

1 BEFORE THE BOARD OF MEDICAL EXAMINERS

2
3 IN THE STATE OF ARIZONA

4 In the Matter of

5 **PHILLIP E. FRY, M.D.**

6 Holder of License No. **5325**
7 For the Practice of Medicine
8 In the State of Arizona.

INVESTIGATION NO. 11790

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

9 **INTRODUCTION**

10 This matter was considered by the Arizona Board of Medical Examiners (Board) at
11 its public meeting on July 29, 1999. After due consideration of the facts and law
12 applicable to this matter, the Board voted to issue the following findings of fact,
13 conclusions of law and order.

14 **FINDINGS OF FACT**

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

17 2. Dr. Fry is the holder of License No. 5325 for the practice of allopathic
18 medicine in the State of Arizona.

19 3. The Board received a malpractice settlement report regarding Dr. Fry's
20 treatment of patient R.R. The report alleges that Dr. Fry failed to elicit sufficient medical
21 history to provide safe anesthetic care; failed to communicate with the surgeon regarding
22 the plan of management; administered general anesthetic in spite of the surgeon's
23 intention to perform the procedure with local anesthesia only; administered an excessive
24 dose of anesthetic drugs; failed to monitor the patient adequately, resulting in an episode
25 of bradycardia and hypotension requiring CPR; performed CPR in a manner that did not

1 follow appropriate ACLS protocols; after resuscitation, did not accompany the
2 unconscious, intubated patient to the receiving hospital; and did not communicate
3 adequate information to the receiving physician in the emergency department.

4 4. On June 11, 1994, patient R.R. was scheduled for outpatient surgery under
5 local anesthetic to debride an infection on his finger. On June 15, 1994, patient R.R. died
6 from complications he developed following the surgery. Dr. Fry was the anesthesiologist
7 during patient R.R.'s surgery at the Phoenix Center for Outpatient Surgery.

8 5. Dr. Fry failed to communicate with the surgeon regarding his anesthetic plan
9 prior to the surgery and was unaware of the surgeon's intention to do the procedure with
10 local anesthesia only.

11 6. While the patient was being prepared for surgery, the pain produced was of
12 such severity that Dr. Fry made the decision to administer a general anesthetic. Dr. Fry,
13 however, administered the general anesthetic without having sufficient information
14 regarding the patient's history, physical or having reviewed the patient's medical summary.
15 The pre-operative information on the nursing intake form did specifically mention
16 "cardiomyopathy" as one of the patient's medical conditions.

17 7. Dr. Fry administered a combination of anesthetic drugs which were not
18 appropriate for patient R.R. Patient R.R. had diminished cardiac function and severe
19 diabetes. Due to patient R.R.'s low cardiac output, the peak effect of the anesthetic drugs
20 were likely delayed by slow circulation and drug distribution, which resulted in an
21 exaggerated effect after the brief procedure was completed. The resulting episode of
22 bradycardia and hypotension was a result of the relatively large dose of propofol, which
23 produced vasodilation and myocardial depression in the patient who had diminished
24 cardiac function and relative hypovolemia secondary to recent dialysis.

25 ...

1 ORDER

2 Based on the foregoing Findings of Fact and Conclusions of Law, it is hereby
3 ordered that:

- 4 1. Dr. Fry shall be issued a Letter of Reprimand.
- 5 2. Dr. Fry shall be placed on probation for 6 months, during which time he is to
6 obtain twenty (20) hours of Board pre-approved Continuing Medical Education (CME) in
7 the area of anesthetic management of high-risk patients and provide Board Staff with
8 satisfactory evidence of completion. The CME hours shall be in addition to the hours
9 required for annual renewal of medical license.

10 RIGHT TO PETITION FOR REVIEW

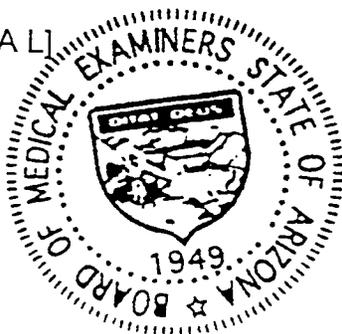
11 Dr. Fry is hereby notified that he has the right to petition for a rehearing. Pursuant
12 to A.R.S. § 41-1092.09, as amended, the petition for rehearing must be filed with the
13 Board's Executive Director within thirty (30) days after service of this Order and pursuant
14 to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a rehearing.
15 Service of this Order is effective five (5) days after the date of mailing. If a petition for
16 rehearing is not filed, the order becomes effective thirty-five (35) days after it has been
17 mailed.

18 Dr. Fry is further notified that the filing of a petition for rehearing is required to
19 preserve any rights of appeal to the superior court that he may wish to pursue.

20 DATED this 18 day of August, 1999.

21 BOARD OF MEDICAL EXAMINERS
22 OF THE STATE OF ARIZONA

23 [SEAL]



24 By *Claudia Foutz*
25 CLAUDIA FOUTZ
Executive Director

1 Original of the foregoing filed this
2 23rd day of August, 1999, with:

3 The Arizona Board of Medical Examiners
4 1651 East Morten, Suite 210
5 Phoenix, Arizona 85020

6 Copy of the foregoing mailed by Certified
7 Mail this 23rd day of August, 1999, to:

8 Phillip Fry, M.D.
9 5133 N. Central Avenue, Suite 200
10 Phoenix, AZ 85012

11 Copy of the foregoing mailed this
12 23rd day of August, 1999, to:

13 Michael Nevels
14 Carson, Messinger, Elliott, Laughlin & Ragan
15 3300 N. Central, Suite 1900
16 P.O. Box 33907
17 Phoenix, AZ 85067-3907
18 Attorney for Dr. Fry

19 Copy of the foregoing hand delivered
20 this 23rd day of August, 1999, to:

21 Marc Harris
22 Assistant Attorney General
23 The Arizona Board of Medical Examiners
24 1651 East Morten, Suite 210
25 Phoenix, Arizona 85020

Christina Verdugo
Board Operations