

**BEFORE THE IOWA BOARD OF MEDICINE**

\*\*\*\*\*

**IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST**

**FAWAD S. ZAFAR, M.D., RESPONDENT**

**FILE Nos. 02-00-995, 02-04-107, 02-04-227,**

**02-05-289, 02-05-527, 02-05-570, 02-06-403 & 02-06-745**

\*\*\*\*\*

**TERMINATION ORDER**

\*\*\*\*\*

Date: November 16, 2012.

1. Respondent was issued license number 30827 to practice medicine and surgery in Iowa on September 1, 1995.
2. Respondent's Iowa medical license is active and will next expire on June 1, 2013.
3. The Board has jurisdiction in this matter pursuant to Iowa Code chapters 147, 148 and 272C.
4. Respondent is an Iowa-licensed physician who practices urology and surgery in several locations in central Iowa.
5. On January 17, 2008, the Board filed formal disciplinary charges against Respondent alleging that he engaged in a pattern of professional incompetency and practice harmful or detrimental to the public. The Board alleged that Respondent failed to provide appropriate surgical care to numerous patients.

6. On October 22, 2010, following hearing, the Board concluded that Respondent failed to provide appropriate surgical care to three patients and prohibited him from practicing general surgery until he received approval from the Board. The Board also issued Respondent a Citation and Warning and ordered him to pay \$5,000 civil penalty and complete a medical record keeping course.

7. On April 19, 2011, the Board approved Respondent's return to the practice of general surgery subject to a Board-approved practice monitoring plan and Board monitoring.

8. Respondent completed the terms of the Board-approved practice monitoring plan and Board monitoring.

9. On November 16, 2012, the Board voted to terminate the order.

**THEREFORE IT IS HEREBY ORDERED:** that the terms and conditions of Respondent's order are terminated and Respondent's Iowa medical license is returned to its full privileges, free and clear of all restrictions.

This Order is issued by the Board on November 16, 2012.



---

Colleen K. Stockdale, M.D., M.S., Chairwoman  
Iowa Board of Medicine  
400 SW 8<sup>th</sup> Street, Suite C  
Des Moines, Iowa 50309-4686

**BEFORE THE IOWA BOARD OF MEDICINE**

---

<b>In the Matter of the Statement of Charges Against:</b>	)	<b>Case Nos. 02-00-995, 02-04-107, 02-04- 227, 02-05-289, 02-05-527, 02- 05-570, 02-06-403, 02-06-745</b>
	)	<b>DIA No: 08DPHMB002</b>
<b>Fawad S. Zafar, M.D.</b>	)	<b>ORDER RE: RESPONDENT'S</b>
<b>Respondent,</b>	)	<b>DEMAND FOR REMOVAL OF</b>
	)	<b>PUBLIC RECORD</b>

---

**To: Fawad S. Zafar, M.D.**

**Date: April 22, 2011.**

Respondent was issued Iowa medical license no. 30827 on September 19, 1995. Respondent's license is active and will next expire on June 1, 2011. Respondent formerly practiced urology and general surgery in several locations in central Iowa. Respondent currently practices urology in West Des Moines and Manning, Iowa. On January 17, 2008, the Iowa Board of Medicine (Board) filed a Statement of Charges against Respondent. The Statement of Charges alleged two counts: 1) professional incompetence, and 2) engaging in practice harmful or detrimental to the public.

On November 19-20, 2009, a hearing was held before a three member Panel of the Board consisting of Siroos Shirazi, M.D., Rodney Zeitler, M.D., and Colleen Stockdale, M.D. On March 10, 2010, the Panel issued a Proposed Panel Decision finding violations on both counts. The Proposed Panel Decision imposed several sanctions including a Citation and Warning and \$5,000 Civil Penalty. The Panel voted to prohibit Respondent from practicing general surgery unless and until he completes a comprehensive clinical competency evaluation at the Center for Personalized Education for Physician (CPEP) in Denver, Colorado, and receives written approval from the Board. The order also required Respondent to complete a medical record keeping course.

Respondent filed an appeal arguing that further evaluation at CPEP was unnecessary because he had already completed an evaluation at the Physician Assessment and Clinical Education Program (PACE). The State filed a cross-appeal arguing that Respondent failed to conform to the minimal standard of care in the practice of general surgery and urology and that the Board should order him to complete a comprehensive clinical competency evaluation at CPEP in both general surgery and urology. The Board issued an Order creating a briefing schedule and setting a hearing for the parties to present oral arguments. A hearing was held on August 19, 2010, before the following Board members: Siroos Shirazi, M.D., Colleen Stockdale, M.D., Janice Galli, D.O., Joyce

Vista-Wayne M.D., Jeffrey Snyder M.D., Paul Thurlow, and Tom Drew. Jeffrey Farrell, an administrative law judge from the Department of Inspections and Appeals, assisted the Board. Assistant Attorney General Theresa Weeg represented the public interest. Attorney Michael Sellers represented Respondent. The hearing was closed to the public at the election of the licensee.

The Board considered the entire record made before the Panel, as well as the briefs and oral arguments made by the parties. The Board voted to affirm the decision of the Panel in its entirety, with the following clarification.

The Panel prohibited Respondent from practicing general surgery unless and until he completes a comprehensive clinical competency evaluation in general surgery at CPEP and he receives written approval from the Board. Respondent objected to that conclusion because he previously completed an evaluation at PACE. However, as pointed out in the Panel decision, PACE did not perform a comprehensive assessment of Respondent's general surgery knowledge or skills. Respondent told PACE that he had limited his practice to urology since 2004. As a result, PACE believed that Respondent no longer practiced general surgery and performed a much less comprehensive assessment in general surgery. Additionally, the Board noted that Respondent's performance on the general surgery testing was troubling, as his scores in some subject areas were below average when compared with a control group of medical students with one to three years of residency training. On one exam, Respondent's score was in the first percentile, that is, 99 percent of the residency students scored better. The Panel and the Board concluded that Respondent has not demonstrated his competency in general surgery.

In contrast, Respondent engaged in a week-long clinical experience in urology and PACE concluded that he performed satisfactorily during the clinical experience. As a result the Panel decided not to restrict Respondent's office-based urology practice. Respondent did not complete a comparable clinical experience in general surgery. The Board agrees with the Panel that Respondent must complete a comprehensive clinical evaluation in general surgery at CPEP before being allowed to practice general surgery. Respondent shall not perform any hospital-based surgery or procedure until he has completed a CPEP evaluation and he has received written approval from the Board. The Board also agreed with the Panels' conclusion that Respondent may continue to conduct an office-based urology practice without restriction. If Respondent chooses to limit his practice to office-based urology, there is no requirement that he complete the CPEP evaluation.

On November 17, 2010, Respondent filed a Request for Rehearing asking the Board to reconsider the October 22, 2010, Findings of Fact, Conclusions of Law, Decision and Order due to concerns that the Board did not have explanatory materials from the PACE program, that had been submitted to the Board for consideration. On November 23, 2010, the Board granted additional oral argument to be held on December 17, 2010. On

January 13, 2011, following additional oral argument, additional information from the PACE program, and testimony from a representative of the PACE program, the Board issued a Decision on Request for Rehearing. The Board denied Respondent's Request for Rehearing, indicating that the Board considered the entire record at hearing, including all material submitted concerning the competency evaluation performed by PACE, the Board concluded that Respondent was prohibited from practicing general surgery unless and until he completes a comprehensive clinical competency evaluation at CPEP and receives written approval from the Board.

On January 26, 2011, Respondent filed a Request to Replace Evaluation Facility asking that the Board approve PACE to perform the comprehensive clinical competency evaluation ordered by the Board. On February 10, 2011, after careful consideration, the Board voted to approve PACE to perform the comprehensive clinical competency evaluation order by the Board. The Board noted that the Findings of Fact, Conclusions of Law, Decision and Order issued by the Board in this matter, requires Respondent to receive written approval from the Board prior to practicing general surgery.

On January 27, 2011, Respondent filed a second Request for Rehearing asking that the Board grant rehearing so that Respondent's request to substitute PACE for CPEP to perform the comprehensive clinical competency evaluation ordered by the Board might be fully discussed with the Board as the resolution of the evaluation process concerns that have been previously expressed by the Board. On February 10, 2011, the State filed a Resistance to Respondent's Second Request for Rehearing arguing that Respondent had already submitted an appropriate request for post-hearing modification of the existing Board order and the Board lacks jurisdiction to consider the second application for rehearing. On February 10, 2011, the Board voted to deny Respondent's second Request for Rehearing because Respondent had already submitted a Request for Rehearing and the Board lacks jurisdiction to consider the second application for rehearing. The Board also noted that the issue raised in the second Request for Rehearing has already been addressed as Respondent's request to substitute PACE to perform the clinical competency evaluation has been approved in this order.

On March 9, 2011, Respondent filed a Demand for Removal of Public Record demanding that the Board remove the Findings of Fact, Conclusions of Law, Decision and Order issued by the Board on October 22, 2010. Respondent argued that; (1) the Order was subject to change through the rehearing process; (2) the Order was not a final order because it required Respondent to complete a comprehensive clinical competency evaluation in general surgery; (3) the Order is void for lack of jurisdiction; and (4) the suspension of Respondent's ability to practice general surgery must be automatically lifted because Respondent completed the Board-ordered clinical competency evaluation.

On March 18, the State filed a Resistance to Respondent's Demand for Removal of Public Record. The State argued that; (1) the Findings of Fact, Conclusions of Law, Decision and Order issued by the Board on October 22, 2010, is a public records pursuant to Iowa Code section 272C.6(4); (2) the Order was a final order of the Board and that the Board's requirement that Respondent complete a clinical competency evaluation in general surgery was an appropriate sanction of the Board and does not change the nature of the Board's final decision; (3) the Order is not void for lack of jurisdiction as the sanctions established by the Board occurred following a full contested case proceeding; and (4) the suspension of Respondent's ability to practice general surgery did not automatically terminate when Respondent completed the Board-ordered clinical competency evaluation, because the Order clearly indicates that Respondent must complete the evaluation and receive "written approval from the Board." On April 6, 2011, Respondent filed a Response to the State's Resistance to Respondent's Demand for Removal of Public Records.

On April 8, 2011, after careful consideration, the Board voted to deny Respondent's Demand for Removal of Public Record. The Board concluded that the October 22, 2010, Findings of Fact, Conclusions of Law, Decision and Order issued by the Board is a public record pursuant to Iowa Code section 272C.6(4). The Board also concluded that the Order is a final order issued following a full contested case proceeding and the requirement that Respondent complete a clinical competency evaluation does not change the fact that the Order is a final order of the Board. The Board also determined that it has proper jurisdiction to issue a final decision in this matter. Finally, the Board concluded that Respondent's completion of the competency evaluation does not automatically terminate the restriction on his ability to practice general surgery. The Order required Respondent to request written approval from the Board to practice general surgery.

### **DECISION AND ORDER**

**THEREFORE IT IS HEERBY ORDERED**, that Respondent's Demand for Removal of Public Record is **DENIED** for the reasons described above.

  
Siroos Shirazi, Chairman

April 22, 2011  
Date

cc: Theresa Weeg  
Assistant Attorney General

Michael Sellers  
Attorney for Respondent

**BEFORE THE IOWA BOARD OF MEDICINE**

---

<b>In the Matter of the Statement of Charges Against:</b>	)	<b>Case Nos. 02-00-995, 02-04-107, 02-04</b>
	)	<b>227, 02-05-289, 02-05-527, 02-</b>
	)	<b>05-570, 02-06-403, 02-06-745</b>
	)	<b>DIA No: 08DPHMB002</b>
<b>Fawad S. Zafar, M.D.</b>	)	
<b>Respondent,</b>	)	<b>AMENDED ORDER</b>

---

**To: Fawad S. Zafar, M.D.**

Date: April 22, 2011.

On January 17, 2008, the Iowa Board of Medicine (Board) filed a Statement of Charges against Respondent. The statement of charges alleged two counts: 1) professional incompetence, and 2) engaging in practice harmful or detrimental to the public.

On November 19-20, 2009, a hearing was held before a three member Panel of the Board consisting of Siroos Shirazi, M.D., Rodney Zeitler, M.D., and Colleen Stockdale, M.D. On March 10, 2010, the Panel issued a Proposed Panel Decision finding violations on both counts. The Proposed Panel Decision recommended imposition of several sanctions including a Citation and Warning and \$5,000 Civil Penalty. The Panel recommended Respondent be prohibited from practicing general surgery unless and until he completed a comprehensive clinical competency evaluation at the Center for Personalized Education for Physician (CPEP) in Denver, Colorado, and received written approval from the Board. The order also recommended Respondent complete a medical record keeping course.

Respondent appealed, arguing that further evaluation at CPEP was unnecessary because he had already completed an evaluation at the Physician Assessment and Clinical Education Program (PACE). The State filed a cross-appeal arguing that Respondent failed to conform to the minimal standard of care in the practice of general surgery and urology and that the Board should order him to complete a comprehensive clinical competency evaluation at CPEP in both general surgery and urology. The appeal hearing was held on August 19, 2010. The Board considered the entire record made before the Panel, as well as the briefs and oral arguments made by the parties. The Board issued its final Findings of Fact, Conclusions of Law, Decision and order on October 22, 2010, in which it affirmed the decision of the Panel in its entirety, with the following clarification:

*The Panel prohibited Respondent from practicing general surgery unless and until he completes a comprehensive clinical competency evaluation in general surgery at CPEP and he receives written approval from the Board.*

*Respondent objected to that conclusion because he previously completed an evaluation at PACE. However, as pointed out in the Panel decision, PACE did not perform a comprehensive assessment of Respondent's general surgery knowledge or skills. Respondent told PACE that he had limited his practice to urology since 2004. As a result, PACE believed that Respondent no longer practiced general surgery and performed a much less comprehensive assessment in general surgery. Additionally, the Board noted that Respondent's performance on the general surgery testing was troubling, as his scores in some subject areas were below average when compared with a control group of medical students with one to three years of residency training. On one exam, Respondent's score was in the first percentile, that is, 99 percent of the residency students scored better. The Panel and the Board concluded that Respondent has not demonstrated his competency in general surgery.*

*In contrast, Respondent engaged in a week-long clinical experience in urology and PACE concluded that he performed satisfactorily during the clinical experience. As a result the Panel decided not to restrict Respondent's office-based urology practice. Respondent did not complete a comparable clinical experience in general surgery. The Board agrees with the Panel that Respondent must complete a comprehensive clinical evaluation in general surgery at CPEP before being allowed to practice general surgery. Respondent shall not perform any hospital-based surgery or procedure until he has completed a CPEP evaluation and he has received written approval from the Board. The Board also agreed with the Panel's conclusion that Respondent may continue to conduct an office-based urology practice without restriction. If Respondent chooses to limit his practice to office-based urology, there is no requirement that he complete the CPEP evaluation.*

On November 17, 2010, Respondent filed a Request for Rehearing asking the Board to reconsider the October 22, 2010, Findings of Fact, Conclusions of Law, Decision and Order, arguing the Board did not have explanatory materials from the PACE program when it reached its decision. On November 23, 2010, the Board granted the request for rehearing. After rehearing was held, the Board issued its Decision on Rehearing on January 13, 2011. The Board denied Respondent's request for relief, finding the Board considered the entire record at hearing, including all material submitted concerning the competency evaluation performed by PACE.

On January 26, 2011, Respondent filed a Request to Replace Evaluation Facility asking that the Board approve the Physician Assessment and Clinical Education Program (PACE) at the University of California, San Diego, to perform the clinical competency

evaluation ordered by the Board. On February 10, 2011, the Board voted to grant Respondent's request for PACE to perform the comprehensive clinical competency evaluation. The Board noted that the Findings of Fact, Conclusions of Law, Decision and Order issued by the Board in this matter require Respondent to obtain written approval from the Board prior to practicing general surgery.

Respondent completed a clinical competency evaluation at PACE from February 28 to March 4, 2011, and submitted the final evaluation report to the Board for consideration on April 6, 2011. Respondent received a "Clear Pass" from PACE which signifies a good to excellent performance in most or all areas measured and is consistent with safe practice and competency. However, the Board also notes that in its October 22, 2010, Findings of Fact, Conclusions of Law, Decision and Order, the Board concluded that Respondent violated the minimal standard of acceptable and prevailing practice of general surgery in his treatment of several patients, including the following:

***Breast cancer cases:** The Board considered the three breast cancer cases together (referred to in Dr. Caropreso's report as general surgery Case Nos. 1, 4, and 5). The central issue concerns whether Respondent should have done surgical procedures when he could have used less invasive procedures, such as a stereotactic or sentinel node biopsy. The primary dispute concerns the availability of equipment to perform the procedure through less invasive means. In 2003-2004, some hospitals had the equipment and others did not. Clarke County was one of the hospitals that did not. There were other hospitals in Des Moines that did. Respondent argued that he correctly proceeded through surgical means because the equipment was not available to him at the hospital where the operation occurred.*

*There is nothing in the statutes or regulations to suggest that the standard of care changes depending on location within the State of Iowa. The Board finds that Dr. Caropreso correctly stated the standard of care is to perform less invasive procedures such as stereotactic biopsies over surgical biopsies. Respondent's experts, such as Drs. Kahn and Stanley, did not expressly disagree with that point. Rather, their opinions were based on the premise that the standard of care was dependent on the equipment available to him at the location he performed the surgery.*

*This case serves as a good example why the standard of care cannot change based on location. Respondent's primary office practice is in West Des Moines. The Des Moines hospitals had the necessary equipment available. If Respondent had privileges at the Des Moines hospitals and the patient had been referred there, the standard of care would have*

*required Respondent to use the less evasive procedure. None of the surgeries were emergent in nature, so there is no reason why the patient could not have been referred to a hospital with available equipment. The standard of care does not change simply because Respondent traveled from his West Des Moines office to a hospital 50 miles to the south.*

*Respondent's intent is not material to the Panel's finding, but his testimony may provide some insight into his actions. Respondent testified with some level of pride how he brought surgery business to Clarke County that had been referred to other hospitals. He discussed the aggressive and successful means he had attracted patients. He also testified to a level of spite that arose between he and competing doctors. This testimony puts into question whether Respondent, in the course of his quest to build his practice, put his own interests above the interests in using less invasive methods to provide for patient care. Respondent could not use equipment in Des Moines hospitals because he did not have privileges there. He would give up business if he made a referral there. The Panel does not criticize Respondent for being assertive in building a practice, but it is possible that he allowed his assertiveness to get in the way of providing the best care for his patients.*

*The Board finds a violation of standard of care in each of these three cases for failure to use less invasive forms of treatment, such as stereotactic or sentinel node biopsy, over the surgical procedures performed by Respondent.*

**Other general surgery cases:** *The Board carefully reviewed the procedures performed in the other general surgery cases. After reviewing Respondent's explanations, documentation, and supporting opinions, we do not find that he committed a violation of the standard of care during the conduct of the surgical procedures in Case Nos. 2, 3, 6, 7, or 8. This is not to say that improvement could not be made, but the procedures themselves were within the standard of care.*

*The Board finds violations in two areas. The first is regarding use of antibiotics in Case Nos. 2 and 8. Dr. Caropreso correctly stated the standard of care that antibiotics should not be used more than 24 hours after surgery unless needed to treat an active infection. There was no evidence of active infections in the two cases cited. Respondent's use of antibiotics was not within the standard of care. The Board does not find a violation of the standard of care as to Case No. 9, as there was an*

*independent ground to use antibiotics in light of the risk of respiratory infection.*

*The Board also found a violation of standard of care in Case No. 9 regarding the lack of adequate documentation to demonstrate the means or manner in which he conducted the operation. The patient suffered complications which required an extended hospital stay. Dr. Caropreso correctly identified concerns with lack of documentation as to the instruments used, the manner which the procedure was performed, and whether Respondent utilized the appropriate caution. The very purpose of documentation is to verify that correct procedures were followed. The Board cannot find that Respondent followed correct procedures due to the inadequacy of Respondent's record-keeping. The Board notes concerns regarding record-keeping in other cases, but this case was the most egregious example.*

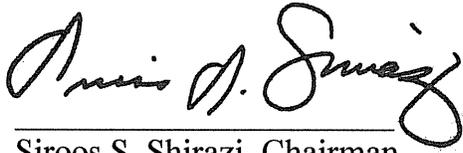
*The Board comments as to other allegations raised on the general surgery cases. Dr. Caropreso stated that the surgeon should take history and perform a physical on each patient. The surgeon must review the history, examine the patient, and discuss treatment options. However, it is acceptable for a family physician to take the history and perform the physical. Regarding the use of drains, the Board did not find a violation of standard of care in any of the cases. The Board agrees with Dr. Caropreso that they were not needed, but do not find that the use of drains violated any standard of care. The Board also agrees with Respondent that it is not necessary to conduct daily rounds in person in every case. It can be appropriate to check on the patient by telephone when the patient is recovering successfully and no complications arise.*

On April 19, 2011, after careful consideration, the Board concluded that Respondent has demonstrated that he may return to the practice of general surgery. However, the Board cannot ignore the fact that Respondent engaged in the serious violations of the standard of care described above, and these violations are not redressed solely through successful completion of a clinical competency evaluation. The Board noted that there is a significant distinction between Respondent's performance during the PACE evaluation and the actual general surgical care that he provided to patients that resulted in the Board's conclusion that he engaged in serious violations of the standard of care. The Board's final order of October 22, 2010, states Respondent cannot resume the practice of general surgery without completing the clinical competency evaluation and obtaining written approval from the Board. The Board imposed this requirement because the Board, not a clinical competency evaluation program, has the final authority to determine how best to protect the public in the event a physician has been found by the Board to have

repeatedly practiced in violation of the standard of care. The Board reiterated it retained final authority to approve Respondent's return to the practice of general surgery in its Order of March 10, 2011, approving Respondent's request to go to PACE rather than CPEP for evaluation. Therefore, the Board concludes that Respondent may return to the practice of general surgery subject to the following terms and conditions:

### **ORDER REINSTATING GENERAL SURGERY**

- 1. GENERAL SURGERY – PRACTICE MONITORING PLAN:** Prior to practicing general surgery under his Iowa medical license, Respondent shall enter into a Board-approved practice monitoring plan. If Respondent fails to fully comply with all requirements of the practice monitoring plan, the Board may initiate action to suspend or revoke Respondent's Iowa medical license or to impose other license discipline as authorized in Iowa Code Chapters 148 and 272 and 653 IAC 24. Respondent shall fully comply with the written practice monitoring plan.
  - A. Respondent shall submit the name and CV of an Iowa-licensed, board-certified, general surgeon, to serve as his practice monitor. The Board shall provide the practice monitor a copy of the practice monitoring plan, all evaluation reports and all other relevant Board material in this matter. The practice monitor shall provide a written statement indicating that the practice monitor has read and understands all Board material provided by the Board and agrees to serve as the practice monitor under the terms of the practice monitoring plan.
  - B. The practice monitor shall meet with Respondent regularly, review selected patients records, ensure that Respondent provides appropriate care and treatment to patients and engage in a quality improvement process that addresses any deficiencies identified through the monitoring process. The practice monitor shall contact the Board immediately if there is evidence that Respondent has provided substandard medical care to patients.
  - C. The practice monitor shall agree to submit written quarterly reports to the Board not later than 1/20, 4/20, 7/20 and 10/20 of each year of this order.
  - D. The practice monitor may be asked to appear before the Board in-person, or by telephone or video conferencing. The practice monitor shall be given written notice of the date, time and location for the appearances. Such appearances shall be subject to the waiver provisions of 653 IAC 24.2(5)(e)(3).



Siros S. Shirazi, Chairman

April 22, 2011  
Date

cc: Theresa Weeg  
Assistant Attorney General

Michael Sellers  
Attorney for Respondent



Theresa Weeg represented the public interest. Attorney Michael Sellers represented Respondent. The hearing was closed to the public at the election of the licensee.

The Board considered the entire record made before the Panel, as well as the briefs and oral arguments made by the parties. The Board voted to affirm the decision of the Panel in its entirety, with the following clarification:

The Panel prohibited Respondent from practicing general surgery unless and until he completes a comprehensive clinical competency evaluation in general surgery at CPEP and he receives written approval from the Board. Respondent objected to that conclusion because he previously completed an evaluation at PACE. However, as pointed out in the Panel decision, PACE did not perform a comprehensive assessment of Respondent's general surgery knowledge or skills. Respondent told PACE that he had limited his practice to urology since 2004. As a result, PACE believed that Respondent no longer practiced general surgery and performed a much less comprehensive assessment in general surgery. Additionally, the Board noted that Respondent's performance on the general surgery testing was troubling, as his scores in some subject areas were below average when compared with a control group of medical students with one to three years of residency training. On one exam, Respondent's score was in the first percentile, that is, 99 percent of the residency students scored better. The Panel and the Board concluded that Respondent has not demonstrated his competency in general surgery.

In contrast, Respondent engaged in a week-long clinical experience in urology and PACE concluded that he performed satisfactorily during the clinical experience. As a result the Panel decided not to restrict Respondent's office-based urology practice. Respondent did not complete a comparable clinical experience in general surgery. The Board agrees with the Panel that Respondent must complete a comprehensive clinical evaluation in general surgery at CPEP before being allowed to practice general surgery. Respondent shall not perform any hospital-based surgery or procedure until he has completed a CPEP evaluation and he has received written approval from the Board. The Board also agreed with the Panel's conclusion that Respondent may continue to conduct an office-based urology practice without restriction. If Respondent chooses to limit his practice to office-based urology, there is no requirement that he complete the CPEP evaluation.

On November 17, 2010, Respondent filed a Request for Rehearing asking the Board to reconsider the October 22, 2010, Findings of Fact, Conclusions of Law, Decision and Order due to concerns that the Board did not have explanatory materials from the PACE program, that had been submitted to the Board for consideration. On November 23, 2010, the Board granted additional oral argument to be held on December 17, 2010. On January 13, 2011, following additional oral argument, additional information from the PACE program, and testimony from a representative of the PACE program, the Board issued a Decision on Request for Rehearing. The Board denied Respondent's Request for

Rehearing, indicating that the Board considered the entire record at hearing, including all material submitted concerning the competency evaluation performed by PACE, the Board concluded that Respondent was prohibited from practicing general surgery unless and until he completes a comprehensive clinical competency evaluation at CPEP and receives written approval from the Board.

On January 26, 2011, Respondent filed a Request to Replace Evaluation Facility asking that the Board approve PACE to perform the comprehensive clinical competency evaluation ordered by the Board. On February 10, 2011, after careful consideration, the Board voted to approve PACE to perform the comprehensive clinical competency evaluation order by the Board. The Board noted that the Findings of Fact, Conclusions of Law, Decision and Order issued by the Board in this matter, requires Respondent to receive written approval from the Board prior to practicing general surgery.

On January 27, 2011, Respondent filed a second Request for Rehearing asking that the Board grant rehearing so that Respondent's request to substitute PACE for CPEP to perform the comprehensive clinical competency evaluation ordered by the Board might be fully discussed with the Board as the resolution of the evaluation process concerns that have been previously expressed by the Board. On February 10, 2011, the State filed a Resistance to Respondent's Second Request for Rehearing arguing that Respondent had already submitted an appropriate request for post-hearing modification of the existing Board order and the Board lacks jurisdiction to consider the second application for rehearing. On February 10, 2011, the Board voted to deny Respondent's second Request for Rehearing because Respondent had already submitted a Request for Rehearing and the Board lacks jurisdiction to consider the second application for rehearing. The Board also noted that the issue raised in the second Request for Rehearing has already been addressed as Respondent's request to substitute PACE to perform the clinical competency evaluation has been approved in this order.

**IT IS THEREFORE ORDERED** that Respondent's Request to Replace Evaluation Facility in this matter is **APPROVED**.

**IT IS FURTHER ORDERED** that Respondent's second Request for Rehearing in this matter is **DENIED**.

**IT IS FURTHER ORDERED** that Respondent must receive written approval from the Board prior to practicing general surgery.

  
Siroos Shirazi, Chairman

March 10, 2011  
Date

Case No. 02-00-995, et al.

DIA No. 08DPHMB002

Page 4

cc: Theresa Weeg  
Assistant Attorney General

Michael Sellers  
Attorney for Respondent

**BEFORE THE IOWA BOARD OF MEDICINE**

---

<b>In the Matter of the Statement of Charges Against:</b>	)	Case Nos. 02-00-995, 02-04-107, 02-04 227, 02-05-289, 02-05-527, 02- 05-570, 02-06-403, 02-06-745
	)	DIA No: 08DPHMB002
	)	
<b>Fawad S. Zafar, M.D.</b>	)	<b>DECISION ON REQUEST</b>
	)	<b>FOR REHEARING</b>
<b>Respondent,</b>	)	

---

**To: Fawad S. Zafar, M.D.**

Date: January 13, 2011.

**STATEMENT OF THE CASE**

On October 22, 2010, the Iowa Board of Medicine (the Board) issued a Final Decision and Order regarding a Statement of Charges against Fawad Zafar, M.D. (Respondent). The statement of charges alleged two counts: 1) professional incompetence, and 2) engaging in practice harmful or detrimental to the public. The Board's decision affirmed a prior decision by a Panel of the Board, in which the Panel found violations on both counts. The Board imposed several sanctions, as set forth in the two orders.

On November 17, 2010, Respondent filed a Request for Rehearing. The Board agreed to hear oral argument from the parties on December 17, 2010. Respondent also offered some evidence, most particularly an undated letter signed by Dr. William Norcross, with attachments. Dr. Norcross is the Director of PACE, which is an assessment program Respondent attended prior to the hearing in this case. Dr. Norcross also briefly testified.

The following Board members appeared for the hearing: Siroos Shirazi, M.D., Colleen Stockdale, M.D., Janice Galli, D.O., Joyce Vista-Wayne M.D., Jeffrey Snyder M.D., Rodney Zeitler M.D., and Paul Thurlow. Jeffrey Farrell, an administrative law judge from the Department of Inspections and Appeals, assisted the Board. Assistant Attorney General Theresa Weeg represented the public interest. Attorney Michael Sellers represented Respondent. The hearing was closed to the public at the election of the licensee.<sup>1</sup>

---

<sup>1</sup> See 653 IAC 24.4(4) (citing Iowa Code section 272C.6(1)).

## DISCUSSION

Respondent offers the letter and testimony from Dr. Norcross to attempt to rebut references in the Board's decisions to the written assessment conducted by PACE. The letter does not persuade the Board that its decision should be changed. The letter states that the Board considered PACE to be incompetent to perform comprehensive assessments of physicians. That assertion is not true. In fact, the Board relied, in part, on the PACE assessment in deciding not to place restrictions on Respondent's office-based urology practice.

The Board imposed sanctions on Respondent's general surgery practice after finding that he violated the standard of care when practicing general surgery. The Board found that the PACE assessment did not alleviate the need for restrictions on Respondent's general surgery practice. The assessment stated that: 1) Respondent informed PACE that he had limited his practice to urology since 2004, 2) PACE conducted a week-long clinical assessment in urology, and in contrast, conducted much more limited testing in general surgery. The Board did not question the competence of PACE to conduct a comprehensive assessment. Rather, the Board cited the assessment report to show that PACE did not assess Respondent's ability to practice general surgery to the same level it assessed his urology knowledge and skills. The letter from Dr. Norcross does not offer any reasoned explanations why the statements in the assessment report are incorrect. Accordingly, the Board affirms its decisions as previously written.

## DECISION AND ORDER

The Board hereby denies Respondent's Request for Rehearing.

---

Dated this 13<sup>th</sup> day of January, 2011.

  
Siroos Shirazi, M.D., Chairman

cc: Theresa Weeg  
Assistant Attorney General

Michael Sellers  
Attorney for Respondent

**BEFORE THE IOWA BOARD OF MEDICINE**

---

<b>In the Matter of the Statement of Charges Against:</b>	)	<b>Case Nos. 02-00-995, 02-04-107, 02-04 227, 02-05-289, 02-05-527, 02- 05-570, 02-06-403, 02-06-745</b>
	)	<b>DIA No: 08DPHMB002</b>
<b>Fawad S. Zafar, M.D.</b>	)	<b>FINDINGS OF FACT,</b>
<b>Respondent,</b>	)	<b>CONCLUSIONS OF LAW,</b>
	)	<b>DECISION AND ORDER</b>

---

**To: Fawad S. Zafar, M.D.**

**Date:** October 22, 2010

Fawad Zafar, M.D. (Respondent) was issued Iowa medical license no. 30827 on September 19, 1995. Respondent's license is active and will next expire on June 1, 2011. Respondent formerly practiced urology and general surgery in several locations in central Iowa. Respondent currently practices urology in West Des Moines and Manning, Iowa. On January 17, 2008, the Iowa Board of Medicine (Board) filed a Statement of Charges against Respondent. The Statement of Charges alleged two counts: 1) professional incompetence, and 2) engaging in practice harmful or detrimental to the public.

On November 19-20, 2009, a hearing was held before a three member Panel of the Board consisting of Siroos Shirazi, M.D., Rodney Zeitler, M.D., and Colleen Stockdale, M.D. On March 10, 2010, the Panel issued a Proposed Panel Decision finding violations on both counts. The Proposed Panel Decision imposed several sanctions including a Citation and Warning and \$5,000 Civil Penalty. The Panel voted to prohibited Respondent from practicing general surgery unless and until he completes a comprehensive clinical competency evaluation at the Center for Personalized Education for Physician (CPEP) in Denver, Colorado, and receives written approval from the Board. The order also required Respondent to complete a medical record keeping course.

Respondent filed an appeal arguing that further evaluation at CPEP was unnecessary because he had already completed an evaluation at the Physician Assessment and Clinical Education Program (PACE). The State filed a cross-appeal arguing that Respondent failed to conform to the minimal standard of care in the practice of general surgery and urology and that the Board should order him to complete a comprehensive clinical competency evaluation at CPEP in both general surgery and urology. The Board issued an Order creating a briefing schedule and setting a hearing for the parties to present oral arguments. A hearing was held on August 19, 2010, before the following Board members: Siroos Shirazi, M.D., Colleen Stockdale, M.D., Janice Galli, D.O., Joyce

Vista-Wayne M.D., Jeffrey Snyder M.D., Paul Thurlow, and Tom Drew. Jeffrey Farrell, an administrative law judge from the Department of Inspections and Appeals, assisted the Board. Assistant Attorney General Theresa Weeg represented the public interest. Attorney Michael Sellers represented Respondent. The hearing was closed to the public at the election of the licensee.<sup>1</sup>

The Board considered the entire record made before the Panel, as well as the briefs and oral arguments made by the parties. The Board voted to affirm the decision of the Panel in its entirety, with the following clarification.

The Panel prohibited Respondent from practicing general surgery unless and until he completes a comprehensive clinical competency evaluation in general surgery at CPEP and he receives written approval from the Board. Respondent objected to that conclusion because he previously completed an evaluation at PACE. However, as pointed out in the Panel decision, PACE did not perform a comprehensive assessment of Respondent's general surgery knowledge or skills. Respondent told PACE that he had limited his practice to urology since 2004. (Exhibit A, p. 2). As a result, PACE believed that Respondent no longer practiced general surgery and performed a much less comprehensive assessment in general surgery. Additionally, the Board noted that Respondent's performance on the general surgery testing was troubling, as his scores in some subject areas were below average when compared with a control group of medical students with one to three years of residency training. On one exam, Respondent's score was in the first percentile, that is, 99 percent of the residency students scored better. The Panel and the Board concluded that Respondent has not demonstrated his competency in general surgery.

In contrast, Respondent engaged in a week-long clinical experience in urology and PACE concluded that he performed satisfactorily during the clinical experience. As a result the Panel decided not to restrict Respondent's office-based urology practice. Respondent did not complete a comparable clinical experience in general surgery. The Board agrees with the Panel that Respondent must complete a comprehensive clinical evaluation in general surgery at CPEP before being allowed to practice general surgery. Respondent shall not perform any hospital-based surgery or procedure until he has completed a CPEP evaluation and he has received written approval from the Board. The Board also agreed with the Panels' conclusion that Respondent may continue to conduct an office-based urology practice without restriction. If Respondent chooses to limit his practice to office-based urology, there is no requirement that he complete the CPEP evaluation.

---

<sup>1</sup> See 653 IAC 24.4(4) (*citing* Iowa Code section 272C.6(1)).

**DECISION AND ORDER**

The Proposed Decision of the Panel, issued on March 10, 2010, is hereby **AFFIRMED** and adopted by the Iowa Board of Medicine as the final decision of the Board.

  
Siroos Shirazi, Chairman

October 22, 2010.  
Date

cc: Theresa Weeg  
Assistant Attorney General

Michael Sellers  
Attorney for Respondent

**BEFORE THE IOWA BOARD OF MEDICINE**

---

<b>In the Matter of the Statement</b>	)	<b>Case Nos. 02-00-995, 02-04-107, 02-04</b>
<b>of Charges Against:</b>	)	<b>227, 02-05-289, 02-05-527, 02-</b>
	)	<b>05-570, 02-06-403, 02-06-745</b>
	)	<b>DIA No: 08DPHMB002</b>
<b>Fawad S. Zafar, M.D.</b>	)	
<b>Respondent,</b>	)	<b>PROPOSED DECISION</b>
	)	<b>OF THE PANEL</b>

---

**To: Fawad S. Zafar, M.D.**

**Date: March 10, 2010.**

On January 17, 2008, the Iowa Board of Medicine (the Board) filed a Statement of Charges against Fawad Zafar, M.D. (Respondent). The statement of charges alleged two counts: 1) professional incompetence, and 2) engaging in practice harmful or detrimental to the public.

On November 19-20, 2009, the case came for hearing before a Panel of the Board. The Panel consisted of Siroos Shirazi, M.D., Rodney Zeitler, M.D., and Colleen Stockdale, M.D. Jeffrey Farrell, an administrative law judge from the Department of Inspections and Appeals, assisted the Board. Assistant Attorney General Theresa Weeg represented the public interest. Attorney Michael Sellers represented Respondent. The hearing was closed to the public at the election of the licensee.<sup>1</sup>

After hearing the testimony and examining the exhibits, the Panel convened in closed executive session to deliberate. The Panel directed the administrative law judge to prepare the decision in accordance with its deliberations.

**THE RECORD**

The State's exhibits 1-127 were admitted. The State called witnesses Dr. Phillip Caropreso and Dr. Tim Mulholland.

Respondent's exhibits A-R were admitted. Respondent testified on his own behalf. Respondent also called Drs. Robert Thompson, Seema Khan, Thomas Lower, Syed Bokhari, Bill Stanley, and Mike Bess. The depositions of Drs. Stephen Quinlan and Allen Zagoren were admitted.

---

<sup>1</sup> See 653 IAC 24.4(4) (citing Iowa Code section 272C.6(1)).

## FINDINGS OF FACT

**Background:** Respondent is originally from Pakistan where he grew up in a family of doctors. Respondent's father was a practicing physician and the dean of a medical school in Pakistan. His mother was a doctor with a PhD in pharmacy. She worked for the World Health Organization and taught in medical schools. Respondent has five siblings, all of whom are doctors. Two of his siblings practice in the United States. Respondent attended medical school in England, and performed his residency training in England and Pakistan. (Exhibit D; Respondent testimony).

In 1994, Respondent visited his sister in Indianapolis and considered a move to the United States. He applied for, and received, an Iowa medical license on September 19, 1995. He took a one year fellowship at Methodist Hospital in Indianapolis beginning in September of 2004. While serving the fellowship, he received a contact from Mahaska County Hospital in Oskaloosa, Iowa. Mahaska County was looking for a doctor who could perform urology and general surgery. Respondent received residency training in both. He accepted an offer from Mahaska County. (Exhibit D; Respondent testimony).

While working for Mahaska County, Respondent served at local outreach clinics in Bloomfield, Chariton, Corydon, and Centerville. Respondent testified that the Iowa Clinic, which is headquartered in Des Moines, also had outreach clinics in the area at the time he began to practice. He testified that the Iowa Clinic received fewer referrals after he established a local presence in the area. Respondent claims this to be notable, because the Board later received complaints from physicians who were competitors and connected with the Iowa Clinic, and from former patients who later saw doctors from the Iowa Clinic. (Exhibit D; Respondent testimony).

Respondent obtained privileges at other rural hospitals, including Clarke County Hospital in Osceola. Respondent testified that Clarke County was an old facility that was less-equipped than some hospitals he had worked in Pakistan. After he began working at Clarke County in 1997, the number of surgical and urology cases increased from approximately 5-6 per month to 50 per month. This growth was financially beneficial to the hospital. (Respondent testimony; Exhibit R).

In 1999, Respondent moved to the Des Moines area and opened a private practice in West Des Moines. Respondent advertised aggressively and picked up new patients who had a shorter wait for openings than with the Iowa Clinic. Respondent sought privileges with Broadlawns Hospital and Des Moines General Hospitals. Des Moines General

denied him privileges because he was not board-certified.<sup>2</sup> Respondent testified that Broadlawns denied privileges after doctors from the Iowa Clinic sent “strongly-worded letters” to the hospital. Respondent later obtained privileges at the VA Hospital in Des Moines. He retained privileges at rural hospitals outside of Des Moines. (Respondent testimony).

On October 16, 2000, the Board received a complaint from a doctor who was on the credentials committee at Des Moines General. The complaint questioned whether Respondent had the requisite training to be licensed in Iowa. Specifically, the doctor questioned whether Respondent spent one year in an approved residency program in the United States. The Board investigated the complaint, and the State introduced the report and associated documents as part of the record in this case. The State did not seek to revoke or rescind Respondent’s license on this ground. (Exhibits 11-13).

On or about February 23, 2004, the board received a complaint from Dr. Gerald Baker. Dr. Baker is a staff surgeon for Iowa Methodist Medical Center and in private practice with the Iowa Clinic. Dr. Baker expressed concerns about a patient who had been seen by Respondent. Respondent performed a biopsy of her breast five weeks before being seen by Dr. Baker. Dr. Baker expressed concerns that Respondent had not timely followed up with treatment after removing two masses. Dr. Baker further stated his concern that an urologist was involved in breast care. (Exhibit 18).

On April 30, 2004, the board received a complaint via Larry Frazier, who is a program coordinator in the Health Facilities Division of the Department of Inspections and Appeals. Mr. Frazier received an email from a hospital surveyor from his office, Lisa Campbell, who had spoken with Vickie Irvin, who was the chief clinical officer at Clarke County Hospital. Ms. Irvin reported that Respondent had not scrubbed prior to surgery, dictated post-operative notes prior to procedures and falsified documentation in post-operative notes. Ms. Irvin wanted her complaint to be forwarded to the Board, which Ms. Campbell did through Mr. Frazier. (Exhibit 24).

Respondent testified that the Clarke County complaint arose after the hiring of a new hospital administrator, David Coates. Respondent stated that Mr. Coates recruited a second surgeon to Clarke County Hospital and talked of contracting with Iowa Clinic to perform urology cases. Respondent said there was no need for either. Thereafter, Mr. Coates confronted Respondent with a list of patient care issues that were ultimately part of the complaint to the Board. Many of these concerns were documented as part of a Plan of Correction, that the hospital required Respondent to sign if he was to continue

---

<sup>2</sup> Respondent must complete a full residency program in the United States to become board-certified. Respondent testified that he considered attending a residency program, but felt he would be relearning things he already knew.

working there. Respondent stated that Mr. Coates asked him to resign, with the representation that the hospital would take no further action if he did. Respondent elected to resign. The complaints were filed with the Board on the following day. Clarke County replaced Respondent's services with doctors from the Iowa Clinic.<sup>3</sup> (Respondent testimony; Exhibits 54-55, R).

The Board began an investigation on these two competency complaints. During the course of the investigation, the Board received numerous additional complaints in 2005 and 2006. Two of the complaints came from patients. Both were treated by physicians from the Iowa Clinic after being treated by Respondent. The other complaints were filed by Dr. Stephen Quinlan and Dr. Markham Anderson. Dr. Anderson is with the Iowa Clinic, but Dr. Quinlan is not. (Exhibits 5-6, 68, 75, 86-87, 101, 106; Quinlan deposition).

The Board formed a peer review committee consisting of Drs. Kenneth McCalla, Timothy Mulholland, and Philip Caropreso. Dr. Caropreso reviewed complaints relating to general surgery. Drs. Mulholland and McCalla reviewed complaints relating to urology. They identified a number of cases in which they determined that Respondent violated the standard of care. On January 17, 2008, the Board filed its statement of charges in accord with the findings of the peer review committee. At hearing, the cases were narrowed down to nine general surgery cases and five urology cases, although the State produced evidence on other urology cases in which there was no express finding of a violation of standard of care. (Exhibits 5-6).

Respondent continues to practice urology and general surgery. Approximately 60 percent of his income derives from his urology office practice, which he described as his "bread and butter." The remainder of his practice is general surgery at hospitals including the VA and rural hospitals around Des Moines. In the last two years, Respondent has established a relationship with the Iowa Clinic and local urologists regarding practice coverage and patient referrals. Respondent reported that competing doctors have not filed complaints since those arrangements were reached. Respondent himself filed with the Board a number of complaints against physicians from the Iowa Clinic. He is no longer filing complaints and stated that he has "put it behind him." (Respondent testimony).

---

<sup>3</sup> Dr. Zafar's rendition of these events are largely corroborated by Dr. George Fortiadis, who was the hospital's medical director and a local family physician. (See Exhibit M.) Dr. Fortiadis stated that it would be a "gross disservice to the public" and Respondent if Respondent's resignation from Clarke County was used as a criticism of his abilities as a physician.

### General Surgery Cases

**Standard of Care:** Dr. Caropreso has practiced general surgery in Iowa for 33 years. He is an adjunct professor at the University of Iowa and a fellow of the American College of Surgeons (ACS). Dr. Caropreso used a statement of practice created by ACS in assessing whether Respondent complied with the standard of care in the nine cases he reviewed. He reviewed standard of care in three phases. The first is conducting a thorough pre-operative evaluation in which the surgeon reviews all pertinent aspects of the patient's case and presents to the patient the range of options available. Second, the surgeon is responsible for the safe and competent performance of the operation. Third, the surgeon is responsible for post-operative care of the patient until the effects of the condition and surgery are resolved. Dr. Caropreso emphasized that proper documentation is critical to demonstrate that all requirements of the standard of care are met. (Exhibit 5; Caropreso testimony).

Dr. Caropreso's reliance on the ACS was criticized by one of Respondent's witnesses, Dr. Robert Thompson. Dr. Thompson was a long-time general surgeon and a former member of ACS who recently retired from that practice. He testified that the ACS is an exclusive group who adopt standards that are applicable to members of the fellowship, but not necessarily to doctors outside the group. Dr. Thompson does not believe it is fair to apply ACS standards to all doctors nation-wide. (Thompson testimony).

Dr. Caropreso also discussed standards of care particular to the types of surgeries performed by Respondent. They are discussed below as relative to each of the nine cases. They are discussed in the order they were addressed in Dr. Caropreso's report.

**Case No. 1:** This case involved a 47 year-old woman who was found to have palpable masses in her right breast. An ultrasound revealed a cystic lesion. Prior to surgery, the patient's family physician performed a history and physical exam. On January 9, 2004, Respondent performed a biopsy. He removed the lesion, and during the operation, he palpated a second mass. He also excised this mass. The final pathology report demonstrated fibrocystic disease and an incompletely excised invasive ductal carcinoma. Approximately five to six weeks later, the patient saw Dr. Baker, who performed a modified radical mastectomy. The patient told Dr. Baker that Respondent suggested that she have a full mastectomy, but that he would not perform it because he is an urologist. (Exhibits 5, 18, 40).

Dr. Caropreso explained his practice in breast cancer cases. He first meets with the patient to get her general medical history, family history, and prior medical background. He conducts a physical exam. He then offers options and a recommendation how to proceed. Dr. Caropreso considers the pre-operative meeting to be particularly important

in a breast cancer case, as breast cancer is the second highest cause of cancer death. He opined that Respondent violated the standard of care because the history and physical were done by the family doctor, and although there was a record that Respondent performed a preoperative evaluation of the patient, Respondent did not document his evaluation and discussion of treatment options. (Caropreso testimony).

Dr. Caropreso also concluded that Respondent's choice of procedure violated the standard of care. Dr. Caropreso testified that Respondent should have performed a stereotactic biopsy with other surgical procedures planned after receiving the pathology report. This is a less invasive procedure than the biopsy performed by Respondent. Dr. Carapreso testified that he would have recommended a stereotactic biopsy, and he would have declined to provide further treatment if the patient had not accepted his recommendation. (Caropreso testimony; Exhibit 5).

Dr. Caropreso did not find other violations of the standard of care in this case, but noted other concerns. Dr. Baker had raised an issue that Respondent had "cut across the cancer," thus leaving part of the cancer in the breast. The pathology report supported this finding. Dr. Caropreso did not find a violation because the mass was not determined to be cancerous until later, but noted that the failure to remove the entire mass resulted in additional surgery later. Dr. Caropreso noted that the six week delay in follow-up was "prolonged and without adequate justification," but there was no evidence that the patient was harmed by the delay. However, the combination of violations and other concerns led Dr. Caropreso to doubt Respondent's knowledge, learning, and skill to care for this patient. (Exhibits 5; Caropreso testimony).

Respondent disagreed with Dr. Caropreso's conclusion that the surgeon must personally perform a patient's preoperative history and physical. He does not believe that to be outside the standard of care. He found Clarke County's record-keeping to be insufficient, so he kept records in his office. (Respondent testimony).

Regarding the surgery itself, Respondent testified that the local hospital did not have the equipment to conduct a stereotactic biopsy in 2004 and it was not required standard of care. Respondent called Dr. Bill Stanley to support his view. Dr. Stanley practiced general surgery at Des Moines General Hospital and other hospitals in Des Moines for 22 years, before moving his practice to southern Iowa eight years ago. Dr. Stanley examined the medical records relative to this case (as well as the other eight general surgery cases), and found no violation of the standard of care. Dr. Stanley confirmed that the equipment to perform a stereotactic biopsy was not available in all hospitals in 2004, and concluded that Respondent's decision to perform a surgical biopsy was within the standard of care at the time. (Stanley testimony; Exhibit E).

Dr. Seema Khan also testified on Respondent's behalf on this case. Dr. Khan is a professor of surgery at Northwestern University where she specializes in breast cancer treatment. Dr. Khan testified that a stereotactic biopsy could have been performed, but the facilities to do so were not available to Respondent in this case. She found that Respondent reasonably removed the lesion by surgery. However, she bases that decision on the equipment available at the facility. She testified that a sentinel node biopsy, which is another less invasive option to traditional surgery, is the standard of care if available at the hospital. (Khan testimony; Exhibit K).

**Case No. 2:** On March 21, 2003, Respondent performed a colonoscopy with a possible biopsy or polypectomy of a patient who presented with a possible 1.6 cm tumor at the rectosigmoid junction, which is approximately at 6 cm. During the colonoscopy, a perforation occurred. Respondent discontinued the biopsy and closed the perforation. The perforation occurred at a site distinct from the tumor. The tumor was later removed by another surgeon. (Exhibits 5, 31).

Dr. Caropreso had the same pre-operative concerns in this case, in that the history was obtained by the family doctor rather than Respondent. Additionally, Respondent failed to document that he performed a rectal exam prior to the procedure, although Dr. Caropreso assumes he did so. (Caropreso testimony; Exhibit 5).

Dr. Caropreso did not conclude that the perforation that resulted from Respondent's care was a violation of the standard of care. Perforations occasionally occur, approximately 1 out of 1000 cases. However, Dr. Caropreso was concerned with some of Respondent's actions. Respondent did not perform the biopsy of the mass at 6 cm, although he removed a polyp at 20 cm. Dr. Caropreso was surprised that Respondent did not follow through with the biopsy of the mass at 6 cm, even after the perforation. The procedure would only take minutes and the patient would avoid a second procedure. Dr. Caropreso criticized the use of a nasogastric tube, which did not likely benefit the patient and runs the risk of extending care. Dr. Caropreso disagreed with Respondent's decision to treat with antibiotics for more than 24 hours after the operation, as there was no documentation of an active infection. The combination of all concerns led Dr. Caropreso to conclude that Respondent lacks the training or skill needed to perform a colonoscopy. (Exhibit 5; Caropreso testimony).

Respondent testified that he did not remove the mass at 6 cm because he usually does biopsies as he is removing the scope. As he was removing the scope, he saw the perforation. Respondent had difficulty seeing the mass at that point, and other staff members in the operating room were panicking. He removed the scope and repaired the perforation. He defended his use of the drains as within the standard of care. (Respondent testimony; Exhibit R).

Respondent's actions were defended by other doctors, including Dr. Praveen Prasad. Dr. Prasad defended each of Respondent's actions, including the procedure and use of drains. He also discussed antibiotics, which he found to be reasonable due to contamination of the peritoneal cavity and not simply for prophylactic measures. Dr. Prasad did agree generally with Dr. Caropreso that the trend in medicine is to limit use of antibiotics to 24 hours for prophylactic purposes. (Exhibit P).

**Case No. 3:** A 45 year-old man presented with complaints of stomach pain. On February 13, 2004, Respondent performed an esophagogastroduodenoscopy (EGD) with biopsy on Seventeen days later, the patient was hospitalized with a bleeding ulcer, which was treated by another surgeon. Respondent denied that he missed the ulcer, and argued it developed between the two procedures. Dr. Caropreso did not find that Respondent's treatment fell below the standard of care, but he continued to question Respondent's pre-operative evaluation and procedures, and his record-keeping. (Exhibits 5, 41; Caropreso testimony).

**Case No. 4:** A 71 year-old woman presented with a biopsy-proven carcinoma in her right breast. On October 10, 2003, Respondent performed a modified radical right breast mastectomy. One concern raised in the complaint was whether the diagnosis after the biopsy was consistent with the pathology report in the discharge summary. Respondent removed all lymph nodes during the surgery, and all were negative for cancer. Additionally, hospital staff questioned the extent of breast tissue remaining after the procedure. (Exhibits 5, 42).

Dr. Caropreso had concerns that Respondent failed to document and/or discuss the potential treatment options with this patient. In particular, he felt she would have been an excellent candidate for a less-invasive needle localization, lumpectomy, and sentinel node biopsy. He found no documentation that Respondent explained the options to the patient. He believes that the failure to explain and recommend the less invasive procedure fell below the standard of care, for the same reasons discussed in Case No. 1. (Exhibit 5; Caropreso testimony).

Dr. Caropreso did not find fault with the consistency of the diagnosis in the records. He also did not find that the conduct of the procedure itself fell below the standard of care, although there were concerns that Respondent did not remove all breast tissue, as would typically be required of a mastectomy. Dr. Carapreso did find violations of standard of care regarding documentation of a discussion of the treatment options, as well as the use of antibiotics despite the lack of documented need. Dr. Caropreso concluded that this case further demonstrated Respondent's lack of knowledge in treating breast cancer. (Exhibit 5; Caropreso testimony).

Respondent stated that the patient understood that she had treatment options and chose the mastectomy over other procedures. The patient had no family members that could drive her to six weeks of radiation, which would have been necessary had she chosen another procedure. She elected the mastectomy as the best choice for her. Respondent testified that the Board should consider the decision in that context. Respondent's opinion is supported by the opinion of Dr. Khan, who saw no reason to debate the choice of procedure in this case. Respondent defended his use of antibiotics as recommended by the cardiologist. (Respondent, Khan testimony).

**Case No. 5:** A 35 year-old woman presented with complaints of tenderness in her left breast. The physical exam did not reveal any breast masses, but a mammogram and ultrasound identified a solid mass of approximately 1.6 cm in the right breast. The pre-operative history from the patient's family doctor described the lump at the right upper outer area, whereas the patient consent described the procedure as a right medial lumpectomy. Hospital staff noticed the inconsistency and informed Respondent that the forms were inconsistent. Respondent stated that he would remove the lump that the patient wanted removed and everything would be fine. The staff did not accept that answer and asked the family doctor to amend the history to accurately reflect the mammogram and ultrasound. On March 10, 2004, Respondent performed the operation, which he described as a lumpectomy. He asked the patient to note the area that bothered her, and she pointed to the medial area of the breast. Respondent ultimately removed two masses, one from each area identified. The masses removed measured 4-5 cm. The pathology report showed fibrocystic disease and no cancer. (Exhibits 5, 43).

Dr. Caropreso found violations of the standard of care for Respondent's record-keeping and for performing a procedure that could have been treated through less invasive means. Respondent described the procedure as a lumpectomy in an operative summary, and a biopsy in a handwritten note. Dr. Caropreso found the inconsistency in terminology troubling because a lumpectomy is only performed to remove breast cancer. In this case, there was no palpable mass, and Dr. Caropreso concluded that there was no reason to perform a biopsy. Dr. Caropreso would not have performed surgery and would have continued to monitor the patient. If a biopsy was necessary, Dr. Caropreso would have performed a less-invasive ultrasound guided or by stereotactic technique. Dr. Caropreso was also concerned that Respondent removed nearly 10 cm of benign breast tissue. He concluded that there was no benefit to the patient by performing this surgery. (Exhibit 5; Caropreso testimony).

Respondent testified that the patient wanted the lumps removed due concerns about her family history. He felt a biopsy was justified by the identification of lumps and the patient's wish to have them removed. Both lumps were found to be benign, but he could not know that until they were removed. Respondent stated that hospital staff did not need to obtain a correction from the family physician because it was his responsibility to

obtain patient consent, and the consent is consistent with the information from the family physician. Dr. Khan supported Respondent's position on each point. Dr. Stanley responded to Dr. Caropreso's statement that the patient received no benefit; Dr. Stanley stated that the patient was able to rule out cancer, which is "always the #1 concern." (Exhibits E, K, R; Respondent, Khan testimony).

**Case No. 6:** On June 13, 2003, Respondent performed a laparoscopic tubal ligation on a 28 year-old woman for voluntary sterilization. The final pathology report showed 1.0 cm of fibro muscular tissue without definite fallopian tube components, thus leading to concerns whether surgery was successful. Dr. Caropreso now believes the surgery was probably successful based on additional records provided by Respondent during the discovery leading up to the hearing. However, he noted the concern that the records were not readily available through the hospital file. (Exhibits 5, 44; Caropreso testimony).

**Case No. 7:** On October 5, 2003, Respondent was consulted regarding a 24 year-old woman with complaints of right flank and abdominal pain. She stated she had pain for one week. A CT scan was normal. Respondent recommended surgery to remove the appendix. He stated in a note that "while it is not a clear picture of appendicitis, I think that we do not have much else to go for as all the studies are negative and patient is not better." Respondent performed a laparoscopic appendectomy. The pathology report confirmed appendicitis, although the microscopic examination indicated that it was at an "early evolving" level. (Exhibits 5, 45; Carapreso testimonmy).

Dr. Carapreso concluded that Respondent violated the standard of care when he proceeded to surgery based on the facts known at the time that decision was made. The patient had week-long pain, but the symptoms were otherwise unremarkable. He testified that Respondent could have waited to see if some of the classic symptoms of appendicitis appeared before proceeding to surgery. Because the pathology report shows the appendicitis was at an early evolving level, he found it unlikely that the appendix caused the patient's symptoms. Dr. Caropreso questioned some of Respondent's description and use of terminology in describing the surgery, but acknowledged that the procedure itself was successfully performed. He also criticized Respondent's use of a drain without sufficient cause to do so. (Caropreso testimony; exhibit 5).

Respondent testified that he received the patient on a referral. He initially told her to watch her symptoms. He performed the surgery two days later when the problem had not resolved. He saw no reason to wait, as he did not want the appendix to perforate before performing the surgery. The operation resolved her pain and symptoms, and the pathology report shows appendicitis. Respondent defended his use of a drain to alleviate some blood loss; stating that he removed the drain the following day. (Respondent testimony).

Dr. Stanley defended Respondent's decision to remove the appendix notwithstanding the negative CT. He has learned that CT scans are not completely reliable, and Respondent was justified based on the presenting symptoms and Respondent's two day observation period. Dr. Stanley stated his amazement that Dr. Caropreso criticized Respondent notwithstanding the pathology report showing appendicitis. Dr. Stephen Haggerty offered a similar opinion. (Exhibits E, F).

**Case No. 8:** On February 9, 2004, Respondent performed a hemicolectomy on a 76 year-old woman after a colonoscopy revealed a carcinoma of the colon. The woman was hospitalized for eight days. Respondent saw the patient during daily rounds on the first two days after the surgery, but followed up by telephone thereafter. The patient was seen by family doctors until discharged. (Exhibits 8, 50).

Dr. Caropreso found two violations of the standard of care. First, he stated that the surgeon should follow up with the patient by seeing her each day until her discharge from the hospital. He believes this necessary to ensure that the recovery is proceeding toward resolution. He does not believe telephone contact is sufficient. Second, Dr. Caropreso found that Respondent used an excessive amount of antibiotics. The patient remained on antibiotics for five days, and he prescribed oral antibiotics after she was discharged. Dr. Caropreso found similar problems with record-keeping as outlined in other cases. He did not find that the surgery itself violated the standard of care, but expressed concern that Respondent's documentation contained incorrect use of terminology. Dr. Caropreso expressed concerns that Respondent did not have the knowledge needed to properly evaluate and conduct this type of surgery. (Caropreso testimony; exhibit 5).

Respondent testified that he saw the patient for three days after surgery and she was doing fine. He followed up by daily phone calls. He would have gone back if there were any problems, but none arose. He testified that other physicians use the same post-operative procedures for follow-up, and the hospital by-laws do not require in-person visits each day. Dr. Stanley offered a similar opinion. Respondent defended his use of antibiotics by stating that there was no standard of care in 2004 to limit the use of antibiotics as suggested by Dr. Caropreso. This statement was supported by Dr. Haggerty. (Respondent testimony; Exhibits E, F).

**Case No. 9:** On April 11, 2003, Respondent performed a laparoscopic cholecystectomy to remove gall stones on a 71 year-old woman who complained of abdominal pain. Respondent encountered a blood vessel while removing the gall stones and the patient lost approximately 200 cc of blood during the procedure. Respondent did not convert the procedure to an open laparotomy to repair the blood loss, which led Dr. Caropreso to question whether Respondent is capable of performing the open procedure. The patient remained in the hospital for four days with decreased hemoglobin, elevated white blood

count, and management of pulmonary problems. Respondent inserted a drain and prescribed antibiotics post-operatively. (Exhibits 5; 53).

Dr. Caropreso concluded that Respondent violated the standard of care. He stated that the record did not adequately describe the procedure, which was particularly concerning in light of the complications and extended hospital stay. A patient receiving this type of procedure is usually discharged on the same or following day. Respondent described part of the surgery as “peeling the gall bladder off the liver bed,” but he did not describe the technique or instruments used. This procedure runs a risk of bleeding, so the absence of documentation leaves questions whether he used proper caution. Dr. Caropreso repeated past concerns about Respondent’s use of antibiotics. He also questioned the use of the drain, which had no benefit and ran the risk of developing a clot.<sup>4</sup>

Dr. Constance Frantzides stated that it was not unreasonable to use a JP drain in light of the patient’s age. He noted that the drain was removed when the output was minimal, and that the use of the drain had no risk of increasing morbidity or recovery time. He found the use of antibiotics to be within the standard of care due to the patient’s long history as a smoker, which would increase the chances of respiratory complications. Dr. Stanley also supported these points. Neither Drs. Frantzides nor Stanley spoke directly to the concern of lack of documentation. (Exhibit G).

**Additional information:** Respondent received other support from physicians beyond that specifically outlined here. Some of the opinions were general in the sense they had reviewed medical records and found no violations of the standard of care. (See e.g. exhibits J, Q). The Board reviewed each opinion before reaching any decision, but will not summarize in this decision each opinion on each case reviewed. The findings of fact fairly outline the evidence presented by each party.

### **Urology Cases**

Drs. Mulholland and McCalla (jointly referred to as “the committee”) reviewed a number of patient records. The committee concluded that Respondent performed appropriate evaluation and treatment most of the time. The committee did not find evidence to support complaints that Respondent pushed patients toward higher-revenue procedures or performed too many surgeries. The committee also found little proof to support complaints of questionable interaction with patients, medical staff, and other doctors. Dr. Mulholland acknowledged at hearing that some of the complaints appeared petty. (Exhibit 6; Mulholland testimony).

---

<sup>4</sup> Dr. Caropreso referenced the excessive use of drains in other cases, but the discussion was most prominent in this case.

The committee found some concerns with individual cases conducted during the review. They discussed these individual cases in their report, and Dr. Mulholland further discussed them at hearing. Both moderated their findings based upon additional information that Respondent provided them prior to their depositions, which were taken late in the case. Dr. McCalla ultimately found no violations of the standard of care. Dr. Mulholland found violations in two instances.

**Page 11 of Exhibit 6, Patient GH:** Respondent treated a 46 year-old woman for urinary incontinence. The woman presented as obese with a history of anxiety. Respondent initially placed a Foley catheter, but she did not tolerate it well. He then attempted a suprapubic tube under local anesthetic. The nurse had concerns that Respondent did not allow enough time for the anesthetic to work. The patient was very uncomfortable with the procedure and Respondent was not successful in placing it. (Exhibit 6).

Dr. Mulholland found a violation of the standard of care. He first questioned the use of the Foley catheter, which is not a good treatment for incontinence in a 46 year-old woman. He further questioned the placement of a suprapubic catheter under local anesthetic on an obese woman with an anxiety disorder. The committee members stated that they have rarely placed suprapubic tubes under local anesthetic, except in case of an emergency. There was no emergent reason here. Dr. Mulholland stated at hearing, that Respondent's decision to proceed in the manner he did was "doomed to fail and it did." (Exhibit 6; Mulholland testimony).

Respondent testified that he inserted the first catheter to address the patient's leakage so she could dry out. After five days, the patient was doing much better. He referred her to her regular physician to remove the catheter. She returned to his care with blisters and said that her regular physician recommended a suprapubic catheter. He could not place the catheter because it was not long enough. He claimed he allowed enough time for the anesthetic to work and stated that all patients have "their unique tolerance to pain, regardless of the anesthetic used." (Respondent testimony; exhibit R).

**Urology Case No. 4 (pages 22-23 of exhibit 6):** Respondent treated a male patient for a prostrate procedure in March of 2003. In January and February of 2005, the patient developed clot retention, and Respondent performed a clot evacuation and catheter placement. The committee expressed concern that Respondent performed the clot evacuation procedure in the office setting. The patient was admitted to the Wayne County Hospital and Respondent had him transferred to his private office in West Des Moines to perform the procedure. The committee found it very unusual to transfer a patient from a hospital to a private office to perform this procedure. Dr. Mulholland testified that there can be many unknowns with this type of procedure – the physician may encounter bleeding and may need to remove tissue or a tumor. Dr. Mulholland indicated that the clot evacuation should have been performed in the hospital, particularly

since the patient was already in the hospital. Dr. Mulholland testified that this case exemplifies why it is important that the surgeon have privileges at a nearby hospital so distance between office and the hospital does not affect the surgeon's judgment. (Exhibit 6; Mulholland testimony).

Respondent stated that he took this patient after receiving a call from the emergency room at Wayne County Hospital. Respondent was performing a procedure in his office and the patient was under sedation. Wayne County Hospital is ninety minutes from his office. Respondent indicated that he was capable of performing the procedure in the office and he had the patient transferred to the office while he was performing another procedure so that he could treat the patient sooner. The patient had a son who lived in the Des Moines area, so the patient was able to stay there after the procedure. (Respondent testimony).

Respondent testified that Dr. McCalla withdrew his concern about this case after learning that Respondent has a CRNA in his office. Respondent stated that Dr. McCalla admitted performing the same procedures in his own office practice. (Respondent testimony).

**Microwave thermotherapy and other complaints:** Dr. Mulholland discussed Respondent's frequent use of microwave thermotherapy rather than more traditional means of treatment. Dr. Mulholland testified that few urologists use microwave therapy as a first course of treatment; they typically use medication and monitoring to determine if the matter will resolve, and only proceed to microwave therapy if the condition worsens. He indicated that the reimbursement for microwave therapy is excellent, so the complaints might have been based on the belief that Respondent was seeking profit over patient care. Still, Dr. Mulholland did not find Respondent's use of microwave therapy to be outside the standard of care because each patient showed symptoms that could reasonably be treated with microwave therapy. (Exhibit 6; Mulholland testimony).

Dr. Stephen Wilson reviewed four of the urology cases discussed in the peer review report. Dr. Wilson stated that thermal therapy has been legal and ethical in this country since the late 1980's, and Respondent should not be criticized for advocating and using an accepted therapy. Dr. Wilson stated that Respondent has been a victim of persecution by physicians with the Iowa Clinic. He found the complaints to be trivial and would not warrant any finding of discipline. (Exhibit O).

Dr. Mulholland also discussed Respondent's use of sedation in his office versus a hospital setting. One of the physician complaints alleged that it was inappropriate to perform a certain procedure (in this case, a lithotripsy case discussed in exhibit 6, page 25) under general anesthesia in an office setting. Respondent provided documentation to show that he used sedation instead of general anesthesia, so Dr. Mulholland ultimately did not find a violation of the standard of care. However, Dr. Mulholland noted that most

urologists perform the procedure under general anesthesia, even though sedation is accepted. Dr. Mulholland further noted that Respondent had only referred two patients to the hospital, which is an unusually low number. Accordingly, even though Respondent's practice in this area was within the standard of care, it was not within the norm of most practitioners. (Exhibit 6; Mulholland testimony).

**PACE review:** Prior to the hearing, Respondent and Board staff agreed that he would undergo an evaluation at the Physician Assessment and Clinical Education Program (PACE) at the University of California at San Diego (UCSD). The evaluation was conducted in two phases in March and May of 2009. Phase I included two days of oral tests, written tests, chart reviews, and mock examinations. Phase I covered general surgery and urology. The urologist reviewer recommended a more complete clinical review on urology. Phase II consisted of a five day program in a clinical environment at the UCSD Medical Center. Phase II did not include a review of general surgery. The report states that Respondent told the program that his practice has been limited to urology since 2004. (Respondent testimony; Exhibit A).

PACE reported that Respondent's performance on Phase I was variable but satisfactory. His performance on Phase II was also satisfactory. Specifically, PACE reported that Respondent "has demonstrated sufficient medical knowledge and clinical skill to execute safe practice as an urologist." The program did not make any recommendations for further action. (Exhibit A).

### **CONCLUSIONS OF LAW**

**Regulatory framework:** The Board is a professional licensing board created to review applications for licenses and regulate the profession. *See generally* Iowa Code chapters 147, 148. The Board may discipline licensees pursuant to the standards set forth in the code. *See* Iowa Code section 147.55. The Board has adopted rules pursuant to Iowa Code chapter 17A to help define the statutory standards. *See* 653 IAC ch. 23.

The statement of charges sets forth two related counts. The first alleges that Respondent committed acts of professional incompetency in violation of 653 IAC 23.1(2)(c)-(f). Professional incompetency may be shown by any of the following:

- c.* A substantial lack of knowledge or ability to discharge professional obligations within the scope of the physician's or surgeon's practice;
- d.* A substantial deviation by the physician from the standards of learning or skill ordinarily possessed and applied by other physicians or surgeons in the state of Iowa acting in the same or similar circumstances;

e. A failure by a physician or surgeon to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician or surgeon in the state of Iowa acting in the same or similar circumstances;

f. A willful or repeated departure from or the failure to conform to the minimal standard of acceptable and prevailing practice of medicine and surgery or osteopathic medicine and surgery in the state of Iowa;

The second count alleges that Respondent engaged in practice harmful or detrimental to the public. 653 IAC 23.1(3). Practice harmful or detrimental to the public includes, but is not limited to, the failure of a physician to possess and exercise that degree of skill, learning and care expected of a reasonable, prudent physician acting in the same or similar circumstances in this state. The State has the burden to prove each count by a preponderance of the evidence. *See Eaves v. Iowa Board of Medical Examiners*, 467 N.W.2d 234 (Iowa 1991).

Respondent submitted considerable evidence questioning the motives of the complaining parties. However, the Panel noted that its responsibility is to determine whether Respondent violated the standard of care in his treatment of the patients in question without regard to the possible motives of the complainants. In considering the evidence, the Panel focused on undisputed evidence, unbiased medical opinions, and the medical records.

**Breast cancer cases:** The Panel considered the three breast cancer cases together (referred to in Dr. Caropreso's report as general surgery Case Nos. 1, 4, and 5). The central concern is whether Respondent should have performed surgical procedures when he could have used less invasive procedures, such as a stereotactic or sentinel node biopsy. The primary dispute concerns the availability of equipment to perform the procedure through less invasive means. In 2003-2004, some hospitals had the equipment and others did not. Clarke County Hospital did not. There were other hospitals in Des Moines that did. Respondent argued that he properly recommended surgery because the necessary equipment was not available at the hospital where the operation was performed.

The Panel noted that the standard of care is the same regardless of location where the care is provided in the State of Iowa. The Panel finds that Dr. Caropreso correctly stated that the standard of care is to perform less invasive procedures such as stereotactic biopsies over surgical biopsies. Respondent's experts, such as Drs. Kahn and Stanley, did not expressly disagree with that point. Rather, their opinions were based on the premise that the standard of care was dependent on the equipment available to Respondent at the location where he performed the surgery.

This case serves as a good example why the standard of care is the same regardless of the location where care is provided. Respondent's primary office practice is in West Des Moines. The hospitals in Des Moines had the necessary equipment available. If Respondent had privileges at the Des Moines hospitals and the patient had been referred there, the standard of care would have required Respondent to use the less invasive procedure. The Panel noted that none of the surgeries were emergent in nature, so there was no reason why the patient could not have been referred to a hospital with proper equipment available. The standard of care does not change simply because Respondent traveled from his West Des Moines office to a hospital 50 miles south.

Respondent testified with some level of pride how he brought surgery business to Clarke County that had previously been referred to other hospitals. He discussed the aggressive and successful means he used to attract patients. He also described the contentious relationship that he developed with competing physicians. This testimony raises questions whether Respondent, in the course of his quest to build his practice, put his own interests above the interests in using less invasive methods for patients. Respondent did not have access to the proper equipment in the Des Moines hospitals because he did not have privileges there. He would give up business if he referred patients to Des Moines. The Panel has concerns that Respondent allowed his own interests to get in the way of providing the best care for his patients.

The Panel finds a violation of standard of care in each of these three cases for failure to use less invasive forms of treatment, such as stereotactic or sentinel node biopsy, over the surgical procedures performed by Respondent.

**Other general surgery cases:** The Panel carefully reviewed the procedures performed in the other general surgery cases. After reviewing Respondent's explanations, documentation, and supporting opinions, the Panel concluded that Respondent did not violate the standard of care in Case Nos. 2, 3, 6, 7, or 8. This is not to say that improvement could not be made, but the procedures themselves were within the standard of care.

The Panel finds violations of the standard of care in two areas. The first is regarding use of antibiotics in Case Nos. 2 and 8. Dr. Caropreso correctly stated the standard of care that antibiotics should not be used more than 24 hours after surgery unless needed to treat an active infection. There was no evidence of active infections in the two cases cited. Respondent's use of antibiotics was not within the standard of care. The Panel does not find a violation of the standard of care as to Case No. 9, as there was an independent justification for the use antibiotics in light of the risk of respiratory infection.

The Panel also found a violation of standard of care in Case No. 9 regarding the lack of adequate documentation to demonstrate the means or manner in which he conducted the operation. The patient suffered complications which required an extended hospital stay. Dr. Caropreso correctly identified concerns with lack of documentation as to the instruments used, the manner which the procedure was performed, and whether Respondent utilized appropriate caution. Proper documentation is necessary to verify that correct procedures were followed. The Panel cannot find that Respondent followed correct procedures due to the inadequacy of Respondent's record-keeping. The Panel notes concerns regarding record-keeping in other cases, but this case was the most egregious example.

The Panel comments as to other allegations raised in the general surgery cases. Dr. Caropreso indicated that the surgeon should perform a preoperative history and physical for each patient. The Panel concluded that it is acceptable for a surgeon to rely the history and physical performed by a primary care physician for anesthesia purposes. However, the surgeon must carefully evaluate the patient to determine whether surgery is appropriate, including the risks, benefits and treatment options, for each patient. Regarding the use of drains, the Panel did not find a violation of standard of care in any of the cases. The Panel agrees with Dr. Caropreso that they were not needed, but do not find that the use of drains violated the standard of care. The Panel also agrees with Respondent that it is not necessary to conduct daily rounds in person in every case. It can be appropriate to check on the patient by telephone when the patient is recovering successfully and no complications arise.

**Urology cases:** The Panel finds one violation of the standard of care in the urology cases, regarding patient GH. The Panel agrees with Dr. Mulholland regarding violations of the standard of care in all aspects of the placement of the suprapubic catheter. As Dr. Mulholland summarized well, Respondent's attempt to place the catheter was doomed to fail from the beginning, and it did fail. The Panel also noted that Respondent's decision to perform the procedure under local anesthetic caused the patient unnecessary pain.

The Panel does not find violations in any of the other urology cases. Respondent was eventually able to provide documentation to satisfy members of the peer review committee. With regard to the urology Case No. 4, in which Dr. Mulholland held to his opinion of a violation of the standard of care, the Panel finds no violation. Respondent provided adequate explanation why he recommended that the patient be transferred from the hospital to his office, and he had adequate resources in his office to conduct the procedure. However, the Panel has serious concerns that the necessary documentation was not provided the Board and its peer reviewer until late in the discovery process in this case.

## SANCTION

The Panel's primary motive in considering a sanction is the protection of the public. The State argued that Respondent should be directed to attend an evaluation at the Center for Personalized Education for Physicians (CPEP). The State argued that the evaluation at PACE was inadequate. The Board has regularly uses CPEP as its evaluation center of choice. The State argued that CPEP can provide a more rigorous review that will provide better information regarding Respondent's competency.

Respondent argued that the PACE evaluation shows he is a safe and competent practitioner who does not require any further evaluation, restrictions, or monitoring. Respondent pointed out that the Board staff and attorney agreed to the PACE evaluation, and argued that it would be unfair to send him to another evaluation center simply because the State does not like the result.

The Panel agrees with Respondent regarding his urology office practice. Phase II of the PACE evaluation consisted of a five day clinical review of the practice of urology. The Board's peer review committee reviewed numerous urology cases, and the Panel ultimately found only one instance of a violation of standard of care. An additional intensive evaluation at CPEP is not warranted under the present facts.

The Panel agrees with the State's recommendation regarding Respondent's general surgery practice. Phase II of the PACE evaluation was focused on urology, not general surgery. The PACE report stated that Respondent represented that he has limited his practice to urology since 2004. The program may not have seen a need for a clinical evaluation for general surgery with its understanding that Respondent was not practicing in that area. The Panel has serious concerns that Respondent has not completed a detailed clinical evaluation for general surgery. In light of the Panel's findings of violations of standard of care on multiple issues involving multiple patients, the Panel finds that such a thorough evaluation is needed.

## DECISION AND ORDER

1. **CITATION AND WARNING:** Respondent is hereby **CITED** for engaging in professional incompetence and practice harmful and detrimental to the public in the practice of medicine. Respondent is hereby **WARNED** that such practice in the future may result in further disciplinary action, including suspension or revocation of his Iowa medical license.
2. **CIVIL PENALTY:** Respondent shall pay a civil penalty of \$5,000. The civil penalty shall be paid within thirty (30) days of the date of this Order and shall be paid by delivery of a check or money order, payable to the Treasurer of Iowa, to the executive director of the Board. The civil penalty shall be deposited in the State General Fund.

**3. RESTRICTION-GENERAL SURGERY:** Respondent is indefinitely prohibited from practicing general surgery unless and until he completes a comprehensive clinical competency evaluation in the area of general surgery at the Center for Personalized Education for Physicians (CPEP) in Denver, Colorado. Respondent shall not perform any hospital-based surgery or procedure until he has completed a CPEP evaluation and he has received written approval from the Board.

If Respondent completes a CPEP competency evaluation in general surgery, he shall ensure that a copy of the report is provided directly to the Board. If areas of need are identified, and it is recommended, Respondent shall submit, for Board approval, a formal educational plan which addresses all identified areas of need. Respondent shall fully comply with all recommendations made by CPEP and the Board following the evaluation, including any program of remediation. All costs associated with the evaluation shall be Respondent's responsibility. Respondent may file a formal request to ask the Board to remove the restriction after the report has been reviewed by the Board.

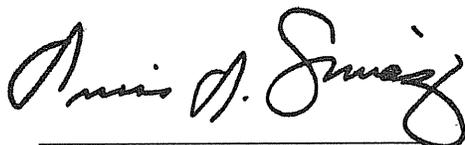
**4. OFFICE-BASED UROLOGY:** Respondent may continue to conduct an office-based urology practice without restriction. If Respondent chooses to limit his practice to office-based urology, there is no requirement that he complete the CPEP evaluation.

**5. MEDICAL RECORD KEEPING COURSE:** Respondent shall complete a course on medical records within 60 days of the date of this Order. Respondent shall provide written proof of completion to the Board within that same time period.

**6. LAWS AND RULES:** Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in Iowa. In the event Respondent violates or fails to comply with any of the terms or conditions of this Order the Board may initiate action to suspend or revoke the Respondent's Iowa medical license or to impose other license discipline as authorized by Iowa law.

**7. HEARING FEE:** Respondent shall pay a disciplinary hearing fee of \$75.00. Iowa Code section 272C.6(6); 653 IAC section 25.33(2). Respondent shall also pay any costs certified by the executive director. *See* 653 IAC 25.33(3). All sanctions, fees and costs shall be paid in the form of a check or money order payable to the State of Iowa and delivered to the Board within thirty days of the issuance of the final decision.

Dated this 10<sup>th</sup> day of March, 2010.



Siroos S. Shirazi, Chairman

Case No. 02-00-995, et al.

DIA No. 08DPHMB002

Page 21

cc: Theresa Weeg  
Assistant Attorney General

Michael Sellers  
Attorney for Respondent

Before the Iowa Board of Medicine

---

In the Matter of the Statement	)	File Nos. 02-00-995 et al.
of Charges Against:	)	DIA No. 08DPHMB002
	)	
Fawad S. Zafar, M.D.,	)	
	)	<b>ORDER ON REQUEST TO</b>
Respondent.	)	<b>RECONSIDER</b>

---

**ORDER**

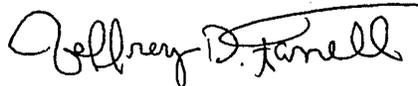
05-17-10P02:31 RCVD

On March 10, 2010, a panel (the panel) of the Iowa Board of Medicine (the board) issued a proposed decision regarding a statement of charges against respondent Fawad Zafar. On March 26, 2010, respondent filed an application to remand case for further proceedings. The board referred the motion and all associated filings to the undersigned administrative law judge to issue a decision. On April 16, 2010, I issued a decision denying the application.

On April 30, 2010, respondent filed a request for reconsideration of order on application to remand. The request largely consists of a request by the board to reconsider my order of April 16, 2010. However, the prayer includes a request that I reconsider my order and remand the matter to the panel, as previously requested in the application to remand.

The board referred the request to me to make a decision. To the extent the request seeks a decision at the administrative law judge level, the request must be denied. My order was entered pursuant to authority granted by 653 IAC 25.6. That decision is subject to review, but only by interlocutory appeal, as set out in 653 IAC 25.23. Interlocutory appeals must be decided by the board. There is no provision for an administrative law judge to reconsider his or her own order. The only provisions relating to reconsideration or rehearing are from a final decision of the board. Iowa Code section 17A.16(2); 653 IAC 25.26. Accordingly, respondent's only procedural remedy from my April 16, 2010 order, is an appeal to the board.

Dated this 14<sup>th</sup> day of May, 2010.



Jeffrey D. Farrell  
Administrative Law Judge

cc: IBM – Kent Nebel (Local mail)  
AGO – Theresa Weeg (Local mail)  
Atty – Michael Sellers (Regular mail)

Before the Iowa Board of Medicine

---

In the Matter of the Statement	)	File Nos. 02-00-995 et al.
of Charges Against:	)	DIA No. 08DPHMB002
	)	
Fawad S. Zafar, M.D.,	)	
	)	<b>ORDER ON APPLICATION</b>
Respondent.	)	<b>TO REMAND</b>

---

**STATEMENT OF THE CASE**

On March 10, 2010, a panel (the panel) of the Iowa Board of Medicine (the board) issued a proposed decision regarding a statement of charges against respondent Fawad Zafar. On March 26, 2010, respondent filed an application to remand case for further proceedings. Respondent wants the panel to: 1) consider a prepared transcript of the hearing, which was not available when the proposed decision was drafted, 2) review findings made regarding the PACE competency evaluation, 3) review findings regarding the "locality rule," and 4) review findings regarding the standard of care. Respondent also filed a protective notice of appeal in the event his application to remand is denied.

On April 6, 2010, the State filed a resistance to respondent's application to remand. The State argued that the board's rules only allow for an appeal of a proposed decision to the board. The State claimed there is no procedural mechanism to remand a case to the panel prior to consideration by the board. The State also filed a notice of cross-appeal.

Respondent filed a response. Respondent cited the board's rule authorizing the taking of additional evidence after a proposed decision. Respondent also cited the board's rule authorizing the board to remand a case to the original hearing panel for further hearing.

On April 16, 2010, the board referred all above-referenced items, with attachments, to the undersigned administrative law judge to make a decision. The board's rules allow pre-hearing matters to be decided by an ALJ on the board's behalf. 653 IAC 25.6.

**DISCUSSION**

The board has the option to assign a case to a panel of board members or hear the case as a final finder of fact. 653 IAC 25.24. If the case is heard by a panel, the panel shall issue a proposed decision including findings of fact, conclusions of law, and an order. The proposed decision shall be reviewed by the board within 30 days of its issuance. The decision becomes final unless appealed by one of the parties.

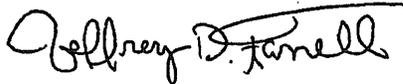
The board considers appeals of panel decisions based on the record made before the panel and additional arguments made by the parties. The parties may also file a request to present additional evidence. A request to present additional evidence will not be granted unless the proposed evidence is material, arose after the completion of the original hearing, and good cause exists for the failure to present the evidence. A request to present additional evidence must be filed with the notice of appeal. The board may preside over the hearing at which additional evidence is presented, or it may remand the case to the panel to take the additional evidence.

Respondent's application to remand is not authorized by these procedural rules. He may file an appeal, which he has done. However, there is no procedural mechanism for the case to be remanded directly to the panel unless done so by the board pursuant to a request to present additional evidence. No such request has been filed at this time. Further, respondent's application to remand does not seek to present additional evidence, and he does not make any showing that would meet the standards for presenting additional evidence. Rather, his application consists of arguments why the proposed decision should be modified or reversed. He can make those arguments during his appeal to the board.

**ORDER**

Respondent's application to remand case for further proceedings is denied.

Dated this 16<sup>th</sup> day of April, 2010.



Jeffrey D. Farrell  
Administrative Law Judge

cc: IBM – Kent Nebel (electronic mail)  
AGO – Theresa Weeg (electronic mail and LOCAL)  
Atty – Michael Sellers (electronic mail and regular mail)

Before the Iowa Board of Medicine

---

In the Matter of the Statement	)	File Nos. 02-00-995 et al.
of Charges Against:	)	DIA No. 08DPHMB002
	)	
Fawad S. Zafar, M.D.,	)	
	)	<b>ORDER ON MOTION</b>
Respondent.	)	<b>TO EXCLUDE</b>

---

**INTRODUCTION**

On October 23, 2009, the parties held a prehearing conference. Theresa Weeg represented the State. Mike Sellers represented respondent. The purpose of the prehearing conference was to help the parties prepare for hearing. At the conference, I offered to order any deadlines requested by the parties. They were continuing to conduct discovery and only asked for deadlines for exhibits and witnesses. The parties agreed to a final deadline of November 13, 2009. The other deadlines were preliminary and designed to help the parties agree to the admissibility of as many exhibits as possible so they could be provided to board members prior to the hearing.

Since the prehearing conference, I have had three conference calls with the parties to address questions of discovery and admissibility of evidence. Each conference was held before the November 13, 2009 deadline for exhibits and witnesses. During those calls, I reminded the parties that I would have set earlier deadlines if they had been requested, and the only deadlines imposed were based on the agreements made by the parties.

On November 16, 2009, the State filed a motion to exclude. The State seeks to exclude three doctors listed on respondent's witness list (Drs. Bokhari, Thompson, and Bess) because respondent has not provided expert witness reports. The State seeks to exclude Dr. Farley because he is not listed as a witness. The State seeks to limit the testimony of Dr. Mulcahy to the information contained in his report, which was filed by the November 13 deadline.

Also on November 16, 2009, respondent filed a resistance. Respondent argued that there is no rule or order that required him to provide written opinion documentation prior to the appearance of an expert witness. He added that he was not able to timely file expert witness reports because he only recently received the transcript of the deposition of the State's expert, which is the testimony he seeks to rebut.

## DISCUSSION

Parties to a contested case before the Board of Medicine have a right to request a prehearing conference. 653 IAC 25.15. The clear purpose of the prehearing conference is to consider matters that will help the parties prepare for the case and submit their evidence in a manner that will best serve their interests and the process as a whole. The topics of discussion at a prehearing conference may include entry of a scheduling order, stipulations of fact or law, stipulations as to the admissibility of evidence, and deadlines for exhibits and witnesses. The board may exclude any witness or exhibit not listed by an established deadline, absent good cause.

Respondent listed three witnesses, Drs. Bokhari, Thompson, and Bess by the witness deadline. I am sympathetic to the State with regard to its ability to effectively question those witnesses, but the State agreed to the deadlines. There are no legal grounds to exclude them as witnesses.

Respondent has not filed expert witness reports or written summaries regarding those witnesses. The exhibit deadline has now passed, so the respondent cannot now submit any reports as exhibits, absent agreement from the State. If offered, they shall be subject to an objection to exclude. Respondent does not have good cause for filing them after the deadline. It was his decision to conduct discovery late in the case, and that decision is the only cause for filing the reports late. I note that this ruling to exclude exhibits does not absolve respondent from any duty to supplement discovery requests previously made by the State.

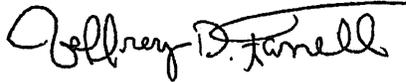
Respondent has not named Dr. Farley as a witness, and there is no indication from the resistance that he intends to call him now. If offered, he would be subject to an objection to exclude his testimony. However, Dr. Mulcahy is listed on the witness list and may testify. His testimony may be limited based on his expert witness report and responds to discovery requests made by the State. Any objections to his testimony will be considered at hearing.

Respondent's attorney stated in his resistance that he would make any offers of proof by calling the witness just as he would if the person was allowed to testify. Counsel should be mindful of 653 IAC 25.19(6), which requires offers of proof to be made by "briefly summarize[ing] the testimony[.]" He does not have the right to make an offer of proof by putting the witness on the stand in the same manner as if he was presenting admissible testimony.

**ORDER**

The motion to exclude is granted in part and denied in part. Any witness not listed by the November 13, 2009, deadline shall be excluded. Any exhibit not listed or produced by the deadline shall be excluded. Respondent shall comply with any responsibility to supplement discovery. Other evidentiary matters shall be considered at hearing.

Dated this 17<sup>th</sup> day of November, 2009.

A handwritten signature in black ink that reads "Jeffrey D. Farrell". The signature is written in a cursive style with a horizontal line above the name.

Jeffrey D. Farrell  
Administrative Law Judge

cc: (all by electronic mail)

IBM – Kent Nebel/Mark Bowdin  
AGO – Theresa Weeg/Jordan Esbrook  
Atty – Michael Sellers

Before the Iowa Board of Medicine

---

In the Matter of the Statement	)	File Nos. 02-00-995 et al.
of Charges Against:	)	DIA No. 08DPHMB002
	)	
Fawad S. Zafar, M.D.,	)	
	)	
Respondent.	)	<b>ORDER ON PREHEARING CONFERENCE</b>

---

On October 23, 2009, the parties held a prehearing conference. Theresa Weeg represented the State. Mike Sellers represented respondent. The following procedural agreements were reached.

**Amendments:** The parties did not request a deadline for amendments. In light of the time remaining for hearing, any amendments to the pleadings is strongly discouraged and will not be granted absent an agreement of the parties, or a showing of good cause and lack of prejudice.

**Discovery:** Mr. Sellers wants to conduct four additional depositions: Drs. Quinlan and Zagoran, as well as the two urologists the State plans to call at hearing. Mr. Sellers agreed to a two hour limit for each deposition. Ms. Weeg provided six available dates to Mr. Sellers, and stated that her co-counsel, Jordan Esbrook, might have other available dates. The parties agreed that the depositions will be completed by November 13, 2009.

**Exhibits and Witnesses:** The parties agreed it will be in their best interests, as well as the interests of the board members who hear the case, to provide exhibits to the board members prior to the hearing. To carry out this intent, the parties agreed to the following schedule:

November 3, 2009 – the parties will exchange preliminary exhibit lists;

November 6, 2009 – the parties will file preliminary exhibit and witness lists with the board; the parties will also attempt to electronically submit exhibits to the board, although some leave is granted to accommodate the large number of exhibits that may need to be downloaded;

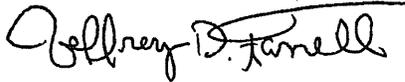
November 13, 2009 – final exhibit and witness lists, and any additional exhibits shall be filed with the board; no additional exhibits or witnesses will be considered at hearing unless listed and provided by the close of business on November 13.

**Final prehearing conference/motion hearing – optional:** I reserved hearing time at 1:30 p.m. on November 13, 2009, if the parties request a final prehearing conference or there any motions to consider prior to hearing. The parties shall email me if they wish to utilize that slot. The parties shall use the same conference code system for that hearing, if it occurs, as they used for this prehearing conference.

**ORDER**

The parties shall comply with all agreements and requirements set forth above.

Dated this 23<sup>rd</sup> day of October, 2009.



Jeffrey D. Farrell  
Administrative Law Judge

cc: (all by electronic mail)

IBM – Kent Nebel/Mark Bowdin  
AGO – Theresa Weeg/Jordan Esbrook  
Atty – Michael Sellers



BEFORE THE IOWA BOARD OF MEDICINE

---

	) DIA NO. 08DPHMB002
IN THE MATTER OF THE	) FILE NOS. 02-00-995, 02-04-107,
STATEMENT OF CHARGES AGAINST:	) 02-04-227, 02-05-289, 02-05-527,
	) 02-05-570, 02-06-403, 02-06-745
	)
FAWAD S. ZAFAR, M.D.	) <b>RULING ON REQUEST</b>
	) <b>FOR RECONSIDERATION OF</b>
Respondent	) <b>RULING, MOTION IN LIMINE</b>
	) <b>AND MOTION TO DISMISS</b>

---

The Respondent filed a Request for a Subpoena on July 14, 2009. The Medical Board and the Deponent filed written resistances to the subpoena. On August 10, 2009, the undersigned issued a ruling denying the subpoena.

The Respondent filed a Request for Reconsideration of Ruling, a Motion In Limine and Motion to Dismiss. The Deponent and the Medical Board filed resistances to the motions.

After a thorough review of the file and the motions and resistances, the undersigned hereby enters the following Order:

First, the Respondent in his request for the subpoena stated that "All counsel agreed, **on the record**, that the deposition would be continued at a later date, which fact was noted at the end of the deposition by the court reporter." As indicated in the ruling, there was no discussion on the record about the fact that the matter would be continued if it were not completed in the four hours allotted because of Dr. Anderson and Mr. Sellers' schedules.

The Respondent argues that "there is no requirement in the Iowa Rules of Civil Procedure that an agreement to continue a deposition at some later date is required to be of record." This is certainly true. However, the Respondent should not state that "All counsel agreed, **on the record**, that the deposition would be continued at a later date" when in fact that discussion was not on the record.

From the filings by all parties, it is clear that there were off-the record discussions and an understandings that the deposition would be continued if it were not

finished. The Respondent shall be allowed to depose Dr. Anderson for two additional hours. That is a reasonable amount of time for a person who is not going to be called as a witness.

Therefore, the previously entered ruling is RECONSIDERED. The Respondent's subpoena to require Markham Anderson, M.D., to submit to a deposition shall be GRANTED, however the continuation of the deposition shall be for no more than two hours.

The Respondent's Motion in Limine and Motion to Dismiss are DENIED.

Dated this 9th day of September, 2009.



John M. Priester  
Administrative Law Judge  
Iowa Department of Inspections and Appeals  
Administrative Hearings Division  
Wallace State Office Building-Third Floor  
Des Moines, Iowa 50319

For the Iowa Board of Medicine

cc: Theresa O'Connell Weeg  
Assistant Attorney General  
Hoover State Office Building  
Des Moines, Iowa 50319 (LOCAL)  
And by email: tweeg@ag.state.ia.us

Michael Sellers, Attorney for Respondent  
Sellers, Haraldson & Binford  
400 Locust Street, Suite 170  
Des Moines, IA 50309-2351  
And by email: sellers@shbiowalaw.com

Kent Nebel  
Director of Legal Affairs  
Iowa Board of Medical Examiners  
400 SW 8<sup>th</sup> St., Suite C  
Des Moines, Iowa (LOCAL)  
And by email: kent.nebel@iowa.gov

BEFORE THE IOWA BOARD OF MEDICINE

---

	) DIA NO. 08DPHMB002
IN THE MATTER OF THE	) FILE NOS. 02-00-995, 02-04-107,
STATEMENT OF CHARGES AGAINST:	) 02-04-227, 02-05-289, 02-05-527,
	) 02-05-570, 02-06-403, 02-06-745
	)
FAWAD S. ZAFAR, M.D.	) <b>RULING ON REQUEST</b>
	) <b>FOR EXTENSION</b>
Respondent	) <b>OF TIME</b>
	)

---

The Respondent filed a Request for Reconsideration of Ruling, Motion in Limine and Motion to Dismiss on August 12, 2009. Under the Iowa Rules of Civil Procedure the State was required to respond by August 25, 2009.

On August 19, 2009, the matter was to come on for a Pre-Hearing Conference to schedule a hearing date. Because the motions were pending the parties agreed that the Pre-Hearing Conference should be continued and reset at a later date.

The State filed a Request for Extension of Time to Respond to the Respondent's motions on August 28<sup>th</sup> 2009. The Respondent filed a Resistance to the Extension request on August 28<sup>th</sup> 2009. The resistance was based solely upon the timeliness of the request.

The undersigned finds that while the Request for an Extension of Time was filed untimely, the State will be granted the extension. The Pre-Hearing Conference has been continued. There is no hearing date presently set. Therefore there is no prejudice in allowing the State to file its responses to the motions by the close of business on September 4<sup>th</sup> 2009.

The Request for Extension of Time is therefore GRANTED.

Emailed this 1<sup>st</sup> day of September, 2009.

Mailed the 2<sup>nd</sup> day of September, 2009.



John M. Priester  
Administrative Law Judge  
Iowa Department of Inspections and Appeals  
Administrative Hearings Division  
Wallace State Office Building-Third Floor  
Des Moines, Iowa 50319

For the Iowa Board of Medicine

cc: Theresa O'Connell Weeg  
Assistant Attorney General  
Hoover State Office Building  
Des Moines, Iowa 50319 (LOCAL & EMAIL)  
And by email: tweeg@ag.state.ia.us

Michael Sellers, Attorney for Respondent  
Sellers, Haraldson & Binford  
400 Locust Street, Suite 170  
Des Moines, IA 50309-2351 (MAIL & EMAIL)  
And by email: sellers@shbiowalaw.com

Kent Nebel  
Director of Legal Affairs  
Iowa Board of Medical Examiners  
400 SW 8<sup>th</sup> St., Suite C  
Des Moines, Iowa (LOCAL & EMAIL)  
And by email: kent.nebel@iowa.gov

## BEFORE THE IOWA BOARD OF MEDICINE

---

	) DIA NO. 08DPHMB002
IN THE MATTER OF THE	) FILE NOS. 02-00-995, 02-04-107,
STATEMENT OF CHARGES AGAINST:	) 02-04-227, 02-05-289, 02-05-527,
	) 02-05-570, 02-06-403, 02-06-745
	)
FAWAD S. ZAFAR, M.D.	) <b>RULING ON REQUEST</b>
	) <b>FOR SUBPOENA/MOTION</b>
Respondent	) <b>TO QUASH SUBPOENA</b>
	)

---

The above-captioned matter is currently scheduled for a pre-hearing conference on August 19<sup>th</sup> 2009. On July 14, 2009, the Respondent filed a Request for Subpoena. The Board of Medicine filed a Motion to Quash Subpoena on July 29, 2009. The Deponent filed a Response to Request for Subpoena on July 29, 2009. The Board delegated ruling on the motion to the undersigned administrative law judge.

The Deponent, Markham Anderson, M.D., initially notified the Board of his concerns with the Respondent's practice of medicine in 2005. The Board investigated Dr. Anderson's concerns and found that the cases did not merit disciplinary action by the Board. However, during the investigation, other matters were discovered that are the basis of the instant disciplinary matter.

The Respondent sought to depose Dr. Anderson in the discovery phase of the disciplinary action. The parties all knew at the commencement of the deposition that the time was limited for the deposition. The deposition commenced at 1:29 p.m. on June 16, 2009 and ended at 4:12 p.m. Thus, the deposition lasted 2 hours and 42 minutes.

The Respondent filed his Request for Subpoena on July 14, 2009, requesting that Dr. Anderson continue his deposition and bring records with him for the deposition. The Respondent stated that "All counsel agreed, on the record, that the deposition would be continued at a later date, which fact was noted at the end of the deposition by the court reporter."

The deposition ends, beginning on page 120, with the following:

Mr. Kelinson: Again, I'll object to that question.

Mr. Sellers: At this point, you know, I'm not sure whether – I know we cannot finish today, so it's just a matter of we go another 15 minutes or so or just stop at this point. I think I would just as soon have him take a look at these records –

The Witness: Can we finish in 15 minutes?

Mr. Sellers: No --

Mr. Kelinson: Then let's break.

Mr. Seelers: -- no possibility. And I want to ask a question off the record. That's why I'm thinking.

(An off-the-record discussion was held.)

By Ms. Weeg:

Q. Doctor, I just have two questions. Have you ever met Dr. Zafar before meeting him at this deposition today?

A. I don't believe so.

Q. And my second question is that are you

(p. 121)

Currently or have you at anytime in the past four or five years, you or your group, agreed to provide emergency or any kind of call coverage for Dr. Zafar when he is not in town?

A. Yes.

Ms. Weeg: Thank you. I don't have anything else.

(An off-the-record discussion was held)

Redirect Examination

By Mr. Sellers:

Q. When you were asked by counsel for the State regarding call coverage for Dr. Zafar, what periods of time were you referring to that call coverage has been arranged?

A. I don't understand.

Q. Ms. Weeg asked you whether the Iowa Clinic has provided call coverage in the last four or five years. She said, have you ever agreed to do call coverage for Dr. Zafar, and you said yes. So I want to know what time period you were referring to when you answered that question?

A. Sometime in the last year we started. We said we would do it, and it's indefinitely.

(p. 122)

Q. So just recently that was arranged? I mean --

A. I can't tell when you.  
Q. But within the last year?  
A. Yes.  
Q. Not back when this was going on?  
A. No.  
Mr. Sellers: Thank you.  
(Deposition adjourned at 4:12 p.m.)

After reading the closing portions of the deposition, it is clear that there was no agreement, on the record, to continue this deposition at a later date. If there was an agreement, it was not on the record as the Respondent's counsel contends.

Thus, there being no agreement of the parties to reconvene this deposition, the rules governing discovery shall be guiding. Discovery procedures applicable in civil actions are applicable in contested cases. 653 IAC 25.12(2). Parties may generally obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action, whether it relates to a claim or defense of the party seeking discovery or a claim or defense of any other party. It is not grounds for objection that the information sought will be inadmissible at trial if the information sought appears reasonably calculated to lead to the discovery of admissible evidence. Rule 1.503(1), I.R.C.P.

In addition, Iowa Code section 272C.6(3) provides that subpoenas may be issued pursuant to the rules of the board on behalf of the board or on behalf of the licensee. A subpoena issued under the authority of a licensing board may compel the attendance of witnesses and the production of professional records, books papers, correspondence, and other records, whether or not privileged or confidential under law, which are deemed necessary as evidence in connection with a disciplinary proceeding. See also 653 IAC 25.13(1).

Dr. Anderson is not going to be called as a witness by the State. The State has made that clear. Thus, the question becomes must Dr. Anderson be subjected to further deposition, after already sitting for 2 hours and 42 minutes of questioning.

After reviewing the motions and the deposition, the undersigned finds that the further deposing of Dr. Anderson will not lead to any information that is relevant to the issues to be resolved in the contested case matter pending before the Board.

Dr. Anderson expressed his concern about six patients seen by the Respondent to the Board. The Board investigated those patients and did not find anything with respect to those patients that warranted disciplinary charges. However, other patients were found that warranted disciplinary charges. Dr. Anderson's testimony is not relevant to the cases that are the basis for the disciplinary action.

Thus, the Motion to Quash shall be GRANTED. The Respondent's request for attorney fees is DENIED.

Dated this 10th day of August, 2009.



John M. Priester  
Administrative Law Judge  
Iowa Department of Inspections and Appeals  
Administrative Hearings Division  
Wallace State Office Building-Third Floor  
Des Moines, Iowa 50319

For the Iowa Board of Medicine

cc: Theresa O'Connell Weeg  
Assistant Attorney General  
Hoover State Office Building  
Des Moines, Iowa 50319 (LOCAL)  
And by email: [tweeg@ag.state.ia.us](mailto:tweeg@ag.state.ia.us)

Michael Sellers, Attorney for Respondent  
Sellers, Haraldson & Binford  
400 Locust Street, Suite 170  
Des Moines, IA 50309-2351  
And by email: [sellers@shbiowalaw.com](mailto:sellers@shbiowalaw.com)

Kent Nebel  
Director of Legal Affairs  
Iowa Board of Medical Examiners  
400 SW 8<sup>th</sup> St., Suite C  
Des Moines, Iowa (LOCAL)  
And by email: [kent.nebel@iowa.gov](mailto:kent.nebel@iowa.gov)

BEFORE THE IOWA BOARD OF MEDICINE

---

IN THE MATTER OF THE	)	DIA NO. 08DPHMB002
STATEMENT OF CHARGES AGAINST:	)	CASE NO.02-00-995,02-04-107
	)	02-04-227,02-05-289
	)	02-05-527,02-05-570
FAWAD S. ZAFAR, M.D.	)	02-06-403,02-06-745
	)	
	)	ORDER FOR PREHEARING
Respondent	)	CONFERENCE

---

Pursuant to the state's request and agreement of the parties, a telephone prehearing conference will be held on **Wednesday, August 19, 2009 at 2:00 p.m.** Please follow the instructions listed below to call in for the prehearing:

**At the date and time scheduled for prehearing, you must do the following:**

- Call 1-866-685-1580
- When prompted, enter the following Conference Code Number: **0009991671** (press # after entering the number)
- The system will ask if you are the leader. **YOU ARE NOT -- DO NOT PRESS THE \* KEY**
- The system will ask you to state your first and last name
- You will be put on hold until the judge enters the conference call; stay on the line until the judge enters the call.

**Important information about participating in the prehearing:**

- You may call in as early as five minutes before your prehearing is scheduled to begin.
- The judge will wait five minutes after the time the prehearing is scheduled to start to allow all parties to call in. If you have not called in by five minutes after the hearing is scheduled to start, the judge may proceed without you.
- **If you have any technical difficulties connecting at the time of the prehearing, please call Karla at (515)281-6468 and ask her to alert the administrative law judge.**

Dated this 27th day of July, 2009.

*Margaret LaMarche*

Margaret LaMarche  
Administrative Law Judge  
Iowa Department of Inspections and Appeals  
Administrative Hearings Division  
Wallace State Office Building-Third Floor  
Des Moines, Iowa 50319

For the Iowa Board of Medicine

cc: Theresa O'Connell Weeg  
Assistant Attorney General  
Hoover State Office Building  
Des Moines, Iowa 50319 (LOCAL)

Michael Sellers  
Sellers, Haraldson & Binford  
400 Locust Street, Suite 170  
Des Moines, Iowa 50309-2351

Kent Nebel  
Director of Legal Affairs  
Iowa Board of Medical Examiners  
400 SW 8<sup>th</sup> St., Suite C  
Des Moines, Iowa (LOCAL)

**BEFORE THE IOWA BOARD OF MEDICINE**

\*\*\*\*\*

**IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST**

**FAWAD S. ZAFAR, M.D., RESPONDENT**

**FILE Nos. 02-00-995, 02-04-107, 02-04-227,**

**02-05-289, 02-05-527, 02-05-570, 02-06-403 & 02-06-745**

\*\*\*\*\*

**STATEMENT OF CHARGES**

\*\*\*\*\*

**COMES NOW** the Iowa Board of Medicine on January 17, 2008, and files this Statement of Charges pursuant to Iowa Code section 17A.12(2)(2007). Respondent was issued Iowa medical license no. 30827 on September 19, 1995. Respondent's Iowa medical license is active and will next expire on June 1, 2009.

**A. TIME, PLACE AND NATURE OF HEARING**

1. Hearing. A disciplinary contested case hearing shall be held on February 28, 2008, before the Board. The hearing shall begin at 8:30 a.m. and shall be located in the conference room at the Board office at 400 SW 8<sup>th</sup> Street, Suite C, Des Moines, Iowa.

2. Answer. Within twenty (20) days of the date you are served this Statement of Charges you are required by 653 IAC 24.2(5)(d) to file an Answer. In that Answer, you should state whether you will require a continuance of the date and time of the hearing.

3. Presiding Officer. The Board shall serve as presiding officer, but the Board may request an Administrative Law Judge make initial rulings on prehearing matters, and be present to assist and advise the board at hearing.

4. Hearing Procedures. The procedural rules governing the conduct of the hearing are found at 653 IAC 25. At hearing, you will be allowed the opportunity to respond to the charges against you, to produce evidence on your behalf, cross-examine witnesses, and examine any documents introduced at hearing. You may appear personally or be represented by counsel at your own expense. If you need to request an alternative time or date for hearing, you must review the requirements in 653 IAC 25.16. The hearing may be open or closed to the public at the discretion of the Respondent.

5. Prosecution. The office of the Attorney General is responsible for representing the public interest (the State) in this proceeding. Pleadings shall be filed with the Board and copies should be provided to counsel for the State at the following address: Theresa O'Connell Weeg, Assistant Attorney General, Iowa Attorney General's Office, 2<sup>nd</sup> Floor, Hoover State Office Building, Des Moines, Iowa 50319.

6. Communications. You may not contact board members by phone, letter, facsimile, e-mail, or in person about this matter. Board members may only receive information about the case when all parties have notice and an opportunity to participate, such as at the hearing or in pleadings you file with the Board office and serve upon all parties in the case. You should direct any questions to Kent M. Nebel, J.D., Legal Director at 515-281-7088 or to Assistant Attorney General Theresa O'Connell Weeg at 515-281-6858.

## **B. LEGAL AUTHORITY AND JURISDICTION**

7. Jurisdiction. The Board has jurisdiction in this matter pursuant to Iowa Code chapters 17A, 147, 148, and 272C.

8. Legal Authority: If any of the allegations against you are founded, the Board has authority to take disciplinary action against you under Iowa Code chapters 17A, 147, 148, and 272C and 653 IAC 25.

9. Default. If you fail to appear at the hearing, the Board may enter a default decision or proceed with the hearing and render a decision in your absence, in accordance with Iowa Code section 17A.12(3) and 653 IAC 25.20.

## **C. SECTIONS OF STATUTES AND RULES INVOLVED**

### **COUNT I**

10. Respondent is charged with professional incompetency pursuant to Iowa Code sections 147.55(2), 148.6(2)(g) and (i), and 272C.10(2), and 653 IAC 23.1(2)(c), (d), (e), and (f) by demonstrating one or more of the following:

- A. A substantial lack of knowledge or ability to discharge professional obligations within the scope of the physician's or surgeon's practice;
- B. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other physicians or surgeons in the state of Iowa acting in the same or similar circumstances;

- C. A failure by a physician or surgeon to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician or surgeon in the state of Iowa acting in the same or similar circumstances; and
- D. A willful or repeated departure from, or the failure to conform to, the minimal standard of acceptable and prevailing practice of medicine and surgery in the state of Iowa.

## **COUNT II**

11. Respondent is charged under Iowa Code section 147.55(3) and 653 IAC 23.1(3) with engaging in practice harmful or detrimental to the public.

### **D. STATEMENT OF MATTERS ASSERTED**

12. Respondent practices urology and surgery in West Des Moines and Osceola, Iowa.

13. The Board alleges that Respondent has demonstrated a pattern of professional incompetency and practice harmful or detrimental to the public in the practice of medicine and surgery by:

- A. Failing to exercise appropriate judgment in the practice of urology, urologic surgery and general surgery;
- B. Failing to demonstrate the necessary education, training and experience in the practice of urology, urologic surgery and general surgery;

- C. Failing to perform proper preoperative evaluations;
- D. Failing to provide proper surgical treatment;
- E. Failing to provide proper postoperative management;
- F. Failing to maintain appropriate medical records;
- G. Failing to provide proper follow-up with patients;
- H. Failing to demonstrate proper communication with nursing staff and other healthcare providers;
- I. Failing to properly manage incontinence;
- J. Improper placement of suprapubic tubes;
- K. Inappropriately performing an extensive surgical procedure without proper cardiac clearance;
- L. Inappropriately transferring a patient from the hospital to perform an extensive surgical procedure in an office setting;
- M. Excessive use of microwave therapy, an expensive office procedure with excellent insurance reimbursement; and/or
- N. Inappropriately recommending expensive surgical procedures rather than more conservative therapy with lower reimbursement.

14. The Board continues to receive new complaints that raise serious concerns that Respondent continues to engage in a pattern of professional incompetency and practice harmful or detrimental to the public in the practice of medicine and surgery.

### **E. SETTLEMENT**

15. Settlement. This matter may be resolved by settlement agreement. The procedural rules governing the Board's settlement process are found at 653 IAC 25. If you are interested in pursuing settlement of this matter, please contact Kent M. Nebel, J.D., Legal Director at 515-281-7088.

### **F. PROBABLE CAUSE FINDING**

16. On January 17, 2008, the Iowa Board of Medicine found probable cause to file this Statement of Charges.



---

Yasyn Lee, M.D., Chairperson  
Iowa Board of Medicine  
400 SW 8<sup>th</sup> Street, Suite C  
Des Moines, Iowa 50309-4686