1 .BEFORE THE ARIZONA MEDICAL BOARD

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In the Matter of **GLENN G. ROBERTSON, M.D.** Holder of License No. 33045 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-16-0820A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR LETTER OF REPRIMAND AND PROBATION**

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7 The Arizona Medical Board ("Board") considered this matter at its public meeting on
8 October 4, 2017. Glen G. Robertson, M.D. ("Respondent"), appeared before the Board for
9 a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H).
10 The Board voted to issue Findings of Fact, Conclusions of Law and Order after due
11 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 33045 for the practice of
16 allopathic medicine in the State of Arizona.

17 3. The Board initiated case number MD-16-0820A after receiving
18 correspondence from the Hospital where Respondent held privileges stating that review of
19 Respondent's care of a patient was found to be substandard and that his documentation
20 was poor.

21 4. On February 27, 2016, JH, a 71 year-old female with dementia, was
22 transferred to the Hospital via emergency medical services ("EMS") from a skilled nursing
23 facility with complaints of shortness of breath. EMS reported that JH denied symptoms,
24 and that she required a 10L oxygen mask to maintain saturations above 88%. Her oxygen
25 saturation was 94% on arrival. Emergency Department ("ED") documentation did not note
distress. JH's breathing was noted to be even, unlabored, and relaxed, and her breath

sounds had wheezes and rhonchi with an oxygen saturation of 90% on 4L/m nasal cannula. Further work up revealed a febrile woman with mild leukocytosis, a chest x-ray showing infiltrates, and acute kidney injury.

5. At 14:41, five hours after JH presented to the ED, the decision was made to admit her, with admitting diagnoses of pneumonia and dehydration. Holding orders were written by the ER provider. At 17:22, JH's respiratory rate was noted to be 18 and was described as regular, with an oxygen saturation of 95% on 3L of 02 per nasal cannula. At 20:00, JH was noted to be non-communicative, with respirations described as tachypneic, and oxygen saturation was noted to be 89% on 4.5L of 02 per nasal cannula. Throughout the night, JH was noted to have been resting comfortably and was incontinent at times.

6. On February 28, 2016 at 07:15, JH's respirations were described as eupneic with a noted oxygen saturation of 89% on 4.5L nasal cannula. At 10:04, JH's respirations were described as tachypneic, and oxygen saturation was noted to be 83% on 4.5L, increased to 15L to raise oxygen to 86%. It was documented that Respondent was contacted and that there were no new orders at that time. At 14:32, Respondent assessed JH and ordered Lasix 40mg IV. At 14:50, nursing staff placed a Foley catheter and JH was noted to be awake, but not responsive to questions. At 16:20, JH was found to have agonal breathing and was noted to be unresponsive. Thirty minutes later, JH was declared dead by Respondent at the bedside.

7. On March 12, 2016, Respondent produced the history and physical documentation and death summary.

8. The standard of care requires timely evaluation of a patient admitted into an acute care hospital, which should be less than 12 hours from the time of initial presentation to the hospital for stable and uncomplicated admissions and within four hours of potentially

unstable or decompensating patients. Respondent deviated from this standard of care by failing to timely evaluate a decompensating patient.

9. The standard of care in the instance of bronchospasm requires a physician to add steroids in the case of purulent sputum in addition to Rocephin, Azithromycin, and Nebulizer treatments. Respondent deviated from this standard of care by failing to order steroids in the case of purulent sputum in a patient receiving Rocephin, Azithromycin, and Nebulizer treatments to treat community acquired pneumonia.

10. The standard of care for treatment of acute heart failure requires a physician to use IV diuretics, beta blockers, monitoring of intake and output of fluids and daily weight, when appropriate, as well as evaluation of ejection fraction by echocardiogram during hospitalization. Respondent deviated from this standard of care by failing to adequately treat JH's heart failure in that only a single dose of Lasix was ordered hours after JH's condition had changed and no additional testing had been ordered for monitoring of progress.

11. Actual harm occurred to the patient in that she died.

12. The Hospital initiated a review of JH's case, and requested a written explanation from Respondent regarding his care and treatment of JH. Respondent failed to respond. The Hospital also requested that Respondent complete a neuropsychological evaluation, which Respondent failed to complete as instructed by the Hospital. Respondent's privileges at the Hospital expired during the pendency of the Hospital's investigation.

13. On April 19-20, 2017, Respondent completed the neuropsychological evaluation with a Board-approved evaluator. On May 1, 2017, the Board received the evaluator's report, stating that Respondent is safe to practice provided he receive appropriate accommodation for a medical condition. The evaluator stated that Respondent

would benefit from undergoing a brief course of psychotherapy to address the medical condition, in addition to the treatment Respondent voluntarily undergoes.

14. During a Formal Interview on this matter, Respondent testified that he initially attempted to transfer the patient to a facility that could provide a higher level of care, and he was told by the emergency room physician that the patient refused transfer. Respondent stated that it was his understanding that the patient was stable in the emergency room and was receiving treatment. Respondent further testified that both understaffing and his own illness contributed to the delay in seeing the patient.

15. With regard to the documentation issues, Respondent testified that the Hospital was experiencing issues with its electronic medical records and physician dictation systems, so that information he entered into the system would not be retained and he could not dictate. Respondent explained that he compensated during this time by handwriting and typing information for patients, causing delays in entering his patient care information into the records.

16. Respondent further testified that he has been regularly seeing a psychiatrist since a previous Board matter that occurred in 2008. Respondent stated that he discussed the findings of the evaluation with the psychiatrist, who rescreened him with improved results. Respondent stated that he allowed his privileges at the Hospital to lapse because he had already been cleared to return to practice by his treating physicians so he determined that it would be better to focus more on his own clinic and improving his handwriting. Respondent stated that he is implementing an electronic medical recordkeeping program into his clinics.

17. During that same Formal Interview, Board members commented that based on Respondent's testimony, it was unclear whether the Hospital or Respondent was at fault for the inadequate documentation. However, Board members agreed that the delay

in care rises to the level of discipline, and noted that Respondent has a prior disciplinary order regarding inadequate medical records.

CONCLUSIONS OF LAW

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

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

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.
2. Respondent is placed on Probation for a period of 6 months with the following terms and conditions:

   a. **Continuing Medical Education**

Respondent shall within 6 months of the effective date of this Order obtain no less than 10 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in an intensive, in-person course regarding medical recordkeeping. Respondent shall within **thirty days** of the effective date of this Order submit his request for CME to the Board for pre-approval. Upon completion of the CME, Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure. The Probation shall terminate upon Respondent's proof of successful completion of the CME.

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 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.

DATED AND EFFECTIVE this 7th day of December, 2017.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed
this 7th day of December, 2017 to:

Glenn G. Robertson, M.D.
Address of Record

ORIGINAL of the foregoing filed
this 7th day of December, 2017 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Mary Bober
Board staff