BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of MOSHE HACHAMOVITCH, M.D., Holder of License No. 11395 For the Practice of Allopathic Medicine in the State of Arizona	Docket No. **03F-980633-MDX** Case No. 98-0633 **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR STAYED SUSPENSION AND PROBATION**

On December 11, 2003 this matter came before the Arizona Medical Board ("Board") for oral argument and consideration of the Recommended Decision of the Administrative Law Judge ("ALJ") including proposed Findings of Fact and Conclusions of Law and Recommended Order.[1] Attached hereto is a copy of the ALJ's Findings of Fact and Conclusions of Law and Recommended Order.

Moshe Hachamovitch, M.D. ("Respondent") was notified of the Board's intent to consider this matter on the aforementioned date at the Board's public meeting. Respondent was not personally present, but appeared through legal counsel Kraig Marton. Dominique Barrett represented the State. Christine Cassetta, Assistant Attorney General with the Solicitor General's Section of the Attorney General's Office, was present and available to provide independent legal advice to the Board.

The Board, having considered the ALJ's report and the entire record in this matter hereby issues the following Findings of Fact, Conclusion of Law and Order.[2]

[1] The Administrative Hearing was held on September 15, 2003 at the Office of Administrative Hearings.
[2] Unless otherwise stated, the ALJ's Findings of Fact and Conclusions of Law and Recommended Order are adopted by the Board.

FINDINGS OF FACT

The Board adopts and incorporates herein the Administrative Law Judge's proposed findings of fact paragraphs 1 through 31.

CONCLUSIONS OF LAW

The Board adopts and incorporates herein the Administrative Law Judge's proposed conclusions of law paragraphs 1 through 6, with the following edits: Conclusion of Law paragraph 6 was edited to reflect that the Board "may" impose hearing costs. This change was made because a statement that the Board "should" impose hearing costs is not a Conclusion of Law.

ORDER

Based upon the Findings of Fact and Conclusions of Law as adopted, the Board hereby enters the following Order:

In view of the foregoing, Dr. Hachamovitch's License No. 11395 is revoked.

The Board rejected the Hearing Officer's Recommended Sanction of a Stayed Suspension and Probation because it found that the record before it regarding Dr. Hachamovitch is atrocious, particularly Dr. Hachamovitch's ethical lapses and his repeated gross negligence and gross incompetence.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review by filing a petition with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09. The petition must set forth legally sufficient reasons for granting a rehearing or review. A.C.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. If a motion 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 16th day of December, 2003.

(SEAL)

ARIZONA MEDICAL BOARD

By: Barry Alexander
Barry A. Cassidy, Ph.D., P.A.-C
Executive Director

Original of the foregoing filed this 16th day of December, 2003, with:

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

Copy of the foregoing filed this 16th day of December, 2003, with:

Cliff J. Vanell, Director
Office of Administrative Hearings
1400 W. Washington, Ste. 101
Phoenix, AZ 85007

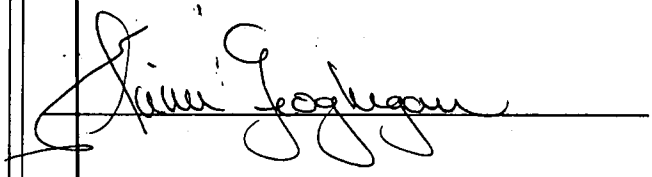
Executed copy of the foregoing mailed by Certified Mail this 16th day of December, 2003, to:

Kraig J. Marton, Esq.
Jaburg & Wilk, P.C.
3200 N. Central Ave., Suite 2000
Phoenix, Arizona 85012

MOSHE HACHAMOVITCH, M.D.,
(address of record)

Executed copy of the foregoing mailed this 16th day of December, 2003, to:

Dominique Barrett
Lewis and Roca, LLP
40 N Central Ave.
Phoenix, Arizona 85004-4429
Attorney for the State



IN THE OFFICE OF ADMINISTRATIVE HEARINGS

IN THE MATTER OF : MOSHE HACHAMOVITCH, M.D., Holder of License No. 11395 For the Practice of Allopathic Medicine In the State of Arizona	**No. 03F-980633-MDX** **ADMINISTRATIVE LAW JUDGE DECISION**

HEARING: September 15, 2003. The record was kept open until September 19, 2003 to allow the parties to file post-hearing documents.

APPEARANCES: The Arizona Medical Board was represented by Dawn Bergin, Esq. and Dominique Barrett, Esq. The Respondent, Moshe Hachamovitch, M.D., appeared personally and was represented by his attorney, Kraig Marton, Esq.

ADMINISTRATIVE LAW JUDGE: Brian Brendan Tully

Evidence and testimony were presented and, based upon the entire record, the following Findings of Fact, Conclusions of Law and Recommended Order are made:

FINDINGS OF FACT

1. The Arizona Medical Board ("Board"), formerly known as the Arizona Board of Medical Examiners, is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
2. Moshe Hachamovitch, M.D., is the holder of License No. 11395 for the practice of allopathic medicine in the State of Arizona.
3. Dr. Hachamovitch is also the holder of License No. 97500 issued by the State of New York for the practice of allopathic medicine.
4. Dr. Hachamovitch's primary training and Board certification is in obstetrics and gynecology.

Office of Administrative Hearings
1400 West Washington, Suite 101
Phoenix, Arizona 85007
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5. In or around 1998, the Board initiated an investigation upon receiving a complaint from another physician that Respondent was failing to ensure adequate staffing and training at several clinics in Arizona in which he maintained an ownership interest.
6. During the course of the investigation, Board staff learned of two cases in New York in which Dr. Hachamovitch had been subject to discipline by the New York State Board for Professional Medical Conduct ("NY Board").

NY BOARD CASE BPMC NO. 93-127

7. The NY Board filed a Statement of Charges against Dr. Hachamovitch on or about September 16, 1992.
8. The allegations contained in the Statement of Charges related to Dr. Hachamovitch's care of Patient A, Patient B and Patient C.
9. The duly appointed Hearing Committee held hearings in the matter on November 18 and December 23, 1992, and January 11, 1993, February 3, 11, 17 and 18, 1993, and April 20, 1993.
10. The Hearing Committee deliberated on June 2, 1993 and August 4, 1993.
11. On or about August 18, 1993, the Hearing Committee rendered its Decision and Order.
12. With respect to Dr. Hachamovitch's care of Patient A, who underwent an abortion by him on October 19, 1990, the Hearing Committee sustained the following allegations, which formed the basis of a finding of medical misconduct:

    a. Dr. Hachamovitch intentionally misrepresented and falsified his records regarding Patient A when he recorded that she received continuous oxygen by mask and that there was "no bleeding at all." The Hearing Committee found that Dr. Hachamovitch "intentionally tried to mislead future readers into believing that the patient was mechanically oxygenated and suffered no blood loss."

13. With respect to Dr. Hachamovitch's care of Patient B, who underwent an abortion performed by him on November 3, 1988, the Hearing Committee sustained the following allegations against Dr. Hachamovitch, which formed the basis of a finding of medical misconduct:

    a. Dr. Hachamovitch failed to perform and record an adequate physical examination of the patient prior to inserting laminaria;
    b. Dr. Hachamovitch failed to perform and record an adequate physical examination of the patient prior to evacuating the uterine contents; and
    c. Dr. Hachamovitch failed to perform and/or record a gross examination of the uterine contents.

14. With respect to Dr. Hachamovitch's care of Patient C, who underwent an abortion performed by him on November 3, 1988, the Hearing Committee sustained the following allegations against Dr. Hachamovitch, which formed the basis of a finding of medical misconduct:

    a. Dr. Hachamovitch failed to perform and/or record an appropriate physical examination either prior to the insertion of laminaria or before evacuating the uterus.
    b. Dr. Hachamovitch failed to perform and record a gross examination of the uterine contents.

15. The Hearing Committee sustained the charge of fraud against Dr. Hachamovitch.
16. The Hearing Committee sustained the charge of inadequate records against Dr. Hachamovitch.
17. The Hearing Committee ordered Dr. Hachamovitch's New York medical license be suspended for a period of one year; that 11 months of the suspension be permanently stayed; and that his license actually be suspended for 30 days.
18. By decision entered July 14, 1995, the New York Supreme Court, Appellate Division, Third Judicial Department ("Supreme Court, modified the Hearing

Committee's order by annulling its finding that Dr. Hachamovitch committed fraud in his representation that there was continuous oxygen by mask to Patient A. The finding that Dr. Hachamovitch "intentionally tried to mislead future readers into believing that the patient was mechanically oxygenated and suffered no blood loss" was sustained, however.

19. On October 26, 1994, the Hearing Committee convened to reconsider its decision based on the findings of the Supreme Court. It concluded that its original penalty and order should not be changed.

20. Dr. Hachamovitch served his active 30-day suspension in New York from October 7, 2000 to November 6, 2000.

NY BOARD CASE NO. BPMC-99-261

21. On December 7, 1998, another Statement of Charges was filed against Dr. Hachamovitch by the NY Board.

22. The charges included eight specifications of professional misconduct, which were based on 68 specific charges of misconduct related to the care and treatment of Patient A and the staffing and equipping of Dr. Hachamovitch's recovery room. The allegations included gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, inaccurate records and fraudulent practice.

23. The duly appointed Hearing Committee held hearings on the matter, receiving evidence and the sworn testimony of witnesses.

24. On or about October 14, 1999, the Hearing Committee rendered its Decision and Order.

25. The Hearing Committee's findings of fact included:

    a. Patient A presented at Dr. Hachamovitch's office on September 6, 1996 for a termination of an early second trimester abortion. On that day, laminaria were inserted, and Patient A was told to return the next day for an abortion.

b. On September 7, 1996, Patient A returned to Dr. Hachamovitch's office and underwent an abortion beginning at approximately 1:50 p.m.

c. At about 2:00 p.m., Patient A's blood pressure was recorded as 96/60 with a pulse of 68. At about 2:10 p.m., Patient A's blood pressure had fallen to 60/40 and the pulse had fallen to 52 with shallow respiration. One minute later, the record reveals that Patient A had a thready pulse and a blood pressure that could not be measured.

d. The doctor's receptionist notified the recovery room nurse to check Patient A because her complexion was extremely pale and gray colored.

e. The CRNA was notified that there was a problem at about 2:11 p.m. She immediately went to Patient A, observed that she was not breathing and put the oxygen mask on her face.

f. At this point, Patient A was functionally in cardiac arrest.

g. Dr. Hachamovitch received notification of the problem with Patient A at about 2:15 p.m.

h. Dr. Hachamovitch arrived in the recovery room and examined Patient A. He started a new IV Angiocath with D5W and Ephedrine. He then directed the recovery room nurse to begin CPR and someone to call EMS.

i. The EMS Advanced Cardiac Life Support ("ACLS") team was notified of the call at 2:40 p.m. and arrived at Dr. Hachamovitch's office at 2:41 p.m.

j. When the ACLS team arrived, Patient A was cyanotic, non-responsive, pulseless, apneic and her pupils were fixed and dilated.

k. Patient A was intubated by the ACLS team.

l. Patient A later died.

m. When Dr. Hachamovitch arrived at the recovery room, he should have immediately ascertained the patient's pulse, blood pressure, and if there was vaginal bleeding. This should have taken between 20 seconds, and, at the outside, two to three minutes. He should have realized that the patient was in cardiac arrest and started ACLS. The cause of the arrest was not relevant at that point; the immediate treatment was the same.

n. Given the clinical picture of Patient A at 2:15 p.m., when Dr. Hachamovitch was called to the recovery room, EMS should have been called immediately and the patient intubated. Dr. Hachamovitch never intubated Patient A.

o. Even if Patient A were only in a near arrest situation, Dr. Hachamovitch should have immediately called EMS and instituted the rest of ACLS protocol.

p. Dr. Hachamovitch failed to administer appropriate ACLS drugs, Epinephrine and Atropine, to Patient A. He instead administered Ephedrine, which is not sufficient to restore cardiac function. Dr. Hachamovitch's failure to administer appropriate ACLS drugs deviated from accepted medical standards.

q. At no time during Patient A's stay in the recovery room did Dr. Hachamovitch or any of his staff monitor the patient with an EKG, nor did he use a cardiac defibrillator.

r. Dr. Hachamovitch failed to follow ACLS guidelines for a patient in cardiac arrest. This failure deviated from accepted medical standards.

s. A reasonably prudent physician would not have relied on the pulse oximeter reading in the face of all the evidence to the contrary, in assessing Patient A's condition.

t. Patient A suffered from progressive hypoxia, which led to cardiac arrhythmia and cardiac arrest.

u. The most reasonable clinical diagnosis of Patient A's condition was a respiratory depression, which led to cardiac arrest.

v. Despite an obligation to recognize when a patient is in cardiac arrest and to know how to resuscitate a patient, Dr. Hachamovitch did not recognize that Patient A was in cardiac arrest and did not carry out generally recognized resuscitation measures.

w. Dr. Hachamovitch's recovery room was not sufficiently staffed to adequately monitor patients recovering from general anesthesia.

x. Patient A was not sufficiently monitored while she was in the recovery room.

y. Dr. Hachamovitch's medical record did not accurately reflect the care and treatment rendered to Patient A.

26. The Hearing Committee's Conclusions of Law included;

a. Dr. Hachamovitch failed to appropriately monitor or provide for the appropriate monitoring of Patient A's vital signs in the recovery room, including, but not limited to, EKG and blood oxygen saturation, which demonstrated Gross Negligence and Gross Incompetence.

b. Dr. Hachamovitch failed to run a continuous IV line in Patient A's arm until she was free of the effects of anesthesia. This failure constituted Gross Negligence and Gross Incompetence.

c. Dr. Hachamovitch failed to provide EKG monitoring and advanced cardiac life support and failed to call or arrange for someone to call EMS in a timely fashion. These failures constituted Gross Negligence and Gross Incompetence.

d. Dr. Hachamovitch failed to adequately staff his recovery room on September 6, 1996 with appropriately trained personnel and failed to adequately equip his recovery room. These failures constituted Gross Negligence and Gross Incompetence.

e. Dr. Hachamovitch's chart for Patient A failed to accurately reflect his care and treatment of Patient A. This failure constitutes Inaccurate Records.

27. The terms of Dr. Hachamovitch's New York probation included:

a. In the performance of procedures using general anesthesia, Dr. Hachamovitch must have a practice supervisor, a board certified anesthesiologist on site during all procedures for which general anesthesia is used. This board certified anesthesiologist will supervise Dr.

Hachamovitch's practice relating to the administration of and recovery from general anesthesia. This anesthesiologist shall not be a family member or personal friend or be in a professional relationship, which could pose a conflict with supervision responsibilities.

b. Dr. Hachamovitch shall ensure that the practice supervisor is familiar with the order and terms of probation and willing to report to OPMC. Dr. Hachamovitch shall cause the practice supervisor to report within 24 hours any suspected impairment, inappropriate behavior, questionable medical practice or possible misconduct to OPMC.

c. Dr. Hachamovitch shall authorize the practice supervisor to have access to his/her patient records and to submit quarterly written reports, to the director of OPMC, regarding Dr. Hachamovitch's practice. These narrative reports shall address the administration of general anesthesia in connection with Dr. Hachamovitch's practice including, but not limited to, the supervisor's assessment of patient records.

d. Dr. Hachamovitch must maintain a current advanced cardiac life support certification.

e. There must be present in the recovery room, on each shift, one recovery room staff member who is certified in advanced cardiac life support.

28. Dr. Hachamovitch served his active nine-month suspension in New York from January 8, 2000 to October 7, 2000.

29. Dr. Hachamovitch's New York probation ended in July 2003. During his probationary period, he did not perform surgeries. He worked as an advisor to other physicians who had taken over his practice at two facilities that he continues to own. He testified that he did not, and is not, practicing at those facilities. He testified that he has been on call to those physicians and has been called to advise on OBGYN emergencies. He has seen patients for assessment, but the physician requesting his assessment, not Dr. Hachamovitch, has collected fees for service.

30. Dr. Hachamovitch's New York probation did not have a tolling provision. Dr. Hachamovitch testified that he did not practice medicine during the period of his probation.

31. The last time Dr. Hachamovitch practice allopathic medicine in Arizona was 1998. At that time he closed his Arizona practice when his medical director was criminally charged for events occurring at Dr. Hachamovitch's clinic.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Dr. Hachamovitch.
2. Dr. Hachamovitch raised a jurisdictional issue based upon this matter being sent to hearing by the Board's Executive Director instead of being submitted by the Board pursuant to A.R.S. § 32-1451(j). However, A.R.S. § 32-1405(C)(22) and A.A.C R4-16-406 permit the Executive Director to directly refer cases for hearing in compliance with those provisions. There is no evidence that the Executive Director was not empowered to refer this case to hearing.
3. The Findings of Fact, Conclusions of Law and Orders made by the Hearing Committees for the NY Board described in the above Findings of Fact have collateral estoppel effect in any further proceedings before the Board involving Dr. Hachamovitch. *See, Bigelsen, M.D. v. Arizona State Board of Medical Examiners*, 175 Ariz. 86, 91, 853 P.2d 1133, 1138 (1993) (discussing the applicability of collateral estoppel in administrative proceedings); *United Farm Workers of America v. Arizona Agricultural Employment Relations Board*, 669 F.2d 1249, 1255 (9th Cir. 1982) (holding that decisions of administrative agencies of one state are entitled to the same res judicata effect on all other states as they enjoy in the state of rendition).
4. The conduct and circumstances described in that above Findings of Fact constitute unprofessional conduct by Dr. Hachamovitch pursuant to A.R.S. § 32-1401(24)(o) ("Action that is taken against a doctor of medicine by another licensing or regulatory jurisdiction due to that doctor's mental or physical inability

to engage safely in the practice of medicine, the doctor's medical incompetence or for unprofessional conduct as defined by that jurisdiction and that corresponds directly or indirectly to an act of unprofessional conduct described by this paragraph").

5. The NY Board took disciplinary action against Dr. Hachamovitch's license to practice allopathic medicine in the State of New York on certain finds of unprofessional conduct. Those findings correspond directly or indirectly to the following acts of unprofessional conduct proscribed by Arizona law:

   a. A.R.S. § 32-1401(24)(II) (Conduct that the Board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient).
   b. A.R.S. §32-1401(24)(t) (Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a healthcare institution).
   c. A.R.S. § 32-1401(24)(e) (Failing or refusing to maintain adequate records on a patient).

6. Dr. Hachamovitch should be assessed the costs of the formal hearing pursuant to A.R.S. § 32-1451(M).

RECOMMENDED ORDER

In view of the foregoing, it is recommended that Dr. Hachamovitch's License No. 11395 be disciplined as provided below on the effective date of the entered Order in this matter:

1. That Dr. Hachamovitch's license be suspended for three years with two years and three months of the suspension stayed.
2. That the nine months of active suspension be deemed to have been served consecutively with Dr. Hachamovtich's active suspension in New York from January 8, 2000 to October 7, 2000.
3. The stayed suspension of Dr. Hachamovitch's license for two years and three months shall be effective on the effective date of the entered Order in this matter. During the time period for which the suspension is stayed, Dr. Hachamovitch shall be on probation subject to the following terms:

    a. The probationary terms set forth in NY Board Case No. BPMC-99-261, the terms of which are incorporated herein by reference and also set forth in the above described Finding of Fact No. 27; however, any reference therein to OPMC shall be to the Board instead.
    b. Before practicing medicine in Arizona, Dr. Hachamovitch shall advise the Board in writing of the specific dates that he intends to practice. If, after advising the Board of his intended dates of practice in Arizona, those dates should change, Dr. Hachamovitch shall file a supplemental written notice with the Board.
    c. When practicing medicine in Arizona, Dr. Hachamovitch shall be subject to chart review by the Board or Board staff.
    d. Dr. Hachamovitch shall be assessed the costs of the administrative hearing. The Board shall send Dr. Hachamovitch an invoice for those costs with a payment deadline.
    e. Dr. Hachamovitch's probation in this matter shall toll whenever he is not actively practicing medicine in Arizona. The period of probation shall apply only to his active practice of medicine in

Arizona and is not intended to be a flat two years and three months from the effective date of the entered Order in this matter.

Done this day, October 9, 2003

Brian Brendan Tully
Administrative Law Judge

Original transmitted by mail this 9 day of October, 2003, to:

Barry A. Cassidy, PhD, PA-C, Executive Director
Arizona Medical Board
ATTN: Chris Moser and Lisa McCrane
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By Cruz Teriana