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# BEFORE THE BOARD OF MEDICAL EXAMINERS IN THE STATE OF ARIZONA

In the Matter of

THOMAS J. ROSE, M.D.

Holder of License No. 17017 For the Practice of Medicine In the State of Arizona. Case No. MD-00-0772

CONSENT AGREEMENT FOR A LETTER OF REPRIMAND AND PRACTICE RESTRICTION

#### **CONSENT AGREEMENT**

By mutual agreement and understanding, between the Arizona Board of Medical Examiners ("Board") and Thomas J. Rose, M.D. ("Respondent"), the parties agreed to the following disposition of this matter at the Board's public meeting on June 13, 2002.

- 1. Respondent acknowledges that he has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order. Respondent acknowledges that he understands he has the right to consult with legal counsel regarding this matter and has done so or chooses not to do so.
- 2. Respondent understands that by entering into this Consent Agreement for the issuance of the foregoing Order, he voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement and the Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.
- 3. Respondent acknowledges and understands that this Consent Agreement and the Order will not become effective until approved by the Board and signed by its Executive Director.
- 4. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving

If any part of the Consent Agreement and Order is later declared void or otherwise unenforceable, the remainder of the Order In its entirety shall remain in force and effect:

Neil Mden, Attorney at Law (Counsel For Thomas J. Rose) Reviewed and accepted this\_

Reviewed and approved as to form this 18/16 day of

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- 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. 17017 for the practice of medicine in the State of Arizona.
- 3. The Board initiated case number MD-00-0772 after receiving notice of a malpractice settlement.
- 4. Patient C.A., a twenty-seven year-old female, who had a three month history of severe headaches, presented to urgent care on June 8, 1997. Patient C.A. also complained of vomiting 10-13 times per day, increased sensitivity to noise and light, increased pressure in the back of the head and flickering lights. The urgent care physician recommended a CT scan, non-emergent, and that Patient C.A. follow-up with Respondent, her primary care physician and an ophthalmologist within one week.
- 5. On June 12, 1997, Respondent saw Patient C.A. for the first time. Patient C.A. continued to complain of migraines and informed Respondent of the prior urgent care visit. Respondent did not follow-up on the urgent care recommendation.
- 6. During the June 12, 1997 visit, Respondent administered a trial of Imitrex, SQ in the left arm, followed by Phenergan and Demerol in the right arm. A CT scan was ordered and was negative.
- 7. On June 24, 1997, a nurse practitioner examined Patient C.A., who complained of headaches with increase intensity, dizziness, gait change, palpitations in the right occipital regions, and vision blackouts. The nurse practitioner administered an injection of Toradol 60 mg, prescribed Toradol 10 mg, and made a referral to a neurologist.

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- 8. On June 26, 1997, Respondent examined Patient C.A., who now complained of transient blindness in the field of vision of both eyes, which is known as homonymous hemianopsia. Patient C.A. also complained of the previous symptoms. A neurological exam was normal and the head CT scan was negative. Respondent administered Phenergan and Demerol and prescribed Inderal and Percocet.
- 9. At that time, the referral to the neurologist had not been authorized but Patient C.A.'s complaints of transient homonymous hemianopsia should have resulted in an immediate neurological consult.
- 10. Patient C.A. continued to complain of severe headaches, dizziness, vomiting, photosensitivity, and vision blackouts. The nurse practitioner saw her on July 3 and 10, 1997. However, the referral to the neurologist had not been authorized.
- 11. On July 24, 1997, Patient C.A. received authorization for the neurological consultant and an appointment was scheduled. However, Patient C.A. arrived late and the appointment was cancelled. Respondent did not contact the neurologist about the cancelled appointment.
- 12. Respondent examined Patient C.A. on August 11, 1997. The examination noted the same findings, except for a new complaint of visual scotomata, but Respondent did not examine the eye.
- 13. On August 20, 1997, Patient C.A. returned to Respondent's office with complaints of visual blurring and blackouts. A physical examination revealed fundi with bilateral papilledema. Respondent diagnosed possible pseudotumor cerebri versus a mass lesion.
- 14. Respondent immediately sent Patient C.A. to the emergency room for a CT of the head and lumbar. The CT scans of the lumbar spine puncture revealed a markedly

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high opening pressure of 48 cm. A visual acuity test in the emergency room corroborated that Patient C.A. had no vision.

- 15. Rudolf Kirschner, M.D., Board Medical Consultant, reviewed the case and concluded that Respondent's diagnosis and treatment of Patient C.A. fell below the acceptable standard of care. Specifically, Dr. Kirschner noted Respondent's failure to personally contact the insurance company or the neurologist regarding the urgency. Dr. Kirschner also noted that Respondent failed to exam Patient C.A.'s eye after the complaint of scotoma.
- 16. During an April 8, 2002 investigation interview, Respondent admitted that he failed to ensure that the neurological consult was timely and failed to appreciate the severity of Patient C.A.'s condition and lack of improvement after treatment.
- 17. Respondent did not meet the standard of care in diagnosing and treating patient C.A.'s severe neurologic problem, which resulted in total permanent blirdness.

### **CONCLUSIONS OF LAW**

- The Board possesses jurisdiction over the subject matter hereof and over Respondent.
- 2. The conduct and circumstances above in paragraphs 5 through 16 constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (25)(q) ("[a]ny conduct or practice which is or might be harmful or dangerous to the health of the patient or the public.")
- 3. The conduct and circumstances above in paragraphs 5 through 16 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(II) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.")

#### **ORDER**

## IT IS HEREBY ORDERED THAT:

- 1. Respondent is issued a Letter of Reprimand for his failure to perform an adequate physical examination, to properly diagnose pseudotumor cerebri, to timely arrange referrals to specialists, to act on the urgent care physician's recommendations, and failure to follow-up or discuss Patient C.A. with the specialist.
- 2. Respondent shall not practice clinical medicine or any medicine involving direct patient care, and is prohibited from prescribing any form of treatment including prescription medications, until Respondent applies to the Board and affirmative y receives the Board's approval to return to practice. The Board may require any combination of staff approved physical examination, psychiatric and/or psychological evaluations, or successful passage of the Special Purpose Licensing Examination or other competency examination/evaluation or interview it finds necessary to assist it in determining Respondent's ability to safely and competently to return to the active practice of medicine.
- 3. The Board retains jurisdiction to initiate a new investigation based on any violation of this Order.
  - 4. This Order is the final disposition of case number MD-00-0772.

DATED this 13th day of \_\_\_\_\_\_, 2002.

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA



CLAUDIA FOUTZ, Executive Director

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1	ORIGINAL of the foregoing filed this
2	
3	The Arizona Board of Medical Examiners 9545 East Doubletree Ranch Road
4	Scottsdale, AZ 85258
5	EXECUTED copy of the foregoing
6	mailed by U.S. Certified Mail this
7	<u> 14を</u> day of <u> </u>
8	Neil Alden, Esq. Sanders & Parks, PC
9	3030 N. Third St., Ste. 1300 Phoenix, AZ 85012
10	
11	EXECUTED copy of the foregoing mailed this \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
12	1
13	Thomas J. Rose, M.D. 4141 N Scottsdale Rd Ste 300
14	Scottsdale, AZ 85251-3938
15	COPY of the foregoing hand-delivered this
16	<u>। 144</u> day of <u>। 1014</u> , 2002, to:
17	Christine Cassetta Assistant Attorney General
18	Sandra Waitt, Management Analyst Lynda Mottram, Compliance Officer
19	Investigations (Investigation File) Arizona Board of Medical Examiners
20	9545 East Doubletree Ranch Road
21	Scottsdale, AZ 85258
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-23	Jan foogligus
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In the Matter of

THOMAS J. ROSE, M.D.

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Case No. MD-00-0772

AMENDMENT TO CONSENT AGREEMENT AND ORDER DATED JUNE 13, 2002

### INTRODUCTION

This matter was considered by the Arizona Medical Board ("Board") at its public meeting on October 2, 2002. The Board was presented with the request of Thomas J. Rose, M.D. ("Respondent") to amend the Consent Agreement for a Letter of Reprimand and Practice Restriction ("Board Order"), which he entered into with the Board on June 13, 2002. Respondent requested that the Board amend the Board Order to remove the practice restriction component only. After due consideration of the facts and law applicable to this matter, the Board voted to remove the practice restriction upon Respondent providing satisfactory documentation that he had successfully completed a Board approved evaluation program and passed the Special Purpose Licensing Examination ("SPEX").

Respondent has provided satisfactory documentation that he has successfully completed the Physician Assessment and Clinical Education Program ("PACE") and passed the SPEX examination.

#### **ORDER** 2 IT IS HEREBY ORDERED THAT: 3 1. Respondent's practice is no longer restricted and he may return to the practice of clinical medicine. 4 DATED AND EFFECTIVE this 24th day of December, 2002. 5 6 ARIZONA MEDICAL BOARD 7 [Seal] 8 9 **Executive Director** 10 11 ORIGINAL of the foregoing filed this <u>A4</u> day of <u>Dicentil</u>, 2002, with: 12 Arizona Medical Board 13 9545 E. Doubletree Ranch Road Scottsdale AZ 85258 14 15 EXECUTED COPY of the foregoing mailed by Certified Mail this Att day of Windy, 2002 to: 16 17 Neil Alden, Esq. 18 Sanders & Parks, PC 3030 N. Third St., Suite 1300 19 Phoenix, AZ 85012 Attorney of Record 20 21 EXECUTED COPY of the foregoing mailed this day of <u>Strumber</u>, 2002, to: 22 23 Thomas J. Rose, M.D. 4141 N. Scottsdale Road, Suite 300 24 Scottsdale, AZ 85251-3938

EXECUTED COPY of the foregoing hand-delivered this day of NIMM, 2002, to:

Christine Cassetta, Assistant Attorney General Sandra Waitt, Management Analyst Arizona Medical Board 9545 E. Doubletree Ranch Road Scottsdale, AZ 85258