BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **ROBERT W. SOMMER, M.D.,** Holder of License No. 31443 For the Practice of Allopathic Medicine In the State of Arizona.	Case No.15A-31443-MDX **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER (Revocation)**

On June 3, 2015, this matter came before the Arizona Medical Board ("Board") for consideration of the Administrative Law Judge (ALJ) Tammy L. Eigenheer's proposed Findings of Fact, Conclusions of Law and Recommended Order. Robert W. Sommer, M.D., ("Respondent") appeared before the Board; Assistant Attorney General Carrie H. Smith, represented the State. Christopher Munns with the Solicitor General's Section of the Attorney General's Office, was 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

1. The Arizona Medical Board (Board) is the authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
2. Robert W. Sommer, M.D. (Respondent) is the holder of License No. 31443 for the practice of allopathic medicine in Arizona.
3. On December 4, 2014, the Board received a complaint from a person who wished to remain confidential. The complainant asserted that Respondent had recently lost his motor vehicle driver's license privileges following several accidents; had been found to have neuropsychological deficits; had been prescribing medication to himself and to a person or persons living with him without establishing a medical record or normal doctor-patient relationship; and had been hospitalized with mental and cognitive impairments.
4. On or about December 4, 2014, the Board notified Respondent that a complaint had been received and that, after consideration of the allegations, the Board's staff and Chief

Medical Consultant determined that an assessment with the Board's Physician Health Program (PHP) was necessary. The letter indicated that Respondent was required to contact the director of the PHP within 3 days of receiving the letter to schedule an assessment and to complete the assessment within 10 days of receiving the letter.

5. Respondent made an appointment for the PHP assessment, but then canceled the appointment. Respondent failed to appear for the second scheduled appointment.

6. During a telephone conversation with Board staff, Respondent admitted to prescribing medication to a person without documenting that treatment in a medical record.

7. After presenting these facts to the investigative staff, the medical consultant and the lead Board member concluded that it would be appropriate to offer Respondent an Interim Consent Agreement to limit Respondent's practice.

8. On or about January 15, 2015, the Board sent an Interim Consent Agreement for a Practice Limitation and Assessment (Interim Consent Agreement) to Respondent at his address of record. Respondent was required to sign the Interim Consent Agreement by 5:00 p.m. on January 23, 2015. Respondent did not return the signed Interim Consent Agreement by the deadline.

9. During a telephone call with Board staff on January 30, 2015, Respondent confirmed that he was not going to sign the Interim Consent Agreement. During that conversation, Respondent also acknowledged that he had problems with his memory including being unable to recall the name of the street he had lived on for 12 years.

10. On February 2, 2015, the Board held a Summary Action meeting at which it found that the public health, safety, or welfare imperatively required emergency action and summarily suspended Respondent's medical license pursuant to A.R.S. § 21-1451(D).

11. On February 13, 2015, the Board issued a Complaint and Notice of Hearing to Respondent alleging Respondent had engaged in unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public") and A.R.S. § 32-1401(27)(dd) ("[f]ailing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the board"). The Complaint and Notice of Hearing was sent via certified mail to Respondent at his address of record.

12. A hearing was held at the Office of Administrative Hearings (OAH) on March 20, 2015. Respondent did not request to appear telephonically at the duly noticed hearing and did not request that the hearing be continued. Although the start of the hearing was delayed 20 minutes to allow Respondent additional travel time, he did not appear, personally or through an attorney, and did not contact the OAH to request that the start of the hearing be further delayed. Consequently, Respondent did not present any evidence to defend his license.

13. At hearing, Elle Steger, Board investigator, testified that during her telephone conversations with Respondent, he appeared to have memory issues. Ms. Steger indicated she had to repeat herself several times and that Respondent often explored other topics unrelated to his medical license. Respondent acknowledged having memory issues and a brain injury, but did not feel they impaired his ability to practice medicine.

14. At hearing, Dr. Kathleen Muriel Coffer, Medical Consultant, testified as to her review of Respondent's medical records and her conclusion that Respondent was not safe to practice medicine. Dr. Coffer concluded that Respondent's medical records indicated significant memory impairments dating back to 2010. Dr. Coffer also stated that Respondent failed to meet the minimum standard of care when he prescribed medications to himself and others in that Respondent failed to record a health history, a history of present illness, vitals, physical findings, indications for a prescription, and a discussion of potential medication side effects.

CONCLUSIONS OF LAW

1. The Complaint and Notice of Hearing that the Board mailed to Respondent at his address of record was reasonable, and Respondent is deemed to have received notice of the hearing. See A.R.S. § 41-1092.04; A.R.S. § 41-1061(A).

2. The Board has jurisdiction over Respondent and the subject matter in this case.

3. Pursuant to A.R.S. § 41-1092.07(G)(2) and A.A.C. R2-19-119(B), the Board has the burden of proof in this matter. The standard of proof is by clear and convincing evidence. A.R.S. § 32-1451.04.

4. The evidence established Respondent has memory issues that affect his ability to safely practice medicine and that Respondent failed to maintain adequate medical records

when prescribing medications. Therefore, the Board established that Respondent committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public").

5. The evidence established Respondent failed to undergo the PHP assessment as ordered. Therefore, the Board established that Respondent committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(dd) ("[f]ailing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the board").

6. The legislature created the Board to protect the public. See Laws 1992, Ch. 316, § 10. Respondent's repeated failures to undergo the PHP assessment and his acknowledged and demonstrated memory issues indicate that he cannot be regulated at this time. Therefore, the Board should revoke Respondent's license to practice allopathic medicine.

ORDER

Based on the foregoing, IT IS ORDERED that the Board's December 19, 2014 Order for Summary Suspension of License is upheld.

IT IS FUTHER ORDERED that on the effective date of the Board's final order in this matter, License No. 31443 for the practice of allopathic medicine in Arizona previously issued to Respondent Robert W. Sommer, M.D. is REVOKED.

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 this 4th day of June 2015.

THE ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

ORIGINAL of the foregoing filed this 4th day of June, 2015 with:

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

COPY of the foregoing filed this 4th day of June, 2015 with:

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Executed copy of the foregoing mailed by U.S. Mail this 4th day of June, 2015 to:

Robert W. Sommer, M.D.
Address of Record

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