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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of  
**DWIGHT C. LUNDELL, M.D.**  
Holder of License No. **6960**  
For the Practice of Allopathic Medicine  
In the State of Arizona.

Board Case No. MD-02-0478A

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

(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.

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

16           5.     Medical Consultant was asked if the additional material Respondent  
17 indicated was in his patients' charts was in the charts reviewed by Medical Consultant.  
18 Medical Consultant stated that the additional material was in the charts, but that he  
19 believed the acceptable standard of practice required Respondent to evaluate the patient  
20 with a history and physical to decide if the additional studies are warranted rather than  
21 simply noting a patient has trouble walking and then order an arteriogram and other  
22 studies that are then accumulated as a full chart. Medical Consultant stated that doing so  
23 does not relieve the physician of the responsibility of doing an adequate initial evaluation  
24 and documenting his findings. Medical Consultant noted that Respondent's initial  
25

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

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

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

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

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

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

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

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



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

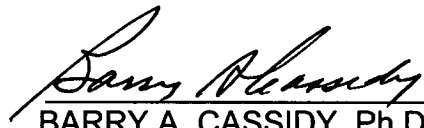
6 Respondent is further notified that the filing of a motion for rehearing or review is  
7 required to preserve any rights of appeal to the Superior Court.

8 DATED this 14<sup>th</sup> day of November, 2003.

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ARIZONA MEDICAL BOARD

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

ORIGINAL of the foregoing filed this  
17<sup>th</sup> day of November, 2003 with:

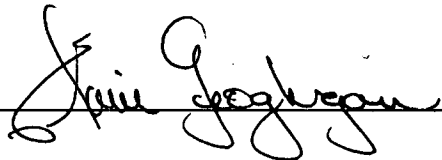
The Arizona Medical Board  
9545 East Doubletree Ranch Road  
Scottsdale, Arizona 85258

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

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

1 Executed copy of the foregoing  
2 mailed by U.S. Mail this  
3 17 day of ~~June~~ 2003, to:

4 Dwight C. Lundell  
5 Address of Record

6  A handwritten signature in cursive script, appearing to read "Dwight C. Lundell", is written over a horizontal line. The signature is positioned between the 5th and 6th line numbers.

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