BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **IRFAN MIRZA, M.D.** Holder of License No. 28306 For the Practice of Allopathic Medicine In the State of Arizona.	**Case No. MD-18-1183A, MD-20-0310A, MD-21-0358A, MD-22-0789A** **INTERIM CONSENT AGREEMENT FOR PRACTICE RESTRICTION**

INTERIM CONSENT AGREEMENT

Irfan Mirza, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Interim Consent Agreement for Practice Restriction but not with respect to any Board action related to the underlying allegations and consents to the entry of this Order by the Arizona Medical Board ("Board").

INTERIM 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 No. 28306 for the practice of allopathic medicine in the State of Arizona.

MD-18-1183A

3. The Board initiated case number MD-18-1183A after receiving notification from a Regional Hospital that Respondent's privileges voted to continue a summary suspension on November 15, 2018 during an investigation regarding alleged violations of the standard of care and other professional conduct issues including inappropriate supervision of a scribe, as well as falsification of documentation and billing.

4. Based on the Regional Hospital's report, Board staff requested Medical Consultant ("MC") review of Respondent's care and treatment of three patients (JJ, TM and JG).

5. JJ was a 49 year-old male that presented to the Regional Hospital with an acute inferolateral myocardial infarct ("MI"). JJ was hypotensive, bradycardic, had ECG changes, and his troponin was elevated. JJ was taken to the catheterization lab by Respondent and was found to have severe disease with total occlusion of the right coronary artery ("RCA") and left anterior descending ("LAD") artery. Respondent noted an ejection fraction of 15-20%, poor hemodynamic status, and determined that JJ was not stable enough for transport. During the procedure, JJ went into cardiogenic shock, and required pressure support with Levophed, a temporary pacemaker, and an urgent cardioversion from atrial fibrillation. Respondent performed an RCA percutaneous transluminal coronary angioplasty ("PTCA") and stent. JJ was transferred to the ICU. Respondent's plan was to bring him back to the lab for further intervention. Respondent placed an intra-aortic balloon pump ("IABP") and the RCA was found to be reoccluded. JJ was intubated on return to the ICU and transferred to a higher level of care for surgery or transplant.

6. TM was an obese 65 year-old male who presented to the Regional Hospital with an acute inferolateral MI and cardiogenic shock. In the cath lab TM was found to have 100% occlusion of the RCA, 90% occlusion in the LAD, and an ulcerated plaque-like lesion in the left circumflex artery ("CX") that was significant. There was thrombus in the RCA and this was the culprit stenosis. Respondent opened and stented the RCA. Respondent proceeded with the CX stenosis and then the LAD because TM was hemodynamically unstable and still experiencing chest pain. While addressing the

occlusion in the LAD, Respondent perforated the vessel. Despite efforts to resolve the perforation including covered stents, TM expired.

7. JG was a female patient with end-stage renal disease, cardiomyopathy, and an ejection fraction of 20% with severe CAD who presented with weakness and had an implantable cardioverter-defibrillator placed and was discharged the next day. The day after discharge JG passed out at hemodialysis and was transferred to the Regional Hospital. A chest x-ray showed no pneumothorax. JG had significant thrombocytopenia evidence of congestive heart failure and marked bruising. A repeat chest x-ray showed a large left sided pneumothorax. A second chest x-ray confirmed the pneumothorax and Respondent was notified of the findings by a nurse. In the morning, another chest x-ray was performed that showed the same findings and a chest tube was place by Respondent. TM was having issues with oxygenation. JG was receiving dialysis when she went into VT/V fib and cardiac arrest. Resuscitative attempts were unsuccessful.

8. The MC identified deviations from the standard of care for all patients, including failure to timely implement the placement of an IABP or Impella device in a patient experiencing a cardiac event, failure to initiate a transfer to a higher level of care in a timely manner for a patient experiencing a cardiac event and failure to timely insert a chest tube in a patient with a pneumothorax.

9. The Board alleges was actual and potential harm identified in that Patient TM expired, Patient JJ was at risk of respiratory distress, cardiac instability and death, and the MC found that the delay in placement of JG's chest tube may have contributed to the patient's demise.

10. Respondent denies that he deviated from the standard of care for patients JJ, TM and JG.

MD-20-0310A

11. The Board initiated case number MD-20-0310A after receiving a complaint regarding Respondent's care and treatment of a 76 year-old male patient ("CW") alleging failure to perform an electrical cardioversion, failure to adequately treat, premature discharge, and inadequate care and treatment. Based on the complaint, Board staff requested MC review of Respondent's care and treatment of CW.

12. On June 26, 2019, CW presented to Respondent's office for an initial consultation for CAD and cardiomyopathy. Respondent recommended a cardiac catheterization.

13. On July 18, 2019, Respondent performed a cardiac catheterization with stents for CW. During the procedure, Respondent noted CW had an atrial flutter and prescribed CW aspirin and Brilinta.

14. Respondent continued managing CW's care post-operatively through October, 2019 when he performed an in office cardioversion for CW with Versed 2mg and Fentanyl 100mcg. At a follow-up the next day, Respondent noted that CW was in sinus rhythm.

15. On October 6, 2019, CW presented to the Regional Hospital via EMS after being "found down" for unknown duration. CW was in hypercapnic respiratory failure and atrial flutter on admission. A brain CT showed evidence of a parietal stroke. CW was intubated and transferred to the ICU. CW had a prolonged hospitalization with respiratory failure and recurrent issues with atrial flutter.

16. The Board's MC opined that Respondent deviated from the standard of care for CW by failing to initiate anticoagulants timely and at the appropriate dosage for CW's newly diagnosed atrial flutter.

17. The MC opined that there was actual patient harm in that CW experienced respiratory failure and stroke.

18. Respondent denies that he deviated from the standard of care regarding his treatment of CW.

MD-21-0358A

19. The Board initiated case number MD-21-0358A after receiving a complaint from patient ("DW") alleging that Respondent entered a false and/or inaccurate medical history, refused to amend medical records, charged a fee for services not rendered, obtained a fee by fraud, deceit, or misrepresentation, and made a false statement in the practice of medicine.

20. Respondent previously treated DW on one occasion in 2014 in Respondent's office as a follow-up appointment to an emergency room visit. DW received a Medicare co-pay bill for a visit to Respondent's office on August 21, 2020. Respondent reported that a Nurse Practitioner in his office saw DW, and Respondent subsequently submitted a corrected claim to Medicare.

21. CS was employed by Respondent as a student observer between September-November, 2017 at the Regional Hospital and was subsequently approved to observe Respondent in the catheterization lab. On March 13, 2018 CS became Respondent's scribe. CS was subsequently terminated by the December 5, 2018 due to numerous issues, including writing discharge prescriptions for a patient and assisting in the performance of a paracenteses when Respondent was not in the surgical room.

22. Respondent disputes the findings of the Regional Hospital's investigation.

MD-22-0789A

23. The Board initiated case number MD-22-0789A after receiving notification that Respondent failed to obtain a passing grade on the Professional/Problem-Based

Ethics ("ProBE") program for Ethics and Boundaries offered by the Center for Personalized Education for Physicians ("CPEP") as ordered by the Board.

24. Respondent was issued an Order for Letter of Reprimand and Probation; and Consent to Same in MD-14-1195A ("Prior Order"). The Prior Order included a requirement that Respondent take and successfully pass the CPEP ProBE course.

25. On August 9, 2022, CPEP notified the Board that Respondent failed the ProBE course. CPEP noted that Respondent participated appropriately during the program, but failed the final essay.

26. The aforementioned information was presented to the investigative staff, the medical consultant and the lead Board member. All reviewed the information and concur that the interim consent agreement to restrict Respondent's practice is appropriate.

27. The investigation into this matter is pending and will be forwarded to the Board promptly upon completion for review and action.

INTERIM CONCLUSIONS OF LAW

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

2. Pursuant to A.R.S. § 32-1405(C)(25) the Executive Director has authority to enter into a consent agreement when there is evidence of danger to the public health and safety.

3. Pursuant to A.A.C. R4-16-504, the Executive Director may enter into an interim consent agreement when there is evidence that a restriction is needed to mitigate danger to the public's health and safety. Investigative staff, the Board's medical consultant and the lead Board member have reviewed the case and concur that an interim consent agreement is appropriate.

INTERIM ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is prohibited from engaging in the practice of medicine in the State of Arizona as set forth in A.R.S. § 32-1401(22) until Respondent applies to the Executive Director and receives permission to do so.

2. Respondent may request, in writing, release and/or modification of this Interim Consent Agreement. Respondent's request must be accompanied by information demonstrating that Respondent is safe to practice medicine. The Executive Director, in consultation with and agreement of the lead Board member and the Chief Medical Consultant, has the discretion to determine whether it is appropriate to release Respondent from this Interim Consent Agreement.

3. The Board retains jurisdiction and may initiate new action based upon any violation of this Interim Consent Agreement, including, but not limited to, summarily suspending Respondent's license.

4. Because this is an Interim Consent Agreement and not a final decision by the Board regarding the pending investigation, it is subject to further consideration by the Board. Once the investigation is complete, it will be promptly provided to the Board for its review and appropriate action.

5. Following completion of the Board's investigation and Board review of same, Respondent reserves his right to request a formal hearing pursuant to A.R.S. §§ 32-1451 and 41-1092.01.

5. This Interim Consent Agreement shall be effective on the date signed by the Board's Executive Director.

DATED this 2nd day of February, 2023.

ARIZONA MEDICAL BOARD

By Kristina Jensen for
Patricia E. McSorley
Executive Director

RECITALS

Respondent understands and agrees that:

1. The Board, through its Executive Director, may adopt this Interim Consent Agreement, or any part thereof, pursuant to A.R.S. § 32-1405(C)(25) and A.A.C. R4-16-504.

2. Respondent has read and understands this Interim Consent Agreement as set forth herein, and has had the opportunity to discuss this Interim Consent Agreement with an attorney or has waived the opportunity to discuss this Interim Consent Agreement with an attorney. Respondent voluntarily enters into this Interim Consent Agreement and by doing so agrees to abide by all of its terms and conditions.

3. By entering into this Interim Consent Agreement, Respondent freely and voluntarily relinquishes all rights to an administrative hearing on the matters set forth herein, as well as all rights of rehearing, review, reconsideration, appeal, judicial review or any other administrative and/or judicial action, concerning the matters related to the Interim Consent Agreement.

4. Respondent understands that this Interim Consent Agreement does not constitute a dismissal or resolution of this matter or any matters that may be currently

pending before the Board and does not constitute any waiver, express or implied, of the Board's statutory authority or jurisdiction regarding this or any other pending or future investigations, actions, or proceedings. Respondent also understands that acceptance of this Interim Consent Agreement does not preclude any other agency, subdivision, or officer of this State from instituting civil or criminal proceedings with respect to the conduct that is the subject of this Interim Consent Agreement. Respondent further does not relinquish Respondent's rights to an administrative hearing, rehearing, review, reconsideration, judicial review or any other administrative and/or judicial action, concerning the matters related to a final disposition of this matter, unless Respondent affirmatively does so as part of the final resolution of this matter.

5. Respondent acknowledges and agrees that upon signing this Interim Consent Agreement and returning it to the Board's Executive Director, Respondent may not revoke Respondent's acceptance of this Interim Consent Agreement or make any modifications to it. Any modification of this original document is ineffective and void unless mutually approved by the parties in writing.

6. Respondent understands that this Interim Consent Agreement shall not become effective unless and until it is signed by the Board's Executive Director.

7. Respondent understands and agrees that if the Board's Executive Director does not adopt this Interim Consent Agreement, Respondent will not assert in any future proceedings that the Board's consideration of this Interim Consent Agreement constitutes bias, prejudice, prejudgment, or other similar defense.

8. Respondent understands that this Interim Consent Agreement is a public record that may be publicly disseminated as a formal action of the Board, and that it shall be reported as required by law to the National Practitioner Data Bank.

9. Respondent understands that this Interim Consent Agreement does not alleviate Respondent's responsibility to comply with the applicable license-renewal statutes and rules. If this Interim Consent Agreement remains in effect at the time Respondent's allopathic medical license comes up for renewal, Respondent must renew the license if Respondent wishes to retain the license. If Respondent elects not to renew the license as prescribed by statute and rule, Respondent's license will not expire but rather, by operation of law (A.R.S. § 32-3202), become suspended until the Board takes final action in this matter. Once the Board takes final action, in order for Respondent to be licensed in the future, Respondent must submit a new application for licensure and meet all of the requirements set forth in the statutes and rules at that time.

10. Respondent understands that any violation of this Interim Consent Agreement constitutes unprofessional conduct under A.R.S. § 32-1401(27)(s) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter.").

IRFAN MIRZA, M.D.

DATED: January 31st 2023

EXECUTED COPY of the foregoing e-mailed
this 2nd day of February, 2023 to:

Maria Nutile, Esq.
Nutile Law and Associates
7395 South Pecos Road, Suite 103
Las Vegas, Nevada 89120
Attorney for Respondent

ORIGINAL of the foregoing filed
this 2nd day of February, 2023 with:

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

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Board staff