

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 Frank R. Bowers M.D.
19 Frank R. Bowers, M.D.

Reviewed and accepted this 9th
day of October, 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 20858 for the practice of
5 allopathic medicine in the State of Arizona.

6 3. The Board initiated case number MD-00-0191 upon receiving a complaint
7 from R.S. (Complainant), the mother of patient L.S., a child.

8 4. Respondent treated patient L.S. for approximately one year and diagnosed
9 her as being bipolar, with attention deficit hyperactivity disorder and obsessive compulsive
10 disorder. During the one year of treatment, Respondent prescribed Dexedrine, Clonidine,
11 Lithium, and Remeron. Although Lithium was prescribed, Respondent failed to monitor
12 lithium levels after prescribing.

13 5. On January 5, 2000, Respondent changed patient L.S.'s medication. He
14 discontinued Dexedrine and Clonidine to be eventually replaced with Paxil, but continued
15 Lithium. Respondent scheduled a follow-up visit for March 8, 2000.

16 6. Following the change of medication, patient L.S. experienced physical
17 symptoms including nausea, vomiting, anger and aggression. On February 14, 2000,
18 Complainant phoned Respondent's office and requested an emergency appointment.
19 Prior to the scheduled appointment on February 16, 2000, Respondent's office phoned
20 Complainant and informed her that Respondent's office no longer accepted her insurance,
21 but Respondent would provide the required prescriptions for continuing care until the
22 patient could make arrangements with another physician.

23 7. Complainant contacted her insurer and was given the names of three
24 psychiatrists to contact, but the earliest available appointment was April 30, 2000.

25

1 8. On February 17, 2000, Complainant requested additional prescription refills
2 from Respondent. On February 18, 2000, Complainant contacted the pharmacy for
3 additional refills. The pharmacist informed Complainant that Respondent had not
4 responded to the request for prescription refills.

5 9. James M. Campbell, M.D. ("Dr. Campbell"), Board Medical Consultant,
6 reviewed the file. Dr. Campbell noted that acceptable medical practice requires the
7 monitoring of Lithium blood level not only for toxicity but more importantly to determine if
8 the Lithium prescribed is within the therapeutic window and during the one-year period of
9 treatment Respondent should have tested patient L.S.'s Lithium levels at least twice. Dr.
10 Campbell also stated that Respondent had a responsibility to provide emergency care for
11 a patient whom he had seen a month before and made major changes in the patient's
12 medication because of worsening symptoms.

13 10. Respondent fell below the standard of care in failing to monitor patient L.S.'s
14 Lithium levels after prescribing and failing to see patient L.S. who continued to regress
15 following his instituting a major medication change.

16 **CONCLUSIONS OF LAW**

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

19 2. The conduct and circumstances described above in paragraphs 3 to 10
20 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(q)(“[a]ny conduct or
21 practice which is or might be harmful or dangerous to the health of the patient or the
22 public.”)
23
24
25

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand for the unprofessional conduct described above.
2. This Order is the final disposition of case number MD-00-0191.

DATED AND EFFECTIVE this 12th 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
12 day of October, 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 12 day of October, 2001 to:

Frank Richard Bowers, M.D.
8557 Summer Vista Avenue
Las Vegas, NV 89145-4863

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EXECUTED COPY of the foregoing
hand-delivered this 12 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)
c/o Arizona Board of Medical Examiners
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258


