Arizona Medical Board

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FINAL MINUTES FOR BOARD REVIEW COMMITTEE B TELECONFERENCE MEETING
Held on Wednesday, April 6, 2022
1740 W. Adams St., Board Room A • Phoenix, Arizona

Committee Members
Gary R. Figge, M.D., Chair
Bruce A. Bethancourt, M.D., F.A.C.P.
David C. Beyer, M.D., F.A.C.R., F.A.S.T.R.O.
Laura Dorrell, M.S.N., R.N.
Eileen M. Oswald

GENERAL BUSINESS

A. CALL TO ORDER.
Chairman Figge called the Committee's meeting to order at 8:01 a.m.

B. ROLL CALL
The following Committee members participated in the virtual meeting: Chairman Figge, Dr. Bethancourt, Dr. Beyer, Ms. Dorrell and Ms. Oswald.

ALSO PRESENT
The following Board staff participated in the virtual meeting: Patricia McSorley, Executive Director; Kathleen Coffer, MD; Medical Consultant; Michelle Robles, Board Operations Manager; and, Amy Skaggs. Carrie Smith, Assistant Attorney General ("AAG") was also present.

C. OPENING STATEMENTS
Chairman Figge read the civility policy for the record.

D. PUBLIC STATEMENTS REGARDING MATTERS LISTED ON THE AGENDA
No individuals that addressed the Committee during the Public Statements.

E. APPROVAL OF MINUTES

- February 3, 2022 Board Review Committee B Teleconference, including Executive Session

  MOTION: Dr. Bethancourt moved for the Committee to approve the February 3, 2022 Board Review Committee B Teleconference; including Executive Session minutes.
  SECOND: Ms. Dorrell.
  VOTE: The following Committee members voted in favor of the motion:
  VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
  MOTION PASSED.

LEGAL MATTERS

F. FORMAL INTERVIEWS

1. MD-21-0824A, DAN J. CAPAMPANGAN, M.D., LIC. #37418

Dr. Capampangan was present virtually with counsel Flynn Carey.

Board staff summarized that this case was initiated after a report was received from a hospital disclosing that Dr. Capampangan allowed a high school student observer to perform a nerve block procedure on an autistic patient, in violation of their policies. Banner noted that although consent was obtained, it was under the auspices of the student being a medical student as Dr. Capampangan introduced the student as "doctor student". During the procedure the sterile field was broken by the high school student. The patient's mother was reported to be an RN and she reported the occurrence. Dr. Capampangan did not follow the standard observer process flow which would require him to complete a separate form stating that the observer cannot touch a patient. It was also noted that the observer was given a student badge instead of an observer badge. Additionally, Dr. Capampangan contacted the patient's mother and she reported feeling uncomfortable that he questioned her. In August 2021, Dr. Capampangan was placed on leave then terminated with cause for unprofessional conduct in September 2021. Board staff also reviewed the medical records from the date in question and noted that the procedure documentation was completed by Dr. Capampangan and documented an uneventful procedure. Board staff noted that there was no documentation that an Observer was present or performed some of the nerve blocks. Board staff determined that Dr. Capampangan failed to maintain adequate records and allowed a student observer to perform 2 nerve blocks. SIRC reviewed the case and remained concerned with the poor judgment on behalf of Dr. Capampangan and stated that despite him not being provided with the second form; it is clear that an observer may only observe. SIRC considered Dr. Capampangan's decision to allow a high school student to perform an injection as egregious. In addition, the medical record did not reflect the student's participation in the procedure. Therefore, SIRC recommended a Letter of Reprimand.

Dr. Capampangan provided an opening statement where he apologized for what occurred and explained that he misunderstood the requirement for an observer. Dr. Capampangan stated that he completed an ethics course to ensure that he meets all hospital policies and procedures in the future.

Mr. Carey provided an opening statement and requested a non-disciplinary advisory letter and as this was a onetime event. Mr. Carey asserted that this case was complicated by the process breakdown at the hospital and noted that as a result of this case Banner has changed its procedures to establish how observers are used. Mr. Carey further asserted that this was not an attempt by the physician to be dishonest and that this was a case of miscommunication with no patient harm.

During questioning, Dr. Capampangan informed the Committee that he was given the forms to allow the observer to rotate with him on his service, but he received the wrong forms. Dr. Capampangan informed the Committee of his interpretation of an observer and that they are there to see the day-to-day operation. Dr. Capampangan explained that her badge stated student and he did not question it and introduced her as a student. Dr. Capampangan noted that he spent additional time training the student to ensure she knew what she was doing and noted that the procedure had no complications. Dr. Capampangan stated that he regretted allowing a high school student to perform a nerve block and placing the patient and his mother in this situation. He has learned from this experience and no longer plans on teaching and working with observers in the future. Dr. Capampangan confirmed he left the room when he had to get a new needle after the student touched it. Dr. Capampangan admitted that he made a mistake by not listing the student as part of the procedure in the medical records. Dr. Capampangan stated that he did not feel he put the patient at risk and that he carefully selects patients for these procedures. Dr. Capampangan stated that he put himself at risk due to the consequences of this occurrence and that he thought he had gone through the appropriate channels. Dr. Capampangan confirmed he took the PBI course in ethics and professionalism and explained what he learned.

Dr. Beyer commented that it is obvious that a high school student should not be performing a nerve block even with a competent physician standing by and inquired how the physician believes this does not rise to the level of discipline.

Dr. Capampangan explained that he has been an academic teacher his whole career and that he was under the impression that since Banner was a teaching hospital that it was okay at the time. Dr. Capampangan further explained that this was the first time he had a high school student shadow him and he did what he normally does with someone who rotates with him. Dr. Capampangan explained that it was normal for a resident and/or medical student to rotate with him and the distinction did not occur at the time. Dr. Capampangan commented at the time he selected the patient he felt there was no risk but given the comments and feedback of today's discussion he understands there was low risk. Dr. Capampangan confirmed that he now has a position as an independent contractor and does not work with residents or medical students.

Mr. Carey provided a closing statement where he stated that this was a situation where the physician did not intend to do harm or deceive. The physician did not have the institutional awareness that he should have. Mr. Carey stated that an error occurred but will not be repeated in the future and requested the Committee issue an Advisory Letter.

During deliberations, Ms. Oswald opined that there has been unprofessional conduct by allowing an unlicensed high school student to perform two nerve blocks and in the process break the septic field or potentially put the patient at risk. Ms. Oswald commented that the physician did not maintain adequate medical records as there was no notation of observer or student and their part in the procedure.

MOTION: Ms. Oswald moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(e) and (r) for reasons as stated by SIRC.
SECOND: Dr. Beyer.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Dr. Beyer, Ms. Dorrell and Ms. Oswald.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

Ms. Oswald opined that this does rise to a level of discipline and agreed with the recommendation for a Letter of Reprimand.

MOTION: Ms. Oswald moved for the Committee to issue a Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand.
SECOND: Dr Beyer.

Dr. Bethancourt commented that there has clearly been unprofessional conduct but spoke against the motion as this physician has already completed the PBI course and was terminated from his employment. Dr. Beyer commented that it should be obvious without a policy that an unlicensed and untrained high school student without knowledge of anatomic landmarks should not perform this procedure. Dr. Beyer commented that even without evidence of malice this was far over the line and a Letter of Reprimand is appropriate. Dr. Figge commented that there is a distinct difference between teaching medically trained students to perform procedures versus somebody who is shadowing and observing. Dr. Figge opined that this was an egregious violation and there was potential harm to the public having an untrained individual performing the procedure. Dr. Figge agreed that the physician has been punished by losing his job but this is not something that should require reflection, a high school student should not touch a patient and certainly does not perform a procedure on them regardless of the low risk.

VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Beyer, Ms. Dorrell and Ms. Oswald. The following Committee member voted against the motion: Dr. Bethancourt.
VOTE: 4-yay, 1-nay, 0-abstain, 0-recuse, 0-absent.

MOTION PASSED.

G. FORMAL INTERVIEWS

1. MD-21-0361A, ABDULLAH M. YONAN, M.D., LIC. #27691
   Dr. Yonan was present virtually with counsel Flynn Carey.

   Board staff summarized that this case was initiated after receiving a report from a hospital disclosing that Dr. Yonan's clinical privileges were summarily suspended on April 17, 2021 based on allegations of unprofessional conduct for battery against an ICU nurse who disagreed with the rate of Dr. Yonan's ordered intravenous sedative medication to be administered to a patient. In his response, Dr. Yonan reported that he made multiple requests to the nurse to reduce the Precedex drip, which she failed to do, citing that the patient was aggressive when sedation was reduced. Dr. Yonan explained that as he was walking back to the patient's room, the nurse came toward him with stretched out arms to hug him and they walked to the room together. After meeting with the Medical Executive Committee ("MEC"), Dr. Yonan's privileges were reinstated and he completed the PACE professional boundaries courses ordered by the hospital in June 2021. The nurse reported to the police that Dr. Yonan grabbed her neck and dragged her to the patient's room. The nurse stated that she thought Dr. Yonan was putting his arms out to hug her; however, he put his arm over her shoulder and held it tightly, turning her around and walked down the hall holding her shoulder until they reached the patient's room. Board staff obtained the peer review records and interviews with witnesses and the nurse. The nurse reported that Dr. Yonan dragged her to the patient's room and demanded the Precedex be changed. A witness confirmed the nurse's report and that Dr. Yonan held the nurse under her arm and swopped her pulling her into the room and raised his voice. Another nurse reported that he saw Dr. Yonan with his arms lifted up but he turned around and only heard noise in the room. The MEC determined that it was undisputed that Dr. Yonan's arm was around the nurse and remained there for the duration of the walk to the patient's room, which was an unwanted physical touch and a violation of the Code of Conduct and met the definition of inappropriate conduct. The MEC lifted the suspension, required Dr. Yonan to take PACE's boundary course, apologize to the nurse, and enter into a behavioral stipulation. Board staff determined that Dr. Yonan engaged in unprofessional conduct by knowingly making a false statement to the Board and hospital relating to his responses when questioned about the incident and for touching a nurse in an inappropriate and aggressive manner. SIRC recommended a Letter of Reprimand.

   Mr. Carey provided an opening argument on behalf of Dr. Yonan and stated that there is a significant dispute between the physician, nurse and eyewitness's report of what occurred. Mr. Carey asserted that there are multiple perspectives of what the physical contact was and how it happened, but the standard to prove that a violation occurred has not been met. Mr. Carey noted that the MEC's minutes were not a direct statement from the physician and argued that this could not support a finding that the physician was dishonest. Mr. Carey further argued the idea that physical contact with a nurse has now become harm to the public is not consistent with the Board's rules. Mr. Carey asserted that there are mitigating factors in this case, stating that there was no evidence of dishonest or selfish motive, the MEC committee reinstated Dr. Yonan's privileges, and he has completed CME. Mr. Carey requested that the Committee issue an Advisory Letter in this case.

   During questioning, Dr. Yonan discussed the use and administration of the medication. The plan was to reduce the sedation and remove the tube. Dr. Yonan explained the plan was discussed in the morning and the nurse did not follow the orders. Shortly after the incident he was called by the CMO and asked to leave the premise. Dr. Yonan stated that he completed a three-day boundaries course and that he learned that having better communication is the best course of action. Dr. Yonan stated that from his standpoint he felt his communication was very clear and that his intention was not to touch the nurse. Dr. Yonan explained that he was making a pointing motion and the nurse came to hug him so he put his arm around her shoulder to redirect her and gave the order to reduce

the drip and left. Dr. Yonan agreed that the physician should give the orders to be carried out and there should be no physical contact.

Dr. Beyer inquired about the dishonesty violation that was cited in the SIRC report.

Board staff explained that the justification is in the conclusion of the SIRC report where Dr. Yonan initially stated that he hugged the nurse and that he did not yell and then subsequently stated that he redirected her. Other parties stated that there was yelling. There are inconsistencies even today from what was initially reported.

Dr. Yonan noted that the statement that he wrote the day of the incident and informed the Committee that he has a recording of his call with the CMO where he stated he did not hug the nurse. Dr. Yonan stated there was no dishonesty on his side.

Mr. Carey provided a closing argument and noted that Dr. Yonan acknowledged that there was physical contact. Mr. Carey reiterated his argument that there were discrepancies from the parties on what occurred and that there is no proof of dishonesty.

Board staff confirmed that the request to obtain the nurses personnel records from the hospital was denied as that would not negate that a physical touch occurred, which was the conduct that was under review. Staff did request medical consultant review of the care, and no deviation from the standard of care was identified. Board staff commented that despite the argument that nurses are not a member of the public; a nurse can file a complaint just like anybody else if they have concerns about a doctor and the Board will review those complaints. The Board has acknowledged that if a doctor and a nurse have negative interactions, there is a high risk for the potential for patient harm if nurses feel unsafe. Board staff noted that the physician and counsel did not provide the recording of the phone call with the CMO during the investigation.

During deliberation, Ms. Dorrell opined that there has been unprofessional conduct.

MOTION: Ms. Dorrell moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(r), (u), (jj) and (kk) for reasons as stated by SIRC.
MOTION FAILED DUE TO NO SECOND.

Committee members agreed to vote on the potential violations individually.

MOTION: Ms. Oswald moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(r) for reasons as stated by SIRC.
SECOND: Ms. Dorrell.

Dr. Bethancourt commented that having conflict between the team does put the patient at harm and that a nurse is a public member. Dr. Figge noted that the unwanted physical touching is cited in SIRC as a violation of A.R.S. § 32-1401(27)(r).

VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Dr. Beyer, Ms. Dorrell and Ms. Oswald.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

MOTION: Dr. Bethancourt moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(jj) for reasons as stated by SIRC.
SECOND: Dr. Beyer.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Dr. Beyer, Ms. Dorrell and Ms. Oswald.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

MOTION: Dr. Beyer moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(kk) for reasons as stated by SIRC.
SECOND: Ms. Dorrell.

Ms. Oswald expressed concern regarding the discrepancies and recollection of the events. Dr. Beyer noted that there are reasons to believe that different versions of the story have been heard. Dr. Beyer found it troubling that the physician stated he had a recording that could have been provided at any time during the investigation. Dr. Bethancourt spoke against the motion, opining that there appears to be misperception of what occurred and that there was no intent to mislead. Dr. Figge agreed that there was not clear and convincing evidence that the physician intended to make a misleading statement.

VOTE: The following Committee members voted in favor of the motion: Ms. Dorrell, Ms. Oswald and Dr. Beyer. The following Committee members spoke against the motion: Dr. Figge and Dr. Bethancourt.
VOTE: 3-yay, 2-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

Ms. Dorrell opined that this does rise to the level of discipline.

MOTION: Ms. Dorrell moved for the Committee to issue a Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand.
SECOND: Dr. Bethancourt.
Dr. Bethancourt commented that the argument that other physicians had some issues with this particular nurse is not relevant to the issue. There is a chain of command that if a physician has an issue with a nurse, it should be reported to the head nurse and follow the chain of command. Ms. Oswald commented that there are other ways to achieving the results desired through communication, influence, and the chain of command without touching. Dr. Figge agreed with the violations and that physical contact is not warranted and that the chain of command should have been followed. Dr. Figge commented that regardless of whether it was aggressive or not, physical contact occurred and it became an issue that was reported. Dr. Figge opined that the intent of the physician was not to cause harm but to take care of the patient. There was no patient harm and the Medical Consultant ("MC") agreed with Dr. Yonan's decision making regarding the drip. Dr. Figge opined that there is a potential for harm when the team cannot work together to take care of the patient. The MC felt professional boundaries course was appropriate which was taken by the physician. Dr. Figge spoke against the motion as this does not rise to the level of discipline.
VOTE: The following Committee members voted in favor of the motion: Dr. Bethancourt, Dr. Beyer, Ms. Dorrell and Ms. Oswald. The following Committee member voted against the motion: Dr. Figge.
VOTE: 4-yay, 1-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

H. FORMAL INTERVIEWS

1. MD-19-1177A, KURT W. SPRUNGER, M.D., LIC. #37779
   Dr. Sprunger participated virtually without counsel.

Board staff summarized that the Board initiated the case after receiving notification of a malpractice settlement regarding Dr. Sprunger's care and treatment of a 51-year-old male patient ("ER") alleging failure to properly monitor patient in recovery from gastric bypass surgery with subsequent death. On November 23, 2016, ER underwent a Laparoscopic converted to open Roux-en-Y gastric bypass performed by Dr. Sprunger at a Hospital. The surgery started laparoscopic and was converted to an open procedure due to difficulties with adhesions and body habitus, associated to that the patient presented with macronodular disease on his liver. There was a tear of the splenic capsule that was associated to possible portal hypertension and cirrhosis made it difficult to control bleeding, leading to splenectomy. At 1227, ER was transferred to the PACU

and monitored by the anesthesia team and nurses. The JP drainage with blood color content was reported by the RN staff to Dr. Sprunger. In the PACU, ER had a low marginal blood pressure and was slightly tachycardic. Subsequently, Dr. Sprunger had started a procedure on another patient. Dr. Sprunger asked the assisting physician to check on ER in PACU. The assisting physician reported an amount of 460 mL of blood in the JP drain. Dr. Sprunger tried to seek another room to take the patient back to the operating room while the assisting physician finished the current surgery. However, Dr. Sprunger was informed that there was a lack of staff and therefore they need to follow themselves. Dr. Sprunger went to the PACU as he heard the patient was being re-intubated. When Dr. Sprunger arrived in the PACU, ER was undergoing full code resuscitative efforts and the team was able to take him back to the operating room. However, efforts to find the bleeding site were unsuccessful. ER went into ventricular fibrillation and was unresponsive to resuscitation maneuvers. The Board's MC reviewed the case and determined that Dr. Sprunger deviated from the standard of care by failing to timely address the patient's post-operative bleeding. The MC opined that Dr. Sprunger should have canceled the subsequent surgery in order to be more certain of the patient's real status. SIRC discussed the case and observed the MC's determination that there was poor communication, as well as a lack of communication from the nurses and CRNA team about hypotensive episodes and a follow up CBC that had been ordered but was not completed during the patient's deteriorating condition. SIRC stated that Dr. Sprunger as the surgeon had the responsibility to ensure that his patient was stable, and the source of bleeding identified prior to proceeding with another surgery. Therefore, SIRC determined that this rises to the level of discipline and recommended a Letter of Reprimand. SIRC also recommended that the hHspital be referred to AZ Department of Services (DHS) due to the identified system issues which impacted the patient's care.

During questioning, Dr. Sprunger clarified that he would not say there was a large amount of blood in a post op patient who may have had residual bloodedness peritoneal cavity which came out the drain during the initial phase, after closing the abdomen. Dr. Sprunger explained that if he knew about the hypotensive episode, he would have taken him back to surgery immediately. He explained that he does not typically check the nursing notes if the nurse is present. Dr. Sprunger informed the Committee that it is standard to keep the patient in the PACU if there is blood present in the drain as it is a precaution to have the patient closely monitored in the PACU to see if the drain continued to fill with blood. Dr. Sprunger explained that the second surgical procedure was emergent and his intention was to have his assistant surgeon take the ER back to the OR until he could join but there was no other OR staff available. Dr. Sprunger explained the timeframe of the three surgeries he conducted during that day. Dr. Sprunger stated that the JP drain appeared nearly full of blood, but only had 55 millimeters of blood after 40 or 45 minutes. The amount of blood was not large, and the patient was stable.

In closing Dr. Sprunger stated that a physician cannot be held responsible for the deterioration of a patient if he was not informed of the deterioration. Dr. Sprunger stated that this was a treatable complication that should not have resulted in the patient's demise. Dr. Sprunger informed the Committee of the steps he would have taken had he been informed of the hypotensive episode. Dr. Sprunger explained the CRNA in this case was specifically assigned to the PACU and should have communicated with him. The CRNA ordered fresh frozen plasma which he was not aware of until a couple of days later when he reviewed the medical records. There was no reason to order fresh frozen plasma. Dr. Srunger stated that the fact that an H and H was not obtained and the patient was not given a blood transfusion was the proximate cause of the patients demise.

During deliberations, Dr. Bethancourt commented that clearly there were issues with communication and if there was a large amount of blood then he should not have gone on to a second case. Dr. Figge commented that his interpretation was that in hindsight there was not a lot of blood but at the time he felt there was a significant amount of blood and therefore the patient remained in the PACU for him to remain under supervision. Dr. Beyer agreed that he interpreted there was enough of a concern regarding the bleeding to have the patient held for observation.

Dr. Bethancourt opined that there has not been unprofessional conduct.

MOTION: Dr. Bethancourt moved to dismiss.
SECOND: Dr. Beyer.
Multiple Committee members noted the physician's intent to monitor the patient for development, and the breakdown in communication from PACU staff, and the impact on the patient outcome.

VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Dr. Beyer, Ms. Dorrell and Ms. Oswald.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

GENERAL BUSINESS

I. DISCUSSION REGARDING DEBRIEFING ON COMMITTEE PROCESSES

Dr. Beyer commented that the meeting went smoothly other than some audio issues. Dr. Figge stated that he appreciated everybody's diligence and effort in reviewing, discussing and engaging in thoughtful deliberations.

J. ADJOURNMENT

MOTION: Dr. Bethancourt moved for the Committee to adjourn.
SECOND: Dr. Beyer.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Dr. Beyer, Ms. Dorrell and Ms. Oswald.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

The Committee meeting adjourned at 11:30 a.m.

Patricia E. McSorley, Executive Director