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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

JOHN N. GLOVER, M.D.

Holder of License No. **8971**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-05-0390A

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

(Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on August 10, 2006. John N. Glover, M.D., ("Respondent") appeared before the Board for a formal interview with legal counsel Stephen M. Booth 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. 8971 for the practice of allopathic medicine in the State of Arizona.
3. The Board initiated case number MD-05-0390A after receiving a complaint regarding Respondent's care and treatment of an eighty-two year old male patient ("EA"). EA was referred to Respondent in November 2000 for evaluation of a pleural effusion and he presented with a chest x-ray – a single film from September 9, 2000. Respondent planned a thoracentesis, but ultrasound did not reveal enough fluid for the procedure. Respondent then followed EA by ordering serial x-rays for the next one and one-half years. In April 2002 EA presented with weight loss, worsened oxygen saturation, and a new infiltrate in the right upper lobe. Respondent offered no differential diagnosis, conducted no work-up and recommended continuing to follow the chest x-rays. In his June 2003 response to the Board, Respondent stated he suggested EA consider a

1 chest CT and EA did not want further evaluation. However, Respondent's chart is not consistent
2 with this statement. Respondent did not document EA's refusal of the CT. EA presented to his
3 primary care physician in June 2004 and was diagnosed with cocci and both IgM and IgG titers
4 were positive.

5 4. Respondent testified his differential diagnosis is not written in the record, but is
6 apparent from the studies he ordered from the thoracentesis and included cultures for various
7 organisms to exclude pleural space infection, cytology to exclude pleural malignancy, protein,
8 LVH, and cell count, which would serve to confirm or deny heart failure of hemothorax as the
9 cause of the effusion. Respondent next ay EA on November 17 and the radiologist had found
10 insufficient free fluid to tap and had not done the tap. Respondent's differential diagnosis from
11 that point on was pleural fibrosis or organized plural reaction, with underlying lung scarring. The
12 Board asked what happened with the other items in Respondent's original differential diagnosis –
13 heart failure, malignancy, etc. Respondent testified that because there was no free fluid a
14 malignant pleural effusion would not be present (it was an organized pleural reaction) and the
15 same would be true for heart failure, Hemothorax and infection.

16 5. Respondent's treatment plan for pleural fibrosis was observation keeping in mind
17 EA had minimal symptoms, was not hypoxic, and was able to walk into Respondent's office
18 unaided. The Board noted Respondent's statement that EA was not hypoxic and asked if
19 Respondent normally took an O₂ saturation, vital signs and weight. Respondent noted the
20 medical record reflects EA's oximetry was measured on room air after walking into the office on
21 each and every visit and his weight was taken on every visit but one. The Board noted EA's O₂
22 saturation on one visit was ninety-three percent and on another it was greater than or equal to
23 ninety-six percent and asked if, even though Respondent said EA was not hypoxic, on
24 presentation he appeared hypoxic. Respondent agreed, but noted the pertinent issue was
25 whether EA's oxygen level was low enough to require oxygen supplementation and to the extent
he had an abnormal chest x-ray, Respondent would expect the efficiency of oxygenation or

1 matching of ventilation perfusion would be less than normal, so a oxygen at less than ninety or
2 ninety-six percent would not be a surprise. Respondent agreed it would however be abnormal
3 and if that number were to change over time and perhaps even worsen it would be a red flag, but
4 EA's oxygen sats were always over ninety. The Board noted Respondent himself had pointed out
5 that the predicted value is greater than or equal to ninety-six percent and anything less is
6 abnormal, therefore ninety-three was abnormal.

7 6. EA next saw Respondent on February 16, 2001 and, by x-ray, there was no
8 change from 2000. EA had moderate pleurar capacity on the right, at the costophrenic angles
9 some linear opacity at the right base, and was not complaining of pleuritic chest pain or increased
10 breathlessness or night sweats or fever or spitting of blood. Respondent next saw EA on May 11,
11 2001 and his symptomatic review revealed EA had some exertional breathlessness, but no
12 progressive dyspnea and other pertinent negatives. The Board asked if the exertional dyspnea
13 was of concern to Respondent – was it a red flag. Respondent agreed it could be considered a
14 symptom and he thought the rate with which it progressed and the degree to which it would be
15 out of keeping with his known x-ray findings would make it more or less of a red flag. The Board
16 whether it was not concerning, in light of a persistently abnormal x-ray, subjective change in
17 dyspnea (which was noted by Respondent and EA) and the persistent decrease in O2.
18 Respondent noted EA's symptoms were minimal and as you go through the remainder of the
19 record the symptoms waxed and waned with minimal breathlessness being the average and a dry
20 non-productive cough being the average. The Board noted none of these things are normal.
21 Respondent agreed and stated if EA were normal he would not be coming to a pulmonary
22 disease office. The Board noted that was exactly the point and would expect a pulmonary disease
23 office to be the most aggressive in working these things up. Respondent testified the risk and
24 benefit would have to be contemplated for any proposed course of action.

25 7. The Board asked how else these things could be worked up other than
thoracentesis that failed, since Respondent already stated it is abnormal for EA to have a low O2

1 saturation, an abnormal chest x-ray and now the new symptom of exertional breathlessness.
2 Respondent testified he observed EA, monitored his oxygen sats to be sure he did not need
3 oxygen therapy, and contemplated further diagnostic studies when his chest x-ray changed in
4 2003. The Board confirmed Respondent did not actively intervene and asked if this was below the
5 standard of care. Respondent quoted from article regarding the management of pleural fibrosis
6 that "[s]upportive care is usually the best option. Oxygen therapy may be required for patients
7 with hypoxemia at rest or with exertion." Respondent next saw EA November 9, 2001. The Board
8 asked if there were any changes in EA's course compared to the initial visit or previous visits.
9 Respondent testified EA had no worrisome symptoms of hemoptysis, blood spitting, chills, sweats
10 or fever; recounted he had been to and from Russia on a trip; the shortness of breath was no
11 progressive, he was able to walk into the office unaided, and sustained a post walk oxymetry of
12 ninety-four percent. The Board noted EA's chest x-ray at that time showed changes. The Board
13 asked if Respondent was concerned by the subjective complaints of worsening dyspnea and
14 shortness of breath, chronic changes or continual changes in both the left and right lung, and
15 persistently decreased O2 saturation. Respondent testified it was not and EA did not require
16 oxygen supplement, which would be the treatment if the hypoxia progressed and if he had
17 appropriate symptoms to go with the x-ray changes waxing and waning to suggest either infection
18 or other problems, he would have addressed them. Respondent stated as long as EA's
19 symptoms were minimal and he was not hypoxic he preferred to manage him conservatively.

20 8. Respondent next saw EA on April 9, 2002 and the official report noted a new
21 infiltrate in the right upper lobe laterally and Respondent read this as an interstitial collection of
22 fluid. Respondent noted EA had a number of symptoms and was the sickest EA ever was while
23 under his care. EA had abdominal cramping and diarrhea consistent with an acute gastroenteritis
24 that was not present before, his cough was wet and productive of mucoid, non-purulent sputum,
25 he had shortness of breath, but his spirometry was actually rather good, he registered the best
vital capacity he had ever had with Respondent at 2.5 liters, and his oxygen saturation was

1 ninety-one. The Board noted Respondent's progress note for this date also listed weakness and
2 this was coupled with worsening dyspnea and that the radiologist's report contained bold print
3 stating "[w]orsening chest picture" on the right and left and asked how Respondent's treatment
4 plan changed based on all these things. Respondent stated he advised EA if his symptom
5 worsened that he let Respondent know and otherwise, he was to return in three months for a
6 follow-up visit. Respondent noted he did not hear from EA until eight months later. Respondent
7 noted the commentary in order from the subjective portion of the note says EA had GI complaint
8 and with that lost three or four pounds and felt weak and Respondent concluded gastroenteritis
9 was responsible for this.

10 9. The Board directed Respondent to EA's weight loss from the time he first
11 presented to Respondent to 2002 and noted it was a significant weight loss. Respondent stated
12 the average weight loss was 7.9 pounds for each year. The Board clarified the record reflected
13 the weight loss was actually 11 pounds. The Board noted this significant weight loss with
14 progressively worsening dyspnea, worsening chest x-ray, worsening O2 sats, JAG complaints,
15 and other worsening respiratory complaints, and asked what Respondent, a pulmonologist
16 planned for treatment -- how was he going to further work up EA's worsening clinical picture.
17 Respondent testified he planned to do nothing at that point. The Board asked if it would have
18 been prudent to order a CT scan, a CBC, or a B&P. Respondent noted there was no need for a
19 CT and what he surmised EA had was symptoms consistent with acute chest cold and with acute
20 gastroenteritis and told EA to follow up. Respondent noted EA was on each and every occasion
21 able to walk into the office unaided without oxygen and he made a practical assessment of the
22 level of his dyspnea and not everyone who is short of breath needs oxygen treatment.

23 10. Respondent next saw EA in December 2002 and determined his x-ray picture was
24 largely stable regarding the pleural reaction and underlying lung scarring and what had changed
25 of interest to Respondent was that the infiltrate seen by the radiologist in April had resolved.
Respondent noted EA's spirometry was utterly stable at 2.3 liters of vital capacity, his oxygen sat

1 was 93 percent, his symptoms were reported as doing all right, there was no hemoptysis, night
2 sweats or weight loss and he recommended a six month follow-up with chest x-ray. Respondent
3 next saw EA in June 2003 and there were changes in his x-ray Respondent felt were significant
4 compared to previous x-rays and his symptomatic level, oxygen sat and spirometry were the
5 same and his chest was rather clear to auscultation. Respondent stated he proposed a Cat scan
6 as a three dimensional road map as a prelude to biopsy and EA was interested in neither. The
7 Board asked if Respondent could have worked up EA's worsening clinical picture in any way
8 other than by CT scan. Respondent testified the CT scan was the road map on which to predicate
9 a subsequent biopsy. The Board asked if there would have been any benefit to a CBC or
10 serology (to determine whether EA could have TB or coccidiomycosis or other blood markers).
11 Respondent testified there was no reason to do a Valley Fever serology on EA because he
12 lacked the cardinal signs and symptoms of Valley Fever and he lacked the typical x-ray
13 appearance and progression typical of Valley Fever.

14 11. The Board confirmed Respondent's position was that nothing would benefit EA at
15 that point other than a CT and then asked about a bronchocopy, thoracentesis or thoracoscopy.
16 Respondent then agreed he would do a bronchoscopy if EA were symptomatic – signs or
17 symptoms of infection (chills, sweats, fever) or signs and symptoms of malignancy (blood
18 spitting). Respondent agreed an elevated blood count would be a sign of infection, and the Board
19 noted Respondent did not do a CBC. Respondent next saw EA in April 2004 and EA felt he still
20 had the pleural reaction on the right that was little changed from earlier films and the radiologist's
21 report for 2004 found a volume loss in the right hemothorax with mediastinal shift, extensive
22 pleural and parenchymal disease, pleural fluid and/or pleural scarring on the right, limited
23 parenchymal disease at the left base and the left pleural effusion had gone away entirely.
24 Respondent noted EA was in no worse shape than previous visits. The Board asked what
25 Respondent thought of EA's weight being 158 pounds – twenty-seven pounds light than when EA
first presented. Respondent testified EA's weight was within one pound of the statistical median

1 between the lower end of body mass and the upper end of body mass. The Board asked if this
2 weight loss in EA was significant. Respondent testified it was not because excess mortality is not
3 reported in the elderly unless the body mass index declines below 22 and his body mass index
4 was at 23, comfortably above the danger zone and weight tables for the elderly show the
5 phenomenon of decline in weight with advancing age in healthy subjects absent disease.

6 12. Respondent noted literature suggested a minimum for weight loss beyond which
7 intervention should be entertained of ten percent of body mass loss in a period of six months or
8 less and, for EA, that would calculate to an annual weight loss of 31.6 pounds and his annual
9 weight loss never exceeded eight pounds per year. The Board noted the data evades the point –
10 EA had a significant weight loss that was an indicator of worsening health and the data does not
11 address that. The Board noted EA had a worsening chest x-ray by Respondent's own admission,
12 a worsening clinical picture by his subjective complaints, worsening pulse oximetry, and then
13 significant weight loss and Respondent continued to maintain there was no intervention required.
14 Respondent explain he did not need to take any action because of the risk and benefit of the
15 proposed biopsy included lung puncture or collapse, respiratory collapse, ventilator dependency,
16 bleeding, hemorrhage and death. The benefits would not include diagnosis of Valley Fever
17 because the serologies have shown EA developed Valley Fever after leaving his care and the
18 best that could be hoped for from biopsy was confirmation of pleural and/or parenchymal fibrosis;
19 the prospective clinical confidence he had at the time that a biopsy would provide key clinical
20 information; and a brief consideration of EA's right to self-determination to decline diagnostic
21 and/or therapeutic intervention. The Board asked if Respondent agreed with the analysis of the
22 consultant for the Board that there is no definitive proof EA did not have coccidiomycosis while
23 under Respondent's care. Respondent did not and noted that the consultant found EA developed
24 Valley Fever is 200A and Respondent missed the diagnosis from that point forward, but the
25 positive IgM serology, which is the acute phase reaction on June 1 or thereabouts puts to rest the
idea EA had it in 2002.

1 13. The Board noted Respondent's record stated "an equally valid approach would be
2 to simply follow with chest x-rays" and asked if Respondent stood by that statement. Respondent
3 did and noted it was important to realize exactly what was being said – EA did not want to CT
4 scan so Respondent said they could continue with the x-rays. The Board confirmed Respondent
5 and the radiologist made the diagnosis of pulmonary fibrosis based strictly on the x-rays. The
6 Board asked the prevalence of coccidiomycosis is in Arizona. Respondent noted 98 percent of
7 people that live in Arizona acquire and get over a case of Valley Fever within two years of
8 residency. Respondent noted the symptoms of Valley Fever are fever, cough, malaise, arthralgia,
9 anorexia, headache, pleuritic chest pain, and erythema nodosa. The Board asked which of these
10 symptoms EA manifested. Respondent noted EA only had the cough and it is not a sufficient
11 platform upon which to posit the need for workup of Valley Fever. The Board asked if EA's weight
12 loss could have been a manifestation of anorexia. Respondent stated it could, but EA never
13 complained of decreased appetite. The Board asked if Respondent ever asked EA about his
14 appetite and Respondent noted he did not. The Board asked whether, with the prevalence of
15 Valley Fever should it not have been a diagnosis on his list of differential diagnoses as a
16 possibility. Respondent noted this was an excellent point, but the cough was the only symptom
17 and this is not a sufficient reason to proceed with a workup for Valley Fever because a cough is a
18 ubiquitous symptom in pulmonary disease and, if he demand EA be worked up serologically for
19 Valley Fever based on the cough alone, one could argue EA should have been worked up
20 serologically for sarcoid. The Board disagreed because Valley Fever is more common than
21 sarcoid.

22 14. The Board asked if in a patient presenting with three years' current symptoms or
23 weight reduction, fatigue, worsening x-ray, a simple blood test might have been beneficial.
24 Respondent testified he was not aware EA was complaining of fatigue and when you look at his
25 weight loss it was within the realm of expectation from aging alone and was normal. The Board
asked how many eighty-five year-old people tend to lose 27 pounds. Respondent testified a good

1 number do. The Board noted Respondent had an elderly man he was following for pulmonary
2 disease who has a relatively large weight loss over a short period of time, yet Respondent did not
3 do something as simple as getting a serology to look for something obvious, and asked him to
4 explain. Respondent testified EA's body weight was normal and was declining at a rate that would
5 be expected from aging alone, and EA had significant pleural fibrosis on the right that was
6 organized. Respondent agreed something simple could have been done such as drawing a blood
7 test for Valley Fever at any point, but there was no clinical indication for it.

8 15. The Board reminded Respondent he testified he recommended a CT to EA and
9 EA declined and then directed Respondent to his medical record, specifically to the June 12,
10 2003 note reading "[h]ave mentioned to him that we could follow-up the increased rounded
11 reaction in the right upper chest with a CT, but I think that an equally valid approach would be to
12 simply follow with plain chest x-rays given the fact that he is basically asymptomatic." The board
13 noted this note reveals Respondent considered a CT, but decided not to proceed and there is no
14 note that EA refused the CT. Respondent acknowledged the Board was correct and there is
15 nothing he can do to refute the note other than to say his recollection is that he discussed the
16 findings, what they could do about them, and EA refused the CT. The Board noted the record
17 appeared to show that somewhere along the line Respondent developed tunnel vision regarding
18 EA, stopped looking for an etiology, and justified his failure to do anything additional by the fact
19 that EA's spirometry results looked good, his oxygen saturations remained in the 90s and he
20 wrote off the weight loss as normal weight loss with age.

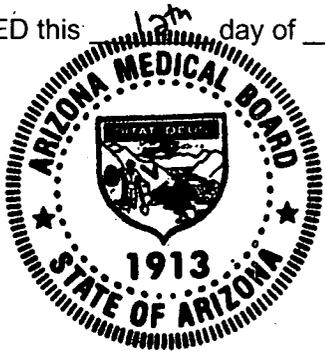
21 16. The standard of care required Respondent to pursue the etiology of the original
22 abnormal chest x-ray and EA's progressively worsening clinical picture and to appreciate the
23 progression of the chest x-ray abnormalities.

24 17. Respondent deviated from the standard of care because he did not pursue the
25 etiology of the original chest x-ray or EA's progressively worsening clinical picture and because
he failed to appreciate the chest x-ray abnormalities.

1 Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a
2 petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35)
3 days after it is mailed to Respondent.

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

6 DATED this 13th day of October, 2006.



THE ARIZONA MEDICAL BOARD

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

12 ORIGINAL of the foregoing filed this
13 13th day of October, 2006 with:
14 Arizona Medical Board
15 9545 East Doubletree Ranch Road
16 Scottsdale, Arizona 85258

17 Executed copy of the foregoing
18 mailed by U.S. Mail this
19 13th day of October, 2006, to:

20 Stephen M. Booth
21 Kent & Wittekind, P.C.
22 111 West Monroe Street – Suite 1000
23 Phoenix, Arizona 85003-1731

24 John N. Glover, M.D.
25 Address of Record

John N. Glover