BEFORE THE ARIZONA MEDICAL BOARD

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| In the Matter of<br><br>**DWIGHT C. LUNDELL, M.D.**<br><br>Holder of License No. **6960**<br>For the Practice of Allopathic Medicine<br>In the State of Arizona. | Board Case No. MD-02-0478A<br><br>**FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER**<br><br>(Decree of Censure & Probation) |

The Arizona Medical Board ("Board") considered this matter at its public meeting on October 8, 2003. Dwight C. Lundell, M.D., ("Respondent") appeared before the Board with legal counsel, Heather Hendrix, for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). After due consideration of the facts and law applicable to this matter, the Board voted to issue the following findings of fact, conclusions of law and order.

## 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.

3. In June 2000 the Board issued an Order for a Decree of Censure and Probation to Respondent. One of the terms of probation provided that Board Staff would conduct a chart review after Respondent had completed continuing medical education ("CME") in medical record keeping. Board Staff conducted the ordered chart review and forwarded 20 charts to a Board Medical Consultant ("Medical Consultant") for review. The Medical Consultant opined that 13 of the 20 charts fell below the acceptable standards of practice for medical chart maintenance.

4. Respondent testified that although Medical Consultant opined that Respondent's chart for patient T.D. had inadequate documentation of peripheral vascular disease, the chart did contain an outside Doppler ultrasound report, an office Doppler report, a history and physical examination by a primary care physician, as well as an arteriogram. Respondent stated that there can be no further complete examination of peripheral vascular disease than this. Respondent also noted that although Medical Consultant opined that Respondent's chart for patient K.K also had inadequate documentation of peripheral vascular disease, the chart did contain ten separate individual vascular tests, a CT scan, ultrasound, an aortogram with runoff, a carotid magnetic resonance angiogram, an arterial Doppler, a carotid Doppler, a popliteal arterial Doppler and ultrasound, a femoral arterial Doppler and ultrasound, and microscopic examination of the artery. Respondent noted that the history, physical, discharge summary and operative notes were all contained in the chart. Respondent addressed additional charts that the Medical Consultant had opined on. Respondent testified that the Board had been provided with an inaccurate, incomplete and extremely biased report.

5. Medical Consultant was asked if the additional material Respondent indicated was in his patients' charts was in the charts reviewed by Medical Consultant. Medical Consultant stated that the additional material was in the charts, but that he believed the acceptable standard of practice required Respondent to evaluate the patient with a history and physical to decide if the additional studies are warranted rather than simply noting a patient has trouble walking and then order an arteriogram and other studies that are then accumulated as a full chart. Medical Consultant stated that doing so does not relieve the physician of the responsibility of doing an adequate initial evaluation and documenting his findings. Medical Consultant noted that Respondent's initial

evaluations were incomplete and insufficient and eventually additional studies were added to the chart.

6. Respondent testified that he is currently active in the practice of cardiovascular and thoracic surgery, operating on seven or eight patients per week with between 5 and 10 patients in the hospital at any given time. In regard to patient G.H. who Respondent diagnosed with severe bilateral carotid stenosis on the order of 80 to 99 percent bilaterally, and noted that she would be sent for an MRA "to assess further problem", Respondent was asked where in G.H.'s chart his history and physical could be located. Respondent stated that there was no physical examination other than the dictated directed examination, that no physical examination was performed during the preoperative visit. Respondent was also asked where in the chart G.H.'s symptoms were noted. Respondent stated that they were not.

7. Respondent testified that when he sees a new patient in his office he obtains a complete history and it is recorded, not in the chart at that time, but when the patient is admitted to the hospital. Respondent was asked how he remembered what the history and physical revealed between the time he sees the patient preoperatively in the office and when he dictates it at the hospital. Respondent testified that he remembers it and if he forgets something, he asks the question again. Respondent reiterated that he does not document his preoperative history and physical.

8. Respondent was asked what conditions other than carotid stenosis a patient who presents with dizziness could have. Respondent noted a patient with dizziness could be suffering from a wide variety of conditions. Respondent testified that in G.H.'s case he did not rule out other conditions, such a brain tumor or intracranial arterial stenosis, before going ahead with the surgery. Respondent stated that he did not believe doing so was necessary because with severe stenosis stroke prevention is critical and the surgery is the

first thing that should be done unless there are signs and symptoms indicating one would do anything else.

9. Medical Consultant noted that there were no deficiencies in the selection of surgical candidates and there was no question that the surgeries performed were appropriate. Medical Consultant summed up for the Board that the deficiencies he found were not in Respondent's operative reports, discharge summaries or his hospital based history and physicals, but solely in the record of the initial encounter with the patient. Medical Consultant noted that he took issue with the simple notes in Respondent's charts that say "dizzy," or "bruits," because these abbreviations do not show any depth of knowledge or knowledge of the patient as to whether the patient is actually a suitable candidate. Medical Consultant noted that, regardless of the reports received from other physicians, a physician needs to do his/her own history and physical because the physician has his/her own focus as to what he/she needs to know about the patient.

10. Respondent was asked how his records differ now that he was previously required to complete CME in record keeping. Respondent stated that his charts are more complete, more organized and the preoperative checklist and history examination is more complete. However, in some of the cases reviewed by the Board the check sheets, histories and physicals are the same in that there a blood pressure noted and maybe one or two additional words and no further history or physical. Also, although the charts contain checklists, Respondent does not utilize them.

11. Medical Consultant also noted that although reports from other physicians and testing reports are in the patient's chart, Respondent does not note the existence of the reports or what they mean to him and how his assessment of the patient is impacted by the reports. Respondent's notes do not show that he has this additional information available to him, what parts of it relate to his surgery and what his thinking is.

12. Respondent testified that the statute requires only that he "maintain" an adequate record, not that he create one. Respondent's argument is without merit.

## CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances constitute unprofessional conduct pursuant to A.R.S. § 32-1401(26)(e) ("[f]ailing or refusing to maintain adequate records on a patient.")

## ORDER

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

IT IS HEREBY ORDERED that:

1. Respondent is issued a Decree of Censure for failing or refusing to maintain adequate records

2. Respondent is placed on probation for two years with the following terms and conditions:

a. Board Staff shall conduct quarterly chart reviews during the term of probation. Respondent shall bear the expense of the chart reviews. The Board retains jurisdiction to take additional disciplinary or remedial action based upon the results of the chart reviews.

## RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive

Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09. The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

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

DATED this 14th day of November, 2003.


ARIZONA MEDICAL BOARD

BARRY A. CASSIDY, Ph.D., PA-C
Executive Director

ORIGINAL of the foregoing filed this 17th day of November 2003 with:

The Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 17th day of November, 2003, to:

Heather Hendrix
770 North Monterey
Suite F
Gilbert, Arizona 85233-3821

Executed copy of the foregoing
mailed by U.S. Mail this
17th day of November, 2003, to:

Dwight C. Lundell
Address of Record