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No. 09A-24093-MDX

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

(License Revocation)

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1 4. The Board sent a copy of the Complainant and Notice of Hearing to
2 Respondent via certified mail at her address of record, which was also her last known
3 address.

4 5. Before the hearing, the Board requested and was granted permission to
5 present telephonically the testimony of its outside medical consultant and expert witness,
6 David Gates, M.D.

7 6. Respondent did not request to appear telephonically at the hearing.

8 7. A hearing was held on the date and time set forth in the Complaint and Notice
9 of Hearing, June 1, 2009 at 9:00 a.m.

10 8. Although the beginning of the duly noticed hearing was delayed fifteen
11 minutes to allow Respondent additional travel time, she neither appeared personally or
12 through an attorney, contacted the Office of Administrative Hearings to request a
13 continuance or that the time for the hearing be further delayed, nor presented any
14 evidence to defend her license for the practice of allopathic medicine in Arizona.

15 9. The Board presented the testimony of Dr. Gates and its Case Manager
16 Marlene J. Young and submitted twenty-four exhibits.

17 HEARING EVIDENCE

18 The Malpractice Case

19 10. Ms. Young testified that, on April 9, 2007, the Board received a copy of a
20 default judgment dated October 30, 2002 in Maricopa County Case No. CV 2002-000158
21 ("the malpractice case") from Michelle Worhacz at the law office of Beale, Micheaels &
22 Slack, P.C., who represented W.B. and his wife J.B. The judgment awarded W.B. and
23 J.B. \$1.5 million against Respondent. Ms. Young was assigned to investigate the matter.

24 11. On April 17, 2007, the Board obtained a copy of the superior court complaint
25 that had been filed in January 2002 in the malpractice case against Respondent, which
26 alleged the following facts:

27 11.1 On January 7, 2000, Respondent had examined W.B. at his home. W.B.
28 was complaining of fatigue, weight loss, increased thirst, increased urination, and sores
29 on his tongue. Respondent diagnosed W.B. with Cocksackie virus and recommended
30 vitamin therapy. Respondent did not recommend diagnostic studies or follow up
treatment.

1 11.2 On the morning of January 19, 2000, W.B.'s condition became acute.
2 Respondent again examined W.B. at this home and recommended increased fluids for
3 dehydration.

4 11.3 On the evening of January 19, 2000, Respondent again examined W.B. at
5 his home. By that time, W.B. was unresponsive. Respondent recommended transport to
6 a hospital for emergency treatment and W.B. was admitted to Mayo Clinic.

7 11.4 Although W.B. survived, he sustained permanent injury. His medical records
8 from Mayo Clinic showed diagnoses of diabetic ketoacidosis and pancreatitis. He was
9 determined to be permanently disabled as a result.

10 11.5 Attached as an exhibit to the complaint in the malpractice case was a
11 handwritten note from Respondent dated January 7, 2000 for W.B., which instructed him
12 to take varying doses of Vitamin C, zinc, Vitamin E, Echinacea, and other nutritional
13 supplements and advising him that, "[w]hen in stress need to beef up your nutrition a lot."

14 **Ms. Young**

15 12. On April 17, 2007, Ms. Young on behalf of the Board sent a letter to
16 Respondent, to which was attached a copy of the default judgment in the malpractice
17 case. Ms. Young informed Respondent that her failure to properly diagnose and treat
18 W.B., which resulted in diabetic ketoacidosis and pancreatitis, violated the applicable
19 standard of care. In addition, Respondent had failed to disclose the malpractice judgment
20 on her renewal applications for 2002, 2004, and 2006.

21 13. On April 17, 2007, Ms. Young on behalf of the Board obtained from W.B. and
22 J.B.'s attorney's office a copy of a Waiver of Service of Summons of the complaint in the
23 malpractice action, which Respondent had signed on February 1, 2002. Respondent had
24 acknowledged receipt of a copy of the complaint in that document.

25 14. On April 25, 2007, Respondent sent an e-mail in response to Ms. Young's
26 letter, which included the following assertions:

27 14.1 W.B. was not her patient, but was a family friend. She had repeatedly
28 urged W.B. to obtain lab work and go to his doctor but he declined because he lacked
29 health insurance and was afraid of needles.

30 14.2 Respondent "went to the hospital as a friend of the family" after W.B. had
been taken to Mayo Clinic.

1 14.3 Respondent had no knowledge of W.B.'s and J.B.'s malpractice case or the
2 default judgment. She was never properly served with the malpractice complaint.

3 14.4 Respondent also noted that at Mayo Clinic W.B.'s "prognosis was not good"
4 and that "[h]e appeared to be dying." Respondent claimed to have "healed" W.B., in
5 relevant part as follows:

6 In addition to being a medical doctor, I am also an [sic] Native
7 American Healer. So I prayed over him. I prayed to take on
8 his illness because he had a family and two young children to
9 care for. The staff at the ICU would not speak to me directly
10 but only through his wife. So I prayed to remove his illness
11 through me. He improved steadily through the next three
12 days, during which time I became very ill.

13
14 [W.B.] probably should not have survived this ordeal but he
15 was soon moved from intensive care to a medical floor.

16 I continued to be ill for some time after this healing I did for
17 him. The doctors at the Indian Health Center said that I
18 apparently had gastric lymphoma. As you know, this is a
19 deadly diagnosis. I went to the Lakota Sweat Lodge of which
20 I was a member and was healed of this affliction after six
21 months.

22 15. Ms. Young obtained from W.B. and J.B.'s attorney's office a copy of an
23 Explanation of Benefits from United Health Care, which had paid Respondent for an
24 office visit on April 4, 1999 on W.B.'s behalf.

25 16. The medical records that Ms. Young obtained also included an Emergency
26 Medical Service ("EMS") report for the emergency transport of W.B. to Mayo Clinic on
27 January 19, 2000. Respondent was listed as W.B.'s physician. The January 19, 2000
28 emergency department admission report from Mayo Clinic stated as follows:

29 [T]he patient's physician who arrived after the patient had
30 been her for a short while informed me that the patient was
diagnosed by her with Cocksackie virus a month ago. Since
that time, he has had a declining course in that he has been
getting fatigued and weak. She also states that he has been
eating lots of sweets, urinating a lot, and drinking lots of fluids.
She states that she has never checked his sugar but recently
found out that his brother was diabetic.

1 17. The Board also submitted Respondent's biennial license renewal applications,
2 which she signed on March 28, 2002 (2002 biennial renewal application), February 20,
3 2004 (2004 biennial renewal application), and March 28, 2006 (2006 biennial renewal
4 application). All three renewal applications answered "no" to the question #11, "Within the
5 past 5 years, have you been named as a defendant in a malpractice matter currently
6 pending or that resulted in a settlement or judgment against you?"

7 18. The Board also submitted an affidavit from Ms. Worhacz, which avowed that
8 she was employed by the firm of Beale, Micheaels & Slack, P.C. since 1995 and that, on
9 February 1, 2002, she had personally met Respondent in her firm's conference room.
10 Ms. Worhacz also avowed that, on February 1, 2002, she "spoke with [Respondent] for
11 quite some time about the procedural issues regarding [W.B.'s malpractice] lawsuit."

12 19. The Board submitted a Consent Agreement dated May 14, 1996, in which the
13 Board had ordered and Respondent had agreed to continue psychological treatment with
14 a Board-approved psychologist, to practice medicine only in a structured setting, and to
15 submit to random biological fluid testing. The Board had entered a letter of reprimand
16 against Respondent on August 27, 1997 after she failed to comply with the consent
17 agreement.

18 20. The Board also submitted its letter terminating the Consent Agreement,
19 effective April 28, 2000.

20 21. Ms. Young testified that she asked Respondent to provide W.B.'s medical and
21 billing records but Respondent never provided any records. Ms. Young obtained W.B.'s
22 records from Mayo Clinic and from W.B. and J.B.'s attorney's office.

23 22. On July 9, 2007, Ms. Young wrote an investigative report, in which she
24 concluded that Respondent had violated A.R.S. § 32-1401(27)(jj) by knowingly making a
25 false statement on the 2002, 2004, and 2006 biennial renewal applications when she
26 stated that there were no malpractice suit pending or malpractice judgment entered
27 against her. Ms. Young opined that Respondent knew about the malpractice lawsuit,
28 since she had signed the waiver of service of process in February 2002, but that she may
29 not have known about the default judgment.

30 23. Ms. Young testified that, after Dr. Gates prepared his report on whether
Respondent had complied with the standard of care, she forwarded both reports to the

1 Board's Chief Medical Consultant, who also prepared a report. The three reports were
2 sent to Respondent in July 2007 but were returned, marked "Return to Sender." Ms.
3 Young testified that she contacted Respondent via telephone and obtained a new
4 address. Ms. Young sent the three reports to the new address and requested that
5 Respondent provide a supplemental response. Although the Board never received a
6 supplemental response from Respondent, the envelope containing the three reports and
7 the Board's letter was not returned.

8 24. On September 19, 2007, the Board's Staff Investigational Review Committee
9 ("SIRC") considered this matter and concluded that Respondent had violated A.R.S. § 32-
10 1401(e), (q), (dd), (jj), and (ll) in her care of W.B., which had resulted in actual harm to
11 W.B., in her failure to keep or provide medical records, in her biennial renewal
12 applications, and in her failure to respond to the Board's enquiries. As a result, SIRC
13 recommended that a decree of censure be issued against Respondent for failing to
14 investigate a patient's reported symptoms, keeping inadequate medical records, making a
15 false statement on a license renewal form, and failing to provide requested information to
16 the Board in a timely manner. SIRC also recommended that Respondent be placed on
17 probation for two years and required to undertake 20 hours of continuing medical
18 education in ethics and 20 hours of continuing medical education in professional
19 boundaries.

20 25. On November 29, 2007, the Board sent a letter to Respondent at the address
21 she had provided, inviting her to voluntarily appear for a formal interview. Instead of a
22 formal interview, the Board offered Respondent a Consent Agreement that included the
23 terms that SIRC recommended. The Board also advised Respondent of her right to
24 request a formal hearing instead of voluntarily submitting to a formal interview or entering
25 into a consent agreement.

26 26. Ms. Young testified that the November 29, 2007 letter was returned to the
27 Board as undeliverable.

28 27. On January 4, 2008, the Board sent via certified mail another letter to
29 Respondent at another address, where Respondent had indicated at one time that she
30 was staying, inviting her to a formal interview, offering a consent agreement, and

1 informing her of her right to request a hearing. Ms. Young testified that this letter was
2 delivered.

3 28. Ms. Young testified that she had spoken to Respondent on the telephone
4 twice. The first time, Respondent had seemed surprised and said that W.B. was not her
5 patient and provided an e-mail address. The second time, Respondent had provided the
6 new address. The Board also submitted staff notes that documented messages left for
7 Respondent on her cellular phone on April 28, 2009 and May 4, 2009 regarding the
8 administrative hearing on the pending complaint against her license. Ms. Young testified
9 that Respondent did not respond to these messages.

10 29. Ms. Young testified that the Board's Complaint and Notice of Hearing had
11 been sent via certified mail to Respondent's last known address, which was the same
12 address as on Respondent's 2008 biennial renewal. The Complainant and Notice of
13 Hearing were returned as undeliverable.

14 Dr. Gates

15 30. The Board assigned investigation of the complaint against Respondent
16 involving departure from the standard of care for allopathic physicians to Dr. Gates. After
17 reviewing the documents that Ms. Young had forwarded, including the complaint and
18 medical records, on June 28, 2007, Dr. Gates issued a Medical Consultant Report and
19 Summary.

20 31. Dr. Gates' report concluded that Respondent had a doctor-patient relationship
21 with W.B., based on the handwritten homeopathic instructions from the January 7, 2000
22 home visit and the prior billing. The legal documents also established that Respondent
23 had been served with the malpractice complaint and that, therefore, her statement that
24 she did not know about the complaint was false.

25 32. Dr. Gates' report also concluded that Respondent had departed from the
26 following standards of care in her treatment of W.B. in January 2000:

27 32.1 Office records for W.B. should have existed and should have been provided
28 to the Board;

29 32.2 Respondent should have been honest about her involvement with W.B. and
30 that a relationship of some sort existed;

1 32.3 Respondent should have made standard allopathic investigation of W.B.'s
2 complaints, including documented examination, blood work, and other diagnostic
3 inquiries, consistent with the physician's training and experience; and

4 32.4 Respondent should have been honest about the details of the malpractice
5 issue.

6 33. Dr. Gates' report also concluded that W.B. had been actually harmed by the
7 delay in the diagnosis of his diabetes.

8 34. Dr. Gates' report also noted as an aggravating factor that, "[i]f one is
9 functioning as an allopathic [physician], one has the obligation of evaluating each
10 particular patient's complaint within the context of standard medical care which includes
11 documentation, physician examination, differential diagnoses, diagnostic studies,
12 appropriate therapeutic intervention, etc."

13 35. Dr. Gates testified at the hearing that the complaint against Respondent was
14 the worst of the 40 to 50 cases that he had reviewed for the Board as an outside medical
15 consultant.

16 36. Dr. Gates testified that the doctor-patient relationship between Respondent
17 and W.B. in January 2000 was established by the handwritten homeopathic instructions
18 Respondent had prepared on January 7, 2000, the 1999 billing statement, and the
19 references in the EMS report and Mayo Clinic admission. In addition, Respondent had
20 admitted in her initial response to the complaint that she spoke to Mayo Clinic staff after
21 W.B. was admitted on January 19, 2000 about his history and condition.

22 37. Dr. Gates testified that W.B. exhibited classic symptoms of diabetes on
23 January 7, 2000. If Respondent had correctly diagnosed W.B., the exacerbation of his
24 symptoms might have been avoided. But, without diagnostic and laboratory tests,
25 including a finger stick glucometer test, which is available in most allopathic physicians'
26 offices, a definitive diagnosis could not be made.

27 38. Dr. Gates testified that, on January 19, 2000, due to W.B.'s elevated glucose,
28 his brain became dehydrated and he suffered a diabetic coma and pancreitis. W.B. could
29 have died or suffered permanent organ failure. Dr. Gates opined that Respondent was
30 grossly negligent in her treatment of W.B.

1 39. Dr. Gates testified that Respondent's reference to Native American healing
2 practices was "most troublesome." He testified that, if Respondent held herself out as a
3 medical doctor, she is held to the standards and typical avenues of treatment of allopathic
4 medical care, regardless of her personal cultural or spiritual beliefs. Respondent's
5 handwritten homeopathic instructions and diagnosis did not constitute standard allopathic
6 treatment.

7 40. Dr. Gates testified that Respondent's statement in her e-mail to the Board that
8 she had taken W.B.'s illness into her own body raised a "red flag" because allopathic
9 physicians are "not afforded the luxury of injecting their personal beliefs into their medical
10 practice." Allopathic medicine is an evidence-based practice. Applicable standards of
11 care cannot depend on a practitioner's spiritual beliefs.

12 41. Dr. Gates testified that Respondent's subterfuge in denying a doctor-patient
13 relationship with W.B. was "not a statement of fact" and called into question Respondent's
14 ethics.

15 **CONCLUSIONS OF LAW**

16 1. The notice of the hearing that the Board mailed to Respondent at her address
17 of record was reasonable Respondent is deemed to have received notice of the
18 hearing.¹

19 2. The Board has jurisdiction to consider this complaint and to discipline
20 Respondent's license to practice allopathic medicine in Arizona.²

21 3. The Board bears the burden of proof and must establish Respondent's
22 statutory violations and cause to discipline her license to practice allopathic medicine in
23 Arizona by a preponderance of the evidence.³

24 4. "A preponderance of the evidence is such proof as convinces the trier of fact
25 that the contention is more probably true than not."⁴ A preponderance of the evidence is
26 "[t]he greater weight of the evidence, not necessarily established by the greater number of
27 witnesses testifying to a fact but by evidence that has the most convincing force; superior

28 ¹ See A.R.S. §§ 41-1092.04; 41-1092.05(D).

29 ² See A.R.S. § 32-1451.

30 ³ See A.R.S. § 41-1092.07(G)(2); A.A.C. R2-19-119; see also *Vazanno v. Superior Court*, 74 Ariz. 369, 372,
249 P.2d 837 (1952).

⁴ Morris K. Udall, ARIZONA LAW OF EVIDENCE § 5 (1960).

1 evidentiary weight that, though not sufficient to free the mind wholly from all reasonable
2 doubt, is still sufficient to incline a fair and impartial mind to one side of the issue rather
3 than the other.”⁵

4 5. The Board established that Respondent had a doctor-patient relationship with
5 W.B. in January 2000.

6 6. The Board established that Respondent committed unprofessional conduct
7 as defined by A.R.S. § 32-1401(27)(e) by failing or refusing to maintain adequate
8 medical records for W.B. in January 2000.

9 7. The Board established that Respondent committed unprofessional conduct
10 as defined by A.R.S. § 32-1401(27)(q) by rendering care and treatment to W.B. in
11 January 2000 that could have and actually did cause W.B. harm.

12 8. Respondent was bound by a consent agreement to practice medicine only in
13 a structured setting when she treated W.B. at his home in January 2000. The Board
14 therefore established that Respondent committed unprofessional conduct as defined by
15 A.R.S. § 32-1401(27)(r) when she violated the terms of that consent agreement by
16 examining and treating W.B. at his home in January 2000.

17 9. The Board established that Respondent committed unprofessional conduct
18 as defined by A.R.S. § 32-1401(27)(dd) when she failed to furnish W.B.’s medical
19 records or to respond to the Board’s investigator’s inquiries in a timely manner.

20 10. The Board established that Respondent committed unprofessional conduct
21 as defined by A.R.S. § 32-1401(27)(jj) when she falsely denied in the her biennial
22 license renewal applications for the years 2002, 2004, and 2006 that any malpractice
23 suit was pending, after she had waived service of process and the summons and
24 complaint for W.B.’s malpractice case against her.

25 11. The Board established that Respondent also committed unprofessional
26 conduct as defined by A.R.S. § 32-1401(27)(jj) when she falsely denied in her response
27 to the complaint that W.B. was her patient or than she knew about his malpractice
28 action.
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⁵ BLACK’S LAW DICTIONARY at page 1220 (8th ed. 1999).

1 12. The Board established that Respondent committed unprofessional conduct
2 as defined by A.R.S. § 32-1401(27)(II) because her care and treatment of W.B. was
3 grossly negligent⁶ and resulted in harm to him.

4 13. With respect to the appropriate penalty, Respondent has a prior disciplinary
5 history, the current complaint includes multiple offenses, Respondent intentionally failed
6 to comply with the Board's orders, Respondent made at least two false statements during
7 the course of the Board's investigation, and Respondent refused to acknowledge the
8 wrongful nature of her conduct in treating W.B. and in her response to the Board's
9 complaint. Five of the seven aggravating factors set forth in A.A.C. R4-16-604 are
10 present in this case.⁷

11 14. Respondent's initial response to the complaint showed a complete lack of
12 insight that her treatment of W.B. was inadequate. Respondent's multiple false and
13 misleading statements to the Board and her failure to appear for the hearing or to defend
14 her license to practice allopathic medicine in Arizona demonstrate that she cannot be
15 regulated at this time.

16 15. The legislature created the Board to protect the public.⁸ Under the
17 circumstances of this case, protection of the public requires that Respondent's license to
18 practice allopathic medicine be revoked.

19 ORDER

20 Respondent's License No. 24093 shall be revoked on the effective date of the
21 Order entered in this matter.

22 RIGHT TO PETITION FOR REHEARING OR REVIEW

23 Respondent is hereby notified that he has the right to petition for a rehearing or
24 review. The petition for rehearing or review must be filed with the Board's Executive
25

26 ⁶ "Negligence" has been defined by the legislature as "a want of such attention to the nature or probable
27 consequence of the act or omission as a prudent man ordinarily bestows in acting in his own concerns."
28 *Caldwell v. Arizona State Bd. of Dental Examiners*, 137 Ariz. 396, 400, 670 P.2d 1220, 1224 (App. 1983)
(quoting A.R.S. § 1-215.20). "Gross negligence" has been equated by [the Arizona] supreme court with
29 'wanton negligence.'" *Id.* (citing *Evans v. Pickett*, 102 Ariz. 393, 396, 430 P.2d 413, 416 (1967)).

30 ⁷ The record does not establish that Respondent had a dishonest or selfish motive or that W.B. was
especially vulnerable when she treated him, although it is clear that he and his wife relied upon
Respondent's care and professional expertise.

⁸ See Laws 1992, Ch. 316, § 10.

1 Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The
2 petition for rehearing or review must set forth legally sufficient reasons for granting a
3 rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days
4 after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not
5 filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to
6 Respondent.
7

8 Respondent is further notified that the filing of a motion for rehearing or review is
9 required to preserve any rights of appeal to the Superior Court.
10

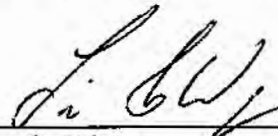
11 ///

12 ///

13 DATED this 5TH day of August, 2009.
14



17 THE ARIZONA MEDICAL BOARD

18 By 

19 Lisa S. Wynn
20 Executive Director

21 ORIGINAL of the foregoing filed this
22 5TH day of August, 2009 with:

23 Arizona Medical Board
24 9545 East Doubletree Ranch Road
25 Scottsdale, Arizona 85258

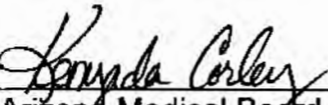
26 COPY OF THE FOREGOING FILED
27 this 5TH day of August, 2009 with:

28 Cliff J. Vanell, Director
29 Office of Administrative Hearings
30 1400 W. Washington, Ste 101
Phoenix, AZ 85007

1 Executed copy of the foregoing
2 mailed by U.S. Mail this
3 5th day of August, 2009 to:

4 Robbi Borjeson, M.D.
5 Address of Record

6 Anne Froedge
7 Assistant Attorney General
8 Office of the Attorney General
9 CIV/LES
10 1275 W. Washington
11 Phoenix, AZ 85007

12 
13 Arizona Medical Board Staff