had any  
22 documentation that he ever notified MM that the labs needed to be repeated or that there may be  
23 abnormal values. Respondent testified he did not remember.

24           8.       MM said she went to Respondent for a checkup to make sure she was appropriate  
25 to go ahead with a fertilization procedure, but Respondent's recollection was that she came in for

1 a different complaint. Respondent testified MM came to him for a general checkup and she never  
2 came back. Respondent testified MM never mentioned a fertility workup and, if she had, normally  
3 he sends his record to the doctor doing the fertility treatment. Respondent testified when MM's  
4 husband came in for her record the chart was not available and this is where the problem  
5 happened because he printed the labs off his computer right away after the husband said it was  
6 an emergency and at that time he circled the copy saying MM needed to make sure to recheck  
7 again in two weeks. Respondent testified he never hesitated to give labs to a patient and that is  
8 why there are so many copies. Apparently labs were ordered and the allegation is that the  
9 abnormal lab values were not noted and no one was notified. The Board confirmed at the time of  
10 MM's visit Respondent's office policy was not to notify patients about lab values unless they were  
11 abnormal. When MM did not hear from Respondent she assumed she had clearance to go  
12 ahead with the fertility treatment. Respondent testified he notifies of abnormal lab values and,  
13 when the patient comes in, he discusses them in detail. Respondent testified MM showed up for  
14 her appointment and she started looking at fertility treatment without his clearance.

15 9. The Board directed Respondent to the medical record on page 49 of MM's  
16 complaint that indicated MM was there for a complete checkup and frequent urination. The  
17 pluses or minuses in the record indicated Respondent looked at the issue and it is either positive  
18 or negative. The Board asked Respondent to explain why there were two different values for the  
19 urine results. Respondent testified the second one was from the non-contemporaneous entities  
20 that were missing at the time the record was going into storage. Respondent testified his current  
21 office policy is to notify patients of normal and abnormal lab results and they log the phone calls  
22 made to patients.

23 10. Respondent testified he first saw MM on the February 22, 2003 visit, but she had  
24 seen his wife previously under a maiden name. The Board directed Respondent to page ten of  
25 his response to the Board containing a July 13, 2001 medical record that has an entry under

1 "Family History" for "sister" and it says "Sister has thalassemia" and asked Respondent how  
2 thalassemia, a significant congenital hemoglobinopathy, is transmitted. Respondent testified it  
3 was transmitted by gene. The Board asked if the gene was recessive or dominant, in other words  
4 did it have any bearing for MM and did it have any relationship with hereditary spherocytosis.  
5 Respondent testified it did and he remembered there is some relationship between her  
6 spherocytosis and thalassemia. Respondent noted the July 13 entry was made by his wife.  
7 Respondent was in possession of information that would have helped make the diagnosis, yet  
8 failed to order appropriate tests or consultations.

9 11. The standard of care required Respondent to follow-up on the abnormal lab values  
10 and notify the patient and other treating physicians of these values.

11 12. Respondent deviated from the standard of care because he did not follow-up on  
12 the abnormal lab values or notify other treating physicians and it is not clear whether he notified  
13 the patient.

14 13. MM underwent fertilization despite her hematologic abnormalities that were  
15 unknown to her other treating physicians and she had a pregnancy complicated by a severe  
16 blood disorder that caused her to become critically ill and required a therapeutic abortion.

#### 17 CONCLUSIONS OF LAW

18 1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof  
19 and over Respondent.

20 2. The Board has received substantial evidence supporting the Findings of Fact  
21 described above and said findings constitute unprofessional conduct or other grounds for the  
22 Board to take disciplinary action.

23 3. The conduct and circumstances described above constitutes unprofessional  
24 conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice which is or might be  
25 harmful or dangerous to the health of the patient or the public"); A.R.S. § 32-1401(27)(t)

1 (“[k]nowingly making any false or fraudulent statement, written or oral, in connection with the  
2 practice of medicine. . . .”); and A.R.S. § 32-1401(jj) (“[k]nowingly making a false or misleading  
3 statement to the board or on a form required by the board or in a written correspondence,  
4 including attachments, with the board”).

5 **ORDER**

6 Based upon the foregoing Findings of Fact and Conclusions of Law,

7 IT IS HEREBY ORDERED:

8 1. Respondent is issued a Decree of Censure for knowingly making false or fraudulent  
9 statements in connection with the practice of medicine, knowingly making a false or misleading  
10 statement to the Board, and for failing to adequately follow up on abnormal lab tests.

11 2. Respondent is placed on probation for one year with the following terms and  
12 conditions:

13 a. Respondent shall obtain 10 total hours of Board Staff pre-approved Category I  
14 Continuing Medical Education (“CME”) in ethics. Respondent shall provide Board Staff with  
15 satisfactory proof of attendance. The CME hours shall be in addition to the hours required for  
16 biennial renewal of medical license.

17 3. Respondent shall obey all federal, state, and local laws and all rules governing the  
18 practice of medicine in Arizona.

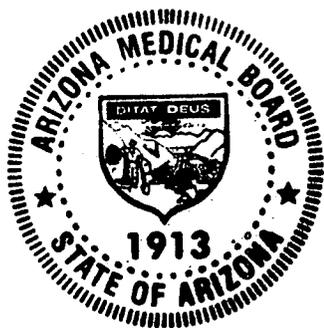
19 4. In the event Respondent should leave Arizona to reside or practice outside the  
20 State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall  
21 notify the Executive Director in writing within ten days of departure and return or the dates of non-  
22 practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during  
23 which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent  
24 residence or practice outside Arizona or of non-practice within Arizona, will not apply to the  
25 reduction of the probationary period.

1 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

2 Respondent is hereby notified that he has the right to petition for a rehearing or review.  
3 The petition for rehearing or review must be filed with the Board's Executive Director within thirty  
4 (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review  
5 must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103.  
6 Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a  
7 petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35)  
8 days after it is mailed to Respondent.

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

11 DATED this 7<sup>th</sup> day of December 2006.



THE ARIZONA MEDICAL BOARD

17 By *Timothy C. Miller*  
18 TIMOTHY C. MILLER, J.D.  
19 Executive Director

20 ORIGINAL of the foregoing filed this  
21 8<sup>th</sup> day of December, 2006 with:

22 Arizona Medical Board  
23 9545 East Doubletree Ranch Road  
24 Scottsdale, Arizona 85258

Executed copy of the foregoing  
21 mailed by U.S. Certified Mail this  
22 8<sup>th</sup> day of December, 2006, to:

23 Edwin M. Gaines, Jr.  
24 Chandler & Udall, LLP  
25 33 N. Stone, Suite 2100  
Tucson, Arizona 85701-1415

1 Zulfiqar Farooqui, M.D.  
2 Address of Record

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*L. M. Grant*

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