

1 express or implied, of the Board's statutory authority or jurisdiction regarding any other
2 pending or future investigation, action or proceeding. The acceptance of this Consent
3 Agreement does not preclude any other agency, subdivision or officer of this State from
4 instituting other civil or criminal proceedings with respect to the conduct that is the subject
5 of this Consent Agreement.

6 6. All admissions made by Respondent are solely for final disposition of this
7 matter and any subsequent related administrative proceedings or civil litigation involving
8 the Board and Respondent. Therefore, said admissions by Respondent are not intended
9 or made for any other use, such as in the context of another state or federal government
10 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or
11 any other state or federal court.

12 7. Upon signing this agreement, and returning this document (or a copy thereof) to
13 the Board's Executive Director, Respondent may not revoke the acceptance of the
14 Consent Agreement. Respondent may not make any modifications to the document. Any
15 modifications to this original document are ineffective and void unless mutually approved
16 by the parties.

17 8. If the Board does not adopt this Consent Agreement, Respondent will not
18 assert as a defense that the Board's consideration of this Consent Agreement constitutes
19 bias, prejudice, prejudgment or other similar defense.

20 9. This Consent Agreement, once approved and signed, is a public record that will
21 be publicly disseminated as a formal action of the Board and will be reported to the
22 National Practitioner Data Bank and to the Arizona Medical Board's website.

23 10. If any part of the Consent Agreement is later declared void or otherwise
24 unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force
25 and effect.

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11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) (“[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter”) and 32-1451.



MICHAEL A. EPSTEIN, M.D.

DATED: 4/2/07

FINDINGS OF FACT

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2 1. The Board is the duly constituted authority for the regulation and control of
3 the practice of allopathic medicine in the State of Arizona.

4 2. Respondent is the holder of license number 9945 for the practice of
5 allopathic medicine in the State of Arizona.

6 3. The Board initiated case number MD-05-0664A after receiving notification of
7 a malpractice settlement involving Respondent's care and treatment of a twenty-three
8 year-old female patient ("SJ").

9 4. On July 18, 2001 at 2:45 p.m. SJ was transported to the emergency room
10 following a reported seizure. The emergency room physician ("ER Physician") examined
11 SJ for altered mental status and seizures and noted SJ had increased motor activity and
12 tone, agitated behavior non-purposeful movements and constant lower and upper
13 extremity movements. ER Physician ordered laboratory tests and administered Pavulon
14 and Valium. SJ's computed tomography scan and drug screen were reported negative. ER
15 Physician's diagnosis was altered mental status with tachycardia ruling out a drug
16 overdose, indicating possible serotonin syndrome or status epilepticus. ER Physician
17 contacted Respondent telephonically at approximately 4:45 p.m. for a neurology
18 consultation and to discuss SJ's condition. Respondent suggested SJ have an
19 electroencephalogram ("EEG") if possible. Respondent did not immediately present to see
20 SJ.

21 5. On July 18, 2001, at approximately 6:00 p.m., Respondent evaluated SJ.
22 Respondent's dictation from that visit noted SJ demonstrated opsoclonus of her eye
23 movements, random darting movement of both eyes in a connective fashion, large pupils
24 that were otherwise symmetric and responsive, diffusely increased motor tone and that SJ
25 was not actively withdrawing from pain or sensation. Respondent's diagnosis was a benign

1 process of serotonin syndrome because SJ was afebrile and hyperflexia excluding a
2 neuroleptic malignant syndrome. Respondent noted SJ would recover over time when the
3 antidepressant medications wore off. Respondent noted an EEG was scheduled for the
4 next day and he ordered hospital staff to continue administering Dilantin while awaiting the
5 EEG results.

6 6. In response to the Board's investigation Respondent stated that he
7 immediately diagnosed SJ with status epilepticus. However, Respondent's dictated note
8 indicating he diagnosed SJ with serotonin syndrome contradicts this statement. There is
9 no evidence in the medical record indicating Respondent provided a differential diagnosis
10 of status epilepticus and a treatment plan after his evaluation of SJ on July 18, 2001.
11 Respondent did not see SJ until hours after her admission to the hospital and after his
12 evaluation Respondent did not develop a differential diagnosis or treatment plan. Also a
13 diagnosis of status epilepticus required Respondent to order an immediate EEG. In his
14 response, Respondent stated he ordered ER Physician to get a stat EEG, however, there
15 is no evidence in the record that Respondent ordered a stat EEG and when an EEG was
16 not available on July 18, 2001 there is no evidence in the medical record that Respondent
17 ordered SJ to be transferred to another hospital for an EEG. Specifically, in Respondent's
18 dictated note Respondent noted an EEG was scheduled for tomorrow, July 19, 2001.

19 7. Respondent also stated in his response that he ordered ER Physician to
20 administer Phenobarbital injections and this is confirmed with ER Physician's notes that
21 Respondent ordered Phenobarbital. However, in a handwritten nursing note on July 18,
22 2001 at 9:00 p.m. after ordering the Phenobarbital, Respondent ordered the nursing staff
23 not to administer the Phenobarbital and to return it to the pharmacy. Further, Respondent's
24 neurology consultation note does not mention he ever ordered Phenobarbital, rather he
25

1 ordered ER Physician to continue administering Dilantin for serotonin syndrome, while
2 awaiting the EEG results.

3 8. On July 19, 2001 at approximately 8:00 a.m. SJ obtained the EEG that
4 revealed status epilepticus. Respondent placed SJ in a Phenobarbital coma, but she never
5 regained consciousness. SJ was discharged to hospice on July 23, 2001 where she died
6 on July 26, 2001.

7 9. If a patient presents with possible status epilepticus, the standard of care
8 requires a physician to immediately evaluate the patient, develop a differential diagnosis,
9 obtain an EEG and treat the patient with Phenobarbital or benzodiazepines seizure
10 suppressants until status epilepticus is ruled out.

11 10. Respondent deviated from the standard of care because he did not
12 immediately evaluate SJ, he did not develop a differential diagnosis, he did not
13 immediately obtain an EEG and after ordering Phenobarbital, he did not administer
14 Phenobarbital or benzodiazepines to SJ before ruling out status epilepticus.

15 11. SJ died as a result of prolonged status epilepticus.

16 12. A physician is required to maintain adequate legible medical records
17 containing, at a minimum, sufficient information to identify the patient, support the
18 diagnosis, justify the treatment, accurately document the results, indicate advice and
19 cautionary warnings provided to the patient and provide sufficient information for another
20 practitioner to assume continuity of the patient's care at any point in the course of
21 treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because they do
22 not support his diagnosis of status epilepticus, note a treatment plan after his evaluation
23 on July 18, 2001, that he ordered a stat EEG or that he ordered SJ to be transferred to
24 another hospital.

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1 EXECUTED COPY of the foregoing mailed
this 10th day of June, 2007 to:

2
3 Larry J. Cohen
4 The Cohen Law Firm
5 PO Box 10056
6 Phoenix, Arizona 85064

7 EXECUTED COPY of the foregoing mailed
8 this 10th day of June, 2007 to:

9 Michael A. Epstein, M.D.
10 Address of Record

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Investigational Review