BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of	Case No. MD-17-0973A
JOHN D. MARSHALL, M.D. Holder of License No. 10961 For the Practice of Allopathic Medicine In the State of Arizona.	**FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR LETTER OF REPRIMAND**

The Arizona Medical Board ("Board") considered this matter at its public meeting on August 5, 2020. John D. Marshall, M.D. ("Respondent"), appeared with legal counsel, Steve Myers, Esq., before the Board for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order for Letter of Reprimand after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

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

2. Respondent is the holder of license number 10961 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-17-0973A after receiving notification of a malpractice settlement regarding Respondent's care and treatment of a 51 year-old male patient ("EC") alleging failure to diagnose a lung mass.

4. On July 30, 2013, Respondent performed a comprehensive adult wellness examination of EC. EC's chest x-ray showed findings of increased linear stranding consistent with fibrotic changes/scarring from prior inflammation in the right upper lobe ("RUL"). Respondent's note did not include any reference to the findings.

5. On August 17, 2013, Respondent provided EC with the results of genetic testing that showed an increased risk of lung cancer.

6. EC continued to see Respondent for primary care services. On February 19, 2016, EC presented to Respondent with complaints of cough and cold symptoms. A chest x-ray was performed which read "RUL hyperdensity versus infiltrate with cavitary lesion." The radiologist report read "irregular rounded nodular density measuring approximately 2.5 cm in diameter in the right pulmonary upper lobe. A CT scan was recommended for further evaluation.

7. On March 16, 2016, a CT scan showed a "large spiculated right upper lobe lung mass measuring 3.5x5.0x5.0cm with associated traction bronchiectasis on the right upper lobe bronchus and the mass appears to track along the upper lobe bronchus approaching the hilum. Interstitial thickening extends to the pleural surface. Findings are consistent with neoplasm." A subsequent biopsy of the lesion revealed a moderately differentiated pulmonary adenocarcinoma and 17 positive lymph nodes. EC underwent treatment with chemotherapy and radiotherapy.

8. The standard of care requires a physician to diagnose and treat neoplasm of the lung. Respondent deviated from this standard of care by failing to diagnose and treat neoplasm of the lung.

9. The standard of care requires a physician to evaluate and address patient health complaints. Respondent deviated from this standard of care by failing to appropriately evaluate and address EC's health complaints.

10. The standard of care requires a physician to perform an appropriate work up of an abnormal chest x-ray. Respondent deviated from this standard of care by failing to perform an appropriate work up of EC's abnormal chest x-ray.

11. Actual patient harm was identified in that there was a delay in the actual diagnosis and treatment resulting in additional and extended treatment of the patient. There was the potential for patient harm including long-term disability and death.

12. During a Formal Interview on this matter, Respondent testified regarding his treatment of EC. Respondent testified that he no longer performs x-rays in his office. Respondent also testified regarding prior advisory letters issued to him by the Board, and a prior malpractice settlement which resulted in an advisory letter in 1996 for failure to identify a neoplasm in a patient's lung. Respondent stated that with regard to the care rendered to EC, the patient did not display any worsening of symptoms that could be considered cancer related in the time period after the x-ray. In response to a Board member's question regarding why he did not respond to the genetic testing, Respondent noted that the test was later taken off the market. Respondent additionally noted that the patient was difficult and did not like imaging. Respondent did note that the patient's refusal to complete the 2014 x-ray was not adequately documented, and discussed completing medical recordkeeping continuing medical education.

13. During that same Formal Interview, Board members commented that although the Respondent testified regarding prior advisory letters, the existence of those letters did not bear on the question of whether unprofessional conduct was committed in regard to EC's care. Board members also noted that the genetic testing results were consistent with the abnormal chest x-ray finding. During deliberations regarding whether unprofessional conduct had been established, one Board member stated that the essence of the case was an avoidable delay in diagnosing EC's cancer. Board members agreed that Respondent should have followed up on the abnormal x-ray, and if EC declined the follow-up x-ray, Respondent should have better documented the interaction.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("Failing or refusing to maintain adequate records on a patient.").

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(r) ("Committing any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED AND EFFECTIVE this 9th day of October, 2020.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed this 9th day of October, 2020 to:

Steve Myers, Esq.
Mitchell Stein Carey Chapman, PC
One Renaissance Square
2 North Central Avenue, Suite 1450
Phoenix, AZ 85004
Attorney for Respondent

ORIGINAL of the foregoing filed this 9th day of October, 2019 with:

Arizona Medical Board
1740 West Adams, Suite 4000
Phoenix, Arizona 85007

Michelle Rogers
Board staff