1 BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **BILL D. HOLLOMAN, M.D.** Holder of License No. 33572 For the Practice of Allopathic Medicine In the State of Arizona	Case No. MD-14-1411A **ORDER DENYING REQUEST FOR REHEARING OR REVIEW**

At its public meeting on April 5, 2017 the Arizona Medical Board ("Board") considered Bill D. Holloman, M.D.'s ("Respondent"), Request for Rehearing or Review of the Board's Order dated January 13, 2017 in the above referenced matter. After considering all of the evidence, the Board voted to deny Respondent's Request for Rehearing or Review.

ORDER

IT IS HEREBY ORDERED that:

Respondent's Request for Rehearing or Review is denied. The Board's January 13, 2017 Findings of Fact, Conclusions of Law and Order for Probation in Case MD-14-1411A is effective and constitutes the Board's final administrative order.

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RIGHT TO APPEAL TO SUPERIOR COURT

Respondent is hereby notified that he has exhausted his administrative remedies. Respondent is advised that an appeal to Superior Court in Maricopa County may be taken from this decision pursuant to title 12, chapter 7, and article 6 of the Arizona Revised Statutes.

DATED AND EFFECTIVE this 20th day of April, 2017.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed
this 20th day of April, 2017 to:

Bill D. Holloman, M.D.
Address of Record

ORIGINAL of the foregoing filed
this 20th day of April, 2017 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Michelle Robles
Board Staff

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

BILL D. HOLLOMAN, M.D.

Holder of License No. 33572
For the Practice of Allopathic Medicine
In the State of Arizona.

Case No. MD-14-1411A

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR PROBATION

The Arizona Medical Board ("Board") considered this matter at its public meeting on December 7, 2016. Bill D. Holloman, M.D. ("Respondent"), appeared with legal counsel, Stephen 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 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 33572 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-14-1411A after receiving notification that Respondent had resigned his from his group practice during a peer review of five patients.

4. A quality of care review performed by the Board's Medical Consultant ("MC") for five patient charts resulted in the following findings:

Patient VT

5. VT, a 58 year-old female, was seen by Respondent in July of 2014. VT had a history of breast cancer with prior right mastectomy and chemotherapy; cervical cancer with prior hysterectomy; and a family history of lymphoma. VT had been previously

followed by Respondent at a different practice since 2012. VT's labs showed a calcium level of 13.1 and chart notes showed that VT had lost a significant amount of weight over the last year. VT was noted to be taking calcium supplements and diuretics. The calcium level was reported to Respondent that evening and Respondent recommended that VT return for a one-week follow-up appointment. There was no management plan located in the chart regarding the elevated calcium level.

6. VT returned in August of 2014 with symptoms of confusion, abdominal pain and diarrhea. Respondent documented that he had advised VT in July to have her calcium levels rechecked, but that she took an extended trip out of town. Her calcium was noted to be 14.5 with low parathyroid hormone ("PTH") and Respondent referred VT to the emergency room ("ER"). VT was treated in the ER for extreme hypercalcemia with mental status changes during the hospitalization and was found to have a large mass in her spleen with retroperitoneal and mesenteric adenopathy. VT was ultimately diagnosed with diffuse large B-cell Non-Hodgkin's Lymphoma.

7. The standard of care required Respondent to act promptly on VT's hypercalcemia and discontinue calcium supplements and diuretics. Respondent deviated from this standard of care by failing to act promptly on VT's hypercalcemia.

8. VT suffered actual harm in that she became symptomatic. VT was at risk for death from hypercalcemia.

Patient MV

9. MV, a 67 year-old male with a prior medical history of hyperlipidemia and current complaints of fatigue and generalized aching, was seen by Respondent on June 26, 2014. MV had been previously followed by Respondent at a prior practice.[1] Labs

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[1] Records from Respondent's prior practice showed labs drawn on November 8, 2013 that were remarkable for a calcium level of 11.5 and PTH of 4.4., and a repeat PTH taken on November 18, 2013 was found to be 3.5.

dated June 27, 2014 showed a calcium level of 14.8. Respondent's treatment plan was to confirm whether the on call physician had referred MV to the ER and if not, obtain a PTH, have MV hydrate aggressively, and follow up in one week.

10. MV returned for a follow up with Respondent on July 3, 2016. Respondent documented that MV had been asked to return to discuss abnormal lab results. MV denied a change in symptoms but reported mild confusion and intermittent mild generalized aching. Respondent ordered labs including a repeat PTH but not a repeat calcium level. MV's PTH was low at 3.8.

11. On July 15, 2014, MV returned again to Respondent to discuss a recent liver MRI. MV reported continued fatigue and some difficulty thinking. The MRI showed a 10x12 cm mass to the left lobe of the liver with a satellite nodule. MV's labs showed a calcium level of 15.3. Respondent's plan was a liver biopsy and urgent correction of hypercalcemia. Respondent recommended that MV go to the hospital for immediate treatment.

12. MV was admitted to the hospital from July 16 through July 18, 2014 for hypercalcemia and liver mass, reporting mild fatigue and lethargy. MV's treatment included IV fluids, Reclast, and a CT guided biopsy which showed intrahepatic bile duct carcinoma.

13. MV was hospitalized again on July 31, 2014 and the history and physical noted that baseline testing performed by Respondent on MV in November of 2013 showed a calcium level of 11.1. During the hospitalization, MV underwent a laparoscopic surgical ablation of one or more liver tumors and extensive radiofrequency ablation.

14. The standard of care required Respondent to treat MV's high calcium appropriately. Respondent deviated from this standard of care by failing to appropriately address MV's high calcium.

15. MV suffered actual harm in that he experienced delay in diagnosis and treatment. MV was at risk for death from hypercalcemia.

Patient JT

16. JT, a 71 year-old male with a prior medical history of hypertension, hyperlipidemia, hypothyroidism and gastrointestinal reflux disease, was seen by Respondent on April 28, 2014 with complaints of unexplained fatigue, weakness, 18 pound weight loss over two months and anemia. JT also reported that, two years previously, he had a syncopal episode, recurrent hospitalizations, colon surgery and colostomy with subsequent take-down surgery possibly related to diverticulitis. JT's weight was recorded as 140.9 pounds. No physical examination was documented. Respondent's plan was to obtain the prior medical records and then follow up in one month.

17. On May 5, 2014, JT presented to the ER for hypotension and syncope and his comprehensive blood count ("CBC") differential showed a white blood cell count ("WBC") with reduced percentage of lymphocytes and low platelet count. JT was also felt to be anemic and hypotensive and his blood pressure medication was discontinued.

18. At a follow-up visit on May 20, 2014, Respondent changed JT's medication and ordered a CBC. JT's weight was recorded as 133.8 pounds.

19. The CBC was obtained on June 18, 2014 and showed a WBC of 1.4K. The lab counts were reported to Respondent who documented that JT had pancytopenia and should be referred to hematology.

20. JT returned and was seen by Respondent on June 23, 2014. JT reported weakness, with difficulty getting up and down, that he had blacked out in the shower that day and his equilibrium was off. JT was noted to be ataxic by Respondent's medical assistant ("MA") and his weight was noted at 128.56 pounds. Respondent documented that JT's skin appeared pale, he required help getting on to the examination table, generalized weakness and imbalance with no focal deficits. Respondent ordered a CBC

that showed a WBC of 2.0K. Respondent referred JT to an oncologist, and sent a copy of the lab to JT's hematologist.

21. JT was hospitalized on June 25, 2014, subsequently discharged to a rehabilitation facility and then rehospitalized on July 7, 2014. The attending physician at the subsequent hospitalization ordered a brain MRI which showed a 2.9 cm mass in the left cerebellum. Pathology of the mass after removal showed diffuse large B cell CNS lymphoma.

22. The standard of care required Respondent to act promptly to diagnose and treat JT's recurring syncope. Respondent deviated from this standard of care by failing to act promptly regarding JT's syncope.

23. JT suffered actual harm in that his diagnosis was delayed and he also required treatment at an ER. JT was at risk of injury from a fall.

Patient DR

24. DR was a 75 year-old male with a prior medical history including benign prostatic hyperplasia ("BPH") osteoarthritis and congenital deafness. DR had been previously treated by Respondent at a prior practice. DR reestablished care with Respondent on August 4, 2014. DR reported an ER visit the prior month due to left-sided pleuritic chest pain, with a normal work up and prescription for Oxycodone. DR was seen again on August 11, 2014 by a Nurse Practitioner ("NP") in Respondent's practice with complaints of chest pain.

25. Respondent saw DR again on August 13, 2014. DR complained of increasing left pleuritic chest pain. Respondent requested DR's ER records and documented a plan including an EKG, echocardiogram, empiric trial of Cohicine and labs. The EKG showed a borderline 1st degree AV block and nonspecific T wave changes to the septal leads not present on the prior EKG. A CT angiogram ordered by Respondent and performed on August 18, 2014 showed a small focal pulmonary embolism to the left lower

lobe pulmonary artery, with no other defects. Respondent advised DR to follow up in one week.

26. On August 28, 2014, DR was seen by a different provider in Respondent's practice for a hypercoagulable workup. At the time of his appointment, DR was not taking any medications for his embolism. The provider ordered medications to treat the embolism, labs to assess DR's level of hypercoagulation and ASAP lower extremity venous Doppler studies. The studies showed non-occlusive deep vein thrombosis involving the right popliteal vein and the posterior tibial and peroneal veins, and deep veno-occlusive disease involving the left peroneal veins.

27. The standard of care required Respondent to diagnose and treat chest pain and pulmonary embolism promptly. Respondent deviated from this standard of care by failing to treat DR's symptomatic pulmonary embolism.

28. DR suffered actual harm in that his treatment of symptoms was delayed. DR was also at risk for death from his pulmonary embolism.

Patient HC

29. HC was a 77 year-old male with prior medical history of paroxysmal atrial fibrillation, hypertension, hypothyroidism, depression, osteopenia and Parkinson's disease who had been previously treated by Respondent at his prior practice. HC reestablished care with Respondent on April 25, 2014, who performed a comprehensive wellness visit. Labs completed the prior week showed a platelet count of 1,105,000 and a notation that the platelets appeared very increased with 1+ giant platelets and 1+ large platelets. Respondent documented that labs were reviewed with HC but there was no documentation that Respondent addressed HC's critically elevated platelet count.

30. On July 20, 2014, HC presented to the ER with complaints of fatigue and tiredness. He was found to have a hemoglobin of 5.3, hematocrit of 16.7, platelet count of 1155K and WBC of 16K. The admitting physician noted that HC's prior CBC also showed

a platelet count of 1105K. HC reported that he had never seen a hematologist or oncologist. HC was evaluated by both a GI consultant and hematologist who diagnosed HC with an iron deficiency and reactive thrombocytosis. HC was subsequently also diagnosed with myelodysplasia.

31. The standard of care required Respondent to diagnose and treat HC In a timely manner. Respondent deviated from this standard of care by failing to act on HC's very high platelet count.

32. HC suffered actual harm in that his diagnosis and treatment was delayed. HC was at risk for death from complications of a very high platelet count.

33. On May 4, 2016, an Interim Order was issued for Respondent to complete a competency evaluation. Respondent timely appealed the Interim Order to the Board.

34. On August 4, 2016, the Board considered the entire investigative file, including written responses, and denied Respondent's appeal of the Interim Order. Respondent was given additional time to comply with the Interim Order, but failed to complete the evaluation.

35. During a Formal Interview on this matter, Respondent testified that he saw VT and her daughter after office hours and instructed VT regarding the high calcium levels. However, Respondent admitted that he did not document the encounter.

36. With regard to JT, Respondent reported that he relied on a recent CT scan showing no intracranial abnormalities. Board staff noted that Respondent did not document gait testing or tandem gait testing to evaluate the ataxia noted by the MA.

37. With regard to DR, Respondent testified that when he obtained the results of the chest CT, he discussed the finding with the interpreting radiologist, who agreed with Respondent that DR likely had a resolving pulmonary embolus. Respondent testified that based on the results of the tests, DR did not need to be anticoagulated. Board staff noted

that Respondent did not have the results of the Doppler studies at the time he decided against anticoagulation therapy.

38. Respondent testified that he has recently retired from the practice of medicine.

39. In response to a question from a Board member, Respondent stated that when a patient presents with hypercalcemia, there should always be a concern regarding underlying malignancy.

40. Board members noted that the care provided by Respondent to the patients at issue raises concerns regarding Respondent's medical decision-making and patient management.

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)(q) ("Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

4. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(r) ("Violating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under the provisions of this chapter. ").

5. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(dd) ("Failing to furnish information in a timely

manner to the board or the board's investigators or representatives if legally requested by the board.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent's license is placed on Probation for a period of one (1) year with the following terms and conditions:

2. **Practice Restriction**

Respondent's practice is restricted in that he shall not practice medicine in the State of Arizona and is prohibited from prescribing any form of treatment including prescription medications until Respondent applies to the Board and receives permission to do so in accordance with this Order.

3. **Competency Evaluation**

Respondent shall register for a competency evaluation at a facility approved by the Board or its staff **within 30 days** from the date of this Order and successfully complete the evaluation **within 9 months** from the date of this Order. Respondent is responsible for all expenses relating to the evaluation and/or compliance with subsequent practice recommendations. The evaluator is conducting the evaluation and report solely for the benefit of the Board. Respondent shall comply with any recommendations made by the evaluating facility and approved by Board staff, including any requirements for practice monitoring or continuing medical education. If the evaluating facility finds that Respondent is safe to practice without any additional recommended training, monitoring or education, Respondent may immediately apply to the Board's Executive Director for termination of the Practice Restriction. Respondent shall provide a copy of this Order to the evaluating facility and shall sign a consent form to release all confidential evaluation results to the Board. Because Respondent is undergoing this evaluation under Board Order he shall

instruct any attorney retained on his behalf not to contact the evaluating facility. Any questions or concerns must be addressed to Board staff.

4. **Obey all Laws**

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.

5. **Tolling**

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

6. **Probation Termination**

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 14 days prior to the Board meeting. Respondent's request for release must provide the Board with evidence establishing that he 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.

7. **Board Order Violation**

In the event that Respondent does not comply with this Board Order in violation of A.R.S. § 32-1401(27)(r), the matter shall be forwarded to the Office of Administrative Hearings for a Formal Hearing to revoke Respondent's license.

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 13th day of January, 2017.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed
this 13th day of January, 2017 to:

Stephen W. Myers
Myers & Jenkins, PC
714 E Rose Lane, Suite 100
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Attorney for Respondent

ORIGINAL of the foregoing filed
this 13th day of January, 2017 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Mary Bober
Board staff