.BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **THOMAS A. OPECHOWSKI, M.D.** Holder of License No. 22676 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-17-0909A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR LETTER OF REPRIMAND AND PROBATION**

The Arizona Medical Board ("Board") considered this matter at its public meeting on October 22, 2018. Thomas A. Opechowski, M.D. ("Respondent"), appeared with legal counsel, Peter Wittekind, Esq., before the Board 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 for Letter of Reprimand and Probation after due consideration of the facts and law applicable to this matter.

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 22676 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-17-0909A after receiving a complaint regarding Respondent's care and treatment of a 72 year-old male patient ("ET") alleging failure to timely treat patient, improper prescribing of Risperdal for a patient with Lewy Body Dementia, and inadequate follow-up communication with family.

4. ET was admitted to a geriatric psychiatric inpatient care Facility on May 2, 2017 after experiencing progressive decline in overall functioning due to a diagnosis of Lewy Body Dementia. During a phone conversation on May 3, 3017, ET's wife advised Respondent that ET could not be placed on certain medications due to his diagnosis.

5. Respondent prescribed ET Depakote 250 mg twice a day and risperidone 0.25 mg twice a day. In addition, ET continued to be prescribed Lisonopril, which had been prescribed since before ET's admission.

6. On May 7, 2017, ET was admitted to a Hospital for mental status changes after he was found to be in an altered state of consciousness and was slumped over in bed. ET was diagnosed with encephalopathy and stroke before being discharged to hospice services where he subsequently passed away.

7. The standard of care requires a physician to avoid medications that may be contraindicated. Respondent deviated from the standard of care by prescribing a contraindicated medication (risperidone) for a patient with Diffuse Lewy body disease. The standard of care requires a physician to obtain or document an informed consent regarding the risks and benefits of using risperidone in elderly patients with dementia. Respondent deviated from the standard of care by failing to document an informed consent discussion regarding the risks and benefits of using risperidone in elderly patients with dementia.

8. Actual harm was identified in that ET had a stroke while taking risperidone and suffered a serious decline in mental status and functioning that was exacerbated by use of risperidone.

9. During a Formal Interview on this matter, Respondent testified that his use of Risperdal in this patient met the standard of care. Respondent further testified with regard to the initial conversation he had with ET's wife at the time of initial admission, and that he has a routine speech that he gives to all family members at that time, covering sleeping medications, antianxiety medications and mood stabilizers such as antipsychotic medications. Respondent also referred to the broad written consent obtained at initial admission.

10. Respondent explained his initial advice to ET's wife not to visit ET after the admission. Respondent stated that usually patients with dementia have limited ability to process information, and can become distressed when family members leave after visiting. Respondent stated that he advises family members to stay away for the first few days in order to allow the patients more time to become comfortable in their new environment.

11. Respondent further testified that during the initial transition period, family members can receive updates about the patient's status by contacting the nurse and leaving a message, which he returns by the next day, excluding weekends. Respondent testified that after his initial conversation with ET's wife, he spoke with her on two other occasions, once the day after admission and once at the time ET was transferred to another facility.

12. With regard to his decision to prescribe Risperdal over a different medication such as Seroquel, he stated that he has a preference for Risperdal. Respondent testified that he did not recall ET's wife telling him specifically not to prescribe Risperdal during their initial conversation.

13. During that same Formal Interview, Board members recognized the challenging nature of working in a geriatric psychiatric facility. It was also recognized that not all medications are equal and within the class of atypical antipsychotic medications, Risperdal may cause the most increase in dopamine and therefore creates the highest risk of difficulty for a patient with Parkinson's disease and Lewy Body Dementia. Board members commented that Respondent's discussion of the available mediations indicated a lack of knowledge regarding the difference in receptor activities of them.

14. Board members also expressed concern with regard to the limited nature of the communication with ET's family members, both by the physician and the facility staff.

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)("Failing 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)(r)("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 six 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 a course regarding pharmacologic management of geriatric psychiatric patients. 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.

b. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

3. The Board retains jurisdiction and may initiate new action against Respondent based upon any violation of this Order. A.R.S. § 32-1401(27)(s).

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 5th day of December, 2018.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed this 5th day of December, 2018 to:

Peter Wittekind, Esq.
Kent & Wittekind, P.C.
111 West Monroe Street, Suite 1000
Phoenix, Arizona 85003
Attorney for Respondent

ORIGINAL of the foregoing filed this 5th day of December, 2018 with:

Arizona Medical Board
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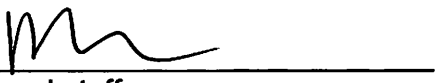
Phoenix, Arizona 85007



Board staff