BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of: **CHARLES E. KELLY, M.D.** Holder of License No. 42668 For the Practice of Allopathic Medicine In the State of Arizona,	Case No: 24A-42688-MDX **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER (Decree of Censure and Probation)**

On September 4, 2024, this matter came before the Arizona Medical Board ("Board") for consideration of Administrative Law Judge ("ALJ") Tammy L. Eigenheer's proposed Findings of Fact, Conclusions of Law and Recommended Order. Charles E. Kelly, M.D., ("Respondent") appeared telephonically represented by his counsel, Sara Stark; Assistant Attorney General Seth T. Hargraves represented the State. Assistant Attorney General Lynette Evans was available to provide independent legal advice to the Board.

The Board, having considered the ALJ's Decision and the entire record in this matter, hereby issues the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. The Arizona Medical Board (Board) is the authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Charles E. Kelly, M.D., (Respondent) is the holder of License No. 42688 for the practice of allopathic medicine in Arizona.

MD-20-0379A

3. On or about May 8, 2020, the Board initiated case number MD-20-0379A after receiving a complaint from Patient LC alleging that Respondent performed an

inappropriate rectal examination by touching her butt cheeks and breasts and failed to provide a suitable chaperone.

4. LC reported that she went to Respondent with complaints of abdominal pain and diverticulitis symptoms. LC stated that Respondent's MA was present for the examination. LC reported that, as he listened to LC's heart, Respondent bumped his hand against her breasts and nipples and moved his hands around acting as if he could not hear her heartbeat. He then completed a rectal exam. LC noted the rectal exam seemed to last longer than it should have. Afterward, LC reported that Respondent spread apart her butt cheeks and wiped her off everywhere spending more time than needed.

5. Respondent's prior Board history included a complaint from Patient PM in 2011 with similar allegations of an inappropriate examination[1]. PM alleged Respondent performed of an unnecessary rectal examination when her only request for appointment was bloodwork. Additionally, PM alleged Respondent placed the stethoscope on her breast instead of chest to listen to her heart. PM indicated Respondent wiped her buttocks off at the end of the exam and did not offer to let her clean herself.

6. During the investigation of LC's complaint, Patient CP alleged that Respondent inappropriately rubbed his crotch on her during an examination.

7. CP reported to Board staff that she went to Respondent for treatment regarding cirrhosis of the liver. CP alleged that, during the examination, Respondent brushed his crotch up against her arm. CP reported that she moved her arm to give him space. Initially, CP thought it was an accident until Respondent did it again when he examined her stomach.

[1] Respondent denied the allegations, and since there was not a third-party present to observe the examination, the case was administratively closed.

MD-20-0897A

8. On or about October 26th, 2020, the Board initiated case number MD-20-0897A after receipt of a complaint from patient RA alleging that Respondent engaged in verbal conduct and physical contact of a sexual nature during a procedure, sexually molested her after performing a procedure, inappropriately touched of her vagina and anus, and failed to properly perform a colonoscopy.

9. RA told Board staff that Respondent engaged in an inappropriate verbal conversation with her as he was putting her under sedation for a colonoscopy. The complaint alleged that prior to being sedated for an endoscopy and colonoscopy, Respondent responded in a manner that reflected sexual innuendo after he instructed her to "open wide," and that he made reference to sending a hamster named "Nibbles" into her rectum--- alluding to the infamous rumor about Richard Gere. RA stated that she awoke prior to the end of the procedure, unable to move, but with the ability to hear and feel what was going on around her. RA reported that she woke up and heard Respondent talking to his assistant about how her hemorrhoids looked like “a little dude.” After the inappropriate commentary, RA explained she felt Respondent’s fingers (at least two) insert into and out of her vagina twice, he then rubbed her clitoral area and then dragged his fingers into her anal area.

MD-20-0379A & MD-20-0897A

10. On October 21, 2020, Respondent was issued an Interim Order for Psychosexual Evaluation.

11. On December 7, 2020, through December 10, 2020, Respondent completed a forensic fitness to practice evaluation at a Board-approved evaluation facility (“Facility”). The results of the evaluation were provided to the Board, together with the recommendations of the evaluator. The assessment team found, in pertinent part, as follows:

- Respondent demonstrated a woefully inadequate degree of insight about the allegations that had been made against him, and he was resistant to considering whether his approach or behaviors could have contributed to the discomfort described by the complaining patients. He was insistent that he was obligated to clean a patient's rectal area following a rectal examination, and showed no regard for the standard of care emphasizing patient choice, i.e. the option to clean themselves, or for the possibility that a patient might not want Respondent to do it.
- The complaints against Respondent were generally credible, and there was a similar pattern of allegations of unnecessary and/or inappropriate examinations.
- Respondent indirectly confirmed elements of RA's complaint, but he remained categorically dismissive of the events RA alleged.
- Respondent did not pass polygraph questions about whether he had ever fondled a patient's genitals or anus for his own sexual gratification, or whether he had made sexual jokes about a patient or their anatomy.

12. Based on the Facility's evaluation findings and results, the Facility opined that Respondent was safe to practice medicine provided he comply with recommendations to utilize a chaperone and undergo treatment and aftercare.

13. As a result of the Facility's recommendations, effective February 12, 2021, Respondent entered into an Interim Consent Agreement for Practice Restriction (Restriction) in case numbers MD-20-0379A and MD-20-0897A, incorporating the Facility's recommendations for Respondent to undergo treatment and aftercare, utilize a chaperone and engage a practice monitor. In entering into the Restriction, Respondent waived his right to a hearing and appeal with respect to the Restriction.

14. The Restriction stated in relevant part:

b. <u>Chaperone</u>

Respondent shall have a Board staff pre-approved female chaperone present while examining or treating all female patients in all settings, including but not limited to office, hospital, and clinic. Within 30 days from the date of this Order, Respondent shall obtain a female chaperone who is an Arizona licensed healthcare provider (i.e. registered nurse, licensed practical nurse or physician assistant) employed by the Respondent, hospital or clinic and may not be a representative or relative who accompanied the patient, nor may she be a member of the Respondent's immediate family as defined by A.R.S. § 32-1401(13). From the effective date of this Order until the date a chaperone is obtained who meets these requirements, Respondent shall have his two currently employed medical assistants present during all examinations of female patients.

Respondent shall instruct any female chaperone to document her presence for each female patient seen by Respondent by contemporaneously maintaining a Board-staff preapproved log, and by electronically signing each chart. Respondent shall instruct the female chaperone to immediately report any inappropriate behavior to the Practice Monitor and the Board. The chaperone shall provide the Practice Monitor with a copy of the patient log on a weekly basis, and to Board staff upon request.[2]

15. From March 1, 2021 through March 19, 2021 Respondent underwent an initial intensive treatment program with the Facility. Prior to discharge, Respondent prepared a Boundary Protection Plan which was submitted to Board staff.

16. An outside medical consultant ("OMC") reviewed the reported cases for quality of care standards, and on May 3, 2021, opined that Respondent did not deviate from the standard of care in his treatment of LC, CP or RA. However, the OMC noted the following suggestions for Respondent:

- Respondent should not do rectal exams in office; a rectal exam prior to colonoscopy under sedation was better as there is no discomfort. In office examinations have discomfort and anxiety associated with it.

[2] Board Exhibit 29.

- Respondent should have a female chaperone for examination of every female patient. He should do away with form signing a waiver altogether from his office.
- While doing a physical exam, he should let the patient know exactly what he was about to do verbally so the patient was not surprised by any of his actions or doubt his intentions. He should give a running commentary to his patients, for example: "I am about to listen to the apex of your heart which is under your left breast, etc."
- He should consider having an Anesthesiologist or a CRNA give anesthesia as some of the cases he was doing require higher dose of drugs due to tolerance because of their medical conditions.

17. On or about June 11, 2021, Respondent, through his attorney, reported that the practice had made changes in the form of requiring female chaperones for all female patients, the inability to waive the presence of a chaperone, rectal exams now performed during colonoscopies, or ensure an assistant is present.

18. Respondent subsequently engaged in a longitudinal professional boundary training program with the Facility. On August 19, 2021 the Facility issued a follow-up report regarding Respondent's ongoing treatment. The Facility opined that Respondent had continued to work on appreciating his patients' potential internal subjective perceptions of his approach to patient treatment. The Facility opined that ongoing use of chaperones and a practice monitor would assist his interactions with female patients and ensure that Respondent remained safe to practice.

19. During a compliance review, Board staff requested thirteen patient charts at random in accordance with the chaperone logs and reviewed the charts to verify documentation of a female chaperone present. Board staff identified the following discrepancies:

- Chart for Patient AC contained an unsigned chaperone waiver form for the visit on August 3, 2021;
- Respondent failed to document the presence of a female chaperone for patient CH on March 8, 2021;
- Respondent failed to document the presence of a second female MA chaperone for patient AC on August 3, 2021;
- The chaperone logs received from Respondent's attorney began Friday, April 2, 2021; however, the chaperone logs received from the Practice Monitor started Tuesday, April 6, 2021;
- Neither the attorney nor the Practice Monitor provided any documentation for Monday April 5, 2021;
- The dates skipped around, and the logs provided by the Practice Monitor were not complete. The chaperone log started at April 6, 2021, and skipped to April 16, 2021, on the same log;
- For Patient LK, the chaperone log is dated April 16th, 2021, however; there was no record of her being seen that day.
- The Practice Monitor did not have chaperone logs for the dates April 2, 2021; June 1, 2021, through June 4, 2021; June 7, 2021, through June 10, 2021.

MD-22-0326A

20. On or about March 30, 2022, the Board initiated case number MD-22-0326A after receiving a complaint regarding Respondent's care and treatment of a 76 year-old female patient, CB, alleging failure to diagnose gallstones and inappropriate and unnecessary performance of three breast examinations. Based on the complaint, Board staff conducted an investigation including an OMC review of Respondent's care and treatment of CB.

21. On May 5, 2021, CB established care with Respondent after an emergency room visit for abdominal pain potentially related to acute pancreatitis. The new patient visit documented "chaperoned by staff." There was no signature, typed, or written name of a chaperone on this progress note. There was no breast examination or abdominal exam documented as having been performed. However, other specific exams were documented as being performed. Respondent ordered omeprazole 40mg and liver serologies including a Fibrosure for possible nonalcoholic steatohepatitis (NASH).

22. On or about July 6, 2021, CB was seen for continuing intermittent nausea. The progress note documented "chaperoned by staff." There was no signature, typed or written name of a chaperone on this progress note. No breast exam was documented; however, an abdominal exam was documented for this visit, amongst other specific exams. Respondent advised CB to continue the omeprazole and added famotidine.

23. On or about August 18, 2021, CB was seen for a follow-up. The progress note documented "chaperoned by Self." There was no signature, typed, or written name of a chaperone on this progress note. No breast exam was documented; however, an abdominal exam was documented for the visit, amongst other specific exams. Respondent recommended an EGD.

24. On or about October 1, 2021, CB underwent an EGD. Nurse Meng was listed as the assistant for the procedure. The procedure report was signed by Respondent only. An esophageal dilation was performed although there was no mention of dysphagia or a stricture in the records. Biopsies were obtained and the pathology showed evidence of specialized columnar epithelium in the distal esophagus consistent with Barrett's esophagus, H. pylori gastritis, and a normal duodenal mucosa. The anesthesia record noted propofol and Versed were administered by a registered nurse.

25. Respondent's records do not indicate the results of the EGD were communicated to CB.

26. On or about March 27, 2022, CB presented to a hospital for persistent/recurrent symptoms of acute pancreatitis with nausea and vomiting. CB was transferred to a second hospital in Las Vegas, Nevada where an ultrasound of the abdomen confirmed the presence of multiple gallstones.

27. On March 28, 2022, CB underwent an uneventful laparoscopic cholecystectomy.

28. During its investigation, the OMC reviewed CB's medical records. Based on the review, the OMC concluded Respondent deviated from the standard of care in his treatment of CB. Specifically, the OMC determined the following:

- The standard of care required a physician to evaluate and identify the cause of acute pancreatitis in an elderly patient with no known risk factors by obtaining an abdominal ultrasound; notify patients of pathology results; and appropriately prescribe medications. The standard of care also required propofol to be administered by an anesthesiologist or a nurse anesthetist and monitored according to general anesthesia guidelines.
- Respondent's note from the May 5, 2021 initial evaluation did not mention the possibility of pancreatitis as the primary diagnosis or a differential diagnosis of pancreatitis.
- Respondent ordered a KUB, an EGD, and liver serologies including a FibroSure for possible nonalcoholic steatohepatitis (NASH), which were inappropriate given CB's history of abdominal pain and pancreatitis in the clinical setting.
- The notes regarding the October 1, 2021 EGD did not mention centimeter markings in the distal esophagus where the biopsies were obtained. That information was necessary to determine if Barrett's esophagus was present and for follow-up.

- Respondent failed to notify CB of the pathology findings of Barrett's esophagus and positive H. pylori gastric biopsies regardless of CB's return to the office. Respondent should have let CB know of the results by telephone, mail, or a patient portal.
- H. pylori gastritis should be treated with an antibiotic regimen unless the physician states why it is not being treated. Nothing in CB's records address why CB was not being treated.
- CB's records do not mention dysphagia prior to the EGD or in subsequent notes. Given the absence of a known esophageal stricture and/or dysphagia complaints, it was unclear to the OMC why the esophageal dilation was performed.
- The anesthesia record was wholly inadequate. The records indicated an RN administered the propofol and Versed. The patient's vital signs should have been checked at 5-minute intervals prior to, during, and after the sedation and documented in the patient's records, which was not done. The EGD record documented only one set of vital signs and did not indicate the time they were taken. There was no signature at the bottom of the anesthesia record or time documented. The standard of care required oxygen saturation and CO2 capnography during propofol anesthesia, but nothing in the records indicated this was done or even available in Respondent's office.
- Other deviations from the standard of care included failing to obtain an abdominal ultrasound to identify the cause of acute pancreatitis in an elderly patient with no known risk factors; failing to notify the patient of pathology findings of Barrett's esophagus and H. pylori gastritis; and inappropriately prescribing a proton pump inhibitor and an H2 blocker in a

patient without clinical evidence of a penetrating duodenal ulcer as the cause of recurrent pancreatitis.

29. The Board staff's audit of CB's chart identified multiple deficiencies regarding Respondent's compliance with the chaperone provision in the Restriction as follows:

- May 5, 2021: CB's chart was not signed off by a chaperone. A nurse's documentation indicated that she entered the room after Respondent began his examination of CB and remained for three minutes.
- July 6, 2021: CB's chart was not signed off by a chaperone. A nurse's documentation indicated that she entered the room after Respondent began his examination of CB and remained for five minutes.
- August 18, 2021: CB's chart was not signed off by a chaperone. A nurse's documentation indicated that she entered the room after Respondent began his examination of CB and remained for five minutes.

30. Board staff also identified inconsistencies between Respondent's notes and the chaperone's notes with the reported times for CB's July 2, 2021 and August 18, 2021 office visits.

31. Board staff interviewed Chevi Caudill, Respondent's Board-approved chaperone from April 2021 through August 2021. Ms. Caudill confirmed that she was typically only in the treatment room for the patient's physical examination and that Respondent was alone with female patients after the exams were completed.

32. Board staff also interviewed Respondent who also confirmed that female chaperones were only present for the physical examination portion of the patient visits. He stated that he would do a 15 to 20 minute history without the chaperone present, call the chaperone into the room for a brief physical, and then let the chaperone leave for the remainder of the office visit.

33. Respondent denied performing a breast exam on CB, but acknowledged performing an abdominal exam during the May 5, 2021 visit that was not documented in the patient's records.

34. After CB filed a complaint with the Board, Respondent filed a lawsuit against CB and her husband in Superior Court alleging defamation. Respondent utilized confidential Board investigative documents including CB's complaint during the course of the Superior Court action.

MD-22-0708A

35. On or about July 20, 2022, the Board initiated case number MD-22-0708A to conduct a periodic chart review to monitor Respondent's compliance with the Restriction for the period of August 1, 2021 through March 31, 2022. The Restriction required a female chaperone to be present while Respondent examined or treated all female patients in all settings, including but not limited to office, hospital, and clinic. Further, the female chaperone was required to be an Arizona licensed healthcare provider, i.e., one registered nurse (RN), licensed practical nurse (LPN), or physician assistant (P.A.), or two medical assistants (MA). In addition, Respondent was required to instruct the female chaperone to document her presence by electronically signing each patient's chart at the time of the examination and the chaperone log.

36. During the review, Board staff reviewed charts for five patients, JFB, JB, JL, KB, and VK, and identified non-compliance for each patient, including that Respondent failed to timely obtain a licensed female chaperone and failed to ensure that one RN, LPN, P.A., or two MAs were present to chaperone during all examinations with female patients. Additionally, the chaperone failed to electronically sign her name on each of the patients' charts.

37. Patient JFB had three visits during the relevant time period:

- On October 25, 2021, only one MA was present as a chaperone.

- On January 7, 2022, the chaperone log documented "no physical exam" and was not singed by the MA; the nurse note was signed and dated by Kathy Fehrman, RMA, and Michelle Meng, reading "no physical was done"; the notes did not indicate that the chaperone was present in the exam room for the entire patient visit; and Michelle Meng was not approved by Board staff as an MA chaperone, thus there was only one MA chaperone that was approved by Board staff.
- On February 2, 2022, the chaperone log only listed one MA; the nurse note was signed and dated by only one MA; and it was noted that the MA was only present during the exam and not the entire visit.

38. Patient JB had three visits during the relevant time period:

- On January 26, 2022, the chaperone log only listed one MA; the nurse note was signed and dated by only one MA and it was noted that the MA was only present during the exam and not the entire visit.
- On March 18, 2022, the chaperone log listed the signature of Kathy Fehrman, RMA; however, the chaperone's name listed on the chaperone log was different than the name on the procedure note. There was not a nurse note in the records, and there was only one MA chaperone present.
- On March 29, 2022, there was only one MA chaperone and there was no signature on the log. The chaperone log listed Kathy Fehrman, RMA, with a date but no signature on the log. The nurse note was signed by KF, RMA, but stated "no physical was done." There was no indication that a chaperone was present.

39. Patient LJ was seen four times during the relevant time period:

- On December 30, 202, there was no signature on the chaperone log, and the names did not match. The chaperone log listed the name Myrna, LPN.

There was a date, but no signature. There was not a record of a nurse note on that date, but a procedure note with the name, Nurse Meng Cude was in the records.

- On January 11, 2022, there was only one MA chaperone present. The chaperone log listed the name Kathy F., with her name, signature, and date on the log. The nurse note stated "I entered the room to chaperone patient during the entire physical exam."
- On February 15, 2022, there was only one MA present in exam according to the chaperone log, and the chaperone was not present the entire exam. The chaperone log did not have the printed name of the chaperone, the chaperone signature was KF, RMA. The nurse note stated "I entered the room to chaperone Patient during the physical exam, along with trainee."
- On March 28, 2022, there was only one MA chaperone present. The chaperone log listed the name Kathy F., RMA, her name, signature, and date on the log. The nurse note stated "I entered the room to chaperone throughout the entire physical exam, along with trainee" signed by KF RMA.

40. Patient KB was seen once during the relevant time period on January 14, 2022, however the date on the chaperone log was January 13, 2022, with no signature. The chaperone log on January 14, 2022, did not show patient KB and only showed one MA chaperone.

41. Patient VK was seen once during the relevant time period on February 28, 2022, at which time only one MA chaperone was present. The chaperone log was not signed and dated by the chaperone, and the nurse note was only signed by one MA chaperone.

MD-22-0896A

42. On or about September 22, 2022, the Board initiated case number MD-22-0896A to conduct a periodic chart review to monitor Respondent's compliance with the Restriction for the period of January 2022 through August 2022. Board staff reviewed charts for five patients, TS, NT, JW, CL, and KA, and identified non-compliance for each patient, including that Respondent failed to ensure there was an RN, LPN, or PA, or 2 MAs present during all examinations of female patients in all settings and the chaperone failed to electronically sign their name on each of the patient's charts for each examination of a female patient pursuant to the terms of the chaperone requirement. Further, Board staff identified a failure to maintain accurate medical records by failing to ensure the chaperone log and visit notes were consistent and accurately documented the appropriate staff present at the time of examination.

43. Patient TS was seen twice during the relevant time period:

- On April 15, 2022, the nurse note was signed by KF, RMA, and LC, RMA. The chaperone log listed one signature and one printed name from Kathy Fehrman. Board staff identified only one MA chaperone documented on the log, which was inconsistent with the note listing two MAs.
- On May 26, 2022, TS had a biopsy procedure at which only one MA was present and an unapproved nurse was identified as chaperone. The operative report documented "Nurse Meng Cude". Nurse Meng was not an approved chaperone and Cude was reported to be an MA. The chaperone log listed only Kathy Fehrman, MA as the chaperone. Board staff identified only one MA documented on the log, which was inconsistent with the operative report, listing a different individual.

44. Patient NT was seen four times during the relevant time period:

- On January 4, 2022, only one MA chaperone was documented on the log, which was inconsistent with the nurse note documenting an unidentified MA. The log only documented chaperone Kathy Fehrman, MA; however, the nurse note was signed and dated by Kathy Fehrman, MA and stated MA trainee (in attendance), but no name was documented for the MA trainee. The board had no request from Respondent for pre-approval for the MA trainee to act as a chaperone.
- On February 14, 2022, only one MA chaperone was documented on the log, which was inconsistent with the nurse note documenting an unidentified MA shadowing. The chaperone log documented Kathy Fehrman, MA. The nurse note was signed and dated by Kathy Fehrman, MA and stated trainee shadowed. However, there was no name provided for the trainee that was shadowing.
- On March 15, 2022, only one MA chaperone was documented on the log, which was inconsistent with the nurse note documenting an unidentified MA shadowing. The chaperone log documented Kathy Fehrman, MA. The nurse note was signed and dated only by chaperone Kathy Fehrman, MA, and stated trainee shadowed. However, there was no name provided for the trainee that was shadowing.
- On March 30, 2022, only one MA chaperone was documented on the log, which was inconsistent with the nurse note documenting an unidentified MA shadowing. The chaperone log documented Denise Cude, MA. The nurse note was signed and dated only by chaperone Denise Cude, MA, and stated trainee shadowed. However, there was no name provided for the trainee that was shadowing.

45. Patient JW was seen once during the relevant time frame on April 4, 2022, at which time only one MA chaperone was documented on the log, which was inconsistent with the nurse note listing another individual. The chaperone log reported the procedure was at Kingman Post-Op and was signed and dated by Kathy Fehrman, MA. However, the nurse note stated two chaperones were present, KF and LC.

46. Patient CL was seen twice during the relevant time period:

- On January 24, 2022, only one MA chaperone was documented on the log, which was inconsistent with the nurse note documenting an unidentified MA shadowing.
- On March 1, 2022, only one MA chaperone was documented on the log, which was inconsistent with the nurse note documenting an unidentified MA shadowing.

47. Patient KA was seen once during the relevant time period on August 26, 2022, at which time only one MA documented her presence as required, and a procedure note identified an unapproved nurse present as chaperone.

MD-23-0529A

48. On or about June 1, 2023, the Board initiated case number MD-23-0529A to conduct a periodic chart review to monitor Respondent's compliance with the Restriction for the period of January 1, 2023, through April 30, 2023. Board staff reviewed charts for four patients, BW, RR, MG, and RF, and identified non-compliance for three of the patients, including that Respondent failed to ensure there was an RN, LPN, or PA, or 2 MAs present during all examinations of female patients in all settings; Respondent hired two new MAs without prior Board approval; and the chaperone failed to electronically sign their name on each of the patient's charts for each examination of a female patient pursuant to the terms of the chaperone requirement. Further, Board staff

identified an inaccurate and inconsistent documentation of chaperones in comparison of the chaperone logs and medical records.

49. Patient RR was seen on February 1, 2023. The nurse note stated that there were two MAs present and both signed the nurse note. The chaperone log had two MA names listed, but no signatures.

50. Patient RF was seen on February 8, 2023. The nurse note stated that there were two MAs present, but only one MA signed the nurse note. There were two MA signatures and printed names on the chaperone log.

51. Patient MG was seen on January 5, 2023. The chaperone log identified one MA present during the visit, and a procedure note identified an unapproved nurse present to serve as a chaperone.

52. Two of the MAs used by Respondent during this time frame were not preapproved by Board staff.

MD-22-0326A, MD-22-0708A, MD-22-0896A, MD-23-0529A

53. On January 3, 2023, these matters came before the Board. At that time, the Board determined that the public health, safety, or welfare required emergency action and voted to summarily suspend Respondent's license pursuant to A.R.S. § 32-1451(D).

54. On or about January 24, 2024, the Board issued a Complaint and Notice of Hearing to Respondent alleging Respondent had engaged in unprofessional conduct pursuant to A.R.S. § 32-1401(27)(a),[3] specifically A.R.S. § 32-3206(C),[4] A.R.S. § 32-1451.01(C) and (E),[5] A.A.C. R4-16-702(A)(2),[6] A.A.C. R4-16-703(A)(1), (3), and (4),[7]

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[3] A.R.S. § 32-1401(27)(a) defines "unprofessional conduct" to include "[v]iolating any federal or state laws, rules or regulations applicable to the practice of medicine."

[4] A.R.S. § 32-3206(C) provides as follows:

> A person who obtains information from the board pursuant to this section may not release it to any other person or entity or use it in any proceeding or action except in connection with the board's review of the investigation, the disciplinary interview and any administrative proceedings or appeals related to the disciplinary interview or hearing. A person who violates this subsection commits an act of unprofessional conduct.

[5] A.R.S. § 32-1451.01(C) and (E) provide, in pertinent part, as follows:

and A.A.C. R4-16-704(A)(1) and (2);[8] A.R.S. § 32-1401(27)(e);[9] A.R.S. § 32-1401(27)(r);[10] A.R.S. § 32-1401(27)(s);[11] A.R.S. § 32-1401(27)(aa);[12] A.R.S. § 32-1401(27)(jj);[13] and A.R.S. § 32-1401(27)(kk)[14].

C. Patient records, including clinical records, medical reports, laboratory statements and reports, any file, film, other report or oral statement relating to diagnostic findings or treatment of patients, any information from which a patient or the patient's family might be
identified or any information received and records or reports kept by the board as a result of the investigation procedure outlined in this chapter are not available to the public.
. . . .
E. Hospital records, medical staff records, medical staff review committee records and testimony concerning these records and proceedings related to the creation of these records are not available to the public, shall be kept confidential by the board and are subject to the same provisions concerning discovery and use in legal actions as are the original records in the possession and control of hospitals, their medical staffs and their medical staff review committees. The board shall use such records and testimony during the course of investigations and proceedings pursuant to this chapter.

[6] A.A.C. R4-16-702(A)(2) provides, in pertinent part, as follows:

A. A physician who performs office-based surgery using sedation in the physician's office
or other outpatient setting that is not part of a licensed hospital or licensed ambulatory surgical center shall:
. . . .
2. Ensure that a staff member who assists with or a healthcare professional who participates in office-based surgery using sedation:
a. Has sufficient education, training, and experience to perform duties assigned;
b. If applicable, has a current license or certification to perform duties assigned; and
c. Performs only those acts that are within the scope of practice established in the staff member's or health care professional's governing statutes;

[7] A.A.C. R4-16-703(A) provides, in pertinent part, as follows:

A. A physician shall ensure that each office-based surgery using sedation performed:
1. Can be safely performed with the equipment, staff members, and health care professionals at the physician's office;
. . . .
3. Is within the education, training, experience skills, and licensure of the physician; and
4. Is within the education, training, experience, skills, and licensure of the staff members and health care professionals at the physician's office.

[8] A.A.C. R4-16-704(A) provides, in pertinent part, as follows:

A physician who performs office-based surgery using sedation shall ensure from the time sedation is administered until post-sedation monitoring begins:
1. A quantitative method of assessing a patient's oxygenation, such as pulse oximetry, is used when minimal sedation is administered to the patient, and
2. When moderate or deep sedation is administered to a patient:
a. A quantitative method of assessing the patient's oxygenation, such as pulse oximetry, is used;
b. The patient's ventilatory function is monitored by any of the following:

Hearing Evidence

55. At hearing, the Board presented the testimony of Raquel Rivera; Dr. Swarnjit Singh, M.D.; Kathryn DesMarais; and Marc Taormina, M.D.

56. Respondent testified on his own behalf and presented the testimony of J.J.; Gregory Brown; Paul Lynch, M.D.; Chevi Caudill; Max Terry, M.D.; and Enrique Carter,

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i. Direct observation,
ii. Auscultation, or
iii. Capnography;
c. The patient's circulatory function is monitored during the surgery by:
i. Having a continuously displayed electrocardiogram,
ii. Documenting arterial blood pressure and heart rate at least every five minutes, and
iii. Evaluating the patient's cardiovascular function by pulse plethysmography,

[9] A.R.S. § 32-1401(27)(e) defines "unprofessional conduct" to include "[f]ailing or refusing to maintain adequate records on a patient."

[10] A.R.S. § 32-1401(27)(r) defines "unprofessional conduct" to include "[c]ommitting any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public."

[11] A.R.S. § 32-1401(27)(s) defines "unprofessional conduct" to include "[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter."

[12] A.R.S. § 32-1401(27)(aa) defines "unprofessional conduct" to include the following:

(aa) Engaging in sexual conduct with a current patient or with a former patient within six months after the last medical consultation unless the patient was the licensee's spouse at the time of the contact or, immediately preceding the physician-patient relationship, was in
a dating or engagement relationship with the licensee. For the purposes of this subdivision,
"sexual conduct" includes:
(i) Engaging in or soliciting sexual relationships, whether consensual or nonconsensual.
(ii) Making sexual advances, requesting sexual favors or engaging in any other verbal conduct or physical contact of a sexual nature.
(iii) Intentionally viewing a completely or partially disrobed patient in the course of treatment if the viewing is not related to patient diagnosis or treatment under current practice standards.

[13] A.R.S. § 32-1401(27)(jj) defines "unprofessional conduct" to include "[e]xhibiting a lack of or inappropriate direction, collaboration or direct supervision of a medical assistant or a licensed, certified or registered health care provider employed by, supervised by or assigned to the physician."

[14] A.R.S. § 32-1401(27)(kk) defines "unprofessional conduct" to include "[k]nowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board."

M.D.; Denise Cude; Anna Feldman Vertkin, M.D.; Kathleen Fehrman, MA; B.L.; Ariana Alonzo; K.L.T.; Daniel Sussman, M.D., Esq.; and Michelle Meng.

57. Dr. Singh, OMC, testified that, based on his review of the medical records relating to patients LC, CP, and RA, he did not find deviations from the standard of care.

- As to LC, Dr. Singh stated that it would be possible to have contact with a patient's breast while listening to the heart, and a patient could misconstrue that contact. Dr. Singh also noted that a patient undergoing a rectal exam is in a vulnerable position and a physician should take care to explain what was happening at each step of the way. Dr. Singh indicated that either the physician or the patient could complete the clean up, but if the physician did it, they needed to explain what was happening.
- As to CP, Dr. Singh indicated he gave Respondent "the benefit of the doubt" that Respondent did not deliberately attempt to rub his crotch against the patient. Dr. Singh noted that CP did not bring up the contact during the interaction even though her husband was present.
- As to RA, Dr. Singh noted that if the "Nibbles" comment occurred, it would have been a deviation of the standard of care, but noted that the use of the anesthesia could have affected her memory.

58. Ms. DesMarais, Compliance Officer, testified as to her review of Respondent's chaperone logs. Ms. DesMarais testified extensively regarding the issues indicated by the chaperone logs, where they were inconsistent with the nurse notes and/or where they did not have the required chaperones listed. Most notably, Respondent regularly had only one MA listed on the chaperone log when two MAs were required.

59. Dr. Taormina, OMC, testified as to his review of Respondent's treatment of CB and his deviations from the standard of care as reported *supra*.

60. Dr. Lynch testified as to the effects of anesthesia on a patient's memory. Dr. Lynch specifically noted that studies have reported patients having sexual hallucinations while under sedation.

61. Ms. Caudill, MA, testified that when she was Respondent's MA, she was only present in the exam room while Respondent performed the physical examination of the patient. Ms. Caudill stated that sometimes she would go into the room initially with the patient and sometimes Respondent would call her in for the exam portion. Ms. Caudill indicated a typical interaction was 20 minutes and she would be present for about 5 minutes. Ms. Caudill said she would sign the chaperone log at the end of the day. Ms. Caudill stated that Ms. Meng filled out the first few columns of the chaperone log with the date and patient's name, but she would fill out at least the last four columns when she signed.

62. Ms. Cude, MA, testified that when she was Respondent's MA, she never observed any inappropriate behavior by Respondent. Ms. Cude acknowledged that, when there was one MA at the office, only one MA would be present during a patient encounter. Ms. Cude stated that Ms. Meng would fill in part of the chaperone log and she would sign it to reflect her attendance. Ms. Cude admitted there were errors in the chaperone logs, but denied they were unreliable.

63. Dr. Carter testified that he reviewed records relating to Respondent's treatment of LC, CP, and RA and did not find any deviations in the standard of care. Dr. Carter opined that, specific to RA, Versed can cause retrograde amnesia and hallucinations.

64. Dr. Feldman-Vertkin testified as to her impression of Respondent's treatment of some patients. Dr. Feldman-Vertkin did not find any deviations from the standard of care.

65. Ms. Fehrman, MA, testified she was employed at Respondent's office for over nine years. Ms. Fehrman denied Respondent ever making any sexual jokes or comments or performing a breast or pelvic exam. Ms. Fehrman stated that Ms. Meng would fill out most of the chaperone log at the beginning of the day and she would sign it where needed. Ms. Fehrman stated that no one told her she needed to fill out the chaperone log at the time of the visit. Ms. Fehrman acknowledged there were some errors in the chaperone logs and ultimately admitted that her recollection was not completely accurate.

66. Ms. Alonzo, MA, testified she was employed at Respondent's office for approximately one year. Ms. Alonzo stated that she would enter a chart note documenting her presence during an exam right after the exam and would sign the chaperone logs at the end of the day.

67. Dr. Sussman testified that he performed a psycho-sexual evaluation of Respondent and did not find any evidence of sexual deviancy or predatory behavior.

68. Ms. Meng, RN and Manager of Kelly Clinic, testified that there was a shortage of available chaperones in the area and they tried extensively to hire appropriate employees. Ms. Meng indicated she filled out the patient names on the chaperone log in the morning based on the scheduled appointment and the chaperones would sign the log before they left for the day. Ms. Meng stated there was always at least one female chaperone in the room with Respondent when there was a female patient. Ms. Meng testified that on one day, no chaperones were available and she canceled the female patients for the day. Ms. Meng testified that, under her RN license, she could "push" moderate sedation with a physician present. Ms. Meng stated she would constantly monitor the patient's vitals, but would only print out the strip if there was a problem during the procedure. Ms. Meng acknowledged that she operated the clinic's Facebook page and, when CB's husband posted negative comments about Respondent, she posted

medical information about him in response. When asked why she did that, Ms. Meng stated, "Because I don't like him."

69. Respondent testified as to the allegations. Respondent denied touching any patient in a sexual manner during an office visit or procedure. Specifically, Respondent stated he would be unable to make any sexual contact during a colonoscopy because one of his hands would be on the scope and one on the controls. Respondent denied making any comment about "Nibbles." Respondent asserted that very rarely did he have only one MA present during the exams.

70. Respondent stated that it was his practice to give every patient a rectal exam as that was what he was taught during his training. Respondent maintained that since these allegations had been made, he changed to only doing rectal exams when indicated for medical reasons. Respondent also stated that it was his practice to clean up the patient after a rectal exam because he was the one who made the mess, so he was the one responsible for cleaning it up.

71. Respondent testified that during discussions with his attorney, he decided to accept the Restriction because he did not want to have a summary suspension, but he believed he would be able to defend himself in a hearing within 60 days. Respondent denied giving his civil attorney any confidential documents from the Board.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over Respondent and the subject matter in this case.

2. Pursuant to statute, the Board has the burden of proof in this matter.[15] The standard of proof is by clear and convincing evidence.[16]

3. The legislature created the Board to protect the public.[17]

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[15] A.R.S. § 41-1092.07(G)(2) and A.A.C. R2-19-119(B).
[16] A.R.S. § 32-1451.04.
[17] *See* Laws 1992, Ch. 316, § 10.

MD-20-0379A and MD-20-0897A

4. The Administrative Law Judge found Respondent's testimony credible regarding his conduct during his treatment of the patients included in these matters.

5. While the patients appeared equally sincere in their reports of Respondent's inappropriate conduct, none were present for the hearing for their credibility to be assessed. Thus, the evidence did not support a finding that such conduct occurred.

6. Throughout the process, Respondent was advised of changes to his practice that he could enact to ensure he avoided such allegations in the future. This included the use of chaperones.

7. The Board failed to establish, by clear and convincing evidence, that Respondent engaged in any unprofessional conduct with respect to the patient's identified in these matters.

8. Accordingly, the Board failed to establish violations of A.R.S. 31-1401(27)(r), (s), (aa), or (kk).

MD-22-0326A

9. The Board established by clear and convincing evidence that Respondent engaged in unprofessional conduct with respect to the administration of sedation during an in-office procedure.

10. Accordingly, the Board established violations of A.R.S. § 32-1401(27)(a), specifically A.A.C. R4-16-702(A)(2), A.A.C. R4-16-703(A)(1), (3), and (4), and A.A.C. R4-16-704(A)(1) and (2).

11. The Board established by clear and convincing evidence that Respondent used information from the Board's investigation of this matter in a civil lawsuit against CB.

12. Accordingly, the Board established violations of A.R.S. § 32-1401(27)(a), specifically A.R.S. § 32-3206(C) and A.R.S. § 32-1451.01(C) and (E).

13. The Board established by clear and convincing evidence that Respondent failed to ensure that his staff was properly filling out the chaperone logs and nurse notes. Further, Respondent appeared unconcerned that Ms. Meng responded to CB's husband's Facebook comment with private medical information.

14. Accordingly, the Board established a violation of A.R.S. § 32-1401(17)(jj).

MD-22-0326A, MD-22-0708A, MD-22-0896A, and MD-23-0529A

15. The Board established by clear and convincing evidence that Respondent failed to properly comply with the terms of the Restriction and/or failed to maintain appropriate documentation of his compliance. Respondent never attempted to have a female chaperone present during the entire office visit with female patients. Respondent's intention was only to have a chaperone present during the physical examination. Assuming, *arguendo*, this was sufficient to comply with the Restriction, Respondent failed on numerous occasions to have the required chaperones present. The records repeatedly demonstrated only one MA present. Further, the patient chart was often inconsistent with the chaperone log.

16. The very nature of the chaperone log, that the names were filled out at the beginning of the day and the chaperones signed at the end of the day, the crossed out signatures, and the signatures for patients who were no shows, called into question the accuracy of the chaperone logs as a whole.

17. While the Administrative Law Judge was sympathetic to Respondent's efforts to secure appropriate employees necessary to fulfill the terms of the Restriction, that does not excuse Respondent's failure to comply with its requirements.

18. Accordingly, the Board established violations of A.R.S. § 32-1401(27)(e), (r), and (s).

Overall

19. While the Administrative Law Judge did not conclude the evidence established the underlying conduct occurred, Respondent willingly signed the Restriction, for whatever reason, and then proceeded to violate the terms of the Restriction repeatedly for years.

20. The purpose of the requirement of a chaperone was to ensure female patients were protected from any potential inappropriate conduct.

21. Respondent's ongoing failure to comply with the terms of the Restriction demonstrate that he cannot be regulated at this time.

ORDER

Based on the foregoing, it is ordered that the Board's Order for Summary Suspension of License is upheld.

It is further Ordered that Respondent Charles E. Kelly's License No. 42668 is issued a Decree of Censure.

Respondent is placed on Probation for a period of five years with the following terms and conditions:

1. **Chaperone**

Respondent shall have a Board staff pre-approved female chaperone present while he is present with, examining, or treating all female patients at all times and in all settings, including but not limited to office, hospital, and clinic. The female chaperone must be an Arizona licensed healthcare provider (i.e. registered nurse, licensed practical nurse or physician assistant) who is employed by the Respondent, hospital or clinic and may not be a representative or relative who accompanied the patient, nor may she be a member of the Respondent's immediate family as defined by A.R.S. § 32-1401(13). Respondent shall provide the Chaperone with a copy of this Order, the Boundary Protection Plan, and a Board staff pre-approved log. Additionally, Respondent shall

ensure that the chaperone has access to his electronic medical record system for purposes of documenting the chaperone's presence.

Respondent shall promptly (the same business day) notify Board staff at any time the chaperone is no longer employed by Respondent, or is otherwise not available to act as a chaperone. Respondent shall not treat female patients during any time period that the chaperone is unavailable or until a new chaperone has been approved by Board staff.

Respondent shall instruct the female chaperone to document her presence for each female patient seen by Respondent by contemporaneously maintaining the Board-staff pre-approved log, and by electronically signing each chart. The chaperone shall be the only authorized individual to document her presence in either the pre-approved log or the patient chart. The chaperone shall complete and sign a log entry immediately after each patient encounter that she observes. Respondent shall instruct the female chaperone to immediately report any inappropriate behavior to Board staff. The chaperone shall provide Board staff with a copy of the patient log on a weekly basis, and be available for interviews at the request of Board staff. Additionally, the chaperone shall provide Board staff with written documentation of her review of the Board Order, Boundary Protection Plan, and Pre-Approved Log as well as direct contact information for Board staff to reach the chaperone prior to acting as a chaperone.

Board staff or its agents may conduct periodic chart reviews, or perform other investigation in order to monitor Respondent's compliance with this provision, including conducting site inspections or interviewing Respondent's staff.

Physician Health Program

2. Within 5 days of the date of this Order, Respondent shall enroll in the Physician Health Program ("PHP") and comply with the following requirements.

3. If requested by the PHP, Respondent shall not consume alcohol or any food or other substance containing poppy seeds or alcohol.

4. Respondent shall not take any illegal drugs or mood altering medications unless prescribed for a legitimate therapeutic purpose.

5. Respondent shall continue to participate in any personalized treatment as recommended by the PHP, including completion of any requested evaluations or assessments and compliance with any therapeutic recommendations, subject to approval by the PHP or Board staff. Respondent shall report on those activities as requested by the PHP, including executing any releases necessary to allow the PHP to monitor his participation and communicate directly with and obtain records from the treating providers for those evaluations, assessments or therapeutic activities. Respondent shall authorize the PHP to communicate directly with the Facility if requested by the PHP. Respondent shall be responsible for all costs of aftercare, including costs associated with compliance of this Board Order.

6. Respondent shall promptly obtain a Primary Care Physician ("PCP") and shall submit the name of the physician to the PHP Contractor in writing for approval. Except in an Emergency, Respondent shall obtain medical care and treatment only from the PCP and from health care providers to whom the PCP refers Respondent. Respondent shall promptly provide a copy of this Order to the PCP. Respondent shall also inform all other health care providers who provide medical care or treatment that Respondent is participating in the PHP. "Emergency" means a serious accident or sudden illness that, if not treated immediately, may result in a long-term medical problem or loss of life.

7. All prescriptions for controlled substances shall be approved by the PHP Contractor prior to being filled except in an Emergency. Controlled substances prescribed and filled in an emergency shall be reported to the PHP within 48 hours. Respondent shall take no Medication unless the PCP or other health care provider to whom the PCP refers Respondent prescribes and the PHP Contractor approves the Medication. Respondent shall not self-prescribe any Medication. "Medication" means a

prescription-only drug, controlled substance, and over-the counter preparation, other than plain aspirin, plain ibuprofen, and plain acetaminophen.

8. Respondent shall enter treatment with a PHP Contractor approved psychiatrist and shall comply with any and all treatment recommendations, including taking any and all prescribed medications. Respondent shall instruct the treating psychiatrist to submit quarterly written reports to the PHP regarding diagnosis, prognosis, current medications, recommendation for continuing care and treatment, and ability to safely practice medicine. The reports shall be submitted quarterly to the PHP, the commencement of which to be determined by the PHP Contractor. Respondent shall provide the psychiatrist with a copy of this Order as well as the Facility's evaluations and treatment records. Respondent shall pay the expenses for treatment and be responsible for paying for the preparation of the quarterly reports.

9. If requested by the PHP Respondent shall participate in a 12-step recovery program or other self-help program appropriate for Respondent's health conditions as recommended by the PHP.

10. If requested by the PHP, Respondent shall submit to random biological fluid, hair and/or nail testing for the remainder of this Order (as specifically directed below) to ensure compliance with the PHP.

a. Respondent shall provide the PHP Contractor in writing with one telephone number that shall be used to contact Respondent on a 24 hour per day/seven day per week basis to submit to biological fluid, hair, and/or nail testing to ensure compliance with the PHP. For the purposes of this section, telephonic notice shall be deemed given at the time a message to appear is left at the contact telephone number provided by Respondent. Respondent authorizes any person or organization conducting tests on the collected samples to provide testing results to

the PHP Contractor. Respondent shall comply with all requirements for biological fluid, hair, and/or nail collection. Respondent shall pay for all costs for the testing.

11. Respondent shall provide the PHP Contractor with written notice of any plans to travel out of state.

12. Respondent shall immediately notify the Board and the PHP Contractor in writing of any change in office or home addresses and telephone numbers.

13. Respondent provides full consent for the PHP Contractor to discuss the Respondent's case with the Respondent's PCP or any other health care providers to ensure compliance with the PHP.

14. The relationship between the Respondent and the PHP Contractor is a direct relationship. Respondent shall not use an attorney or other intermediary to communicate with the PHP Contractor on participation and compliance issues. All inquiries must be directed to Board staff.

15. Respondent shall be responsible for all costs, including costs associated with participating in the PHP, at the time service is rendered or within 30 days of each invoice sent to the Respondent. An initial deposit of two (2) months PHP fees is due upon entering the program. Failure to pay either the initial PHP deposit or monthly fees 60 days after invoicing will be reported to the Board by the PHP Contractor and may result in disciplinary action.

16. Respondent shall appear in person before with the PHP Contractor for interviews upon request, upon reasonable notice.

17. Respondent shall immediately provide a copy of this Order to all employers, hospitals and free standing surgery centers where Respondent currently has or in the future gains or applies for employment or privileges. Within 30 days of the date of this Order, Respondent shall provide the PHP with a signed statement of compliance with

this notification requirement. Respondent is further required to notify, in writing, all employers, hospitals and free standing surgery centers where Respondent currently has or in the future gains or applies for employment or privileges of a violation of this Order.

18. In the event Respondent resides or practices as a physician in a state other than Arizona, Respondent shall participate in the rehabilitation program sponsored by that state's medical licensing authority or medical society. Respondent shall cause the monitoring state's program to provide written quarterly reports to the PHP Contractor regarding Respondent's attendance, participation, and monitoring. The monitoring state's program and Respondent shall immediately notify the PHP Contractor if Respondent is non-compliant with any aspect of the monitoring requirements or is required to undergo any additional treatment.

19. The PHP Contractor shall immediately notify the Board if Respondent is non-compliant with any aspect of this Order or is required to undergo any additional treatment.

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

21. Prior to the termination of Probation, Respondent must submit a written request to the Board for release from the terms of this Order. Respondent's request for release will be placed on the next pending Board agenda, provided a complete submission is received by Board staff no less than 30 days prior to the Board meeting. Respondent's request for release must provide the Board with evidence establishing that he/she has successfully satisfied all of the terms and conditions of this Order. The Board has the sole discretion to determine whether all of the terms and conditions of this Order have been met or whether to take any other action that is consistent with its statutory and regulatory authority.

This Order supersedes any and all Consent Agreements previously entered into by Respondent and the Board regarding this matter. It is additionally ordered that, pursuant to A.R.S. § 32-1451(M), Charles E. Kelly, M.D. be charged for the cost of the formal hearing as determined by the Board. Dr. Kelly shall pay the Board $11,008.18 by certified funds, within 90 days of the effective date of this Order.

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 this 9th day of September 2024.

THE ARIZONA MEDICAL BOARD

By Patricia E. McSorley

Patricia E. McSorley
Executive Director

ORIGINAL of the foregoing filed this
9th day of September, 2024 with:

Arizona Medical Board
1740 W. Adams, Suite 4000
Phoenix, Arizona 85007

COPY of the foregoing filed
this 9th day of September, 2024 with:

Greg Hanchett, Director
Office of Administrative Hearings
1740 W. Adams
Phoenix, AZ 85007

Executed copy of the foregoing
mailed by U.S. Mail and emailed
this 9th day of September, 2024 to:

Charles E. Kelly, M.D.
Respondent
Address of Record

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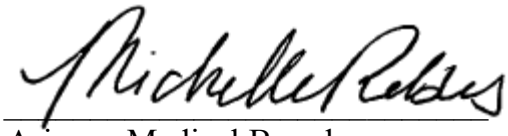
By: 
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