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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of
SAM E. SATO, M.D.
Holder of License No. 14758
For the Practice of Allopathic Medicine
In the State of Arizona

Case No. MD-17-0746A
ORDER GRANTING REVIEW

At its public meeting on August 21, 2018, the Arizona Medical Board ("Board") considered Sam E. Sato, M.D. ("Respondent"), request for rehearing or review (titled "Motion for Reconsideration" and citing R4-16-103) of the Board's Findings of Fact, Conclusions of Law and Order for Letter of Reprimand in the above referenced matter. After considering all of the evidence, the Board voted to grant Respondent's request in part pursuant to A.A.C. R4-16-103(D)(8), by striking Finding of Fact paragraph 9 and replacing it with alternative language.

1 ORDER

2 **IT IS HEREBY ORDERED that:**

3 1. Respondent's request for review is granted in part. The Board's June 14, 2018
4 Findings of Fact, Conclusions of Law and Order for Letter of Reprimand is modified as
5 follows: Finding of Fact paragraph 9 is stricken and replaced with, " During the Formal
6 Interview, the Board found that there was the potential for patient harm." The Board
7 adopts the attached Findings of Fact, Conclusions of Law and Order for Letter of
8 Reprimand as its final order in this case.

9 DATED AND EFFECTIVE this 31st day of August, 2018.

11 ARIZONA MEDICAL BOARD

12
13 By Patricia E. McSorley
14 Patricia E. McSorley
Executive Director

15 EXECUTED COPY of the foregoing mailed
16 this 31st day of August, 2018 to:

17 Licensee, M.D.
18 Address of Record

19 Counsel
20 Attorney for Respondent

21 ORIGINAL of the foregoing filed
22 this 31st day of August, 2018 with:

23 Arizona Medical Board
1740 W. Adams St., Suite 4000
24 Phoenix, Arizona 85007

25 Michelle
Board staff

1 .BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

Case No. MD-17-0746A

3 **SAM E. SATO, M.D.**

**FINDINGS OF FACT, CONCLUSIONS
OF LAW AND ORDER FOR LETTER
OF REPRIMAND**

4 Holder of License No. 14758
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on
8 April 16, 2018. Sam E. Sato, M.D. ("Respondent"), appeared with legal counsel, James W.
9 Kaucher, Esq., before the Board for a Formal Interview pursuant to the authority vested in
10 the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions
11 of Law and Order after due consideration of the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

13 1. The Board is the duly constituted authority for the regulation and control of
14 the practice of allopathic medicine in the State of Arizona.

15 2. Respondent is the holder of license number 14758 for the practice of
16 allopathic medicine in the State of Arizona.

17 3. The Board initiated case number MD-17-0746A after receiving notification
18 that Respondent voluntarily surrendered his clinical privileges at a facility while under, or to
19 avoid, investigation relating to professional competence or conduct.

20 4. Actual patient harm was identified by the Board's medical consultant in that
21 all three patients required corrective surgery.

22 5. Respondent was scheduled to perform surgery to correct exotropia on
23 Patient ND's left eye on April 14, 2017. Respondent initiated the operation on the right
24 eye, which was the non-consented eye. Respondent completed the procedure on the left
25 eye prior to the end of the surgery.

1 6. Respondent was scheduled to perform surgery to correct bilateral exotropia
2 for Patient MT on March 18, 2011, with lateral rectus resection 5 mm planned in both
3 eyes. The right eye was mistakenly rotated laterally instead of medially and a 1 mm
4 incision was made in the conjunctiva medially.

5 7. Respondent performed surgery to correct a left exotropia on Patient AGH on
6 July 25, 2014. Respondent obtained consent for a left medial rectus resection of
7 previously operated on muscle to remove a 2.5 mm scar. Respondent initiated the
8 procedure on the right eye. Respondent completed the procedure on the left eye prior to
9 the end of surgery.

10 8. The standard of care for the management of a patient undergoing strabismus
11 surgery requires a physician to obtain thorough informed consent and discuss with the
12 patient prior to surgery, proper surgical technique at surgery, and all follow up care and
13 communication with the patient postoperatively. Accurate and complete medical records
14 are a standard of care, as well as proper handling of all complications. Respondent
15 deviated from this standard of care by performing strabismus procedures in three cases
16 where the correct eye or the correct direction of procedural intent was not accurately
17 initiated.

18 9. During the Formal Interview, the Board found that there was the potential for
19 patient harm.

20 10. During a Formal Interview on this matter, Respondent acknowledged that
21 errors occurred with regard to the surgical site, and testified with regard to corrective steps
22 he has taken to ensure that similar errors do not occur in the future. Respondent testified
23 that his current practice includes performing a second time-out procedure after the patient
24 is asleep. Respondent stated that only one patient experienced an unnecessary incision,
25 and that the incision did not require further repair. However, Respondent further testified

1 that he would not have made the same incision in two out of the three cases. With regard
2 to Patient AGH, Respondent testified that the incision was necessary due to scarring.
3 Respondent admitted that he did not have a signed informed consent agreement with
4 indicating that surgery on the second eye would be necessary.

5 11. During that same Formal Interview, a Board member commented that while
6 there may not have been actual harm in two of the three cases reviewed, there was the
7 potential for patient harm if the practice continued. A Board member also commented that
8 a time-out procedure should occur when the patient is awake, and relevant staff members
9 are all available to agree with regard to the surgical site.

10 **CONCLUSIONS OF LAW**

11 1. The Board possesses jurisdiction over the subject matter hereof and over
12 Respondent.

13 2. The conduct and circumstances described above constitute unprofessional
14 conduct pursuant to A.R.S. § 32-1401(27)(r) ("Committing any conduct or practice that is
15 or might be harmful or dangerous to the health of the patient or the public.").

16 **ORDER**

17 IT IS HEREBY ORDERED THAT:

18 1. Respondent is issued a Letter of Reprimand.

19 DATED AND EFFECTIVE this 31ST day of August, 2018.

21 ARIZONA MEDICAL BOARD

22 By Patricia E. McSorley
23 Patricia E. McSorley
24 Executive Director
25

