BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of: **ROBBI BORJESON, M.D.** Holder of License No. **24093** For the Practice of Allopathic Medicine In the State of Arizona.	**No. 09A-24093-MDX** **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (License Revocation)

On August 5, 2009, this matter came before the Arizona Medical Board ("Board") for oral argument and consideration of the Administrative Law Judge (ALJ) Diane Mihalsky's proposed Findings of Fact and Conclusions of Law and Recommended Order. Assistant Attorney General Anne Froedge, appeared before the Board and represented the State. Chris Munns, Assistant Attorney General with the Solicitor General's Section of the Attorney General's Office, was present and available to provide independent legal advice to the Board.

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

FINDINGS OF FACT

BACKGROUND AND PROCEDURE

1. The Arizona Medical Board ("the Board") is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.

2. Robbi Borjeson, M.D. ("Respondent") is the holder of License No. 24093 for the practice of allopathic medicine in the State of Arizona.

3. On April 16, 2009, the Board issued a Complaint and Notice of Hearing in this matter, which set forth certain detailed factual allegations and, based on those allegations, charged violations of A.R.S. § 32-1401(27)(e), (q), (r), (dd), (jj), and (ll). The Board quoted the charged statutes in the Complaint and Notice of Hearing.

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

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

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

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

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

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

HEARING EVIDENCE

The Malpractice Case

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

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

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

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

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

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

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

Ms. Young

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

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

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

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

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

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

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

> In addition to being a medical doctor, I am also an [*sic*] Native American Healer. So I prayed over him. I prayed to take on his illness because he had a family and two young children to care for. The staff at the ICU would not speak to me directly but only through his wife. So I prayed to remove his illness through me. He improved steadily through the next three days, during which time I became very ill.
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> . . . .
>
> [W.B.] probably should not have survived this ordeal but he was soon moved from intensive care to a medical floor.
>
> I continued to be ill for some time after this healing I did for him. The doctors at the Indian Health Center said that I apparently had gastric lymphoma. As you know, this is a deadly diagnosis. I went to the Lakota Sweat Lodge of which I was a member and was healed of this affliction after six months.

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

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

> [T]he patient's physician who arrived after the patient had been her for a short while informed me that the patient was diagnosed by her with Coxsackie 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Gates

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSIONS OF LAW

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

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

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

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

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[1] *See* A.R.S. §§ 41-1092.04; 41-1092.05(D).
[2] *See* A.R.S. § 32-1451.
[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).

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

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

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

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

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

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

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

11. The Board established that Respondent also committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(jj) when she falsely denied in her response to the complaint that W.B. was her patient or than she knew about his malpractice action.

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[5] BLACK'S LAW DICTIONARY at page 1220 (8th ed. 1999).

12. The Board established that Respondent committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(ll) because her care and treatment of W.B. was grossly negligent[6] and resulted in harm to him.

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

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

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

ORDER

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

RIGHT TO PETITION FOR REHEARING OR REVIEW

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

[6] "Negligence" has been defined by the legislature as "'a want of such attention to the nature or probable consequence of the act or omission as a prudent man ordinarily bestows in acting in his own concerns.'" *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 'wanton negligence.'" *Id.* (citing *Evans v. Pickett*, 102 Ariz. 393, 396, 430 P.2d 413, 416 (1967)).

[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.

Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review 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 or review is required to preserve any rights of appeal to the Superior Court.

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DATED this 5th day of August, 2009.

THE ARIZONA MEDICAL BOARD

By [signature]
Lisa S. Wynn
Executive Director

ORIGINAL of the foregoing filed this 5th day of August, 2009 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

COPY OF THE FOREGOING FILED this 5th day of August, 2009 with:

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

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

Robbi Borjeson, M.D.
Address of Record

Anne Froedge
Assistant Attorney General
Office of the Attorney General
CIV/LES
1275 W. Washington
Phoenix, AZ 85007

Arizona Medical Board Staff