BEFORE THE BOARD OF MEDICAL EXAMINERS

IN THE STATE OF ARIZONA

In the Matter of **DARRYL R. STERN, M.D.** Holder of License No. **7513** For the Practice of Medicine In the State of Arizona.	Board Case No. MD-97-0197 Investigation No. 10663 **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER ON REHEARING** (Letter of Reprimand)

This matter was considered by the Arizona Board of Medical Examiners ("Board") at its public meeting on June 22, 2001. Darryl R. Stern appeared for a rehearing granted pursuant to the authority vested in the Board by A.A.C. R4-16-102(F). The Board reheard its November 13, 2000 Order issuing a Decree of Censure. After due consideration of the facts and law applicable to this matter, the Board voted to issue the following findings of fact, conclusions of law and order.

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. Dr. Darryl R. Stern is the holder of license No. 7513 for the practice of medicine in the State of Arizona.

3. Board investigation No. 10663 arose from a medical malpractice lawsuit in which it was alleged that the medical care Darryl R. Stern, M.D., rendered to patient G.S. was negligent in the management of chronic pain and drug addiction that resulted in the patient's wrongful death.

4. Darryl R. Stern, M.D., began treating patient G.S. on July 17, 1993, and diagnosed "Major Affective Disorder, Depressed, Non-psychotic, with Dependent and

Passive Aggressive personality traits," secondary to chronic back pain and related disability. There were three outpatient visits, the last being on October 1, 1993. At that last visit, Darryl R. Stern, M.D., recommended admission to Desert Vista Hospital to continue medication trials in a supervised setting.

5. Patient G.S. was admitted to Desert Vista Hospital on October 2, 1993 and discharged October 12, 1993. In the hospital the patient "was found able to take Norpramin 50 mg. h.s., Loxitane 25 mg. h.s., and Ativan 1 mg. q.i.d. without side effects and it was expected that we would increase his Norpramin as an outpatient." A hospital treatment plan to have a family meeting prior to discharge was not followed and the meeting was changed to take place after discharge. Patient G.S. was also to schedule an appointment with a neurologist regarding possible surgery to alleviate chronic back pain. Dr. Stern also stated that the patient "was discharged at that time as the goal of hospitalization was to enable him to begin to take medications, which was met, and not to definitively treat his depression prior to discharge."

6. During the evening hours post-discharge, the patient had an argument with his wife who then left for work. Sometime after attempting to page his wife, the patient barricaded himself in the bathroom and died from an apparent overdose of medications. The Maricopa County Medical Examiner determined that the patient died due to an intentional overdose of oxycodone that resulted in acute acetaminophen toxicity. Toxicology reports indicate that Narpramin, Ativan and Loxitane were not the potential causation.

7. Dr. Stern failed to diagnose and treat chemical dependency, including alcoholism. He was aware of the patient's dependence on narcotic analgesics. Dr. Stern also failed to note that other clinicians consulting on the case recognized drug dependence and he failed to investigate the laboratory results which would have pointed

to chemical dependency, especially alcoholism (increased MCV, increased GGT and decreased folic acid). He also failed to fully determine the patient's mental state prior to a poorly planned discharge. Dr. Stern failed to provide adequate medical diagnosis and treatment was a direct and significantly contributing factor in the death of the patient, whether or not his death was due to an intentional overdose of oxycodone.

CONCLUSIONS OF LAW

1. The Board of Medical Examiners of the State of Arizona possesses jurisdiction over the subject matter hereof and over Darryl R. Stern, M.D.

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 in paragraphs 4 through 7 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(l) (conduct that the Board determines is gross malpractice, repeated malpractice or any malpractice resulting in the death of a patient).

ORDER

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

IT IS HEREBY ORDERED AS FOLLOWS:

A Letter of Reprimand is issued to Dr. Stern for the aforementioned unprofessional conduct.

RIGHT TO APPEAL TO SUPERIOR COURT

Dr. Stern is hereby notified that this Order is the final administrative decision of the Board and he has exhausted his administrative remedies. Dr. Stern is advised that an appeal to superior court in Maricopa County may be taken from this decision pursuant to title 12, chapter 7, article 6.

DATED this 19 day of July, 2001.

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

By _____
CLAUDIA FOUTZ
Executive Director
TOM ADAMS
Deputy Director

ORIGINAL of the foregoing filed this 19 day of July, 2001 with:

The Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

and

Executed copy of the foregoing
mailed by U.S. Certified Mail this
19 day of July, 2001, to:

Darrly R. Stern, M.D.
2034 East Southern Avenue
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and

Executed copy of the foregoing
mailed this 19 day of July, 2001, to:

Duane A. Olson

Olson, Jantsch, Bakker & Blakey, P.A.
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Copy of the foregoing hand-delivered this
19 day of July, 2001, to:

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