BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **L. CLAIR MCDOUGALL, M.D.** Holder of License No. **19322** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-02-0002 **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 11, 2003. L. Clair McDougall, M.D., ("Respondent") appeared before the Arizona Medical Board ("Board") with legal counsel, Dan Jantsch, 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. 19322 for the practice of allopathic medicine in the State of Arizona.

3. The Board first considered this matter at a public meeting on July 10, 2002 when Respondent appeared for a formal interview without legal counsel. During the course of the interview the Board became concerned regarding Respondent's health and his affect. The Board continued the formal interview and ordered Respondent to submit to a bodily fluid test and to undergo certain medical evaluations. Respondent refused to submit to the bodily fluid test, but did complete all other evaluations.

4. The Board initiated case number MD-02-0002 after receiving notification of a medical malpractice settlement involving Respondent's care and treatment of a 35 year-old female patient ("AO").

5. On December 16, 1999, AO presented to Respondent for a well-woman check-up complaining of a vaginal growth that was swollen and painful. AO was examined by a nurse practitioner ("NP") who diagnosed AO as having a 3 centimeter nodule/cyst on the ***right*** side of AO's labia minora. Respondent performed surgery on AO on January 5, 2000 at Casa Grande Regional Medical Center removing an inclusion cyst from ***left*** side of the labia minor and electing not to perform surgery on the right side because AO had not discussed with him how much tissue to remove.

6. During an investigational interview Respondent related that AO's original admission, history and physical was performed by NP and dictated by another nurse in his office who had never examined the patient. Respondent stated that he did not perform the general examination himself. Respondent described AO as being very concerned with every part of her body and as being unhappy with the asymmetry of her vulva ever since a surgery Respondent performed 4 years earlier. Respondent had difficulty explaining his operative note that stated he had not adequately discussed with AO how much tissue was to be removed.

7. AO underwent a second surgery a few days after the January 5, 2000 surgery to remove the tissue from the right side. When the pathologist viewed the tissue from each surgery he did not find a cyst.

8. In response to queries from the Board, Respondent admitted he had operated on the wrong body part and that he had failed to perform a history and physical prior to taking AO to surgery. Respondent was asked how he could account for the description of the cysts when nothing was found in the pathology specimen. Respondent

stated that NP examined AO and he was called in to see AO. Respondent stated that he believed she had a cyst that was causing her discomfort. Respondent stated that at the time of surgery the patient is usually asked again about which side the problem is on, but AO had been put under before the circulating nurse could talk to her.

9. Respondent stated that when he examined AO at the time of surgery he did not see what he thought was there, but he did see on the other side where he had operated several years before what appeared to be scar tissue or a cyst. Respondent stated that he did not feel he should operate on the intended side because it did not look the same to him at the time of surgery. Respondent believed that there was a reoccurrence of the problem from the previous surgery, either scar tissue or something else that was bothering AO that she had mentioned from time to time. Since Respondent had discussed this problem with AO in the past, he decided to operate on AO's right side.

10. Respondent testified that in retrospect it might have been better not to do anything on either side. Respondent was asked if the standard of care required a physician in his specialty to operate on the correct side and to appropriately perform a history and physical to document his findings. Respondent stated that it did.

11. Respondent stated that since this incident he has downsized his practice and no longer does gynecology, only obstetrics. Respondent stated that he works every third night, soon to be every fourth night and every fourth weekend. Respondent noted that at the time of his first interview he was on call every night. Respondent also stated that he does not allow NP to schedule surgery and that a patient has to see him separately the day prior to surgery to indicate the areas to be operated on, which are then marked. Also, Respondent discusses the procedure in detail for a second time. Respondent informed the Board of the medications he is currently taking.

12. Respondent asked to explain why he did not comply with the Board Order to undergo a biological fluid test. Respondent stated that he had been taking Codeine (Tylenol #3) for a knee injury and he knew the Codeine would show up in the urine screen. Respondent said he was concerned about what would happen to him if the Codeine showed up. Specifically, he was concerned that the Board would believe he was addicted to Codeine and that his license would automatically be suspended. Respondent stated that he understood the seriousness of not complying with the Board Order and that it was a mistake for him not to comply. Respondent stated that he should have put his trust in the Board.

13. Respondent was asked if he was under the treatment of a physician who prescribed the Codeine to him. Respondent stated that he was not and that he had self-prescribed the Codeine. Respondent admitted that at the time he self-prescribed the Codeine he was aware that under the Medical Practice Act he was prohibited from self-prescribing such a controlled substance. Based on Respondent's admission to self-prescribing the Board inquired as to whether Respondent would waive notice of this violation and allow the Board to consider this conduct within the pending proceeding. Respondent consulted with counsel and agreed to waive notice.

14. The standard of care required a physician in Respondent's specialty to operate on the correct side and to appropriately perform a history and physical to document his findings.

15. Respondent fell below the standard of care because he did not operate on the correct side and did not appropriately perform a history and physical to document his findings.

16. AO was harmed by the unnecessary removal of tissue and by having to undergo a second surgery.

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 above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(24)(g) "[u]sing controlled substances except if prescribed by another physician for use during a prescribed course of treatment;" 32-1401(24)(r) "[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under the provisions of this chapter;" 32-1401(24)(q) "[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public;" and 32-1401(24)(ll) "[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient."

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for failing to operate on the correct side of the patient; failing to appropriately perform a history and physical to document his findings; self-prescribing a controlled substance; and failing to comply with a Board Order.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing or review must be filed with the Board's Executive Director within thirty days after service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a rehearing or review. Service of this order is effective five days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five 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 10th Day of July ,2003.

ARIZONA MEDICAL BOARD

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

ORIGINAL of the foregoing filed this 10th day of July 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 10th day of July, 2003, to:

Dan Jantsch
Olson Jantsch & Bakker PA
7243 North 16th Street
Phoenix, Arizona 85020-7250

Executed copy of the foregoing
mailed by U.S. Mail this
10th day of July, 2003, to:

L. Clair McDougall, M.D.
1820 East Florence Boulevard
Suite B
Casa Grande, Arizona 85222-5335

Copy of the foregoing hand-delivered this
10th day of July, 2003, to:

Christine Cassetta
Assistant Attorney General
Sandra Waitt, Management Analyst
Investigations (Investigation File)
Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Sandra Waitt