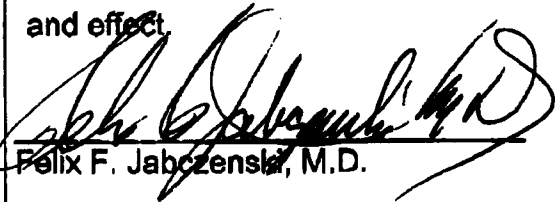


1 4. All admissions made by Respondent are solely for final disposition of this
2 matter and any subsequent related administrative proceedings or civil litigation involving
3 the Board and Respondent. Therefore, said admissions by Respondent are not intended
4 or made for any other use, such as in the context of another state or federal government
5 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or
6 any other state or federal court.

7 5. Respondent acknowledges and agrees that, although the Consent
8 Agreement has not yet been accepted by the Board and issued by the Executive Director,
9 upon signing this agreement, and returning this document (or a copy thereof) to the
10 Board's Executive Director, Respondent may not revoke his acceptance of the Consent
11 Agreement and Order. Respondent may not make any modifications to the document.
12 Any modifications to this original document are ineffective and void unless mutually
13 approved by the parties.

14 6. Respondent further understands that this Consent Agreement and Order,
15 once approved and signed, shall constitute a public record document that may be publicly
16 disseminated as a formal action of the Board.

17 7. If any part of the Consent Agreement and Order is later declared void or
18 otherwise unenforceable, the remainder of the Order in its entirety shall remain in force
19 and effect.

20 
21 Felix F. Jabczynski, M.D.

Reviewed and accepted this 3
day of December, 2001.

FINDINGS OF FACT

1
2 1. The Board is the duly constituted authority for the regulation and control of
3 the practice of allopathic medicine in the State of Arizona.

4 2. Respondent is the holder of license number 3880 for the practice of
5 allopathic medicine in the State of Arizona.

6 3. The Board initiated case number MD-99-0724 after receiving notification of
7 malpractice settlement from Respondent's malpractice insurer.

8 4. On July 4, 1997, patient L.O., a 49 year-old male, entered the Emergency
9 Room at Carondelet St. Mary's Hospital in Tucson, Arizona complaining of severe
10 epigastric and uncontrollable abdominal pain.

11 5. Russell Madsen, M.D. ("Dr. Madsen") examined patient L.O. and reviewed
12 patient L.O.'s previous charts, which revealed a history of hypertension, gallbladder
13 disease and cardiovascular problems. Due to patient L.O.'s cardiovascular problems,
14 another physician opined not to perform surgery in 1993..

15 6. Dr. Madsen diagnosed acute abdominal pain and cholecystitis with
16 cholelithiasis, consulted with Respondent by telephone, and admitted patient L.O. for
17 surgical intervention. An EKG was performed, which noted abnormal sinus rhythm, left
18 axis deviation, incomplete left bundle branch block, left atrial enlargement, and a left
19 ventricular hypertrophy with ST-T abnormalities.

20 7. At 8:00 am on July 5, 1997, Respondent performed a brief history and
21 physical, diagnosed acute cholecystitis and cystic duct obstruction. Respondent did not
22 make note of a pre-operative chest x-ray or the abnormal EKG, and failed to review
23 previous patient records.

1 8. At 10:00 am the nursing staff noted an elevated blood pressure.
2 Subsequently, the anesthesiologist performed a pre-operative anesthesia evaluation. The
3 physical examination was unremarkable and patient L.O. denied any history of drug use.

4 9. The anesthesiologist proceeded to administer Labetalol and Esmolol.
5 Patient L.O.'s blood pressure dropped to 40 systolic and CPR was instituted. Patient L.O.
6 remained in a coma and eventually died on July 23, 1997.

7 10. William J. Kennell, M.D., Board Medical Consultant, reviewed the case and
8 concluded that Respondent failed to adequately evaluate patient L.O. for surgery.
9 Specifically, Respondent ignored patient L.O.'s medical history of hypertension and
10 cardiac problems. Additionally, Respondent failed to review medical records present at
11 the hospital and the nurses' notes.

12 11. Respondent fell below the standard of care in his pre-operative evaluation of
13 patient L.O.

14 12. On November 29, 2001, Respondent informed Board Staff that he is
15 predominately practicing administrative medicine, conducting general exams, ordering
16 tests, and referring patients to other physicians if additional care is warranted.

17 CONCLUSIONS OF LAW

18 1. The Board possesses jurisdiction over the subject matter hereof and over
19 Respondent.

20 2. The conduct and circumstances described above in paragraphs 3 to 11
21 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(l) ("conduct that the
22 board determines is gross malpractice, repeated malpractice or any malpractice resulting
23 in the death of a patient.")

24 3. The conduct and circumstances described above in paragraphs 3 to 11
25 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(q) ("any conduct or

1 practice which is or might be harmful or dangerous to the health of the patient or the
2 public.”)

3 4. The conduct and circumstances described above in paragraphs 3 to 11
4 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(II) (“[c]onduct that the
5 board determines is gross negligence, repeated negligence or negligence resulting in
6 harm to or the death of a patient.”)

7 **ORDER**

8 IT IS HEREBY ORDERED THAT:

9 1. Respondent is issued a Decree of Censure for his failure to properly
10 evaluate a patient as a candidate for gall bladder surgery.

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

13 a. Respondent shall remain in his current mode of practice, which
14 includes practicing administrative medicine, conducting general exams, ordering tests, and
15 referring patients to other physicians, until he meets with the Board and affirmatively
16 receives the Board’s approval to do otherwise.

17 b. As of the effective date of this order, Respondent shall be subject to
18 periodic chart reviews to be conducted by Board staff or its agents. Based upon the chart
19 reviews, the Board retains jurisdiction to take additional disciplinary or remedial action.

20 c. Respondent shall submit quarterly declarations under the penalty of
21 perjury on forms provided by the Board, stating whether there has been compliance with
22 all the conditions of probation. The declarations shall be submitted on or before the 15th of
23 March, June, September, and December of each year.

24 d. In the event Respondent should leave Arizona to reside or practice
25 outside the State or for any reason should he stop practicing medicine in Arizona, he shall

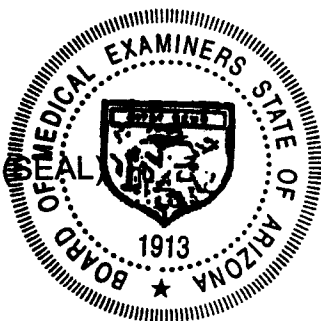
1 notify the Executive Director in writing within ten days of departure and return or the dates
2 of non-practice within Arizona. Non-practice is defined as any period of time exceeding
3 thirty days in which Respond is not engaging in the practice of medicine. Periods of
4 temporary or permanent residence or practice outside Arizona or of non-practice within
5 Arizona, will not apply to the reduction of the probationary period.

6 e. Respondent shall obey all federal, state, and local laws, all rules
7 governing the practice of medicine in Arizona, and remain in full compliance with any court
8 ordered criminal probation, payments and other orders.

9 3. The Board retains jurisdiction and may initiate new action based upon any
10 violation of this order.

11 4. This Order is the final disposition of case number MD-99-0724, as it relates
12 to Respondent.

13 DATED AND EFFECTIVE this 6th day of December, 2001.



14 BOARD OF MEDICAL EXAMINERS
15 OF THE STATE OF ARIZONA

16
17
18 By Claudia Foutz
19 CLAUDIA FOUTZ, Executive Director
20 TOM ADAMS, Deputy Director

21 ORIGINAL of the foregoing filed this
22 6th day of December, 2001 with:

23 The Arizona Board of Medical Examiners
24 9545 E. Doubletree Ranch Road
25 Scottsdale, AZ 85258

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EXECUTED COPY of the foregoing mailed by
Certified Mail this 10th day of December 2001 to:

Felix F. Jabczynski, M.D.
4339 N. Calle Caderia
Tucson, AZ 85754

EXECUTED COPY of the foregoing
hand-delivered this 6th day of
December, 2001, to:

Christine Cassetta, Assistant Attorney General
Sandra Waitt, Management Analyst
Lynda Mottram, Compliance Officer
Lisa Maxie-Mullins, Legal Coordinator (Investigation File)
c/o Arizona Board of Medical Examiners
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

