BEFORE THE BOARD OF MEDICAL EXAMINERS

IN THE STATE OF ARIZONA

In the Matter of: **DWIGHT C. LUNDELL, M.D.** Holder of License No. 6960 For the Practice of Medicine In the State of Arizona.	Investigation No. 11569 **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER (Censure with Probation)**

INTRODUCTION

This matter was considered by the Board of Medical Examiners (hereafter "Board") at its public meeting held on April 27, 2000. Dwight C. Lundell, M.D., appeared before the Board for the purpose of the Board conducting a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(G). After due consideration of the facts and law applicable to this matter, the Board voted at its public meeting on June 21-23, 2000, to issue the following Findings of Fact, Conclusions and Order for disposition of this matter.

FINDINGS OF FACT

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

2. Dwight C. Lundell, M.D., is the holder of Board License No. 6960 for the practice of allopathic medicine in the State of Arizona.

3. Board Investigation No. 11569 was initiated after Board staff received notification from the Credentialing Peer Review Committee of Intergroup Insurance Company that Dr. Lundell was suspended from performing any bilateral carotid endarterectomies pending completion of the peer review process. The aforementioned notification was

received by the Board in December of 1997.

4. The Credentialing Peer Review of Intergroup Insurance subsequently reported on or about February 27, 1998, that it had completed its review of Dr. Lundell and decided to reinstate his privileges to perform bilateral carotid endarterectomies.

5. On or about April 29, 1998, a Board subpoena was issued to Chandler Regional Hospital for medical records of patient R.T. who had been the patient of Dr. Lundell.

6. On or about October 29, 1998, Dr. Lundell appeared for an investigational interview Concerning patient R.T. that was conducted by Richard Zonis, M.D., Board Chief Medical Consultant and William Kennell, M.D., Board Medical Consultant, pursuant to *A.R.S. § 32-1451(C).* Due to the fact that Dr. Lundell indicated during the course of the aforementioned investigational interview that he was fully not prepared to discuss the treatment of patient R.T., the investigational interview was continued and resumed on December 2, 1998. The transcript of the aforementioned investigational interview was part of the materials available to Board members to review when considering this matter.

7. Dr. Lundell is a vascular surgeon who received his general surgical training at the University of Arizona, College of Medicine; and, he completed cardio-thoracic and vascular surgery residency at Yale University in 1979.

8. The medical records for patient R.T. established that he had severe vascular disease which warranted carotid surgery. R.T. underwent a left carotid endarterectomy on October 23, 1997, and the procedure was performed by Dr. Lundell. After the procedure was completed, the patient was taken to the post-anesthesia care unit; and, he was then transported to the intensive care unit at Desert Samaritan Hospital.

9. In his medical consultant report to the Board regarding the medical care provided to R.T. by Dr. Lundell, Dr. Kennell notes that according to the PACU record the patient received two milligrams of morphine intravenously in the recovery room at 11:43 a.m. The minute entry for transporting and receiving the patient at the ICU is identical. The clinical status, however, of R.T was reported by nursing staff as distinctly different. Dr. Kennell reported that when the patient was in the recovery room the nurse documented equal grip and strength bilaterally and responding to verbal stimuli. However, on arrival in the ICU, the nurse there noted that patient R.T. was difficult to arouse with no verbal response and a flaccid right arm. According to the nursing notes, Dr. Lundell was paged and updated on the patient's condition at 1:05 p.m., i.e., one and one half hours after the surgical procedure terminated. The only response was an authorization to administer Narcan to the patient. After administering Narcan, Dr. Lundell was again notified by the ICU nurse of the patient's condition.

10. According to the medical records for R.T., there is no physician assessment of R.T. until Dr. Lundell saw the patient at 5:00 p.m. on October 23, 1997. Dr. Lundell's assessment upon seeing R.T. is documented in the progress notes. Dr. Lundell's notes reflect that he recognized the neurological deficit and states "Doppler shows ICA flow." Dr. Kennell reports that this assertion by Dr. Lundell would imply a duplex evaluation of the carotid arteries which can be difficult post-operatively. However, no ultrasound (Doppler/Duplex study) was documented by Dr. Lundell in the patient's medical records, according to Dr. Kennell. During the course of the Board's formal interview, Dr. Lundell stated that he used a hand-held Doppler and felt the internal carotid of the patient was patent.

11. Dr. Lundell acknowledged during the Board's formal interview that use of the hand held Doppler is not as accurate as the ultrasound guided Doppler. Dr. Lundell acknowledged during the formal interview that the use of a hand-held Doppler ". . . is a crude test but we did it and felt it was open at that point in time and almost everyone thought it would too late to intervene - to make any change by intervening."

12. Dr. Lundell asserted during the Board's formal interview that subsequently an ultrasound guided Doppler was done. Dr. Lundell asserted that the ultrasound guided Doppler showed a disclosed occlusion of the internal carotid artery.

13. Dr. Kennel reported that his review of the patient records disclosed that there was no further evaluation of the patient by Dr. Lundell until the morning of October 24, 1997 when a neurology consult was requested and a CT scan ordered. The CT scan demonstrated that the patient had massive left hemispheric infarction from which the patient made no significant recovery. R.T. was ultimately transferred to hospice care and later died.

14. Dr. Kennell reported that peri-operative stroke is a well known complication of carotid endarterectomy. Acute carotid thromobisis is the most frequent cause of this event and most modern critical reviews would assert a stroke rate in excess of five percent is unacceptable.

15. Dr. Kennell reported to the Board that the patient records for R.T. do document substandard care for the reason that R.T., while recovering from a carotid endarterectomy, had an obvious change in neurological status with virtually no attempt at either evaluation or therapy for at least four hours by Dr. Lundell. Although post-operative stroke is a devastating complication where the precise cause can not always be identified and treatment may not

always alter clinical outcome, prompt evaluation by a qualified physician, if not the surgeon himself, is a minimal standard of care.

16. Dr. Kennell further reported that in the absence of any documentation regarding the status of carotid artery (intro-operative arteriography or duplex evaluation) most vascular surgeons would recommend immediate re-exploration of the patient with a post-operative stroke following carotid surgery. Timing is critical in that the best results are obtained in those patients who undergo early evaluation and therapy. Dr. Lundell did not follow the aforementioned preferred course of action.

17. In regard to Dr. Lundell's slow response to notification of a Board investigation and request for patient records in this matter, Dr. Lundell received three notices from Board staff requesting medical records. The original request was sent of February 12, 1998 from Mark Speicher, former Board executive director. Dr. Lundell did not submit to Board staff his medical records for R.T. until on or about June 24, 1998, i.e., approximately four months after the original request for production of medical records. During the course of the Board's formal interview with Dr. Lundell he was asked to explain the four month delay in producing the patient records and Dr. Lundell responded that he did not have an answer to the question. However, during the course of additional questioning, he indicated that he did not intentionally withhold the information sought by the Board staff. Instead he was under the impression a different patient had been the subject of the peer review by Intergroup Insurance who was also treated at Chandler Regional Hospital.

18. The record keeping by Dr. Lundell for patient R.T. was deficient. Another physician receiving Dr. Lundell's patient records would be unsure of what the medical issues

were concerning R.T. and what was done intra-operatively for the patient, which would be very relevant to the further care and treatment of the patient.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Dr. Lundell, pursuant to *A.R.S. § 32-1401 et seq.*

2. The conduct and circumstances described above in paragraphs 8 through 18 constitute unprofessional conduct as defined at Board statute as follows:

> *A.R.S. § 32-1401(25)(a)*: Failing or refusing to maintain adequate records on a patient.
>
> *A.R.S. § 32-1401(25)(q)*: Any conduct or practice which is or might be dangerous to the health of the patient or public.
>
> *A.R.S. § 32-1401(25)(ll)*: Conduct that the Board determines is . . . negligence resulting in harm or the death of a patient.
>
> *A.R.S. § 32-1401(25)(dd)*: Failing to furnish information in a timely manner to the Board or its investigators or representatives if legally requested by the Board.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that:

1. Dr. Lundell is issued a Decree of Censure for the aforementioned unprofessional conduct; and,

2. He is assessed a civil penalty of $2500.00 to be paid within 15 days of this Order becoming final and effective; and,

3. He is placed on probation for a period of two (2) years and as a condition of

probation he shall comply with the following:

a. In addition to the minimum mandated statutory requirements for continuing medical education (CME), Dr. Lundell shall provide documentary proof to Board staff of satisfactorily completing twenty (20) hours of Board staff pre-approved CME in carotid surgery which shall also include treatment of the patient in the peri-operative period and he shall obtain an additional ten (10) hours of Board staff pre-approved CME in maintaining patient medical records; and,

b. The aforementioned CME must be completed within six months from the effective date of this Order; and,

4. Subsequent to the completion of the CME mandated by this Order, Board staff shall conduct a patient record review of Dr. Lundell's practice. Said patient chart review shall include operative reports of 20 cases completed by Dr. Lundell prior to the issuance of this Order and another 20 surgical cases performed Dr. Lundell after he has completed the aforementioned CME. Dr. Lundell shall promptly comply with Board staff requests for production of the aforementioned patient records.

RIGHT TO FILE MOTION FOR REHEARING OR REVIEW

Dr. Lundell is hereby notified that he has a right to file a motion for rehearing of this matter with the Board pursuant to A.R.S. § 41-l092.09, as amended. A motion for rehearing must be filed with Board's Executive Director in writing within thirty (30) days after service of this Order. Pursuant to A.A.C. R4-16-102, said motion must set forth legally sufficient reasons for granting a rehearing. Service of this Order is effective on the aforementioned physician five (5) days after the date of mailing this Order by Board staff to his address of record. If the motion for rehearing is not timely filed, the Board's Order

becomes effective thirty-five (35) days after it has been mailed to the physician named herein.

Notice is also hereby given that a filing of a motion for rehearing is required to preserve any rights of appeal of this Order to the Superior Court. And the failure to file a timely motion for rehearing or review shall have the affect of waiving the physicians right to seek judicial review of the Board's decision in this matter. *See A.R.S. § 41-1092.09(B).*

ISSUED this 27 day of June, 2000.

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

(SEAL)

By: Tom Adams
CLAUDIA FOUTZ
Executive Director,
TOM ADAMS
Assistant Director for Regulation

Original of the foregoing filed this
27 day of June, 2000 with:

Board Operations Section
Arizona Board of Medical Examiners
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Executed copy of the foregoing
mailed by U.S. certified mail this
27 day of June, 2000, to:

Dwight C. Lundell, M.D.
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COPY of the foregoing mailed this
27 day of June, 2000, to:

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Amanda Reid
Board Operations