BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **AMNON I. KAHANE, M.D.** License No. 23948 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-12-0439A **ORDER FOR LETTER OF REPRIMAND AND CONSENT TO THE SAME**

Amnon I. Kahane, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for Letter of Reprimand; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

FINDINGS OF FACT

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

2. Respondent is the holder of license number 23948 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-12-0439A after receiving a complaint regarding Respondent's care and treatment of a 26 year-old male patient ("RG") alleging failure to provide proper oversight and management of the patient's prescriptions.

4. On November 29, 2011, Respondent saw RG for an initial psychiatric evaluation and documented that RG had a history of bipolar disorder and had been non-compliant with his medications in the past. Respondent continued the diagnosis of Bipolar Affective Disorder - Mixed Type, and he continued RG's medications which included quetiapine, lithium and atenolol. Respondent documented that he would obtain lithium levels when RG was more compliant with his medications.

5. On December 16, 2011, RG returned and reported that he was taking his medication "most of the time." Respondent continued RG's previous medications and

added lamotragine without documenting the reason for the additional medication. There was also no documentation that Respondent reviewed the risks and benefits of the medication with RG. In his plan, Respondent wrote that a lithium level was not relevant to take as RG was nearly fully compliant.

6. On January 13, 2012, Respondent saw RG and documented that his mood was much more stable, but also documented that RG's mood was labile and that he was still not compliant with his medications. Respondent planned to consolidate BID dosing to make compliance easier.

7. A phone message was received from RG's mother dated February 10, 2012 indicating concern that RG had "like 20 bottles of pills." She requested that Respondent return her call and Respondent did return her call. Respondent documented that he did not have RG's permission to communicate with his mother. On February 14, 2012, RG failed to show up for his scheduled appointment. On March 13, 2012, RG returned and stated that he forgot to come to his last appointment. There was no discussion of the phone message from RG's mother. Respondent noted that RG felt more labile and had been less compliant with his medications. Respondent planned to double the lithium dose to 600mg BID, decrease quetiapine and to order a lithium level in ten days. Respondent documented that RG stated he would complete a full medical evaluation by his primary care provider and have blood work done. There was a subsequent chart entry made that a message from RG's mother dated March 19, 2012 reported that RG was admitted to Desert Vista Psychiatric Hospital after he was found disoriented. Respondent's response was documented as "ok." There was no further documentation and no indication that Respondent attempted to contact the patient or the hospital. A final chart entry noted that RG was a no-show to his April 2012 appointment.

8. The Medical Consultant (MC) found that Respondent deviated from the standard of care in several areas of this case. The MC observed that Respondent missed

several opportunities to positively affect the course of RG"s illness. The MC stated that the most concerning aspect of this case is the dangerous manner in which Respondent prescribed lithium while failing to adequately supervise RG and monitor lithium levels, renal function and thyroid function.

9. The standard of care for a new patient with a complex history of poorly controlled bipolar symptoms and non-compliance requires a physician to perform a thorough psychiatric evaluation and follow up with the patient in a timely manner.

10. Respondent deviated from the standard of care by failing to complete a thorough psychiatric evaluation and follow up with a new patient in a timely manner.

11. The standard of care for patients who are suicidal or have a history of suicidal behavior or drug overdose requires a physician to carefully consider the use of lithium in these patients as it has a narrow therapeutic window which requires close monitoring and a stable doctor-patient relationship.

12. Respondent deviated from the standard of care by inappropriate use of lithium in a patient with significant contraindications and by failing to monitor the patient's lithium level, renal function and thyroid function.

13. The standard of care for a serious mental illness patient requires a physician to consider referring the patient to a community based mental health provider, where the patient is more likely to get the case management and structured supervision needed to remain compliant and stable.

14. Respondent deviated from the standard of care by failing to recognize the patient's need for a higher level of care.

15. There are several potential risks that Respondent could have more thoroughly evaluated and attempted to mitigate. RG had a well-established history of poor compliance and suicidal behavior. The unsupervised use of lithium in this patient could have resulted in toxicity and/or death either accidentally or intentionally. RG's failure to

take medications as prescribed and to keep regular appointments indicated that he was not functioning well and should have prompted Respondent to escalate the level of care.

16. According to the MC RG was extremely difficult to treat. This was due in large part to the patient's poor insight and utter lack of compliance, which are hallmarks of his mental illness and SMI patients in general.

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)(e) ("[f]ailing or refusing to maintain adequate records on a patient.")

3. The conduct and circumstances described above constitute 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.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

Continuing Medical Education

Respondent shall within six months of the effective date of this Order obtain 6-10 hours of Board Staff pre-approved Category I Continuing Medical Education (CME) course in management of bipolar disorder and/or psychiatric therapy drug monitoring. 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 license.

DATED AND EFFECTIVE this 7th day of FEBRUARY, 2013.

ARIZONA MEDICAL BOARD

By _____
Lisa S. Wynn
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government

regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

7. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

8. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

9. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

10. Any violation of this Order constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

DATED: 12.14.12

Amnon I. Kahane, M.D.

EXECUTED COPY of the foregoing mailed this 14th day of December, 2012 to:

Charles E. Buri, Esq.
4742 N. 24th Street Suite A-150
Phoenix, AZ 85016-9139

ORIGINAL of the foregoing filed this 7th day of July, 2013 with:

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

Arizona Medical Board Staff