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**BEFORE THE ARIZONA MEDICAL BOARD**

In the Matter of  
**SUDHIR K. GOEL, M.D.**  
Holder of License No. **27103**  
For the Practice of Allopathic Medicine  
In the State of Arizona.

Board Case No. MD-05-1119A

**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. Sudhir K. Goel, M.D., ("Respondent") appeared before the Board with legal counsel Paul J. Giancola 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. 27103 for the practice of allopathic medicine in the State of Arizona.
3. The Board initiated case number MD-05-1119A after receiving a complaint from a forty-five year-old female patient ("MG") alleging Respondent failed to treat her back pain and arthritis. Respondent saw MG nineteen times from November 29, 2004 to June 24, 2005. Respondent's records revealed he documented visits with MG at weekly to bi-weekly intervals for what appeared to be a chronic problem; his medical records appeared to be from a template because the physical examination is essentially the same each visit with little deviation; several of the visits mention MG's complaint of knee arthritis, yet Respondent's examination says only "no

1 leg edema;" and Respondent's notes say "making progress" often as the chief complaint, but  
2 there are no benchmarks as to what this means.

3 4. Respondent disagreed with the summary of the case presented by Board Staff and  
4 stated his chart had not been reviewed very well. Respondent noted MG came to his practice  
5 where he works with his wife and they followed her for almost one year. Respondent's wife  
6 initially evaluated MG and she came to see Respondent on an emergent basis and then insisted  
7 he assume her care. Respondent noted MG often missed appointments and then appeared  
8 without any appointment and presented with a new complaint or problem on every visit and he  
9 documented this in her chart. Respondent noted at one visit MG complained of missed menstrual  
10 periods, another time of nausea and vomiting, then stress incontinence, among other things.  
11 Respondent testified MG's first visit with him was for knee pain as documented in his chart and  
12 that MG had three chronic issues – back pain, anxiety, and hypothyroidism – and he followed her  
13 for all three. Respondent stated he referred her to specialists and authorized MRIs, both  
14 documented in the chart, but MG never went to a specialist and never obtained the MRI.  
15 Respondent noted MG also filed a complaint against his wife.

16 5. Respondent is trained in internal medicine and nephrology and in 2004 was a  
17 primary care physician. The Board directed Respondent to his record of MG's November 29,  
18 2004 visit and noted the subjective complaint he documented was that MG was picking up blocks  
19 from a squatting position and her right knee became very painful and her back hurt. The Board  
20 asked what a complaint of back pain and knee pain while trying to get up from squatting  
21 indicated. Respondent testified the back pain was a continued complaint and MG came to see  
22 him for the knee pain and what it meant to him was that MG either somehow misused her joint,  
23 hurt a muscle, stretched a ligament, or had some injury to the knee joint. Respondent testified  
24 squatting is not very common because it is not very comfortable to do and is stressful on the knee  
25 joint. Respondent's observation of MG began when she walked into room and he looked for

1 whether she was walking okay, placing weight on the knee, limping, or crying from pain.  
2 Respondent stated he wanted to figure out exactly what happened – was there a trauma  
3 involved, was she in an accident, did she fall from a ladder. Respondent's differential diagnosis  
4 when a patient complains of knee pain is whether there is a fracture or dislocation, if there is any  
5 ligamented knee, instability of the joint, an infection, whether it is related to back issues, and  
6 whether there is nerve involvement or signs of cord compression.

7         6.       The Board directed Respondent to his objective findings where he noted MG's  
8 right knee looked swollen and she would not let him do any examination and asked what  
9 Respondent thought he should do at that time. Respondent testified that as he remembered it,  
10 he did examine her and felt comfortable there were no broken bones and MG was able to bear  
11 her weight. Respondent stated he has been practicing for twenty-five years and has extensive  
12 experience in back and knee pain, with family practice being his dominant practice. Although  
13 Respondent testified he examined MG, the only thing written in his objective findings is "[MG]  
14 would not let [him] do a passive range of motion. [He did] not feel any broken bones at this time."  
15 The Board asked Respondent what his plan was for MG. Respondent testified he first wanted to  
16 determine whether or not she had a life threatening injury and then whether or not she had a  
17 fracture, whether MG could remain on an out-patient basis, and whether she could be managed  
18 with conservative treatment. Respondent testified X-rays confirmed his assessment.  
19 Respondent also planned to follow MG soon and, although it is not documented, she refused  
20 several times to go to the emergency room. The Board asked if Respondent examined MG's  
21 back. Respondent testified MG was first seen for her back pain by his wife and his wife  
22 documented MG had a back problem since 2001 and had epidural injections. Respondent  
23 testified MG came in for an acute problem with her knee and that is what he focused on.

24         7.       The Board asked whether Respondent should have done a back examination  
25 knowing MG had back problems. Respondent stated MG had been seen by his wife who had

1 done a thorough physical examination and addressed the back issue and he did not feel MG's  
2 back was the immediate issue because her acute problem was the knee pain. Respondent  
3 prescribed Naprosyn and Prilosec at this visit. Respondent prescribed the Prilosec because MG  
4 insisted she could not take Naprosyn because her stomach hurt. Respondent also assessed  
5 anxiety and testified his wife was treating the anxiety and, at that time, MG was primarily his  
6 wife's patient and only came to him for the emergency because his wife was not in the office.

7 8. MG's next visit to Respondent was on December 2 and he noted subjective  
8 complaints of right knee pain, responding well to treatment, back pain stable, and anxiety level  
9 stays under control. MG's knee pain improved and Respondent was addressing her back pain,  
10 chronic issues, and anxiety level. MG's blood work was done and revealed a normal TSH level  
11 indicating her hypothyroidism was under control. The Board asked Respondent his findings on  
12 the knee examination. Respondent noted MG's X-rays showed no bone injury and there was no  
13 soft tissue injury. The Board noted Respondent's chart says MG's knee pain is stable and  
14 responding to the non-steroidal and she would continue with the treatment and asked  
15 Respondent to explain his objective findings under "extremities" that say only there is "no leg  
16 edema," but there is no knee examination documented. Respondent testified that from his note  
17 and knowing himself he went quickly to the information he noted in his mind and he felt she was  
18 resolved and should remain resolved. Respondent testified MG's swelling had disappeared, her  
19 pain was gone, she was responding well to the medication, her X-ray was normal and, if there  
20 was anything to mention, he would have mentioned it. Respondent also stated his note of "no leg  
21 edema" was more in relation to his systemic examination, whether MG had heart or kidney failure  
22 and that is the only purpose of mentioning the leg – it had nothing to do with the knee pain. The  
23 Board asked where Respondent's documentation was for the knee finding. Respondent directed  
24 the Board to include the X-ray finding in his note. An X-ray finding is not an examination of the  
25 knee. Respondent testified he had no direct documentation of his knee finding.

1           9.       The Board asked why Respondent continued the analgesics with no diagnosis of  
2 any pathology in the knee joint. Respondent testified MG was only on Prilosec and Naprosyn and  
3 he added Percocet at the December 2 visit because she wanted to go back to work and needed  
4 pain medication to be stable. The Board asked why he chose to give MG Percocet on December  
5 2. Respondent testified MG always refused to take nonsteroidals because they hurt her stomach  
6 and she would not take medication that was not relieving her pain so he recommended a small  
7 amount of Percocet and gave her seven pills. Respondent told MG to take one pill only when she  
8 had more pain or pain that was not controlled by the Naprosyn. MG returned in six days.  
9 Respondent believed this visit was a walk-in and MG complained she was not having her  
10 menstrual cycle for the last three months and denied being pregnant. Respondent was reading  
11 MG's subjective complaints and the Board asked for his objective findings – what did he do.  
12 Respondent testified his objective findings were that MG remained alert and oriented, her vital  
13 signs were stable, her lungs were clear to auscultation, her heart remained stable, her four  
14 quadrant abdominal examination was normal, there were no localized findings, and there was no  
15 leg edema. Respondent's assessment was that MG had a right knee injury and was responding  
16 to medication. Respondent testified he gave her Prilosec and Naprosyn for two more weeks.

17           10.       The Board directed Respondent to MG's next visit on December 22 when she  
18 complained of diarrhea, back pain and nausea and asked what kind of work-up is needed to  
19 evaluate these complaints. Respondent claimed MG complained of back pain on every visit, but  
20 there was no neurological examination. Respondent testified he had examined MG and was  
21 trying to get an MRI, had already obtained X-rays of her spine for a baseline and she has a  
22 baseline degeneration of the spine. The Board asked what kind of physical examination he  
23 documented for someone who came in with back pain. Respondent referred to his earlier  
24 testimony that his examination starts when the patient walks in and he observes her – whether  
25 she is walking comfortably in the room, is able to sit on the chair, is able to get up and sit on the

1 examination table – all that means her symptoms are stable. Respondent was speaking like a lay  
2 person when he said he could tell MG had no neurological or back problems from watching her  
3 and the Board asked whether he documented any neurological examination or any range of  
4 motion of the spine. Respondent testified MG's back problem was chronic and was addressed by  
5 his wife on MG's first visit. Respondent testified he had prescribed an MRI, had X-rays of her  
6 spine, and MG never complained of any neurological symptoms, except for baseline back pain.

7 11. The Board asked if Respondent prescribed any pain medication on the December  
8 22 visit. Respondent testified he gave MG Percocet, once per day at bedtime, and Imodium for  
9 the diarrhea. MG received Percocet every time she visited Respondent. Respondent confirmed  
10 MG received a small amount at every visit and this was based on her complete insistence that  
11 she would not take nonsteroidals, especially for her back or knee pain. The Board asked what he  
12 was giving MG the Percocet for. Respondent testified he gave it to support her pain  
13 management. The Board asked Respondent what pain he was referring to. Respondent noted  
14 MG's back pain and knee pain. The Board asked if Respondent was giving narcotics for back  
15 pain to a patient who complained of back pain without any objective signs of back pain.  
16 Respondent testified he was doing a work-up of MG's back and did not have any previous  
17 records and MG said she was taking the narcotics before and insisted her pain was controlled.  
18 Respondent testified he was trying to get the MRI and there was never any change in MG's  
19 baseline. The Board asked how Respondent knew there was no change in the baseline if he  
20 never examined or documented her back symptoms other than what she subjectively told him.  
21 Respondent testified he would have mentioned a change. The Board asked if he ever checked  
22 any of MG's reflexes, sensory, motor loss, or any motion of the spine and whether he thought, as  
23 a family practitioner, it is basic to check the reflexes or sensation. Respondent testified he  
24 understood it should be done, but if the Board looked at MG's visits, she did not keep her  
25 scheduled appointments and came at unscheduled times complaining of acute symptoms. If MG

1 was complaining of acute symptoms it was more of a reason to evaluate her instead of giving her  
2 narcotics. Respondent testified he believed MG was stable and mobile and the back was not an  
3 immediate issue.

4 12. The Board directed Respondent to MG's February 8, 2005 visit where he  
5 documented she told him she was going to visit a place that was cold, has aggravation of her  
6 back pain, and is anxious and he told her to take an extra pill for pain and for anxiety. The Board  
7 asked Respondent what his objective examination was for this visit. Respondent testified he had  
8 given MG limited amounts of medications and was always worried about abuse potential.  
9 Respondent still gave MG one-week supplies and that is why she kept coming back for  
10 medication. Respondent testified MG showed up whenever she felt like it and she had missed  
11 several appointments with his wife. Respondent testified MG told him she had been on these  
12 medications for a long time and did not have any adverse activity and he has to believe his  
13 patient and he did her back work-up. The Board asked if MG ever had the MRI of her back.  
14 Respondent testified his office manager told him recently that she believed MG had gone for the  
15 MRI, but this was not in MG's record. Respondent's objective examination on the February 8 visit  
16 consists of two lines and for the extremities he says "no leg edema" where MG's complaint is  
17 back pain and anxiousness. Respondent testified he did not directly document his objective  
18 findings for MG, but they are documented by the fact that if there were positive findings he would  
19 have written them. Respondent testified he believed MG's anxiety was because of her situation,  
20 not her back pain or her baseline in her chronic problem.

21 13. The Board asked if Respondent believed, as a family physician before he  
22 continued to give medications, he has to evaluate anxiety in a patient who keeps coming back  
23 with anxiety. Respondent testified he has to evaluate it, but MG had no records from her  
24 previous physician and in the meantime he was trying to work her up. The Board confirmed on  
25 the February 8 visit Respondent's objective findings do not document anything with regard to

1 MG's back pain even though her presenting complaint was back pain. Respondent testified he  
2 did not think he had documentation and he knew the patient, his wife had examined her and he  
3 followed her closely and was addressing the back issue, but to the best of his knowledge MG did  
4 not really show any major deviation from her baseline back pain and was functional, traveling and  
5 did not complain of any leg pain. MG returned to Respondent on February 24<sup>th</sup> and stated her  
6 back pain was much more stable and her knee injury was better, but there was no documentation  
7 in his objective findings of exams for the back or knee. Respondent testified he continued  
8 baseline pain management at this visit. The Board asked if MG's nausea could be related to  
9 previous surgeries she had – an ovary removal, tubal ligation and an appendectomy.  
10 Respondent testified he was not concerned because MG did not report having any blood related  
11 to the diarrhea and nausea. The Board asked if Respondent did any workup or stool examination  
12 or blood work. Respondent testified he referred MG to a GI doctor and was comfortable with his  
13 examination and there were no signs of bowel obstruction with no localizing signs. Respondent  
14 testified when a patient complains of fresh blood it is usually from hemorrhoids and, if there is  
15 blackened stool, the patient will have much more serious symptoms and, while MG had  
16 abdominal symptoms a long time ago, she did not have any localizing abdominal signs.

17 14. The Board asked Respondent how he would handle in his chart a patient who had  
18 a seizure disorder to whom he prescribed Dilantin, but chose not to take the Dilantin.  
19 Respondent testified he would put something in the chart to document the refusal. The Board  
20 asked how Respondent would chart a patient with hypertension who chose not to take Lisinopril  
21 as recommended. Respondent testified he would mention in the chart why he was changing  
22 medication. Respondent agreed that it was a standard of care to document in the chart a  
23 patient's refusal to take a medication. The Board asked why then did Respondent not document  
24 MG's refusal to take anti-inflammatory medicine that made his prescribing of narcotics necessary.  
25 Respondent could not argue that he did not document her refusal and testified he should have

1 mentioned MG was taking narcotics before. The Board asked if it was Respondent's practice to  
2 prescribe a narcotic on a repeated basis to all patients who come into his practice. Respondent  
3 testified it was on a patient-by-patient basis and it depended.

4 15. The Board confirmed Respondent was MG's primary care physician, noted a  
5 November 30, 2004 lipid panel was ordered under his wife's name that came back abnormal with  
6 triglycerides of 225, and asked why, in all his visits with MG, things other than knee or back pain  
7 were not addressed. Respondent noted triglycerides are only accurate on a fasting sample so if it  
8 was not a fasting sample it did not mean anything. The Board noted this was not the issue – the  
9 issue was if he was MG's primary care physician why do his notes only document pain and  
10 chronic on-going back and knee pain. Respondent testified he addressed all her issues and  
11 referred her to a GI doctor and to pain management doctors and addressed her acute issues.

12 16. The standard of care for a patient with a chronic problem is to sufficiently interact  
13 with the patient to resolve the problem by trying new medications and conducting more in-depth  
14 examinations.

15 17. Respondent deviated from the standard of care because he saw MG at weekly to  
16 bi-weekly intervals for a chronic problem and continually supplied her with the same drugs and  
17 his physical examination was essentially the same each time.

18 18. Respondent failed to diagnosis and treat MG's underlying ailments and this could  
19 lead to misdiagnosis and incorrect treatment.

20 19. Respondent is required to maintain adequate medical records containing, at a  
21 minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment,  
22 accurately document the results, indicate advice and cautionary warnings provided to the patient  
23 and provide sufficient information for another practitioner to assume continuity of the patient's  
24 care at any point in the course of treatment. Respondent's records were inadequate because  
25 they did not contain information to support the diagnosis, did not justify his treatment, did not

1 accurately document results, did not indicate advice and cautionary warnings provided to the  
2 patient, and did not provide sufficient information for another practitioner to assume continuity of  
3 the patient's care at any point in the course of treatment.

4 **CONCLUSIONS OF LAW**

5 1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof  
6 and over Respondent.

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

10 3. The conduct and circumstances described above constitutes unprofessional  
11 conduct pursuant to A.R.S. § 32-1401(27)(e) (“[f]ailing or refusing to maintain adequate records  
12 on a patient”) and 32-1401(27)(q) (“[a]ny conduct or practice which is or might be harmful or  
13 dangerous to the health of the patient or the public”).

14 **ORDER**

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

16 IT IS HEREBY ORDERED:

17 1. Respondent is issued a Letter of Reprimand for failure to perform adequate  
18 examinations and failure to maintain adequate medical records.

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

21 a. Respondent shall obtain 20 total hours of Board Staff pre-approved Category I  
22 Continuing Medical Education (“CME”) in recordkeeping and patient management in primary care  
23 settings. Respondent shall provide Board Staff with satisfactory proof of attendance. The CME  
24 hours shall be in addition to the hours required for biennial renewal of medical license. The  
25

1 probation will terminate when Respondent supplies proof of course completion satisfactory to  
2 Board Staff.

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

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

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

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

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

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



THE ARIZONA MEDICAL BOARD

By *TC Miller*  
TIMOTHY C. MILLER, J.D.  
Executive Director

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

Arizona Medical Board  
9545 East Doubletree Ranch Road  
Scottsdale, Arizona 85258

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

Paul J. Giancola  
Snell & Wilmer  
One Arizona Center  
404 E. Van Buren  
Phoenix, Arizona 85004-2202

Sudhir K. Goal, M.D.  
Address of Record

*S. K. Goal*