Arizona Medical Board

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

Committee Members
R. Screven Farmer, M.D., Chair
Jodi A. Bain, M.A., J.D., LL.M.
James M. Gillard, M.D., M.S., F.A.C.E.P., F.A.A.E.M.
Pamela E. Jones
Lois E. Krahn, M.D.

GENERAL BUSINESS

A. CALL TO ORDER
Chairman Farmer called the Committee's meeting to order at: 8:02 am

B. ROLL CALL
The following Committee members participated in the virtual meeting: Dr. Farmer, Dr. Gillard, Dr. Krahn, Ms. Bain, and Ms. Jones

ALSO PRESENT
The following Board staff participated in the virtual meeting: Kristina Jensen; Deputy Director; Kathleen Coffer, MD; Medical Consultant; Heather Foster, Board Operations Department; and, Alicia Cauthon. Mary Williams, Assistant Attorney General ("AAG") was also present.

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

D. PUBLIC STATEMENTS REGARDING MATTERS LISTED ON THE AGENDA
No individuals addressed the Committee during the Public Statements portion of the virtual meeting.

E. APPROVAL OF MINUTES

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

  MOTION: Ms. Bain moved for the Committee to approve the February 3, 2022 Board Review Committee A Teleconference Open Session and Executive Session minutes.
  SECOND: Dr. Krahn.
  VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Krahn, Dr. Gillard and Ms. Bain. The following Committee member abstained: Ms. Jones.
  VOTE: 4-yay, 0-nay, 1-abstain, 0-recuse, 0-absent.
  MOTION PASSED.

LEGAL MATTERS

F. FORMAL INTERVIEWS

1. MD-21-0302A, STEPHANIE C. JACKSON, M.D., LIC. #46714
   Dr. Jackson participated virtually with counsel Brenton Barber.

   Board staff summarized that this case was initiated after notification of action taken against Dr. Jackson's license by the Nevada Medical Examiners Board in March 2021 wherein she entered into a settlement for a public reprimand, a $1,000 fine, and 6 hours of continuing medical education for failing to maintain adequate medical records. In her response, Dr. Jackson reported completion of PBI's medical recordkeeping course in June 2021. Board staff reviewed the settlement agreement which outlined 3 counts of failure to complete medical records relating to Dr. Jackson's treatment of 3 patients between 2015-2017. SIRC noted that there were significant medical record deficiencies; therefore, SIRC recommended a Letter of Reprimand.

   Mr. Barber provided an opening statement to the Committee and requested the Committee to adopt the previously-offered consent agreement for a Letter of Reprimand.

   Ms. Williams informed the Committee that they may move to continue the Formal Interview to allow Dr. Jackson time to sign and return the consent agreement.

   Dr. Gillard commented that there are mitigating factors as the physician has been compliant and noted in the past the Board has not always mirrored what has been ordered by another state medical board.

   Board staff noted that the Committee may offer a timeframe for the physician to sign and return the proposed consent agreement previously offered and, if signed, the consent agreement will come back before the Committee at the May meeting.

   MOTION: Dr. Krahn moved to continue the formal interview to allow the physician the opportunity to sign the previously-offerred consent agreement and return it to Board staff within 48 hours .
   SECOND: Ms. Jones.
   VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Krahn, Dr. Gillard, Ms. Jones and Ms. Bains
   VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
   MOTION PASSED.

G. FORMAL INTERVIEWS

1. MD-21-0224A, ERIC D. COHEN, M.D., LIC. #32942
   Dr. Cohen participated virtually with counsel Peter Wittekind.

   Board staff summarized that the case was initiated based on a malpractice settlement regarding the treatment of AN which resulted in the patient's death. In January 2016, AN presented to Flagstaff Medical Center (FMC) with left leg ischemia. A CT scan was performed, which had an incidental finding of a complex abdominal aortic aneurysm ("AAA") that appeared to measure 4.4cm with evidence of significant bilateral renal artery stenosis. AN was evaluated by a vascular surgeon who recommended conservative medical management with follow-up imaging study in six months and ultimately annual imaging. Shortly after this AN underwent pre-continuous angioplasty successfully performed by Dr. Cohen. On July 28, 2016, AN underwent an endovascular aneurysm repair (EVAR) of the AAA performed by Dr. Cohen. Post-operatively, AN experienced complications and expired. The Board's Medical Consultant ("MC") reviewed the case and determined that Dr. Cohen deviated from the standard of care by performing an endovascular AAA repair in a high risk patient without clinical indication for an emergent repair such as associated iliac aneurysm, tenderness, or rapid expansion. The MC stated that the patient's AAA was less than 5.5cm and required repeat imaging at six months to evaluate for rapid expansion, which was not completed. The MC noted that there was no

documentation of a vascular surgeon recommending intervention but only a note recommending conservative medical management. SIRC considered whether disciplinary action was warranted noting that the patient expired. SIRC observed that Dr. Cohen has no prior Board history and the care was rendered in 2016. SIRC recommended a Letter of Reprimand.

During questioning, Dr. Cohen informed the Committee of his decision making and treatment of patient AN. Dr. Cohen felt surgery was the only option to treat the AAA by looking at the clinical presentation and making a clinical judgement to treat this sooner than later given the complexity of the disease. Dr. Cohen also noted that there were multiple CT scans of patient AN and he was fully aware of the anatomy and the AAA loss. Dr. Cohen stated that all his cases were completed with a surgical consultant. This was not planned as an emergency surgery but was a planned elective surgery. Dr. Donnelly recommended against an open surgical repair which Dr. Cohen stated he agreed with. Dr. Cohen stated that he regrets not documenting Dr. Donnelly's and his interactions clearly in the patient's chart. Dr. Cohen stated that going forward all conversations between him and the collaborative surgeon and conversations with the patient and the family will be clearly documented.

Dr. Cohen clarified the timeline that led to the AAA surgery. AN presented to Flagstaff Medical Center with left lower extremity weakness and gate instability. Dr. Donnelly was consulted and recommended an endovascular repair of the left common iliac stenosis which Dr. Cohen was asked to do and the procedure was successful. AN was then referred back to him by AN's primary care provider. About six months later, AN had relief of left lower extremity pain and imaging was performed. Dr. Cohen noted that with regards to the aneurysm he recommended waiting and watching and did not recommend an emergency procedure or an open procedure. At a follow up visit, he discussed with alternative therapies with AN. The AAA surgery was an elected surgery.

Dr. Farmer commented that it was clear in the record that attempts had been made to get the patient to engage in lifestyle modifications and the patient rejected those. Dr. Farmer inquired about Dr. Cohen's thoughts on what the patient's long-term life expectancy would have been without the surgery.

Dr. Cohen commented that it is hard to determine and noted the patient had developed clinical coronary disease and peripheral vascular disease. He previously had a stroke and was not likely to live a long and healthy life. Dr. Cohen explained his reason for not obtaining new imaging prior to the procedure.

With regards to the malpractice settlement, Dr. Cohen felt it was best to settle with AN's family given that the COVID-19 restrictions at the time would have been detrimental to his practice if he would have proceeded with the malpractice trial.

Mr. Wittekind commented that Dr. Cohen got the malpractice case resolved early on and noted that a defense verdict was likely had the case proceeded to trial.
In closing, Dr. Cohen stated that this was a terribly unfortunate circumstance and noted that this is his only malpractice settlement in 40 years of completing high risk surgeries. Dr. Cohen further noted that he and Dr. Connelly have spent almost 10 years together on difficult cases with great success. Dr. Cohen commented that he has to try to make the best decision he can with the data he has.

Mr. Wittekind provided a closing statement to the Board, addressing the MC's statement that the standard of care is that surgery is not performed unless the diameter of the AAA is 5.5. Mr. Wittekind stated that it's actually 5 to 5.5 for open procedures.

Dr. Wolf commented that this physician performed an endovascular repair of an aneurism at 4.4 cm which was not indicated and the patient died. Dr. Wolf found it troubling that Dr. Cohen does not appear to either recognize or acknowledge this. Dr. Wolf commented

that the absolute diameter of the aneurism is significant and relates to the natural history of the disease.

During deliberation, Dr. Farmer opined that Dr. Cohen is thoughtful and wanted the best for his patient. However, there are very clear documentation issues that Dr. Cohen acknowledged. Dr. Farmer commented that there is a very stark difference in opinion between the medical expert and the physician as to the indication for this surgery on AN. The physician thought that there was going to be further progression of the disease. On the other hand, there are fairly clear indications that the size of the lesion as far as its diameter was not growing.

Dr. Krahn acknowledged Dr. Farmer's comments but noted that this physician has a great deal of experience with no prior board history. Although there was a bad outcome there have been many procedures with high risks that did not result in bad outcomes. If the physician had many cases against his license this would be more troubling, then one bad outcome. Dr. Gillard commented that given the six months since the last CT scan was done, he found it troubling that another was not performed prior to the surgery, even though in hindsight it may not have changed the outcome. Dr. Farmer commented that there are troubling things about this case however the physician seems to be a reasonable individual with thoughtful decision making. The Committee needs to make sure it does not have hindsight bias and it is mitigating that the patient pushed for having the procedure done. It seems like both from the record and the physician's comments a fair amount of discussion was involved. Dr. Farmer found it mitigating that there was a vascular surgeon involved in the decision-making process. Dr. Farmer opined that an advisory letter would be appropriate for tracking purposes. Dr. Farmer commented that there was a concern about medical records as well.

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

Dr Farmer reiterated that he found it mitigating that the patient was deeply involved as well as a vascular surgeon. In the mind of the physician, this decision was not lightly taken to perform surgery. There is still concern that the procedure was done and for patient safety an advisory letter for tracking purposes is appropriate.

MOTION: Dr. Farmer moved for an Advisory Letter for inappropriate performance of repair of an abdominal aortic aneurysm and for inadequate medical records. While there is insufficient evidence to support disciplinary action, the Board believes that continuation of the activities that led to the investigation may result in further board action against the licensee.
SECOND: Ms. Bain.
Dr. Gillard acknowledged the physician's significant experience but noted that the Board has an expert opinion as well. Dr. Farmer stated that he takes these concerns seriously and is trying to balance them with the mitigating factors in this case. Dr. Gillard noted that having an updated CT scan may not have made a difference and agreed with the inadequate medical records. Dr. Gillard also noted that this was a patient with a lot of co-morbidities. Ms. Jones commented that she appreciated the physician's detailed explanations and that he acknowledges his lapse in medical records. Ms. Jones found it mitigating that the patient did not make any changes to his lifestyle.
VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Krahn, Dr. Gillard, Ms. Jones and Ms. Bain.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

H. FORMAL INTERVIEWS

1. MD-21-0596A, HARRY D. SILSBY, M.D., LIC. #40441

Dr. Silsby participated virtually without legal counsel.

Board staff summarized that this case was initiated based on a malpractice settlement. JE was a 25 year old male with bipolar disorder. He was admitted on November 14, 2016 after his mother found him gripping a knife and threatening others as well as having asked his grandmother for a gun and threatening to kill himself. He had recently been started on Cymbalta. He was discharged on Haldol and trazadone although the discharging physician was hesitant due to JE's labile presentation. Four months later, on March 31, 2017, a treatment guardian was appointed by the Court along with giving JE's mother responsibility for consulting with providers and mental health professions. A physician affidavit two days prior recommended a 30 day hospital stay to the Cfor the diagnosis of bipolar disorder and personality disorder. The patient was paranoid, threatened to kill himself, and had zero insight into his mental health needs. On April 3, 2017, JE was suicidal and presented to the emergency department. JE had been discharged the day before from another psychiatric hospital where his mother reported aggression and drug use. JE presented with similar issues as he did in his prior visit, unable to communicate his thoughts, not sleeping, not taking his medications, depressed, and nervous. JE was admitted to a psychiatric hospital under the care of Dr. Silsby. Dr. Silsby diagnosed JE with schizoaffective disorder bipolar type with psychotic features, cannabis dependence, nicotine dependence, suicide, and hypertension. Three days later the treatment guardian agreed with the previous recommendation for the stay and involuntary commitment. The following day, Dr. Silsby declined to make a recommendation for involuntary treatment, since he stated there had been improvement. The treatment notes indicated that JE was not participating in group therapy. On April 10th, one week after admission, Dr. Silsby discharged the patient home with outpatient services. Dr. Silsby noted that JE was not felt to be a threat to himself or others and had no suicidal or homicidal ideations. On April 25, 2017, JE died by suicide. SIRC found that Dr. Silsby failed to complete a thorough evaluation. He also did not consult with the guardians nor take into account the recommendation for the 30 day hospital stay. SIRC recommended a Letter of Reprimand.

Dr. Silsby provided an opening statement where he described JE's prior history. Dr. Silsby noted that the recommendation that JE be committed to the state hospital was declined by the Court, which was only 5 days prior to him being admitted to the hospital where he treated him. The Court felt he was not suitable to be admitted at that point. Dr. Silsby opined that the Court did the right thing since JE was inconsistent and the Court appointed a treatment guardian for consistency. Dr. Silsby noted that he was not aware of the treatment guardians when they were contacted by the therapy staff. Dr. Silsby stated that while he was at their hospital, JE denied suicidal ideation, which is in the record. JE was in great denial about his use of marijuana. At this point, they were looking to arrange a therapeutic discharge. Dr. Silsby stated he thought it was important for JE to be in a 12-step program to work on his chemical dependency issues. It appears, after the fact that, that JR'smother had moved, and his treatment guardian had not visited him, so JE was left alone to his own devices for 15 days. Dr. Silsby opined that if he had proper supervision the outcome would have been entirely different. Dr. Silsby stated that in the hospital, JE was compliant with his medication and attended chemical dependency groups as well. Dr. Silsby explained that it was his thinking that rather than be institutionalized it was more therapeutic for the patient to be within his own surroundings, to be with family and to follow up as an outpatient. Dr. Silsby read for the record Dr. Mason Dixon's letter that supported that the patient was better at discharge and that there was no violation of the standard of care. Dr. Silsby also noted that this case was reviewed by the Missouri State Medical Board, the State Board of New Mexico and the Medical Board of Colorado and they found no violation in the standard of care.

During questioning, Dr. Silsby explained that the patient was admitted to his hospital three days after being discharged from a psychiatric hospital. Dr. Silsby commented that

there was a pattern that the mother would bring him into the ER stating he is suicidal. Dr. Silsby commented that in retrospect there was a parent/child conflict. Dr. Silsby noted that during JE's stay at his hospital JE never mentioned a suicidal ideation to him or the staff. Dr. Silsby stated that JE was compliant with his medication, and he was doing well. There was no reason to believe that he would not continue that with the appropriate outpatient follow up. Dr. Silsby opined that chemical dependency is extremely difficult and is a reoccurring relapse illness that was a contributing factor. Dr. Silsby opined that in most cases it's probably more therapeutic to be with your family and be in your own surroundings and be followed by appropriate outpatient care. Dr. Silsby stated that he did not speak to the mother or the treatment guardian but told staff to give them his phone number if they wanted to speak to him. Dr. Silsby stated that he personally did not contact the mother or treatment guardian prior to discharge but that the therapist contacted the mother and the treatment guardian to inform them of the discharge. Dr. Silsby stated that he works as part of the treatment team with the therapist and guardian and that in retrospect he should have communicated more.

Dr. Silsby agreed with the recommendation that a treatment plan needs to be in place as there is a greater risk for the patient the first seven days after discharge and noted that the patient did not harm himself for 15 days after discharge. The hospital does follow up calls but the hospital could not get in touch with the patient. Dr. Silsby stated that they should have tried to get ahold of the treatment guardian. Dr. Silsby stated that in retrospect if he had known that the guardian had moved and was not with the patient they would have appointed treatment guardians who were more responsible. Dr. Silsby opined that this was the weakness of the aftercare plan. Dr. Sislby stated that he learned some things after the fact and if he had known at the time he would have made different decisions. Dr. Silsby noted that he thought the patient was doing well, that he had never attempted suicide in the past and had a good chance at success.

In closing, Dr. Silsby stated that he felt he made the best decisions that he could for this young man and will comply with the Board's recommendations.

MOTION: Dr. Krahn 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: Ms. Jones.
Dr. Gillard opined that he has difficulty finding unprofessional conduct in this case. Other Boards reviewed this and took no action. Dr. Gillard noted that the MC did not have information regarding the autopsy as well as the fact that the patient was intoxicated with cannabinoids and methamphetamine. The patient died by suicide 15 days after discharge. Dr. Gillard opined that there was a great deal of hindsight by the MC and in the SIRC report. Dr. Gillard opined that this was a very unfortunate outcome but noted that there is a difference between suicidal gestures, suicidal attempts and suicidal ideation. Dr. Gillard spoke against the motion. Dr. Krahn opined that there was an assumption that the guardian would fulfill her role and that it was pretty clear that the guardians were not engaged. The Court should have been notified and the treatment team, with the psychiatrists playing an important role, should have developed a more effective discharge plan. Dr. Krahn noted that in the hospital there is enforced sobriety than in the community where the patient can access his drugs. A 30 day stay at the shospital would have ensured sobriety, not that this would have been agreed to by the Court, but the second hospital should have went to the Court and said this is where we are at. If the Court denied the stay a second time then this would be a very different circumstance. Dr. Farmer commented that predicting either suicide or violent behavior towards others can be difficult and it is a complicated mess that psychiatrists wade into as the head of the team. Dr. Farmer commented that the issues with the guardians were not adequately addressed at any point. The hospitalization was sort of looked at in isolation and there was a real problem here in spite of the difficulty in predicting outcomes.

Ms. Williams confirmed with the motion makers that they agree with the deviations cited in the SIRC report.

VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Krahn and Ms. Jones. The following Committee member voted against the motion: Dr. Gillard. The following Committee member was absent: Ms. Ban.
VOTE: 3-yay, 1-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Dr. Krahn commented that this is a very difficult situation and appreciated the physician's explanation for why he recommended the discharge treatment plan that he did. Dr. Krahn found it mitigating that the physician did try to review the records and he observed the patient to be doing better and felt that it was a good treatment plan. Dr. Krahn commented that the option of an injectable where compliance could be mandated needed to be at least discussed with the guardian and considered and that did not happen. Dr. Krahn opined that this does not rise to the level of discipline and an advisory letter is appropriate.

MOTION: Dr. Krahn moved to issue an Advisory Letter for failure to properly communicate with the patient and their guardian prior to discharging the patient. While there is insufficient evidence to support disciplinary action, the board believes that continuation of the actions that led to the investigation may result in further board action against the licensee.
SECOND: Dr. Gillard.
Dr. Krahn commented that the biggest issue here was the lack of communication with the patient's guardian and mother. The responsibility of the team and the ultimate responsibility of the psychiatrist physician leading the team is to ensure that there is adequate communication and work with a guardian and that was absent here.
VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Krahn, Dr. Gillard, and
Ms. Jones votes no.
VOTE: 3-yay, 1-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

GENERAL BUSINESS

I. DISCUSSION REGARDING DEBRIEFING ON COMMITTEE PROCESSES

Ms. Bain inquired about returning to in person meetings. Dr. Farmer informed the Committee that the June 10, 2022 Board training meeting will be in person. A more permanent in person return depends on the construction and availability of the room, which is scheduled to be completed in the fall.

J. ADJOURNMENT

MOTION: Dr. Krahn moved for the Committee to adjourn.
SECOND: Ms. Jones.
VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Krahn, Dr. Gillard, and Ms. Jones. The following Board member was absent: Ms. Bain.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The Committee meeting adjourned at: 10:26 a.m.

Patricia E. McSorley, Executive Director