STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF PROFESSIONAL LICENSING
BOARD OF MEDICINE
DISCIPLINARY SUBCOMMITTEE

In the Matter of

ARUN GUPTA, M.D.,
License No. 43-01-047791

Complaint No. 43-14-135855

CONSENT ORDER AND STIPULATION

CONSENT ORDER

An administrative complaint was filed with the Disciplinary Subcommittee of the Board of Medicine on June 14, 2016, charging Arun Gupta, M.D. (Respondent) with having violated sections 16221(a) and (b)(i) of the Public Health Code, 1978 PA 305, as amended, MCL 333.1101 et seq.

The parties have stipulated that the Disciplinary Subcommittee may enter this consent order. The Disciplinary Subcommittee has reviewed the stipulation contained in this document and agrees that the public interest is best served by resolution of the outstanding complaint. Therefore, the Disciplinary Subcommittee finds that the allegations of fact contained in the complaint are true and that Respondent has violated sections 16221(a) and (b)(i) of the Public Health Code.

Accordingly, for these violations, IT IS ORDERED:

Respondent is FINED Five Thousand and 00/100 Dollars ($5,000.00) to be paid by check, money order or cashier’s check made payable to the State of Michigan (with complaint number 43-14-135855 clearly indicated on the check or money order), and shall be payable within 30 days of the effective date of this
order. The timely payment of the fine shall be Respondent's responsibility.

Respondent shall mail the fine to: Bureau of Professional Licensing, Legal Affairs
Division – Compliance Section, Department of Licensing and Regulatory Affairs,
P.O. Box 30189, Lansing, Michigan 48909.

This order shall be effective thirty days from the date signed by the
Chairperson of the Disciplinary Subcommittee or the Disciplinary Subcommittee's
authorized representative, as set forth below.

Signed on 5/16/18

MICHIGAN BOARD OF MEDICINE

By

Chairperson, Disciplinary Subcommittee

STIPULATION

The parties stipulate as follows:

1. For the purpose of resolving the subject administrative complaint only,
Respondent admits that the facts alleged in the administrative complaint are true
and constitute a violation of sections 16221(a) and (b)(i) of the Public Health Code.

2. The Disciplinary Subcommittee may enter the above Consent Order,
supported by Board conferee Michael Chrissos, M.D. Dr. Chrissos or an attorney
from the Licensing and Regulation Division may discuss this matter with the
Disciplinary Subcommittee in order to recommend acceptance of this resolution.

3. Dr. Chrissos and the parties considered the following factors in reaching
this agreement:
A. Respondent takes full responsibility for the actions that led to the filing of the administrative complaint.

B. Respondent, proactively and of his own volition, completed 19.25 hours of CMFs in the areas of nursing home regulation and the administration of antipsychotic medications to dementia patients. These are in addition to those required for license renewal.

By signing this stipulation, the parties confirm that they have read, understand and agree with the terms of the consent order.

AGREED TO BY:

[Signature]
Eric M. St. Onge (P56830)
Assistant Attorney General
Attorney for Complainant
Dated: 1-5-18

AGREED TO BY:

[Signature]
Arun Gupta, M.D.
Respondent
Dated: 1-7-2018

[Signature]
Alexandra A. Hall (P77868)
Attorney for Respondent
Dated: 1/4/18

LF: 2016-0180254/B/Gupta, Arun, M.D., 185866/Consent – Order and Stipulation – 2017-12-30
STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
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DISCIPLINARY SUBCOMMITTEE

In the Matter of
Arun Gupta, M.D.
License No. 43-01-047791

Complaint No. 43-14-135855

ADMINISTRATIVE COMPLAINT

Attorney General Bill Schuette, through Assistant Attorney General Kelly K. Elizondo, on behalf of the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing (Complainant), files this complaint against Arun Gupta, M.D. (Respondent) alleging upon information and belief as follows:

Jurisdictional Allegations

1. The Board of Medicine, an administrative agency established by the Public Health Code, 1978 PA 368, as amended, MCL 333.1101 et seq, is empowered to discipline licensees under the Code through its Disciplinary Subcommittee (DSC).

2. Respondent is currently licensed to practice medicine pursuant to the Public Health Code.

3. Section 16221(a) of the Code authorizes the DSC to take disciplinary action against Respondent for a violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, whether or not injury results, or any conduct,
practice, or condition that impairs, or may impair, Respondent's ability to safely and skillfully practice medicine.

4. Section 16221(b)(i) of the Code authorizes the DSC to take disciplinary action against Respondent for incompetence, which is defined at section 16106(1) of the Code as "a departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for a health profession, whether or not actual injury to an individual occurs."

5. Section 16226 of the Code authorizes the DSC to impose sanctions against a person licensed by the Board if, after opportunity for a hearing, the DSC determines that a licensee violated one or more of the subdivisions contained in section 16221 of the Code.

Factual Allegations

6. Respondent was the primary care physician for patient A.G. who had a history of diabetes, dementia, depression and ischemic stroke with left hemiparesis. A.G. resided at a long term care facility.

7. On August 4, 2014, the same day A.G. was returned to the facility following rehabilitation for her stroke, A.G. fell and injured her left ankle.

8. Nursing staff notified Respondent of the fall and injury to the left ankle. Respondent ordered an x-ray of the ankle and pain medication.

9. On August 7, 2014, Respondent saw A.G. According to Respondent's progress note for that date, the patient's x-ray of the ankle was negative for a
fracture and swelling was noted at the left ankle. Respondent ordered a podiatry consultation and continued his prior orders.

10. Respondent’ progress note for August 7, 2014, does not demonstrate that he evaluated the left ankle to determine how much pain and tenderness were present. There is no mention of pain complaints despite the fact that nursing staff had documented A.G. complained of the injury being very painful. Furthermore, there is no mention of whether bruising was present on this date as was documented in the nursing notes for August 6, 2014.

11. On August 7, 2014, Respondent was notified that A.G.’s blood pressure was elevated and Respondent ordered an increase in blood pressure medications due to hypertension.

12. Respondent’s note from August 7, 2014, does not document a thorough examination and if a thorough examination had been done it is likely Respondent would have considered the patient’s pain complaint and increased blood pressure were from poor pain control. This would have required a change in the medical regimen to address the pain complaints. Furthermore, the uncontrolled pain and bruising should have led Respondent to consider an undiagnosed fracture and a second x-ray should have been ordered on this date.

13. Respondent should have tried alternative therapies to decrease the patient’s pain such as: a brace or Ace bandage; heat, ice or topical analgesic gel; and regular administration of acetaminophen.
14. Respondent should have ordered an orthopedic consult on August 7, 2014 to evaluate A.G.'s injury instead of a podiatric consult. Respondent should have insured that a consultation occurred within 2 days of the date ordered instead of the 6 days it took for podiatry to see the patient.

15. On August 9, 2014, nursing staff contacted Respondent about the patient becoming agitated and crying out. Respondent ordered Risperdal. Respondent did not document the rationale for the Risperdal. Risperdal is contraindicated for use in dementia patients for agitation. The standard of practice would have required an alternative medication such as an antidepressant or sedative.

16. Furthermore, it is likely that the agitation was not due to the patient's dementia, but rather to pain from her injury. Respondent should have considered this and ordered some of the therapies set forth in paragraph 13, above and should have ordered a second x-ray.

17. On August 13, 2014, nursing staff noted that A.G. was lethargic and unresponsive at times.

18. On August 14, 2014, the podiatric consultation was carried out. The podiatrist noted that A.G. was unresponsive and non-ambulatory. Upon physical examination the podiatrist noted that A.G. was pulling upon palpation of the left ankle. The podiatrist ordered an x-ray of the left ankle and foot. The x-ray report revealed a displaced fracture in the distal shaft of the left fibula well above the level of the ankle with mild overlying soft tissue swelling.
19. Upon receipt of the x-ray report, Respondent ordered that A.G. be transported to the hospital for casting of the left leg.

20. Respondent does not document that there was a change in A.G.'s mental status as documented by the nursing staff and the podiatrist. Respondent should have noted this finding and reduced or discontinued the Risperdal on August 14, 2014.

21. On August 18, 2014, a consent to administer an anti-psychotic medication was obtained from A.G.'s son. The consent was not timely sought or obtained by Respondent prior to prescribing the Risperdal.

COUNT I

22. Respondent's conduct as described above constitutes negligence, in violation of section 16221(a) of the Code.

COUNT II

23. Respondent's conduct as described above constitutes incompetence, in violation of section 16221(b)(i) of the Code.

THEREFORE, Complainant requests that this complaint be served upon Respondent and that Respondent be offered an opportunity to show compliance with all lawful requirements for retention of the aforesaid license. If compliance is not shown, Complainant further requests that formal proceedings be commenced pursuant to the Public Health Code, rules promulgated pursuant to it, and the

RESPONDENT IS HEREBY NOTIFIED that, pursuant to section 16231(8) of the Public Health Code, Respondent has 30 days from receipt of this complaint to submit a written response to the allegations contained in it. The written response shall be submitted to the Bureau of Professional Licensing, Department of Licensing and Regulatory Affairs, P.O. Box 30670, Lansing, Michigan, 48909, with a copy to the undersigned assistant attorney general. Further, pursuant to section 16231(9), failure to submit a written response within 30 days shall be treated as an admission of the allegations contained in the complaint and shall result in transmittal of the complaint directly to the Board’s Disciplinary Subcommittee for imposition of an appropriate sanction.

Respectfully Submitted,

BILL SCHUETTE
Attorney General

Kelly K. Elizondo
Assistant Attorney General
Licensing & Regulation Division
3030 W. Grand Blvd., 10th Floor
Cadillac Place
Detroit, Michigan 48202

Dated: June 14, 2016