BEFORE THE BOARD OF MEDICAL EXAMINERS

IN THE STATE OF ARIZONA

In the Matter of **MUHAMMAD A. KAHN, M.D.** Holder of License No. **9994** For the Practice of Medicine In the State of Arizona.	**No. 00F-09994-MDX** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER FOR STAYED REVOCATION AND PROBATION.**

On October 12, 2001, this case came before the Arizona Board of Medical Examiners ("Board") for oral argument and consideration of the Recommended Decision of the Administrative Law Judge ("ALJ") containing proposed findings of fact, conclusions of law. Muhammad A. Kahn ("Respondent") appeared telephonically and was represented by Ed Hendricks and Michael R. Ross. The State was represented by Assistant Attorneys General, M. Elizabeth Burns, Stephen Wolfe and Montgomery Lee. The Board was advised by its legal advisor, Christine Cassetta, Assistant Attorney General.

The Board, having considered the ALJ's recommendation, and the entire administrative record in this case, hereby issues the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. The Board of Medical Examiners of the State of Arizona ("BOMEX") is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
2. Muhammad Azam Khan, M.D., is the holder of License Number 9994 issued by BOMEX for the practice of allopathic medicine in the State of Arizona. Dr. Khan has held that license since 1977.

3. In a January 26, 1995 Consent Agreement for Probation ("1995 Consent Agreement") between Dr. Khan and BOMEX, Dr. Khan was placed on probation for a period of five years.
4. In the 1995 Consent Agreement, Dr. Khan agreed that as to seven specific patients, his conduct constituted unprofessional conduct pursuant to the provisions of A.R.S. § 32-1401(24)(q) (any conduct or practice which is or might be harmful or dangerous to the health of the patient or public) and A.R.S. § 32-1401(24)(ll) (conduct that the Board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient).
5. The 1995 Consent Agreement contained the following terms of probation for Dr. Khan:

    a) Dr. Khan was to submit a monthly report to BOMEX identifying all of his surgical cases;
    b) BOMEX was to submit five cases from each report for comprehensive review by the Health Services Advisory Group ("HSAG");
    c) HSAG was to evaluate the submitted cases for deficiencies, and, if any found, such cases were then to be evaluated by an HSAG-approved surgeon and by BOMEX;
    d) Dr. Khan was to retain a practice management consultant to recommend practice management changes; and
    e) Dr. Khan was to pay a $3,000.00 administrative penalty.

6. The required case review under the 1995 Consent Agreement found that Dr. Khan's care and treatment of 12 patients had been deficient. As a result0, in 1997 Dr. Khan and BOMEX entered into another Consent Agreement ("1997 Consent Agreement") dated May 8, 1997.
7. In the 1997 Consent Agreement, Dr. Khan agreed that his conduct as to those 12 patients constituted unprofessional conduct pursuant to the following provisions:

a) A.R.S. § 32-1401(25)(e) (failing or refusing to maintain adequate records on a patient);
b) A.R.S. § 32-1401(25)(q) (any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public);
c) A.R.S. § 32-1401(25)(r) (violating a former order, probation or stipulation issued or entered into by the Board or its executive director); and
d) A.R.S. § 32-1401(25)9u) (charging a fee for services not rendered or dividing a professional fee if the patient referrals among health care providers or health care institutions or between those provided in institutions or contractual arrangement which has the same effect).

8. The 1997 Consent Agreement provided that Dr. Khan was to be placed on five years probation subject to the following terms:

a) Dr. Khan was to enroll and complete a three month mini-residency in general surgery at the University of Las Vegas Medical Center ("UNLV-MC");
b) Dr. Khan was to complete an additional nine months of didactic training at UNLV-MC;
c) Dr. Khan was to take and pass the board recertification examination in general surgery;
d) After his first year of probation, Dr. Khan was to submit to periodic office and practice surveys;
e) Dr. Khan was to pay $7,500.00 to reimburse BOMEX for expenses incurred during the investigation;
f) Dr. Khan was to obey all laws; and
g) Dr. Khan was to cooperate fully with BOMEX with respect to pending and future investigations.

9. Pursuant to the 1997 Consent Agreement, Dr. Khan successfully completed a three month mini-residency at UNLV-MC under the direction of Dr. Alex Little, the Chairman of the Department of Surgery.
10. Pursuant to the 1997 Consent Agreement, Dr. Khan successfully completed nine months of additional didactic training under Dr. Little's direction.
11. Pursuant to the 1997 Consent Agreement, Dr. Khan took and passed the board recertification examination prior to November 1, 1998. Dr. Khan placed in the top 10% among the surgeons taking the examination.
12. Pursuant to the 1997 Consent Agreement, Dr. Khan obeyed all laws.
13. Pursuant to the 1997 Consent Agreement, Dr. Khan paid the sum of $7,500.00 to BOMEX to reimburse its investigative expenses.
14. Pursuant to the 1997 Consent Agreement, Dr. Khan's office appointment books were subpoenaed by BOMEX on July 29, 1998. Dr. Khan responded to that subpoena on August 6, 1998.
15. On August 14, 1998, BOMEX subpoenaed records from Dr. Khan by identifying particular patients and particular procedures. Dr. Khan responded to that subpoena on September 1, 1998 by providing records pertaining to the procedures performed on the dates identified in the August 14, 1998 subpoena.
16. It is found that Dr. Khan failed to fully comply with the scope of the August 14, 1998 subpoena.
17. On September 8, 1998, Bill Meidt of BOMEX requested additional information from Dr. Khan, and Dr. Khan provided that information on September 21, 1998.
18. Sometime in December 1998, BOMEX undertook an office and practice survey of Dr. Khan pursuant to the terms of the 1997 Consent Agreement. The treatment and care of patients P.M., R.W., S.B., H.L., B.M., P.G., J.M. and N.M. came to BOMEX's attention through the office survey. Patient I.M. was a separate complaint filed with BOMEX by I.M.'s family in or about August 1998.
19. Dr. Khan submitted to an investigative interview with BOMEX staff on April 14, 1999. During that interview, Dr. Khan provided additional documents to BOMEX.

20. On December 12, 2000, BOMEX filed its Complainant and Notice of Hearing regarding Dr. Khan's care of seven patients. On February 2, 2001, BOMEX filed an Amended Complaint, identifying two additional patients as part of its complaint.

21. On June 26, 2001, BOMEX was granted leave to further amend its complaint, charging Dr. Khan with additional alleged unprofessional conduct related to his response to BOMEX's August 14, 1998 subpoena.

PATIENT I.M.

22. Patient I.M. was born on May 6, 1917.

23. In April 1996, I.M. was diagnosed with cancer of the descending colon and underwent a low anterior resection of the colon at Maricopa Medical Center.

24. In September 1997, I.M. complained about rectal bleeding. He was evaluated by his physician, Dr. Jhandiya, who recommended several tests and a colonoscopy.

25. On September 30, 1997, Dr. Jhandiya performed a colonoscopy on I.M. and found a cancerous mass.

26. As a result of colonoscopy results, I.M. was evaluated by surgeon Dr. Michael Merchant, D.O., on October 22, 1997. Dr. Merchant recommended a colon resection

27. On November 10, 1997, Dr. Merchant performed surgery on I.M. Dr. Merchant encountered numerous adhesions that had formed after the 1996 surgery. It took approximately one hour of dissection to free those adhesions.

28. Because I.M.'s tumor was located too close to the anus to perform a low anterior resection, and since I.M. had been adamant about avoiding a colostomy, Dr. Merchant elected to terminate the surgery and discuss the recommended treatment with him.

29. The preferred treatment for the type and placement of the tumor Dr. Merchant found in I.M. was an abdominal perineal resection, which requires a colostomy.

30. After Dr. Merchant's surgery, I.M. consulted two gastroenterologists, another surgeon and a radiation oncologist regarding treatment options. All of the doctors concurred that an abdominal perineal resection was the preferred procedure.

31. I.M.'s November 1997 EKG test indicated a left axis deviation and the presence of left ventricular hypertrophy. Left ventricular hypertrophy is characterized by the left

chamber of the heart being larger than it should be, which can cause a left access deviation.

32. I.M.'s November 1997 chest x-ray noted bibasilar subsegmental atelectrasis, which results in some segments of the lung to become collapsed.

33. On March 31, 1998, I.M. was evaluated by Dr. Khan. Dr. Khan took a thorough history and assessed that I.M.'s surgical options were either a low anterior resection with anastomosis or an abdominal perineal resection with a permanent colostomy.

34. On April 4, 1998, I.M. underwent a CT of the abdomen and pelvis, which noted "COPD changes" and "atheroschlerotic changes of the aorta."

35. "COPD" stands for chronic obstructive pulmonary disease and is a co-morbid disease.

36. Patients who have "COPD" are at risk for anesthesia and have a high incidence of requiring post-operative ventilation.

37. I.M.'s April 1998 CT scan indicated a "significantly enlarged prostate, measuring 10mm x 6cm x 5cm in size".

38. Dr. Khan again evaluated I.M. on April 14, 1998. I.M. elected to have Dr. Khan perform surgery.

39. During I.M.'s history and physical of April 14, 1998, Dr. Khan assessed that I.M. had elevated PSA and suspected cancer of the prostate. Dr. Khan believed that I.M. had a significantly enlarged prostate and that the "10mm" designation should be corrected to a "10cm" designation.

40. Based on his pre-operative evaluation, along with evaluations by Dr. Faisal Jhandiya, who practices internal medicine, and Dr. Jack Berndt, an anesthesiologist, Dr. Khan determined that it was appropriate to operate on I.M. at Mohave Valley Hospital in Bullhead City, Arizona.

41. In May 1998, the only medical facility where Dr. Khan could perform surgical procedures was at Mohave Valley General Hospital ("Mohave").

42. From 1997 until May 1999, Dr. Khan had been under investigation by Kingman Regional Medical Center. During that investigation, Dr. Khan voluntarily surrendered his hospital privileges to admit patients and perform surgeries at that facility. Upon the return of his hospital privileges, Dr. Khan was required to submit his records for a 100% review for a period of one year.

43. Western Arizona Regional Medical Center ("WARMC") was another hospital in the Kingman/Bullhead City area in 1998. WARMC was decertified by the Healthcare Financing Administration from the Medicare Program effective November 9, 1997. That certification was restored in May 1998.

44. Mohave was a 12-bed facility that had two operating rooms but did not have an Intensive Care Unit ("ICU").

45. Mohave did have a Post-Anesthetic Care Unit ("PACU"). A PACU is designed to stabilize a patient after their anesthesia and operative procedure. A PACU is not designed to replace an ICU.

46. Mohave was equipped and/or staffed with ACLS certified nurses, cardiac life support, respirator/ventilators (located in the operating rooms), blood on hand, an on-call pulmonologist and pulmonary technologist, an on-call cardiologist, central venous catheters, 24 hour nurse support, cardiac and blood pressure monitors, fluid warmers for intravenous fluids and blood administration, the capacity to test blood gases, and a fully operational PACU.

47. While the equipment and staffing at Mohave's operating room and its PACU together contained the minimal elements found in an ICU, those Mohave assets are found not to have been a satisfactory substitute for an ICU in the treatment afforded to I.M.

48. Although Dr. Khan had been "approved" to perform abdominal perineal resection surgery at Mohave, it was still necessary for him to consider, before performing surgery, whether it was appropriate to perform a particular procedure on a particular patient at Mohave, or whether the specialized services of a larger facility were required.

49. No evidence was presented that abdominal perineal resection surgeries had been performed at Mohave prior to Dr. Khan's surgery on I.M.

50. Dr. Paget is a surgeon who had practiced medicine at Mohave. He testified at the hearing as a witness for Dr. Khan.

51. Dr. Paget testified that he did not perform any abdominal perineal resection surgeries during his tenure at Mohave. He recalled having performed two lower anterior resections as well as other colon resections at Mohave. Of the two lower anterior resections that Dr. Paget recalled, neither was similar in age and condition to patient I.M.

52. A lower anterior resection involves a surgeon taking a part of the colon, cutting it out, and reattaching the colon.

53. A sudden significant weight loss depletes the body's reserves and diminishes its ability to manufacture antibodies, resist infection and heal wounds.

54. According to I.M.'s medical records, his weight vacillated between 117.5 and 122 pounds from November 20, 1996 through January 19, 1998.

55. On April 14, 1998, I.M. weighted 120 pounds.

56. At the time of his admission to Mohave on May 4, 1998, I.M. weighted 106 pounds.

57. According to I.M.'s medical records, he lost 14 pounds in the three weeks before his surgery performed by Dr. Khan. I.M.'s bowel prep for the surgery likely accounted for approximately two or three pounds of the lost weight. Furthermore, differences in the calibration of the scales from which those measurements were taken could have added or subtracted approximately another two pounds.

58. During the three week period prior to surgery, I.M.'s actual weight loss was a significant amount in this small, elderly man and placed him at risk.

59. At the time of I.M.'s admission to Mohave, he was anemic. His hemoglobin was 10.2 He had been experiencing rectal bleeding for approximately six months prior to his May 1998 surgery.

60. Given I.M.'s age, medical history and condition at the time of the May 1998 surgery, a reasonable preoperative evaluation of I.M. should have led Dr. Khan to conclude that it was reasonably forseeable that I.M. would require prolonged respiratory care, intensive monitoring and one to one nursing care which could more appropriately be provided by a tertiary hospital rather than Mohave.

61. Dr. Khan's initial surgery to remove I.M.'s cancerous tumor began on May 5, 1998 at 1330 hours.

62. Dr. Khan was assisted in surgery by Dr. Merchant. Dr. Berndt was the anesthesiologist.

63. On the day of I.M.'s surgery, Dr. Khan did not know how many other surgeries, if any, were scheduled at Mohave.

64. At the time of I.M.'s surgery, Dr. Khan did not know how many respirators were already in use at Mohave. Dr. Khan did not know that the only available respirator at Mohave was the one on the anesthesia machine in I.M.'s operating suite.

65. Dr. Khan performed a low anterior resection with colostomy on I.M. Dr. R.V. Stephens, the BOMEX expert witness, agreed that Dr. Khan's surgical technique and his choice of procedure were both within the standard of care for general surgeons practicing in Arizona in May 1998. Dr. Stephens opined that Dr. Khan's decision to perform a colostomy was appropriate and within the standard of care for general surgeons practicing in Arizona in May 1998.

66. Approximately two hours into I.M.'s surgery, the first unit of pack red blood cells was started. At that time, I.M.'s temperature was 93° F. That initial concluded at 1630. At the conclusion of the initial surgery, I.M.'s temperature remained at 93° F.

67. While I.M. was still on the operating table, the Jackson-Pratt drain started draining excessively. Dr. Khan elected to reopen I.M.'s abdomen to locate and control the source of the bleeding. The second surgery started at 1700 hours. I.M.'s temperature was recorded as 93° F.

68. Upon reopening, Dr. Khan noted bleeding in the branches of the right hypogastric artery. He repaired those arterial branches, and the bleeding appeared to stop, except for minimal oozing noted in the presacral area.

69. Although Dr. Khan observed the presence of dark blood after reopening, which would indicate venous or capillary blood rather than arterial blood, none of the medical records or narrative created by Dr. Khan described the color of the blood.

70. While finishing the second procedure, Dr. Khan was told that I.M.'s temperature was 90.7° F. He suspected that hypothemia was causing coagulapathy. Neither Dr. Khan nor Dr. Merchant saw any active bleeding in I.M. at that point.

71. Because the patient had become hypothemic and developed coagulopathy, Dr. Khan determined that the appropriate course of treatment would be to pack the patient's pelvic cavity with lap packs, correct the patient's hypothemia and coagulopathy, and then re-evaluate whether there was any further active bleeding. Dr. Khan's decision to pack I.M.'s abdomen and close the patient was within the standard of care for general surgeons practicing in Arizona in May 1998.

72. Dr. Khan inserted a Jackson-Pratt drain at the close of surgery to assist in monitoring I.M.'s blood loss. He ordered appropriate resuscitation through clotting factors, albumin

and fluids, monitored the patient's blood volume and ordered the requisite laboratory tests.

73. The second surgery concluded on May 5, 1998 at 1730 hours.

74. After completing the second surgery, Dr. Khan closely monitored I.M.'s condition, staying at his bedside throughout the evening of May 5, 1998.

75. From the end of the first surgery through the end of the second surgery, two additional units of packed red blood cells were administered to I.M.

76. On May 5, 1998 at 1738 hours, Dr. Khan received lab results from blood drawn from I.M. at 1638 hours. The results indicated a hemoglobin of 10.5, a PT of 16.4 and an INR ratio of 1.54. Dr. Khan believed that those values proved coagulopathy.

77. PT (Prothrombin time) measures the body's coagulation ability and is used to determine whether clotting problems exist. The normal range for PT is 11.3-13.3 seconds. A PT of 16.4 is only slightly elevated. It does not have a significant bearing on the diagnosis of coagulopathy, and does not prove coagulopathy. The INR ration is meaningless when it comes to making a diagnosis of coagulopathy. It is significant only in patients who are on Coumadin therapy.

78. After the second surgery, attempts were made to try to admit I.M. into a hospital in the Bullhead City area with an ICU. According to Dr. Jhandiya's notes, I.M. "needed to be in ICU until able to be weaned off a ventilator and coagulopathy completely corrected. No bed available at WARMC".

79. According to Dr. Khan's transfer summary, "it was felt that the patient would be a candidate for admission to an intensive care unit. Due to the lack of an intensive care unit in this hospital, arrangements were made for the patient to be transferred to University Medical Center in Las Vegas". Furthermore, Dr. Khan's transfer summary states that he "appreciate[d] the timely support from University Medical Center for accepting this patient to the intensive care unit since this facility lacks one. No other beds are available in the intensive care unit at the neighboring hospital in the Bullhead City area".

80. At the hearing, Dr. Khan testified that his primary reason for transferring I.M. to another facility was the fact that he believed that the patient would need the services of a hematologist and an infusion of platelets. Although no hospital in Mohave County,

Arizona, including Kingman and Bullhead City, maintained a supply of platelets, platelets could be obtained from the regional blood bank in Las Vegas, Nevada, approximately 40 minutes away by air transport. In addition, there was no hematologist on staff in any of the hospitals in Mohave County. However, during his investigative interview with BOMEX staff Dr. Khan did not indicate that his primary reason for transferring I.M. was the need for a hematologist and platelets.

81. At approximately 1815 hours on May 5, 1998, Dr. Khan attempted but was unable to safely extubate I.M.

82. At 1845 hours on May 5, 1998, I.M. was transferred from the operating room to the adjoining recovery room. I.M. was in an unstable condition at that time. Lab results were received which indicated an improved hemoglobin value of 12.

83. At 1915 hours on May 5, 1998, I.M. was transferred back to the operating room to use the respirator on the anesthesia machine to assist his breathing. At that time the Jackson-Pratt drain had drained 300cc of blood. There is credible evidence that the lap sponges inside I.M. were soaked with blood.

84. Lap packs can hold between 200cc and 400cc of fluid.

85. At 2100 hours on May 5, 1998, Dr. Khan finalized arrangements to transfer I.M. to University Medical Center in Las Vegas via air transport. At that time, the last objective findings of which Dr. Khan was aware indicated that I.M.'s hemoglobin values had improved to 12, his blood pressure readings were 129/92 and his temperature was being warmed.

86. At 2140 hours on May 5, 1998, I.M.'s blood pressure declined precipitously to 76/67, indicating that he might be going into hypovolemic shock as a result of active, uncontrolled bleeding.

87. Hypovolemia is low volume of blood fluid within the vessels. Hypovolemic shock occurs when there is inadequate blood volume. Hypovolemic shock affects the kidneys because the kidneys cannot effectively filter the blood and produce viable urine without a sufficient circulating blood volume. Low blood pressure for a sustained period of time results in death of the kidney cells required for filtration. That condition is called acute tubular necrosis.

88. Between 2140 and 2214 hours on May 5, 1998, three units of fresh frozen plasma and other undocumented fluids were administered to I.M. By the time the first unit of fresh frozen plasma was started, I.M.'s temperature had been restored to 98° F.

89. At 2245 hours on May 5, 1998, Dr. Khan received test results which indicated that I.M. had a hemoglobin of 5.7 and a PT of 14.3. In a matter of approximately 3.75 hours, I.M.'s hemoglobin had fallen from 12 to 5.7. Hemodilution from the administration of the undocumented fluids (such as crystalloids and ringers lactate), and the infusion of fluids during surgery, cannot totally account for the decline in hemoglobin values from 12 to 5.7.

90. At the time Dr. Khan received the hemoglobin value of 5.7, he knew that I.M. had received 3000cc of blood/blood products. Since I.M.'s total blood volume was between 2.8 to 3.8 liters, the equivalent of his entire blood volume had been replaced. Dr. Khan also knew that I.M.'s blood pressure was fluctuating significantly (129/92 to 76/67 to 86/66 to 112/66). Meanwhile, the Jackson-Pratt drain continued to drain blood.

91. If a patient experiences active, uncontrolled bleeding, the standard of care requires a reasonably prudent physician to take the patient back into surgery to locate and control the source of bleeding to minimize the insult to the renal system from the hypovolemic shock. It is below the standard of care to merely administer additional blood and blood product for several hours and then transfer the patient to another facility.

92. Having received a hemoglobin value of 5.7 in addition to the other indicators of active, uncontrolled bleeding, it was below the standard of care not to return I.M. to the operating room to correct that bleeding.

93. To ascertain the validity of the blood values received at 2245 hours, another blood sample was drawn. Test results from that sample were received at 2311 hours on May 5, 1998. The repeat test confirmed that I.M.'s hemoglobin readings had fallen precipitously, and that he was experiencing active, uncontrolled bleeding.

94. I.M.'s blood pressure continued to fluctuate throughout the evening of May 5 and early morning of May 6, 1998, and was artificially supported with the use of Ephedrine throughout both surgeries and post-operative care at Mohave.

95. Flight for Life arrived at Mohave to transport I.M. to University Medical Center at 0056 hours on May 6, 1998 and departed at 0117 hours.

96. During the air transport I.M.'s blood pressures ranged from 84/36 to 126/72.

97. When he arrived at University Medical Center at 0200 hours on May 6, 1998, I.M.'s hemoglobin was recorded as 6.1. He was admitted directly into that hospital's intensive care unit.

98. Staff at University Medical Center attempted to stabilize I.M. throughout the next two days so that they could operate to locate and control the source of the active bleeding.

99. Between 0200 and 0400 hours on May 6, 1998, the medical staff at University Medical Center undertook extensive efforts to resuscitate I.M. They placed a central line and started infusing numerous replacement products, including blood, cells, packed cells and normal saline as rapidly as the patient could tolerate.

100. It was not until 0400 hours on May 6, 1998 that I.M. produced 5cc of urine. From 0700 to 1800 hours on May 6, 1998, I.M. produced only 83cc of urine. From 1900 hours on May 6, 1998 to 0600 hours on May 7, 1998, I.M. produced 46 cc of urine.

101. On May 7, 1998, University Medical Center staff undertook urgent surgical intervention to look for the source of I.M.'s uncontrolled bleeding. During that surgery, the surgeon discovered approximately 1150cc of blood in I.M.'s abdomen. The surgeon located a bleeding vessel and ligated it.

102. Given the documented blood pressures of I.M. during his treatment after surgery in Mohave through 0600 on May 7, 1998, coupled with a lack of urine output, I.M. was in acute renal failure.

103. During the first two days after his admission to University Medical Center, I.M. required an extremely large amount of blood and other fluids. Older patients cannot handle large volume shifts of fluids and are sensitive to volume overload. When the fluids being infused cannot be handled by the kidneys, in older patients such as I.M., the fluids back up into the cells of the lungs, which results in volume overload. The kidney specialist at University Medical Center recommended intensive medical treatment for I.M. in an effort to avoid using dialysis to process the volume overload. He recommended trying a Lasix drip and, if that was not successful, then using ultrafiltration and dialysis to remove 2000cc to 3000cc of fluid. The Lasix drip did not succeed, so I.M. underwent ultrafiltration to try to remove the fluid, which resulted in a drop in I.M.'s blood pressure. At that point, the ultrafiltration was discontinued.

104.From May 6, 1998 through May 9, 1998, I.M.'s BUN and creatinine levels were rising. Similarly, I.M.'s urine output was also rising. University Medical Center staff evaluated that I.M. was progressing toward ATN, which is the result of the kidneys being shocked due to hemorrhage. There is a 48 hour delay between the time that an insult to an elderly person's kidneys occurs and the time when the damage will be reflected in creatinine levels. There is credible evidence that the damage to I.M.'s kidneys occurred on May 6, 1998 and that the results began to show on May 7-8, 1998. The records are consistent with I.M.'s progression to non-oliguric ATN.

105.There is credible evidence that by May 12, 1998, I.M. was undergoing high output renal failure, and not prerenal failure. Renal failure secondary to ATN can be characterized as either oliguric, where urine outflow is diminished, or non-oliguric, where urine outflow is increased. Non-oliguric renal failure is also known as high output renal failure. The urine produced in high output renal failure is dilute because it has not been processed by the damaged cells within the tubules of the kidney.

106.On May 13, 1998, University Medical Center obtained a renal consult for I.M. which diagnosed acute renal failure, volume overload and impending respiratory failure secondary to the volume overload.

107.On May 17, 1998, blood was observed in I.M.'s colostomy bag.

108.Patients on dialysis and elderly patients in acute renal failure are susceptible to gastrointestinal bleeding.

109.After a GI consultation on May 29, 1998, an upper endoscopy was recommended. That procedure was performed on I.M. on May 30, 1998 with negative results.

110.On May 31, 1998, I.M. was again coagulopathic. The gastroenterologist was unable to perform another upper endoscopy while I.M. was in that condition.

111.A reasonable and prudent medical doctor would be able to determine whether I.M. was approaching renal failure without the need of FEna test and could treat the patient appropriately.

112.Although I.M. received the drug Cefoxitin during his care and treatment by University Medical Center, it is found to have been appropriate and not a factor in I.M.'s renal failure. The administration of antibiotics was necessary to treat I.M. because infection was highly likely after hemorrhage shock, colon surgery and the exchange of the

patient's blood volume at least three times. Cefoxitin is a cephalosporin whose molecules are relatively small and likely to be captured during the dialysis I.M. received, thereby requiring the administration of higher doses to be effective. The highest dose that the Physician's Desk Reference gives is 12 grams a day. I.M. received no more than 6 grams per day.

113. On June 1, 1998, a large abdominal abscess was found in I.M. The medical decision was made to drain the abscess. Due to I.M.'s coagulopathy, University Medical Center massively infused I.M. with blood and blood products. The coagulopathy needed to be controlled before the abscess could be drained. At the same time, I.M. had a significant infection that University Medical Center was trying to resolve with medication.

114. On June 4, 1998, I.M.'s brain began to fail and he slipped into a coma. This was I.M.'s third body system to fail.

115. After arriving at University Medical Center from Mohave, I.M. developed multiple organ system failure. I.M. passed away on June 22, 1998 while under the continued care of doctors at University Medical Center.

PATIENT J.M.

116. J.M. had been a patient of Dr. Khan's since 1989.

117. J.M. had a history of colonic polyps, internal hemorroids, extensive diverticulitis and recurrent right inguinal hernia.

118. J.M. had a colonoscopy on October 8, 1992 that did not reveal any polyps. He had another colonoscopy on January 21, 1997 that also did not reveal any polyps.

119. On or about June 22, 1998, Dr. Khan saw J.M., a 78 year old male, for rectal bleeding of unknown origin.

120. On June 29, 1998, Dr. Khan performed a partial colonoscopy on the patient. Dr. Khan visualized the rectal, sigmoidal and descending portions of the colon to approximately 50cm. He was not able to visualize the transverse, ascending and cecal portions of the colon because a stenosis at 50cm. Interfered with the passage of the colonoscope beyond that point.

121. During the partial colonoscopy, Dr. Khan removed two polyps from the patient's colon, one at 25cm and another at 30cm.

122. The pathology report reflects that the lab only received one polyp for analysis, the one located at 30 cm, which was diagnosed as a portion of the villotubular adenoma.

123. Dr. Khan's medical records for J.M. include a photograph of the one polyp located at 30 cm taken before it was excised. Dr. Khan could not recall whether he photographed both polyps. Dr. Khan did not note in his operative report or elsewhere in the medical record that he photographed either of the polyps.

124. There is credible evidence to support a finding that a surgeon has a responsibility to note in the medical record that a tissue sample was excised but lost.

125. During his testimony, Dr. Khan had no memory of how the polyp located at 25 cm was actually lost and no explanation for why he did not note the loss in the medical record.

126. Dr. Khan failed to address in the operative report, or elsewhere in the medical records for J.M., why the pathology lab only received one polyp for analysis.

127. A surgeon has a responsibility to adequately describe in his/her operative report the appearance of polyps, the technique used to excise the polyps, and the appearance of the polyps after their excision. Descriptions of those items are important for tracking the development of colonic polyps in a patient over time, making an accurate diagnosis, and preparing timely and appropriate treatment.

128. In his operative report, Dr. Khan described J.M.'s polyps as "benign appearing". That description of the polyps is deemed marginal and insufficient.

129. Illustrative of the need for a descriptive operative report was Dr. Khan's testimony concerning the two polyps. Dr. Khan had no independent memory of the appearance of the polyps. His recollection was based solely upon the description in the operative report, pathology report and photograph. The pathology report and photograph described only one of the polyps. Dr. Khan had no independent memory of the technique used to excise the polyps. He could not described the appearance of the base of the polyps after their excision. He was unable to refresh his recollection of those items by reviewing his operative report because he had not included such information in it.

130. Dr. Khan's failure to adequately describe in his operative report the appearance of the polyps, the technique use to excise the polyps or the appearance of the base of the polyps after their excision exposed J.M. to an increased risk of harm due to the diminished ability to track, diagnose and treat his colonic polyps.

131. BOMEX failed to identify any medical authority that required Dr. Khan to include negative findings in J.M.'s medical records (i.e. an absence of bleeding during a procedure).

132. Because the partial colonoscopy visualized only the first 50 cm of J.M.'s colon, Dr. Khan ordered that a barium examination be scheduled promptly to visualize the remaining portions of the colon to determine whether other polyps were present and to isolate the source of rectal bleeding.

133. Rectal bleeding may indicate colonic cancer, and 40 percent of colon cancers occur in the portion of the colon Dr. Khan was unable to visualize.

134. Dr. Khan discussed his recommendation for a barium examination with J.M., but the patient declined to undergo such an examination. However, Dr. Khan's post-operative progress notes for July 6, 1998 do not reflect that the barium examination was discussed with and rejected by the patient, as do similar progress notes for patient R.W. Dr. Khan acknowledged his failure to document his discussion with the patient about the barium examination. Therefore, Dr. Khan's post-operative progress notes for July 6, 1998 do not reflect that the barium examination was discussed with and rejected by the patient, which is below the standard of care.

135. After the patient rejected the barium examination, Dr. Khan took into account that he had performed a complete colonoscopy on J.M. one and a half years earlier. He advised the patient to undergo another complete colonoscopy in one year.

136. It is below the standard of care to substitute a follow-up colonoscopy in one year for an immediate barium examination to identify the source of rectal bleeding.

PATIENT R.W.

137. Dr. Khan saw R.W., a fifty year old male, on April 20, 1998 when the patient presented with pain at the lower left quadrant of the abdomen and adjoining

paramedian region. The patient reported a history of chronic backaches and peptic ulcer disease. R.W. had previously undergone a partial gastrectomy. He complained of satiety without eating properly and sharp pain in the rectum and at the abdominal wall upon defecation.

138. Dr. Khan ordered appropriate laboratory work and x-rays, and prescribed antibiotic for a working diagnosis of sub-clinical (mild) diverticulitis.

139. R.W. returned to Dr. Khan's office on April 27, 1998 reporting that his abdominal pain had subsided and showing no signs of pain on palpation. R.W. did, however, complain of a change in bowel habits. Dr. Khan assessed "diverticulitis clinically improved, rule out colonic neoplasm."

140. Dr. Khan's notes reflect that he advised R.W. that even though the abdominal pain had subsided with antibiotics, further investigation of the colon with a barium examination or colonoscopy was warranted. The notes also reflect that the patient declined a barium examination, and a colonoscopy was scheduled.

141. On May 8, 1998, which was 18 days after the patient first presented with symptoms of diverticulitis, Dr. Khan attempted to perform a complete colonoscopy. In his operative report Dr. Khan states that he was unable to pass the scope beyond 50 to 60 cm. because "the patient has suffered from diverticulitis about 2-3 weeks ago and there is still some un-resolving inflammation and there is some evidence suggestive of stricture formation." Dr. Khan's post-operative diagnosis was "stenosis/stricture of the sigmoid descending function, can't rule out diverticulitis."

142. After performing the partial colonoscopy, and consistent with his finding some unresolving diverticular inflammation, Dr. Khan again prescribed a course of antibiotics.

143. Dr. Khan performed a barium enema examination on R.W. on May 14, 1998. That follow-up examination adequately evaluated the portions of R.W.'s colon that were not viewed during the May 8 colonoscopy. At the time of the barium examination, R.W.'s inflammation had resolved; no diverticulum or colonic neoplasms were noted.

144. It was below the standard of care for Dr. Khan to perform a colonoscopy less than three weeks after R.W. first presented with symptoms of diverticulitis. Because of the difficulty in ascertaining when diverticular inflammation has actually resolved, a colonoscopy should be performed only after the inflammation reasonably should have

resolved. There was credible evidence presented that a reasonably prudent physician would anticipate that it would take four to six weeks for the inflammation to subside. By performing the procedure several weeks before he could reasonably anticipate that the inflammation had subsided, Dr. Khan exposed the patient to an increased risk for a perforated colon. Dr. Khan also reasonably should have anticipated that he would not be able to visualize the entire colon due to the presence of unresolved inflammation.

145. It is further determined that it was not necessary to perform a colonoscopy promptly because the patient had complained about recent change in bowel habits and the risk of colonic cancer needed to be ruled out. There would have been no significant risk to R.W. from waiting an additional two to three weeks for the inflammation reasonably to resolve before performing a colonoscopy.

146. By performing the colonoscopy before the diverticular inflammation reasonably should have resolved, Dr. Khan was unable to visualize R.W.'s entire colon and the patient had to undergo a follow-up barium examination to visualize the remainder of the colon, thereby causing harm to the patient.

PATIENT B.M.

147. Dr. Khan saw B.M., a 78 year old male, on May 6, 1998 and May 8, 1998 for left lower pain. The patient was recuperating from an abdominal aortic aneurysmectomy on April 10, 1998, and had had previous hernia repairs in 1970 and 1989.

148. Although Dr. Khan did not perform a rectal examination of B.M. in May 1998, such an examination was not necessary, because B.M. had undergone a rectal examination and colonoscopy in January 1998.

149. Although it was appropriate for Dr. Khan to have not performed a rectal examination in May 1998, he should have recorded in B.M.'s medical records why he declined to perform the rectal examination.

150. Dr. Khan repaired the patient's recurrent left inguinal hernia on June 5, 1998. His operative report states that he performed a McVay's procedure. However, that report also states that he approximated the inguinal or Poupart's to the conjoined tendom, which is a description of a Basini procedure.

151.Dr. Khan contends that an error must have occurred when his dictated operative notes were transcribed. The operative report should reflect that it was the Cooper's ligament which was approximated to the conjoined tendon, which would be a correct description of a McVay's procedure.

152.Dr. Khan's judgment-based decision to repair B.M.'s hernia using the McVay's procedure was within the standard of care for general surgeons practicing in Arizona in May 1998. The standard of care did not require Dr. Khan to use mesh in the course of his repair of B.M.'s hernia.

PATIENT H.L.

153.Dr. Khan first saw H.L. , a 78 year old male, on April 14, 1998 regarding a reported lump and swelling in the right lower quadrant of the abdomen. H.L. reported a transurethral resection of the prostate in 1995 and a total hip arthroplasty in 1991 that had been repeated a "couple of years ago."

154.Dr. Khan properly assessed H.L.'s complaints as a Spigelian hernia.

155.On June 5, 1998, Dr. Khan repaired the Spigelian hernia without incident.

156.Dr. Khan's identification of a Spigelian hernia in his operative report provides a minimal but adequate anatomical description such that a subsequent treating physician should know the approximate location at which the operation was performed.

157.There is credible evidence that the standard of care requires the use of prophylactic antibiotics when performing an operation on a patient who has had two previous hip replacements. Prophylactic antibiotics are used to decrease the risk of infection to the area of the artificial hip. If that area were to become infected, the hip would have to be replaced.

158.There is a predominant opinion among surgeons to use prophylactice antibiotics even when operating in a clean surgical field such as H.L.'s surgery.

159.Dr. Khan did not order prophylactic antibiotics for H.L. The patient did not suffer infection from the procedure.

PATIENT N.M.

160.On April 30, 1998, Dr. Khan saw patient N.M., a 59 year old male, regarding a large ulcer on the left side of the tongue at the junction of the anterior two-thirds and the posterior one-third.

161.Dr. Khan performed an incisional biopsy of the patient's tongue under monitored anesthesia care in the operating room.

162.During the procedure, the patient received both local anesthesia and intravenous sedation

163.Dr. Khan's decision to perform an incisional biopsy under the circumstances, instead of performing a punch biopsy under local anesthesia only, was based on his recognition of the patient's apprehension of the procedure, and Dr. Khan's attempt to ensure that he would only need to take one definitive tissue sample of adequate depth.

164.Dr. Khan successfully excised a tissue sample from N.M.'s tongue, and did so without incident or harm to the patient.

165.Dr. Khan's decision to utilize an incisional biopsy under monitored anesthesia was within the standard of care for general surgeons practicing in Arizona during the relevant time period.

166.The use of an anesthesiologist to administer and monitor the intravenous sedation given to N.M. during the procedure indicated that the patient was at some risk, as is the case with the administration of anesthesia care. However, Dr. Khan's judgment-based decision to use monitored anesthesia under the circumstances did not subject N.M. to any unjustifiable or unreasonable risk.

167.Dr. Khan's care did not harm N.M. in any way.

168.Dr. Khan did not fail to adequately document his care for N.M.

PATIENT P.G.

169.On May 27, 1998, Dr. Khan saw P.G., a 71 year old female, for complaints of a right axillary mass. Dr. Khan performed an adequate examination, including examination of

the patient's right axilla and her breasts. Through his examination, Dr. Khan noted that there was no evidence of lymphadenopathy, which established the completeness of his examination.

170. P.G. had not had regular mammograms nor had her breasts been examined regularly.

171. Dr. Khan successfully excised the mass on May 28, 1998 while the patient was placed under general anesthesia.

172. The decision to utilize general anesthesia was discussed between P.G. and the anesthesiologist, Dr. Arthur Ford.

173. After the surgery, Dr. Khan diagnosed the condition as an inflammatory mass in the right axilla.

174. The pathologist diagnosed the specimen which was excised from the patient's right axillae as hidradenitis suppurativa, which is an inflammation of the sweat glands.

175. Dr. Khan definitively treated P.G.'s condition in a low risk fashion. Because this was not a typical presentation of hidradenitis suppurativa, Dr. Khan's judgment-based decision to remove the mass under general anesthesia was proper under the circumstances

PATIENTS P.M. AND S.B.

176. Dr. Khan saw patient P.M., a 59 year old female, on April 20, 1998 for a consultation related to a noticeable lesion of the left breast.

177. Although Dr. Khan's typewritten notes dated April 20, 1998 show that he examined the patient's breasts, those notes do not record that he examined P.M.'s axillae or comment on the status of the axillae.

178. Following a mastectomy procedure, Dr. Khan's typewritten, post-operative progress notes dated June 10, July 9, July 16, July 23, July 30 and August 20, 1998 also do not record that he examined P.M.'s axillae, or comment on the status of the axillae.

179. Dr. Khan saw patient S.B., a 50 year old female, on May 6, 1998 regarding a left breast nodule that was suspicious by mammogram. Dr. Khan's History and Physical for

S.B. stated in part: "BACK [sic]: A palpable nodule is noted in the upper quadrant of the breast at about 12 to 1 o'clock."

180. Dr. Khan's typewritten notes dated May 6, 1998 do not document that he examined S.B.'s breasts, including the axillary areas, or comment on the status of the axillae.

181. Dr. Khan did examine the axillae of patients P.M. and S.B. and the findings were negative, but those negative findings were not recorded in the patients' medical records. Dr. Khan did not believe that it was necessary to document negative findings in his typewritten notes.

182. While there is credible evidence that it is important to record even negative findings of an axillary examination in the medical record because those findings form the basis of subsequent treatment, the evidence of record is inconclusive that the standard of care requires a physician to record such negative findings in a patient's medical record.

183. The results of Dr. Khan's axillary examinations for patients P.M. and S.B. are reflected in his contemporaneous handwritten notes. However, those handwritten notes were maintained in the patients' billing files, and not as part of the patients' medical records, and therefore could not be relied upon by Dr. Khan or any subsequent treating physician for the care and treatment of those two patients.

184. Both sides' expert witnesses agreed that a subsequent treating physician would have to re-examine the axillae in all events.

185. Dr. Khan maintained adequate records for his care of P.M. and S.B. While it has not been established to be a violation of the standard of care, Dr. Khan, having made handwritten notes of the examinations for patients P.M. and S.B., should have included such notations in the medical records for those patients. If those notations were important enough to include in his contemporaneous handwritten notes, they should have been important enough to include in the typewritten medical records.

ALLEGATIONS THAT DR. KHAN FAILED TO PROVIDE INFORMATION TO BOMEX

186. Under the terms of his March 14, 1997 Consent Order, Dr. Khan was required to submit to periodic office and practice surveys.

187. On or about July 29, 1998, BOMEX issued a subpoena for Dr. Khan to produce a complete copy of his office appointment book(s) for May 1998 and June 1998, and complete copies of the appointment book(s) for the Arizona Institute of Medicine and Surgery Outpatient Clinic for May 1998 and June 1998.

188. On or about August 6, 1998, Dr. Khan submitted copies of the requested appointment books to BOMEX.

189. After reviewing copies of the requested appointment books, BOMEX staff selected 20 patients whose records they wanted to examine for an office and practice survey under the 1997 Consent Order.

190. To obtain the medical records of the selected 20 patients, on or about August 14, 1998 BOMEX issued a subpoena to Dr. Khan to produce "any and all information, any and all records, office and outpatient surgery clinic records which you have in your care and custody and power, relating in any manner, either directly or indirectly to" those 20 patients, who were named in the subpoena.

191. Patients B.M., S.B., P.G. and P.M. were among the patients named in the subpoena.

192. On or about September 1, 1998, Dr. Khan provided records to BOMEX in response to the August 14, 1998 subpoena.

193. Despite the August 14, 1998 subpoena, Dr. Khan failed to provide his notes to BOMEX regarding his May 6 and 8 1998 examination of patient B.M. until on or about March 15, 2001.

194. Despite the August 14, 1998 subpoena, Dr. Khan also failed to provide his handwritten notes regarding his April 20, July 16, July 30 and August 20, 1998 examination of patient P.M., his May 6, 1998 examination of patient S.B., and his May 27, 1998 examination of patient P.G. until on or about March 15, 2001.

195. It was Dr. Khan's practice to make handwritten notes of the examinations of his patients, to have those handwritten notes converted into a typewritten report, and then to destroy the original handwritten notes once the typewritten report was prepared.

196. Dr. Khan's handwritten notes of the examinations of patients P.M., S.B. and P.G. were contained in the billing files of those patients, but not in their office or outpatient clinic files.

197. On or about September 8, 1998, Bill Meidt, a medical investigator for BOMEX, asked Dr. Khan to provide the billing records and facility consent forms for the patients listed in the attachment to the August 14, 1998 subpoena because those records had not been furnished as required by the subpoena.

198. On or about September 21, 1998, Dr. Khan provided the billing statements and facility consent forms in response to Mr. Meidt's request. At that time, Dr. Khan did not provide BOMEX his handwritten notes regarding his April 20, July 9, July 16, July 30 and August 20, 1998 examinations of patients P.M., his May 6, 1998 examination of patient S.B., and his May 27, 1998 examination of patient P.G., which allegedly were contained in the respective billing files of those patients.

199. During his investigational interview with BOMEX staff on April 14, 1999, Dr. Khan did not disclose that it was his practice to make handwritten notes of the examinations of his patients, and that copies of his handwritten notes of the examinations of patients P.M. or S.B. might be contained in the billing records for those patients.

200. Dr. Khan failed to furnish information in a timely manner to BOMEX when he failed to provide his typewritten notes for the May 6 and 8, 1998 examination of patient B.M. and his handwritten notes for the April 20, July 9, July 16, July 30 and August 20, 1998 examinations of patient P.M., the May 6, 1998 examination of patient S.B., and the May 27, 1998 examination of patient P.G. until on or about March 15, 2001, even though BOMEX had issued him a subpoena to produce such records on or before August 28, 1998.

201. Dr. Khan is also found to have violated the terms of his March 14, 1997 Consent Order when he failed to provide his notes described in Findings of Fact No. 200 above,

even though he agreed to "submit to periodic office and practice surveys at a frequency to be determined by the Board," and to "cooperate fully with the Board with respect to any pending or future investigations."

PREVIOUS BOMEX ACTIONS AGAINST DR. KHAN IN ADDITION TO THE 1995 CONSENT AGREEMENT AND THE 1997 CONSENT AGREEMENT

202. On January 8, 1981, BOMEX issued Dr. Khan a letter of concern for naiveté and imprudent behavior.

203. On January 19, 1982, BOMEX issued Dr. Khan a letter of concern due to his lack of post-operative hospital notes.

204. On March 12, 1982, BOMEX issued Dr. Khan a letter of concern for the use of externs or clerks from foreign medical schools at Mohave. BOMEX determined that there was a serious error in judgment for accepting medical students in the absence of a formal agreement with an accredited medical education program.

205. On June 13, 1990, BOMEX issued Dr. Khan an advisory letter of concern for failure to forward medical records in a timely fashion when a patient had signed the appropriate release authorization.

206. On September 27, 1990, BOMEX issued Dr. Khan a letter of concern for his failure to recognize that a patient's problem was beyond his ability to handle, and for his failure to obtain a consultation prior to performing surgery.

207. On August 16, 1991, BOMEX issued Dr. Khan an advisory letter of concern for charging a patient for admission and discharge services when those services were handled by an emergency room physician who wrote all the orders.

208. On May 11, 1991, BOMEX issued an advisory letter of concern for Dr. Khan for inadequate documentation, insufficient examination and questionable surgical judgment in a patient's care.

209. On August 3, 1992, BOMEX issued Dr. Khan an advisory letter of concern for his failure to appropriately supervise a physician assistant who wrote a prescription for a

Schedule II medication on a prescription form which contained the Drug Enforcement Agency ("DEA") number of a supervising physician's agent, rather than the number of the supervising physician. BOMEX also expressed concern about Dr. Khan's failure to recognize that Ritalin is a Schedule II drug, and allowing the physician assistant to refill medication without using a DEA number or obtaining a countersignature on the patient records and prescription.

CONCLUSIONS OF LAW

1. BOMEX possesses jurisdiction over the subject matter and over Dr. Khan.
2. BOMEX has the burden to establish that Dr. Khan committed unprofessional conduct under the various subsections of A.R.S. § 32-1401.
3. The conduct and circumstances described in the above-provided Findings of Fact constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(ll) (conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient).
4. The conduct and circumstances described in the above-provided Findings of Fact constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(q) (any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public).
5. The conduct and circumstances described in the above-provided Findings of Fact constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(e) (failing or refusing to maintain adequate records on a patient).
6. The conduct and circumstances described in the above-provided Findings of Fact constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(r) (violating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director).
7. The conduct and circumstances described in the above-provided Findings of Fact constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(dd) (failing to

furnish information in a timely manner to the board or its investigators or representatives if legally requested by the board).

8. Pursuant to the provisions of A.R.S. § 32-1451(K), any physician found to be guilty of unprofessional conduct is "subject to censure, probation...suspension of license or revocation of license or any combination of these, including a stay of action, and for a period of time or permanently." That statutory provision also permits BOMEX to charge the cost of formal hearing to the guilty physician. The evidence of record supports the imposition of disciplinary action against Dr. Khan for the protection of the public health and safety.

ORDER

In view of the foregoing, Respondent's License No. 9994 for the practice of medicine in the State of Arizona is revoked. However, revocation is stayed and Respondent is placed on probation for a period of five years, to be added to the term of his current probation, subject to the following terms and conditions:

1. Respondent shall comply with the remaining applicable terms and conditions of the 1997 Consent Agreement, which are incorporated herein by reference. Every term of the probation is mutually exclusive and is imposed to protect the public. Additionally, Board staff shall conduct periodic reviews of Respondent's major surgical operative cases. Should Board staff find cases that fall outside the standard of care, those cases will be brought to the Board for review.

2. Any violation of the terms and conditions of the effective Order in this matter will result in summary suspension of the Respondent's medical license, and any violation proved after hearing will result in the revocation of Respondent's license.
3. Pursuant to A.R.S. § 32-1451(K), Respondent shall pay to BOMEX the costs of formal hearing no later than one year from the effective date of the entered Order in this matter.

RIGHT TO PETITION FOR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing must be filed with the Board's Executive Director within thirty (30) 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. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

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

DATED this 15th day of October, 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
15 day of October, 2001, with:

Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, AZ 85258

Copy of the foregoing filed this
15 day of October, 2001, with:

Cliff J. Vanell, Director
Office of Administrative Hearings
1400 W. Washington, Ste. 101
Phoenix, AZ 85007

Executed copy of the foregoing mailed
by Certified Mail this
15 day of October, 2001, to:

Ed Hendricks
Michael R. Ross
Meyer, Hendricks & Bivens, P.A.
3003 North Central Avenue
Suite 1200
Phoenix, Arizona 85012-2915

Executed copy of the foregoing mailed
this 15 day of October, 2001, to:

Stephen Wolfe
M. Elizabeth Burns
Montgomery Lee
Assistant Attorneys General
Office of the Attorney General
1275 W. Washington
Phoenix, AZ 85007
Attorneys for the State

and to:

Muhammad A. Kahn, M.D.
3636 Stockton Hill Road
Kingman, Arizona 86401-0514

Executed copy of the foregoing hand delivered

this 15 day of October, 2001, to:

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

Board Operations