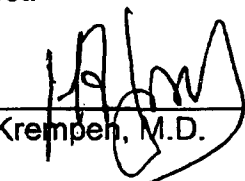


1 the Board and Respondent. Therefore, said admissions by Respondent are not intended
2 or made for any other use, such as in the context of another state or federal government
3 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or
4 any other state or federal court.

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

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

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

18 
19 _____
John F. Kremphen, M.D.

Reviewed and accepted this November
day of 29, 2001.

1 **FINDINGS OF FACT**

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 8444 for the practice of
5 allopathic medicine in the State of Arizona.

6 **Case No. MD-00-0808**

7 3. The Board initiated case number MD-00-0808 upon receiving a notification
8 that Respondent prescribed non-controlled medications, in violation of his June 1999
9 Order.

10 4. On June 10, 1999, Respondent entered into a Consent Agreement for Letter
11 of Reprimand and Probation. The terms and conditions of the June 10, 1999 Consent
12 Agreement are incorporated by reference. The terms of the probation required
13 Respondent to surrender his Drug Enforcement Administration ("DEA") license by July 31,
14 1999, and restricted his practice to assisting surgery only.

15 5. On March 30, 2000, an internet pharmacist phoned Board staff inquiring
16 about Respondent's license status. The pharmacist informed Board staff that Respondent
17 ordered 60 Claritin D tablets and 60 Celebrex 200mg tablets for patient K.F. The
18 prescription also permitted two refills. The pharmacist provided Board staff with
19 documentation of the prescription.

20 6. On April 9, 2000, Respondent, in response to a Board subpoena, stated that
21 patient K.F. was a relative. Although Respondent stated that he fully examined patient
22 K.F., he did not prepare a medical record detailing the examination of patient K.F.

23 7. Respondent fell below the standard of care in failing to prepare a medical
24 record of the K.F.'s examination and his act of prescribing medications violates the June
25 10, 1999 Consent Agreement.

Case No. MD-00-0573

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2
3 11. The Board initiated case number MD-00-0573 upon receiving notification of a
4 malpractice settlement.

5 12. On December 17, 1996, patient S.D., a fifty-two year old female patient
6 entered the Emergency Room at Columbia Northwest Medical Center complaining of pain
7 in her right wrist after sustaining a fall. Patient S.D. had a history of osteoporosis and was
8 taking medication for such.

9 13. On December 18, 1996, Patient S.D. returned to the Emergency Room at
10 Columbia Northwest Medical Center complaining of pain and swelling in her right wrist.
11 She also complained of mild mid-back pain and mild bilateral knee pain. The Emergency
12 Room physician noted moderate edema to the hand and ecchymosis to the hand and
13 dorsal aspect of the wrist. The Emergency Room physician gave the patient Demerol and
14 instructed her to see Respondent.

15 14. On December 20, 1996, Respondent X-rayed the wrist and diagnosed a
16 Colles fracture of the right wrist. Respondent administered local anesthetic, performed a
17 manual closed reduction, and applied a short arm cast.

18 15. Patient S.D. returned to the Emergency Room on December 22, 1996
19 complaining of swelling in her right arm. The Emergency Room physician noted some
20 minor edema of the fingers and that the cast was not tight enough. The Emergency Room
21 physician instructed patient S.D. to keep her hand above heart level when wearing a sling.

22 16, On January 3, 1997, Respondent examined patient S.D., noted good
23 reduction of the wrist, re-cast the fracture, and instructed patient S.D. to return in two-
24 weeks. Subsequently, on January 13, 1997, Respondent removed the cast, instructed her
25 to return to work, and informed her that physical therapy was not needed.

1 17. Jerry Hutchinson, M.D., patient S.D.'s primary care physician, examined her
2 on January 24, 1997. The examination revealed a comminuted fracture involving the
3 distal right radial metaphysis with distraction of fracture fragments and overriding, the
4 surface of the radiocarpal joint was disrupted, and a major part of the radial fracture
5 appeared volar displaced.

6 18. From March 1997 to March 1999, patient S.D. underwent five procedures to
7 repair the right wrist.

8 19. Maxwell MacCollum, M.D., Board Medical Consultant, reviewed the case
9 and concluded that Respondent discontinued immobilization of the patient S.D.'s fracture
10 four weeks after the injury, which is much too early for an intra-articular distal right radial
11 fracture, particularly with an individual who is also suffering from osteoporosis.

12 20. Respondent fell below the standard of care in his treatment of patient S.D.'s
13 intra-articular distal right radial fracture.

14 **CONCLUSIONS OF LAW**

15 1. The Board possesses jurisdiction over the subject matter hereof and over
16 Respondent.

17 2. The conduct and circumstances described above in paragraphs 3 to 7
18 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(e) (“[f]ailing or
19 refusing to maintain adequate records on a patient.”)

20 3. The conduct and circumstances described above in paragraphs 3 to 7
21 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(r) (“[v]iolating a formal
22 order, probation, consent agreement or stipulation issued or entered into by the board or
23 its executive director under the provisions of this chapter.”)

24 3. The conduct and circumstances described above in paragraphs 11 to 20
25 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(q) (“[a]ny 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 11 to 20
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. License number 8444 issued to Respondent is revoked. However, revocation
10 is stayed and Respondent is placed on lifetime probation with terms and conditions listed
11 below. Upon any violation of the probationary term, after giving notice and the opportunity
12 to be heard, the Board shall terminate the probation and revoke Respondent’s license.

13 2. Respondent is placed on lifetime probation with the following terms and
14 conditions:

15 (a) Respondent shall limit his practice of medicine to assisting at surgery
16 only.

17 (b) Respondent shall pay a fine in the amount of \$1,000.00. Respondent
18 shall pay the fine in 10 equal installments of \$100.00 beginning January 1, 2002. The fine
19 shall be paid in full by December 31, 2002.

20 (c) Respondent’s DEA certificate shall remain surrendered.

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

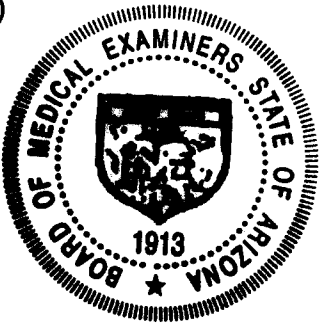
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4. This Order is the final disposition of case numbers MD-00-0808 and MD-00-0573.

DATED AND EFFECTIVE this 6th day of December 2001.

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

(SEAL)



By Claudia Foutz
CLAUDIA FOUTZ
Executive Director
TOM ADAMS
Deputy Director

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

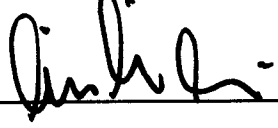
The Arizona Board of Medical Examiners
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed by
Certified Mail this 6 day of December 2001 to:

John F. Krempen, M.D.
2421 E. 6th St., Ste. 1
Tucson, AZ 85719-5234

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

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

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