

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2
3 In the Matter of:

4 **DWIGHT C. LUNDELL, M.D.**

5
6 Holder of License No. 6960
7 For the Practice Medicine
8 In the State of Arizona,

Case No. MD-98-0844
MD-99-0349
MD-00-0030

**CONSENT AGREEMENT AND ORDER
FOR LETTER OF REPRIMAND AND
PROBATION**

9 **CONSENT AGREEMENT**

10 RECITALS

11 In the interest of a prompt and judicious settlement of the above-captioned matter
12 before the Arizona Medical Board (Board) and consistent with the public interest,
13 statutory requirements and responsibilities of the Board and under A.R.S. § 41-
14 1092.07(F)(5), Dwight C. Lundell, M.D. (Respondent), holder of license number 6960 to
15 practice allopathic medicine in the State of Arizona, and the Board enter into the
16 following Recitals, Findings of Fact, Conclusions of Law and Order ("Consent
17 Agreement") as the final disposition of this matter.
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20 1. Respondent has read and understands this Consent Agreement as set forth
21 herein, and has had the opportunity to discuss this Consent Agreement with an attorney
22 or has waived the opportunity to discuss this Consent Agreement with an attorney.
23 Respondent voluntarily enters into this Consent Agreement for the purpose of avoiding
24 the expense and uncertainty of an administrative hearing.
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1 2. Respondent understands that he has a right to a public administrative
2 hearing concerning each and every allegation set forth in the above-captioned matter, at
3 which administrative hearing he could present evidence and cross-examine witnesses.
4 By entering into this Consent Agreement, Respondent freely and voluntarily relinquishes
5 all right to such an administrative hearing, as well as all rights of rehearing, review,
6 reconsideration, appeal, judicial review or any other administrative and/or judicial
7 action, concerning the matters set forth herein. Respondent affirmatively agrees that this
8 Consent Agreement shall be irrevocable.
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11 3. Respondent agrees that the Board may adopt this Consent Agreement or
12 any part of this agreement, under A.R.S. § 32-1451(G)(5). Respondent understands that
13 this Consent Agreement or any part of the agreement may be considered in any future
14 disciplinary action against him.
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16 4. Respondent understands that this Consent Agreement does not constitute a
17 dismissal or resolution of other matters currently pending before the Board, if any, and
18 does not constitute any waiver, express or implied, of the Board's statutory authority or
19 jurisdiction regarding any other pending or future investigation, action or proceeding.
20 Respondent also understands that acceptance of this Consent Agreement does not
21 preclude any other agency, subdivision or officer of this state from instituting other civil
22 or criminal proceedings with respect to the conduct that is the subject of this Consent
23 Agreement.
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1 5. Respondent acknowledges and agrees that, upon signing this Consent
2 Agreement and returning this document to the Board's Executive Director, Respondent
3 may not revoke his acceptance of the Consent Agreement or make any modifications to
4 the document, regardless of whether the Consent Agreement has been issued by the
5 Executive Director. Any modification to this original document is ineffective and void
6 unless mutually approved by the parties in writing.
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9 6. Respondent understands that the foregoing Consent Agreement shall not
10 become effective unless and until adopted by the Board and signed by its Executive
11 Director.

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13 7. Respondent understands and agrees that if the Board does not adopt this
14 Consent Agreement, he will not assert as a defense that the Board's consideration of this
15 Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

16
17 8. Respondent understands that this Consent Agreement is a public record
18 that may be publicly disseminated as a formal action of the Board, and shall be reported
19 as required by law to the National Practitioner Data Bank and the Healthcare Integrity
20 and Protection Data Bank.

21
22 9. Respondent understands that any violation of this Consent Agreement
23 constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(25)(r)([v]iolating a
24 formal order, probation, consent agreement or stipulation issued or entered into by the
25 board or its executive director under the provisions of this chapter) and may result in
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1 disciplinary action pursuant to A.R.S. § 32-1451.

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DATED: 2.13.04

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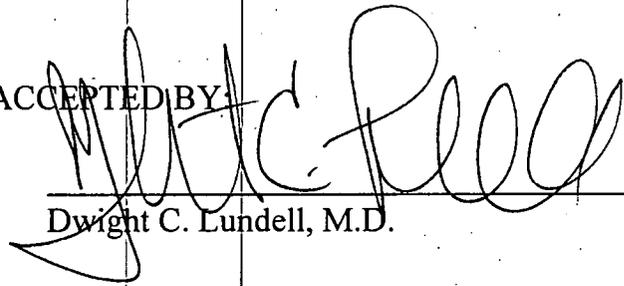
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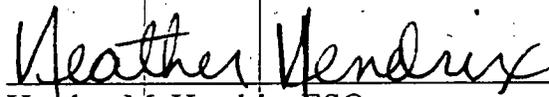
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ACCEPTED BY:



Dwight C. Lundell, M.D.

REVIEWED AND APPROVED AS TO FORM
BY:



Heather M. Hendrix, ESQ.
Counsel for Respondent

FINDINGS OF FACT

By stipulation of the parties, the following Findings of Fact, Conclusions of Law and Consent Order are entered for final disposition of the matters described therein.

Respondent acknowledges that sufficient evidence exists for the Board to make the following 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. 6960 for the practice of allopathic medicine in the State of Arizona.

Case No. MD-98-0844

3. On November 9, 1998, the Board received a letter of complaint alleging that

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Respondent had failed to provide competent treatment to Patient following a coronary angiogram and coronary artery bypass grafting, which resulted in an infection in her leg and scarring. The Board opened an investigation.

4. On November 25, 1997, Patient was admitted to Desert Samaritan Hospital, at age 73, with recurrent coronary artery disease. Patient had undergone previous coronary artery bypass grafting. The patient was markedly obese. After admission, Patient underwent a cardiac catheterization, which showed that she had severe progression of disease of the previous bypass grafts.

5. On November 28, 1997, Respondent performed a quadruple coronary bypass graft using the saphenous vein from Patient's right leg. The grafts were to the left anterior descending coronary artery, the posterior descending branch of the right, posterolateral branch of the right and to the obtuse marginal branch to the circumflex.

6. Respondent made progress notes of follow-up visits on November 29 and 30, 1997, but these notes do not mention the status of the leg incision. Respondent made no further progress entries during Patient's final five days of hospitalization.

7. Following the surgery, nursing notes of December 2, 1997 observe that Patient's right groin and thigh incision was "discolored, tight, tender to touch" and would be reported to the doctors in the morning.

- 1 8. December 3, 1997 nursing notes indicate the right groin and thigh incision to be
2 swollen, ecchymotic (bruised), with blisters along the incision line, and oozing
3 from the blisters.
- 4
- 5 9. December 4, 1997 nursing notes indicate serious drainage was continuing. The
6 notes indicate that the pacing wire was still in place.
- 7
- 8 10. Patient claims that Respondent removed the wire from her chest on December 4,
9 1997, but did not examine her leg incision even though she had expressed
10 concerns about it. There are notes indicating that the wire was removed.
- 11
- 12 11. The patient discharge summary from the hospital dated December 5, 1997, with
13 home health care and orders to see Respondent in two weeks.
- 14
- 15 12. On December 6, 1997, the home health nurse reported the appearance of the leg
16 incision to Respondent's office.
- 17
- 18 13. On December 8, 1997, the home health nurse again reported the appearance of the
19 leg incision to Respondent's office. Patient was given an appointment later that
20 same day.
- 21
- 22 14. Respondent examined Patient and noted that the wound was open and was
23 infected and Patient was immediately hospitalized with a plastic surgeon
24 consultation.
- 25
- 26 15. Although the nursing notes during the first hospitalization were consistent with
the description of a developing infection, there is no evidence in the chart to

1 suggest that Respondent examined the leg. Although vein donor leg wounds,
2 especially in the groin area of obese elderly people, are commonly complicated by
3 infection after coronary bypass surgery, Patient was discharged from the hospital
4 with an infection in her leg.
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6 16. Respondent failed to provide records of a pre-operative consultation or to provide
7 clinical information of any value prior to surgery. Respondent's operative report
8 not did not contain any mention of the harvesting of the saphenous vein and his
9 post-operative visits were not adequately documented.
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11 17. The Respondent did not meet the standard of care when he failed to provide
12 adequate treatment after Patient's coronary bypass surgery by failing to recognize
13 the early signs of infection and acting on it and thereby limiting the extent of the
14 infection in her right leg where the grafting vein had been harvested. Mitigating
15 this conduct, Respondent did provide immediate and appropriate care to Patient
16 after the identification of the infection.
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18 18. Respondent admits that the above described conduct violates the provisions of the
19 Arizona Medical Practices Act and constitutes professional misconduct as set
20 forth in that Act.
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23 **Case No. MD-99-0349**

24 19. On April 26, 1999, the Board received a letter of complaint alleging that
25 Respondent had performed an inadequate pre-operative evaluation leading to an
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ill-advised open surgery; billed inappropriately for services not performed; and, failed to provide appropriate follow-up care for Patient. An investigation was opened.

20. Patient had been diagnosed in November, 1995 with renal cell carcinoma of the left kidney. Another physician had performed a radical nephrectomy and followed Patient with a thorough six-month office evaluation.

21. In November, 1996, Respondent saw Patient for a mass in the sternum on referral from the patient's primary care internist. Respondent's dictated note says, "This is a gentleman who has a sternal mass. He is about a year post-resection of a renal carcinoma. This will be resected soon." There are no other entries as to Respondent's evaluation.

22. The operative permit was for resection, or removal, of sternal mass. The admitting history and physical is a short form outpatient surgery form which is undated and contained only brief entries.

23. On December 2, 1996, Patient was admitted to Desert Samaritan Medical Center by Respondent for resection of the chest mass. Respondent made a 3 to 4 centimeter incision transversely over the top of the mass. The tumor mass was incised with a scalpel and massive bleeding occurred. The bleeding was nearly impossible to control and became life-threatening. Ultimately the bleeding was controlled with electrocautery and by packing the area with an absorbable

- 1 hemostatic material called Nu-Knit. The blood loss was reported as at least 3500
2 cc. A subclavian line was inserted for fluid replacement. Respondent abandoned
3 the resection of the tumor because of the unexpected and massive hemorrhage.
4
- 5 24. Respondent's hand written operative report stated that he had removed a piece of
6 the tumor for a frozen section pathology analysis. The report further stated that
7 "the mass turned out to be a cavity with partial destruction of the manubrium and
8 appeared to be a large lake of blood vessels."
9
- 10 25. The pathology report of the surgery indicated that the mass was consistent with
11 metastatic renal cell carcinoma.
12
- 13 26. A single sentence entry on December 3, 1996 states, "stable today - probably
14 home in a.m." The note for December 4, 1996 states only, "home today."
15 Although there had been blood labs on the day of surgery, no further blood
16 sampling was carried out. There are no references to home care instructions or
17 follow-up in the Respondent's progress notes or the order sheet. A nurse's entry
18 on December 4, 1996 indicates that "verbal and written instructions given with
19 wife present - Rx given - patient verbalizes understanding."
20
- 21
22 27. In Respondent's discharge summary for Patient, he points out that the MRI
23 demonstrated this mass was destroying bone in the manubrium. He stated that the
24 patient's post-operative course was benign, and that Patient was discharged to be
25 followed closely as an outpatient. There is no documentation in Respondent's
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- 1 office chart of any follow-up visits.
- 2 28. The complaint states that the family called Respondent on December 13, 1996
- 3 because Patient was experiencing increased pain, redness, and swelling of the
- 4 sternal wound and they did not receive a call back from Respondent or his office.
- 5 On the following Monday, they were informed that Respondent was out of town,
- 6 and that they had been instructed to inform them that pain and swelling were
- 7 normal because of the packing used during surgery.
- 8
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- 10 29. On December 24, 1996, Patient's daughter called Respondent, who stated the
- 11 swelling was normal, but Respondent telephoned in a prescription for an
- 12 antibiotic and gave Patient an appointment for the following Monday, December
- 13 30.
- 14
- 15 30. On December 26, 1996, Patient was seen by an associate of Respondent who
- 16 advised hospitalization and indicated he felt infection had penetrated the bone.
- 17 There was a progression to an osteomyelitis of the sternum which required
- 18 intensive intravenous antibiotic therapy. Because of the infection, standard
- 19 radiation therapy of the mass could not be administered. Additional sites of
- 20 metastatic disease became evident and the patient did not respond to any
- 21 appreciable degree to intensive chemotherapy and radiation attempts to control
- 22 the disease. Patient died the latter part of May, 1997.
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- 25 31. Respondent's billing showed a surgery charge described as excision of
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mediastinal mass. Due to the unexpected bleeding, the actual surgery was partial excision of the sternal mass.

32. Respondent deviated from the standard of care by performing an inadequate pre-operative evaluation leading to an ill-advised open surgery on a metastatic mass resulting in extensive blood loss, prolonged infection, and limitation of radiation therapy because of the persistent infection. There is no record that Respondent considered a less invasive or more conservative approach. In mitigation, there is no evidence that the deferral of radiation therapy to the sternal area altered the ultimate course of this patient's widely metastatic renal cell carcinoma.

33. Respondent violated the Arizona Medical Practice Act by his inappropriate billing for a mediastinal mass excision, when the procedure was more appropriately a soft tissue chest wall mass biopsy. In mitigation, the procedure was modified after the commencement of the surgery because of the bleeding. Also, Respondent made restitution for the billing error and has modified office procedures to insure accuracy of billing by referring to operative notes.

34. Respondent deviated from the standard of care by failing to specify and document post-operative care, and failure to supervise office personnel resulting in delays of post-operative care. These actions could have caused harm to the Patient.

35. Respondent admits that the above described conduct violates the provisions of the Arizona Medical Practices Act and constitutes professional misconduct as set

- 1 39. Respondent saw Patient on October 6, 1999 for consultation, but Respondent's
2 records fail to record evidence of a thorough preoperative evaluation, history or
3 discussion with the patient. There was no pre-operative chest x-ray taken.
4
- 5 40. Admission records for Patient at Chandler Regional Hospital indicates that on
6 October 11, 1999, a history and physical short form was completed as follows:
7 chief complaint states simply "abdominal aortic aneurysm." Past medical and
8 surgical history states "AAA found on x-ray, HTN (hypertension), MI"
9 (myocardial infarction), and another term which is indecipherable. The remainder
10 of the history is checked off as non-contributory. Physical examination is by
11 check marks in boxes that indicate the general appearance, mental status, HEENT,
12 heart, lungs, breasts are all normal. Under "Focused Examination" it states
13 "pulsatile abdominal mass." Under diagnosis it states, "AAA." Under immediate
14 postoperative note it states, "see dictation." These two pages are signed by
15 Respondent.
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- 19 41. The dictated operative note indicates a rather straightforward resection of an
20 abdominal aortic aneurysm. Respondent ordered a post-operative chest x-ray to
21 confirm placement of the right jugular line.
22
- 23 42. The post-operative x-ray report indicates "increased density in the right perihilar
24 region which appears to represent an interstitial infiltrate. a small patchy density
25 measuring less than one centimeter is seen at the right base. This does not appear
26

1 to be a solid lesion, but more likely represents either scarring or additional
2 infiltrate.”

3
4 43. Respondent's post-operative notes are brief and indicate no problems except for
5 some mild nausea. However, the laboratory data indicates that later in the day of
6 surgery and the following day, Patients' laboratory data indicated continued mild
7 renal dysfunction, but improving. His creatinine had gone from 1.8 at borderline
8 high to 2.0 after surgery. Patient also had mild post-operative anemia of
9 hematocrit of 29%. Blood gases post-operatively indicated PO2 of 73 on two
10 liters nasal cannula. These values were not checked again prior to discharge to
11 see if they had progressed to normal. The Patient was asymptomatic as to
12 respiratory status prior to discharge. Respondent states that the creatinine level
13 had returned to normal range prior to discharge.

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17 44. Following his release from the hospital, Patient exhibited a marked shortness of
18 breath, weakness and anorexia. His family called Respondent's office on October
19 20, 1999 and received an appointment that afternoon.

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21 45. Respondent noted that Patient had hiccups and shortness of breath. His last x-ray
22 in the hospital showed some question of pneumonitis. He had no fever “but we
23 will check an x-ray to be sure.” There is no indication that Respondent examined
24 Patient. The history assessment in the office, apparently taken by an office nurse,
25 indicated that Patient was “very short of breath even with talking.”
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- 1 46. A chest x-ray was taken on the same day indicated right lower lobe infiltrate
2 and/or effusion. The x-ray results were called to Respondent's office the same
3 day.
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- 5 47. According to the complainant, oxygen therapy was ordered for Patient on October
6 20, 1999, but the home health care company refused to deliver oxygen until a
7 pulse oximeter report was performed on October 26, 1999, at Respondent's
8 office. In mitigation, Respondent had ordered a pulse oximeter test on the date of
9 the visit and faxed the order to the provider, but the provider failed to complete
10 the test.
11
- 12 48. When Patient failed to improve, his family took him to the emergency room on
13 November 3, 1999. Further medical problems were discovered and Patient died
14 sometime later from metastatic carcinoma to the brain.
15
- 16 49. Respondent's performance was below the standard of care for failing to document
17 an adequate evaluation of the patient prior to aneurysmal surgery; failing to
18 appreciate the patient's recent medical history, which showed significant renal
19 disease, a chronic anemia and evidence of failing health and should have been
20 addressed prior to subjecting patient to major elective surgery; inadequate hospital
21 history and physical prior to surgery; failure to obtain a pre-operative chest x-ray;
22 and, failure either to document, or to conduct, an examination of patient post-
23 operatively. Had a more thorough evaluation been conducted, the cancer may
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have been discovered and the surgery for the aneurysm may have been unnecessary.

50. Respondent admits that the above described conduct violates the provisions of the Arizona Medical Practices Act and constitutes professional misconduct as set forth in that Act.

51. Respondent has completed the PACE record keeping course after Respondent's care in the above cases were completed. Respondent was re-certified in 2001 by the American Board of Thoracic Surgeons.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter and over Respondent.
2. The conduct and circumstances described above in paragraphs 3 through 18 constitute unprofessional conduct pursuant to *A.R.S. § 32-1401(25)(q)* "Any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public," and, *A.R.S. § 32-1401(25)(e)* "Failing or refusing to maintain adequate records on a patient."
3. The conduct and circumstances described above in Paragraph 19 through 35 constitute unprofessional conduct pursuant to *A.R.S. § 32-1401(25)(e)* "Failing or refusing to maintain adequate records on a patient;" and, *A.R.S. § 32-1401(25)(u)* "Charging a fee for services not rendered or dividing a professional fee for patient referrals among health care providers or health care institutions or between these

1 providers and institutions or a contractual arrangement which has the same
2 effect;" *A.R.S. § 32-1401(25)(q)* "Any conduct or practice which is or might be
3 harmful or dangerous to the health of the patient or the public."
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- 5 4. The conduct and circumstances described above in Paragraphs 36 through 49
6 constitute unprofessional conduct pursuant to *A.R.S. § 32-1401(25)(q)* "Any
7 conduct or practice which is or might be harmful or dangerous to the health of the
8 patient or the public" and pursuant to *A.R.S. § 32-1401(25)(e)* "Failing or refusing
9 to maintain adequate records on a patient."
10

11 CONSENT ORDER

12 **IT IS THEREFORE ORDERED that:**

- 13
- 14 1. Respondent Dwight C. Lundell, M.D., License No. 6960, is hereby issued
15 a Letter of Reprimand for the unprofessional conduct described above.
16
 - 17 2. Respondent Dwight C. Lundell, M.D., License No. 6960, is placed on
18 probation for 2 years with the following terms and conditions.
 - 19 A. Within 60 days of the effective date of this order, Respondent Dwight C.
20 Lundell, M.D., License No. 6960, shall, at his own expense, enroll in the
21 Physician Assessment and Clinical Education Program (PACE) and shall
22 undergo the comprehensive assessment program including the
23 measurement of medical skills, clinical knowledge, clinical judgment and
24 decision-making, the appraisal of physician health and neuropsychological
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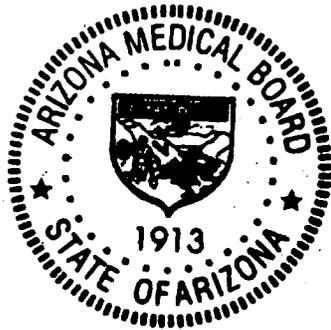
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screening. After assessment, the PACE Evaluation Committee will review all results and make a recommendation to the Board or its designee and the Respondent as to what clinical training is required, including the scope and length, treatment of any medical or psychological condition, and other factors affecting the Respondent's practice of medicine. The Respondent shall undertake whatever clinical training and treatment of any medical or psychological condition as may be recommended by the PACE program. Finally, at the completion of the PACE program, Respondent shall submit to an examination on its contents and substance. The examination shall be designed and administered by the PACE faculty. Respondent shall not be deemed to have successfully completed the program unless he passes the examination. Respondent agrees that the determination of the PACE program faculty as to whether or not he had passed the examination and/or successfully completed the PACE program shall be binding.

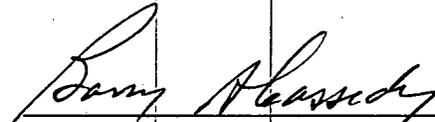
B. Respondent shall obey all federal, state, and local laws and all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

1 DATED AND EFFECTIVE this 10th day of March, 2004.

2
3 [SEAL]



ARIZONA MEDICAL BOARD

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5 

6 Barry A. Cassidy, Ph.D., P.A.-C
Executive Director

7
8 **Original** of the foregoing filed this
10th day of March, 2004, with:

9 Arizona Medical Board
10 9545 E. Doubletree Ranch Road
11 Scottsdale, Arizona 85258

12
13 **Executed Copy** of the foregoing mailed
14 mailed by U.S. Certified Mail, this
10th day of March, 2004, to:

15 Dwight C. Lundell, M.D.
16 1520 South Dobson Road, Ste. 308
17 Mesa, Arizona 85202
Respondent

18 ///

19 **COPIES** of the foregoing mailed
20 this 10th day of March, 2004, to:

21 Heather M. Hendrix, Esq.
22 770 North Monterey, Ste F
23 Gilbert AZ 85233-3821

24 Dean E. Brekke
Assistant Attorney General
25 1275 W. Washington, CIV/LES
26 Phoenix, Arizona 85007

1 Attorney for State

2 Amanda Diehl

3 Assistant Director, Arizona Medical Board
4 9545 E. Doubletree Ranch Road
5 Scottsdale, Arizona 85258

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7 Planning and Operations

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