BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

JAMES GOUGH, M.D.

Holder of License No. **7317**For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-05-1211A

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

(Letter of Reprimand and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on October 9, 2008. James Gough, M.D., ("Respondent") appeared before the Board with legal counsel Gary A. Fadell for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

- The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
- Respondent is the holder of License No. 7317 for the practice of allopathic medicine in the State of Arizona.
- 3. The Board initiated case number MD-05-1211A after receiving a complaint from an attorney representing RN, a former female patient of Respondent, that Respondent failed to timely provide patient records upon receipt of a written authorization in violation of A.R.S. section 32-1401(27)(a) and A.R.S. section 12-2293(A).
- 4. The matter came before the Board at a formal interview in April 2007. During the interview, Board members voted to continue the matter because the last note in Respondent's file indicated that RN was diagnosed with a brain tumor. Board members noted that Respondent had treated RN for eight years; however, the medical records failed to indicate that Respondent performed a neurological examination before diagnosing or prescribing medication to RN. The

Board voted to continue the matter to review the quality of care issues and bring the matter back to the Board.

- 5. After further investigation, the case returned to the Board for a Formal Interview on October 9, 2008.
- 6. RN's first office visit with Respondent occurred on July 19, 1996. The records of that visit contain no documentation of a physical examination; review of symptoms or systems; patient history; mental status; diagnosis; or plan. In addition, the records contain no evidence that Respondent prescribed medications for RN.
- 7. Although the medical records for July 19, 1996 do not document that Respondent prescribed medications to RN, Respondent's files contain an August 12, 1996 office message from RN in which she states that she cannot sleep while taking Prozac and which contains a reference to Klonopin. RN's next office visit note dated August 20, 1996 also contains a reference to Prozac and Klonopin.
- 8. Respondent's medical file on RN also contains information regarding Respondent's treatment of RN's family members.
- 9. Respondent treated patient RN for eight years, but the medical records contain no evidence that he ever conducted a physical examination of RN.
- 10. Respondent claimed that he did perform a physical examination of RN, but admitted that there was nothing in RN's medical records to substantiate that claim. Respondent also conceded that if a medical procedure is not documented, then the presumption is that it did not take place.
- 11. At the formal interview, Respondent admitted that his records of his initial and follow-up visits with this patient were insufficient. He also admitted that he improperly commingled treatment records for members of RN's family in the file designated for patient RN.

- 12. The standard of care in a psychiatric consultation requires an initial evaluation to include a psychiatric review of symptoms, a medical psychiatric and social history, a mental status exam and a treatment plan.
- 13. Respondent's initial evaluation deviated from the standard of care by not including a psychiatric review of symptoms, a medical psychiatric and social history, a mental status exam and a treatment plan.
- 14. The standard of care for psychiatric treatment requires follow-up visits to include review of symptoms, updates of mental status including suicide risk, update of diagnoses and a treatment plan.
- 15. Respondent deviated from the standard of care in follow-up visits by generally failing to perform review of symptoms, update mental status including suicide risk, and update diagnoses and the treatment plan.
- 16. The standard of care for psychiatric treatment of family members requires independent evaluation of each patient with a new and unique chart.
- 17. Respondent deviated from the standard of care by treating family members and including their treatment records in RN's chart.
- 18. The standard of care requires patients to be seen and evaluated prior to prescribing medication.
 - 19. Respondent prescribed medication to RN without any examinations:
- 20. Respondent's failure to perform physical or mental status examinations potentially harmed RN because, had those examinations been performed, her brain tumor could have been detected sooner.

CONCLUSIONS OF LAW

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

- 2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.
- 3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. §32-1401 (27)(a) ([v]iolating any federal or state laws or rules and regulations applicable to the practice of medicine."); A.R.S. §12-2293A ("[e]xcept as provided in subsections B and C of this section, on the written request of a patient or the patient's health care decision maker for access to or copies of the patient's medical records and payment records, the health care provider in possession of the records shall provide access to or copies of the medical records to the patient or the patient's health care decision maker. "); A.R.S. §32-1401(27)(e) ("failing or refusing to maintain adequate records on a patient."); and A.R.S. § 32-1401(27)(q) ("[a]ny conduct that is or might be harmful or dangerous to the health of the patient or the public.")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

- 1. Respondent is issued a Letter of Reprimand for failing to properly evaluate the patient during the initial and follow-up visits; for inappropriately including information regarding the treatment of family members in another patient's chart; for failing to release records to a patient in a timely manner; and for inadequate medical records.
- Respondent is placed on probation for six months with the condition that he complete the Physician Assessment and Clinical Education (PACE) Evaluation in general medical fund of knowledge within the probationary period.
- Respondent shall obey all federal, state and local laws and rules governing the practice of medicine.
 - 4. The Board retains jurisdiction and may initiate new action based upon any

6

7 8

9

10 11

12

13 14

15

16

17

18

19

20

21 22

23

24

25

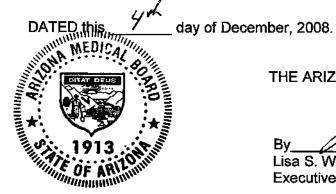
violation of this Order.

5. In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

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.



ORIGINAL of the foregoing filed this day of December, 2008 with:

THE ARIZONA MEDICAL BOARD

Lisa S. Wynn **Executive Director**

1	Arizona Medical Board 9545 East Doubletree Ranch Road Scottsdale, Arizona 85258
2	
3	Executed copy of the foregoing mailed by U.S. Mail this day of December, 2008, to:
4.	
5	Gary A. Fadell
6	Fadell, Cheney & Burt, PLLC 1601 North Seventh Street, Suite 400
7	Phoenix, Arizona 85006-2204
8	James S. Gough, M.D. Address of Record
9	
10	Min Samo
11	- Charles
12	#328012
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	
	1