Arizona Medical Board

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DRAFT MINUTES FOR BOARD REVIEW COMMITTEE A MEETING
Held. on Wednesday, February 1, 2023
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.
David C. Beyer, M.D., F.A.C.R., F.A.S.T.R.O.
Lois E. Krahn, M.D.
Constantine Moschonas, M.D., F.A.A.N.
Eileen M. Oswald

GENERAL BUSINESS

A. CALL TO ORDER
Chairman Farmer called the Committee's meeting to order at 11:03 a.m.

B. ROLL CALL
The following Committee members were present: Dr. Farmer, Dr. Beyer and Dr. Moschonas.

The following Committee member participated telephonically: Ms. Bain.

The following Committee member was absent: Dr. Krahn and Ms. Oswald.

ALSO PRESENT
The following Board staff participated in the virtual meeting: Patricia E. McSorley, Executive Director; Claude Deschamps, MD; Chief Medical Consultant; Michelle Robles, Board Operations Manager; and Amy Skaggs; Investigations. Carrie Smith, 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
Individuals that addressed the Board during the Public Statements portion of the teleconference appear beneath the matter(s) referenced.

E. APPROVAL OF MINUTES
- December 1, 2022 Board Review Committee A Teleconference; including Executive Session

  MOTION: Dr. Moschonas moved for the Committee to approve the December 1, 2022 Board Review Committee A Teleconference minutes; including the Executive Session minutes.
  SECOND: Dr. Farmer.

VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Moschonas and Ms. Bain. The following Committee member abstained: Dr. Beyer. The following Committee members were absent: Dr. Krahn and Ms. Oswald.
VOTE: 3-yay, 0-nay, 1-abstain, 0-recuse, 2-absent.
MOTION PASSED.

LEGAL MATTERS

F. FORMAL INTERVIEWS

1. MD-22-0541A, DOUGLAS J. CAMPBELL, M.D., LIC. #28543

Dr. Campbell was present with counsel Randy Yavitz. Dr. Brinkerhoff addressed the Committee during the Public Statements portion of the meeting on behalf of Dr. Campbell..

Board staff summarized that this case was initiated after receiving two unfavorable chart reviews required by a Decree of Censure and five-year probation. A medical consultant (MC) reviewed two patient charts. In the case of FO, the MC found inadequate evaluation and follow-up after abnormal CT results and inadequate treatment and evaluation of a complicated UTI in the setting of uncontrolled diabetes. In the case of SG, the MC found the patient had a history of poorly controlled hypertension that remained unaddressed in prior office visits with inadequate lab workup and evaluation, inadequate follow-up of an abnormal EKG in this setting, and inadequate evaluation of a fall with no history of present illness ("HPI"), or neurological exam documented. SIRC noted the MC expressed concerns regarding poor charting in both patients. SIRC agreed with the MC regarding the identified deviations from the standard of care and remained concerned regarding the inadequate documentation despite an extensive period of probation and chart reviews. SIRC observed that Dr. Campbell's current Board Order for a Decree of Censure and five-year probation would have been completed in May 2022 and recommended a Letter of Reprimand and two-year probation and completion of intensive in-person CME in medical recordkeeping with continuation of chart reviews. SIRC further recommended that Dr. Campbell's prior Board order be terminated.

Dr. Campbell provided an opening statement to the Board. Dr. Campbell informed the Board of the effect that his previous probation has had on his practice and what a second probation may result in. Dr. Campbell stated that no patient harm was done and opined that his care was appropriate.

Mr. Yavitz provided an opening statement to the Board and requested that the Board not issue discipline in this case.

During questioning, Dr. Campbell informed the Committee of FO's timeline and treatment. Dr. Campbell explained that he referred her to a urologist and that he had a discussion with the patient regarding lorazepam and tramadol. Dr. Campbell explained his thought processes for prescribing cipro since the patient reported that other antibiotics did not work for her. Dr. Campbell admitted that this comment should have been documented in the records but opined that this drug was appropriate for the patient. Dr. Campbell noted that his probation and chart reviews have resulted in changes in his practice and processes.

In closing, Dr. Campbell stated that he is committed to improving his documentation and opined that continuing probation is not appropriate.

Mr. Yavits provided a closing statement to the Committee.

During deliberation, Dr. Moschonas opined that there has only been unprofessional conduct for recordkeeping.

MOTION: Dr. Moschonas moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(e) for reasons as stated by SIRC.
SECOND: Dr. Beyer
VOTE: The following Committee members voted in favor of the motion: all
The following Committee members were absent: Krahn and Oswald.
VOTE: 0-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

Dr. Moschonas referred to Dr. Brinkerhoff's public statement regarding the proactive approach being taken by the hospital and opined that CME for recordkeeping is appropriate.

Dr. Moschonas moved to issue an Order for Non-Disciplinary CME. Within six months, complete no less than 10 hours of Board staff pre-approved Category I CME in an intensive, in-person course regarding medical recordkeeping. The CME hours shall be in addition to the hours required for license renewal.
SECOND: Dr. Farmer.
Dr. Beyer stated that he would be in favor of an Advisory Letter and CME. Dr. Beyer opined that there shouldn't be a lower standard for physicians practicing in a rural community. Dr. Beyer noted that the records and care is in the range. Dr. Beyer noted that although there were issues with the records this does not rise to the level of discipline. Dr. Beyer agreed with terminating the current probation.

Ms. Smith noted that the committee can recommend that the termination request be placed on the next full board meeting.

Dr. Farmer spoke in favor of the motion.
VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Beyer, Dr. Moschonas, and Ms. Bain. The following Committee members were absent: Dr. Krahn and Ms. Bain
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

G. FORMAL INTERVIEWS

1. MD-21-0552A, ROBIN HURLBERT, M.D., LIC. #23011

Dr. Hurlbert was present with counsel James Kaucher. M.B. addressed the Committee during the Public Statements portion of the meeting.

Board staff summarized that the Board received a complaint regarding Dr. Hurlbert's care and treatment of a 64 year-old female patient (BM) during and after a Transforaminal Lumbar Interbody Fusion (TLIF). Intraoperatively, the patient experienced loss of somatosensory and motor evoked potentials in both legs after the insertion of the interbody cage. There was no intraoperative improvement on the right side and some improvement on the left side. The patient demonstrated bilateral weakness and numbness with associated pain and a right foot drop 6 months after surgery. SIRC noted that an MC determined that Dr. Hurlbert deviated from the standard of care by failing to properly supervise his resident during a crucial portion of the surgery performed on patient BM and failed to explore the operative site or obtain a postoperative MRI to evaluate the cause of BM's left lower extremity weakness. Dr. Hurlbert indicated that he understood the reasons for BM's postoperative neurological deficits to be secondary to nerve root retraction but also indicated that he was puzzled by the proximal lumbar level deficiencies. The MC reiterated that when neurological deficits become apparent absent a known etiology then intra-operative exploration of the surgical site and/or postoperative diagnostic radiological studies are appropriate. The details of cage insertion were reviewed at length by parties involved though Dr. Hurlbert's expert described a cage insertion approach opposite of that described by the licensee. The Dr. Hurlbert's expert

indicated that he thought Dr. Hurlbert's surgery simply failed to improve BM's pre-surgical status and BM's postoperative condition was not related to any aspects of the surgery itself. However, the MC clarified that very significant differences existed between the patient's pre-operative and post-operative neurological condition. SIRC discussed the case and was concerned with Dr Hurlbert's judgment in allowing his resident to perform a critical portion of the surgery unsupervised, which resulted in BM's nerve injury. SIRC also considered it an aggravating factor that Dr. Hurlbert failed to further investigate the etiology of the lower extremity weakness. Therefore, SIRC recommended a Letter of Reprimand.

Dr. Hurlbert provided an opening statement to the Board and explained his history with the resident he was working with for this case. Dr. Hurlbert opined that the cages were inserted correctly and explained the procedure in detail. Dr. Hurlbert stated that if he had performed the surgery himself the outcome would have been the same and that a post operative MRI was not indicated.

Mr. Kaucher provided an opening statement to the Board and commented that it was an inaccurate finding that the resident was unsupervised and that it was acceptable for the physician not to order additional imaging that he opined was not needed.

During questioning, Dr. Hurlbert informed the Board of the consent process and what is included in the form. Dr. Hurlbert noted what his typical response is regarding patient's questions about the risk of paralysis.

During questioning, Dr. Hurlbert informed the Committee about the cage placement and neuromonitoring. Dr. Hurlbert explained the checklist that is followed for intraoperative monitoring. Dr. Hurlbert informed the Board of the post-op deficit the patient had and noted that it is not that common to have bilateral complications. Dr. Hurlbert explained his differential at this time and informed the Committee of the discussion he had with the patient after the surgery.

Dr. Hurlbert explained thought process when potential dropped and that you would not withdraw the cage once you've impacted since the cage pulling it out would cause it to pass the nerves again. Dr Hurlbert informed the Committee of the time during the procedure where he is completely hands off when the resident was impacting the cages. Dr. Hurlbert stated that once a complication happens it's on him and he needs to scrub in and evaluate. Dr Hurlbert noted that if he has to scrub in he will finish the case and that nothing he saw explained the event other than the two applicators being there but the space looked ok. Dr. Hurlbert opined that the resident was capable of the procedure and that he needs to learn how to handle complications and seeing how the supervising physician handles it is a learning experience.

In his closing statement, Dr. Hurlbert apologized to the patient.

Mr. Kaucher provided a closing statement to the Committee where he noted that part of the training process is to allow the resident to get hands on experienced once the supervising physician feels the resident is ready.

During deliberation, Dr. Farmer expressed concerns regarding communication and informed consent. Dr. Beyer acknowledge the importance of training residents however, opined that it is careless not to be scrubbed in during the moment when something can go wrong in the procedure. Dr. Farmer noted that it is part of residency to teach but as a patient it would be nice to know the physician is scrubbed in. Dr. Farmer commented that a little handholding could have taken place. Dr. Farmer noted that for disciplinary purposes there needs to be a clear and convincing standard and there isn't a clear and convincing standard that the physician should have been scrubbed in. Dr. Farmer opined that the timing of follow-up appointments could have been expedited.

Ms. Smith clarified the violations identified in this case by Board staff.

Dr. Farmer commented that this is tragic and that there are things to be learned but that there is not clear and convincing evidence that the physician should have been scrubbed in or if it would have made a difference.

Ms. Smith noted that not being scrubbed in was found to be an aggravating factor.

Dr. Beyer opined that there is no r violation but would uphold the jj violation.

MOTION: Dr. Beyer moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27) (jj) for reasons as stated by SIRC.
SECOND: Dr. Farmer
VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Ms. Bain, Dr. Beyer and Dr. Moschonas. The following Committee members were absent: Dr. Krahn and Ms. Oswald.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

Dr. Farmer opined that the care was thoughtful, well-intended and probably technically great, however; the patient should be fully informed about who is being scrubbed in. Neurosurgery is a tough and busy field and with the benefit of hindsight there should be more handholding.

MOTION: Dr. Farmer moved for an Advisory Letter for inadequate supervision of a resident during a surgical procedure. 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: Dr. Beyer.
VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Ms. Bain, Dr. Beyer and Dr. Moschonas. The following Committee members were absent: Dr. Krahn and Ms. Oswald.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

H. FORMAL INTERVIEWS

1. THIS CASE HAS BEEN PULLED FROM THE AGENDA.

I. FORMAL INTERVIEWS

1. MD-21-0835A, DANIEL I. SHAPIRO, M.D., LIC. #20700
   Dr. Shapiro was present with counsel Jay Fradkin.

   Board staff summarized that the Board received a complaint from the patient who had surgery performed by Dr. Shapiro for intracapsular rupture of a right breast implant. The patient experienced increasing pain after surgery and was eventually diagnosed with a deep venous thrombosis (DVT) in the right arm and segmental pulmonary emboli. Of note, the patient was taking birth control pill Lo Loestrin FE at the time of the procedure. The patient eventually was anticoagulated and recovered. SIRC noted that the patient was dissatisfied with the final cosmetic result but declined another intervention by Dr Shapiro because she had lost trust in him related to the events described herein. SIRC observed that the MC found deviations from the standard of care in the delay in diagnosing the DVT, in the description of the procedure in the operative report and in the fact that the birth control pill had not been stopped weeks before the procedure. The MC could not rule on the allegation of unprofessional language. The MC accepted Dr. Shapiro's explanation of a clerical error in the operative report but maintained the

deviations regarding the delay in diagnosis of the DVT and the failure to discontinue the oral contraceptive pre-operatively. SIRC stated that oral contraceptives are known to cause blood clots and the manufacturer of Lo Loestrin FE was very clear that patients should discontinue the medication for a minimum of four weeks prior to a surgical procedure and for two weeks after. SIRC agreed with the MC that the probability for DVT was high based on the failure to stop birth control and Dr. Shapiro failed to order a STAT ultrasound when concern for DVT was present. For these reasons, SIRC recommended a Letter of Reprimand.

Dr. Shapiro provided an opening statement to the Committee and explained his thought process and treatment of the patient. Dr. Shapiro disagreed with the MC's findings and opined that he did not fall below the standard of care.

Mr. Fradkin provided an opening statement to the Committee and noted their own consultant's opinion regarding the standard of care of physician's following the medication recommendation insert for the birth control.

During questioning, Dr. Shapiro explained the timeframe for the initial consultation and the surgery a year later. Dr. Shapiro explained that this type of rupture are incidental findings on an MRI and typically recommend these to be addressed in an urgent fashion. Dr. Shapiro explained that the capsule was a result of the silicone. With the amount of inflammation that the patient had he recommended removing the capsule. Dr. Shapiro explained why suspending the oral birth control is not the standard of care and opined that the black box warning is a recommendation and is not practical in terms of the risk. Dr. Shapiro confirmed that this is a decision he makes on his own and not a discussion with the patient. Dr. Shapiro explained that the discrepancy in the operative report was a transcription error. Dr. Shapiro stated that his office notes are written on the day of the visit. Dr. Shapiro confirmed that there was a chaperone and no feedback from the chaperone was given to him.

In closing, Dr. Shapiro stated that he felt terrible that she had this complication but felt that his care was good and that he did not fall below the standard of care.

In closing, Mr. Fradkin stated that there was no evidence that Dr. Shapiro fell below the standard of care.

Dr. Beyer questioned that the study was not ordered as a stat study and led to a day delay.

During deliberation, Dr. Beyer commented that he was originally surprised that the oral contraceptives were not discontinued and questions whether it is the standard of care and it is not clear whether it should be discontinued. Dr. Beyer noted that there were communication issues and the fact that a patient who knew she had a complication and was happy with the care filed a complaint. Dr. Beyer opined that he cannot point to a clear violation of the medical practice act. Dr. Moschonas noted that he does not know the standard of care for stopping oral contraceptives but with respect to oral contraceptive for this procedure most across the country do not stop it. Dr. Farmer commented that everything in health care is a risk versus benefit evaluation and opined that these articles address the topic on hand to support not having discontinued the oral contraceptive. Dr. Farmer commented that he did not find fault in the progress notes and that although there is a concern when patients report inappropriate comments this physician had a chaperone in the room.

MOTION: Dr. Beyer moved to dismiss.
SECOND: Dr. Farmer
VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Moschonas and Dr. Beyer. The following Committee member voted against the

motion: Ms. Bain. The following Committee members were absent: Dr. Krahn and Ms. Oswald.
VOTE: 3-yay, 1-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

CONSENT AGENDA

J. APPROVAL OF DRAFT FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

1. MD-21-0409A, XIHUA YANG, M.D., LIC. #54135

MOTION: Dr. Farmer moved to approve the Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and Two-Year Probation, retroactive to October 28, 2021, with terms and conditions consistent with his Interim Order. The Probation shall not terminate except upon affirmative request of the physician and approval by the Board, and Dr. Yang's request for termination shall be accompanied by a recommendation from his PHP Contractor stating that monitoring is no longer required.
SECOND: Dr. Moschonas
VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Moschonas and Ms. Bain. The following Committee member abstained: Dr. Beyer. The following Committee members were absent: Dr. Krahn and Ms. Oswald.
VOTE: 3-yay, 0-nay, 1-abstain, 0-recuse, 2-absent.
MOTION PASSED.

GENERAL BUSINESS

K. DISCUSSION REGARDING DEBRIEFING ON COMMITTEE PROCESSES

No discussion took place regarding this topic.

L. ADJOURNMENT

MOTION: Dr. Beyer moved for adjournment.
SECOND: Dr. Farmer.
VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Ms. Bain, Dr. Beyer and Dr. Moschonas. The following Committee members were absent: Dr. Krahn and Ms. Oswald.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

The meeting adjourned at 1:51 p.m.

Patricia E. McSorley, Executive Director