# Arizona Medical Board

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## FINAL MINUTES FOR BOARD REVIEW COMMITTEE B MEETING
## Held on Friday, December 13, 2024
## *1740 W. Adams St., Board Room B • Phoenix, Arizona*

***Committee Members***
Lois E. Krahn, M.D., Chair
Katie S. Artz, M.D., M.S.
Jodi A. Bain, M.A., J.D., LL.M.
David C. Beyer, M.D., F.A.C.R., F.A.S.T.R.O.
James M. Gillard, M.D., M.S., F.A.C.E.P., F.A.A.E.M.
Pamela E. Jones

## GENERAL BUSINESS

### A. CALL TO ORDER
Chairwoman Krahn called the Committee's meeting to order at: 12:25 p.m.

### B. ROLL CALL
The following Committee members were present: Dr. Krahn, Dr. Artz, Ms. Bain, Dr. Beyer, Dr. Gillard and Ms. Jones.

### ALSO PRESENT
The following Board staff participated in the meeting: Heather Foster, Public Records Coordinator, Amy Skaggs, SIRC Coordinator and Carrie Smith, Assistant Attorney General ("AAG") was also present.

### C. OPENING STATEMENTS
Dr. Krahn read the civility policy for the record.

### D. PUBLIC STATEMENTS REGARDING MATTERS LISTED ON THE AGENDA
Individuals who addressed the Board during the Public Statements portion of the meeting appear beneath the case.

### E. APPROVAL OF MINUTES

- June 5, 2024 Review Committee B Minutes; including Executive Session

  **MOTION: Ms. Bain moved to approve the June 5, 2024 Review Committee B Minutes, including Executive Session.**
  **SECOND: Dr. Artz.**
  **VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Dr. Artz, Ms. Bain, Dr. Gillard and Ms. Jones. The following Board member abstained: Dr. Beyer.**
  **VOTE: 5-yay, 0-nay, 1-abstain, 0-recuse, 0-absent.**
  **MOTION PASSED.**

## LEGAL MATTERS

## F. FORMAL INTERVIEWS

1. MD-18-0884C, JOHN A. BROWN, M.D., LIC. #33209

Dr. Brown was present with counsel Bob Milligan. Complainant T.K., C.W., and B.K. spoke at Call to the Public.

Board Staff summarized that this case came to the attention of the Board because of a complaint against Dr. Brown regarding the care rendered to patient JK. JK was 86-year-old when he was admitted to the Hospital 11 days after a fall in a parking lot. After a cardiology clearance was obtained, he underwent open reduction and internal fixation of his post traumatic left patella fracture on December 20, 2017 by another surgeon. No intra- or post-operative complications were noted, despite JK's significant medical conditions of coronary heart disease, hypertension, cardiomegaly and congestive heart failure, and the presence of an implanted defibrillator. Included in the discharge instructions from the hospital to the skilled nursing facility (SNF) were the specifications that JK's post-operative dressing was to be left in place until he presented for follow-up at the orthopedist's office and these directions were apparently stringently followed. He was admitted at a second Hospital on January 3rd with hyponatremia and worsening pain. Purulent drainage and partial wound dehiscence were noted the following day by a PA. The subsequent clinical course over the next several days was significant for septic shock, leukocytosis, wound drainage, renal failure, and confusion. He was seen and treated by other physicians including cardiologist, hospitalist, intensivists and 2 other orthopedic surgeons. On January 5, JK underwent an irrigation and debridement performed by an orthopedic surgeon, Dr Hadi. The surgeon reported that he utilized the previously made skin incision described as a 'straight, long, midline incision'. The surgeon noted that purulent material was evident. The hardware was not removed at that time. A PICO vacuum dressing was applied to remain in place for one week but eventually failed. During the subsequent several days, the wound deteriorated, white cell count remained elevated, there were positive blood cultures with Methicillin Susceptible Staphylococcus Aureus and endocarditis was ruled out with a Trans Esophageal Echocardiogram. Dr Brown was first contacted on January 13 because of increasing concerns regarding the wound which showed necrotic skin, exposed wires and pus. The patient further deteriorated, diagnosed with pneumonia, septic shock, renal failure and was placed on a ventilator. Dr Brown aspirated and irrigated the joint and debrided the wound at the bedside. He brought the patient to the operating room later that day, further irrigated the joint, removed the hardware, evacuated a left thigh abscess and applied a wound VAC. In the following days, notes from the ICU, Hospitalist and ID physicians all pointed to septic shock due to left knee infection and pus draining from left knee wound. Ventilator weaning attempts failed and JK had developed anasarca. Subsequently, JK underwent a PEG tube placement, a tracheostomy, and bilateral pleurocentesis. From January 22, 2018, through January 30, there was no documentation from any orthopedic service providers. For 12 days, from January 19 to January 31, nurse's notes regarding wound dressing changes described JK knee wound as edematous and exhibiting abnormal color, necrotic tissue with slough, foul odor and visible bone and tendon. On January 31, 2018, Dr. Brown consulted with another orthopedic surgeon who recommended continued wound VAC treatment until JK was medically stable to undergo a vascularized muscle flap to cover the open left knee wound. On February 2, 2018, JK was discharged to a long-term care facility and expired on February 15, 2018. The Board's Medical Consultant ("MC") reviewed the case and cited multiple deviations from the standard of care which included failure to recognize a septic joint in a septic patient as an orthopedic emergency, which dictates surgical intervention as soon as possible. Additionally, the MC stated that Dr. Brown failed to fulfill the duties of a supervising physician over physician assistants and failed to appropriately monitor this severely ill patient, missing the opportunity to recognize that additional irrigations and debridements were required. The MC also expressed concern that the patient's hardware was not removed until ten days after admission in spite of continued leukocytosis and sepsis and stated that any practitioner should be aware of the greater risk of persistent infection in this situation. The MC also stated that Dr. Brown failed to be aware of the limitations and contraindications of negative pressure wound therapy which led to inadequate and inappropriate care in the face of necrotic tissue and eschar. The MC additionally reported

that Dr. Brown failed to investigate for osteomyelitis and failed to respond when the chosen treatment resulted in recurrent sepsis and extension of a joint infection into adjacent soft tissue. Dr. Brown, in his supplemental response defended his care and included supportive opinions from an Infectious Disease physician, an anesthesiologist/critical care physician and an orthopedic physician who opined that Dr. Brown, the other orthopedic physicians, and the involved PAs met the standard of care in their treatment of the patient. SIRC reviewed the case and agreed with the findings and conclusions of the Board Medical Consultant. SIRC noted that the MC reported that Dr. Brown had instructed a PA to evaluate the patient with a recurrent worsening orthopedic infection and noted that the PA had sent Dr. Brown a picture of the knee on January 13, 2018. The MC noted that gross, obvious worsening of an infected operative site in a hospitalized patient went unaddressed until other medical colleagues repeatedly pointed out the urgency of the patient's condition. The MC additionally observed that while the entire orthopedic service showed an over-riding lack of interest in caring for the patient, the initial deviations from the standard of care still applied to the January 13 - February 2 period, and therefore applied to Dr. Brown.

Dr. Brown provided an opening statement to the Committee. Dr. Brown agreed that continuity of care was important and further admitted that he did not complete medical records during JK's hospitalization. Dr. Brown informed the Committee that he has since completed CME. Dr. Brown sympathized with JK's family.

Mr. Milligan provided an opening statement to the Committee and stated that Dr. Brown should not be judged on what the other orthopedics did. Mr. Milligan noted that the last time this case was before the Board there were conflicting opinions and the Board should evaluate the opinions based of facts. Mr. Milligan further noted that the MC is not board certified and has did not actively practice. Mr. Milligan explained that the wound did not look good and was ready for grafting when JK was ready but JK was not ready for grafting. Mr. Milligan requested that the Committee issue an Advisory Letter in this case.

During questioning, Dr. Brown confirmed that the other physicians who performed the surgeries were from his group. Dr. Brown explained that the fracture itself was pretty stable and that the transverse pattern of the patella allows for displacement. Regarding leaving the dressing on for one to two weeks, Dr. Brown explained that this was not a wound to worry about. Dr. Brown confirmed that there are nurse practitioners (NP) in the practice who complete rounds on the patients. The NPs will report back to the physician and they will compare notes and discuss patient care. Dr. Brown confirmed that the patella is outside of the knee joint. Dr. Brown informed the Committee that a septic knee is not life threatening but joint threatening. JK was at risk for this infection and noted that the infection was 3 to 4 days into developing. Regarding the septic knee, Dr. Brown stated that he never saw the previous surgery prior to his and that the metal and eschar was not from anything he did. Dr. Brown stated that the wound did not look good but it would not due to the trauma and loss of skin. Dr. Brown explained that he was able to discuss the options with the patient's family and noted that he wanted to preserve his knee to get him back home. Dr. Brown further stated that his goal was to create the healthiest wound possible to preserve the knee and function. Dr. Brown explained that during hospitalization the original surgeon was aware of the hospitalization but not involved in JK's care. Dr. Brown provided the Committee with a timeline of JK's care and treatment and that on January 13th all eyes were off JK. Dr. Brown stated that JK was supposed to be discharged, but started to go downhill and the hospitalist started to chase red herrings looking for a source of infection. Dr. Brown noted that he was at the hospital seeing other patients and that the hospital was aware that he was there. Dr. Brown confirmed that the PA was going to see JK on January 13th while he was in the OR and was going to discuss her findings with him. Dr. Brown stated that JK started to deteriorate two to three hours prior to the PA seeing him. Dr. Brown agreed that the medical records were disturbing and that he wished he had placed a note in the chart. Dr. Brown stated that he saw the patient at least every other day personally at his bedside. Dr. Brown confirmed that he did not write a note for eight days in a row.

In closing, Dr. Brown stated that he was sorry for the family's loss and that if there was a lapse in care that he apologizes for that.

In closing, Mr. Milligan requested that the Committee make a decision based only on Dr. Brown's care and not that of the other physicians and that the Committee issue an Advisory Letter.

During deliberations, Dr. Artz stated that was a very difficult case and outcome. Dr. Artz appreciated Dr. Brown's hindsight and what he would change for a better outcome. Dr. Artz commented that we have all had to deal with call outs and that once the physician saw the wound the patient was scheduled for the OR. Dr. Artz questioned if the knee was aspirated a few days before would change the outcome. Dr. Artz further commented that when reading the notes, it appears that no one saw the patient. Dr. Artz opined that if there are no notes then it did not occur. Dr. Artz opined that there has been a violation of inadequate medical records however, Dr. Artz did not find sufficient evidence to sustain the other two cited violations.

**MOTION: Dr. Artz 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: Dr. Krahn, Dr. Artz, Ms. Bain, Dr. Beyer, Dr. Gillard, and Ms. Jones.**
**VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

Dr. Artz recommended an Advisory Letter only since the physician has already completed 19 hours of CME. Dr. Beyer opined that from the time Dr. Brown met the patient to the time of discharge, he demonstrated good care to the patient and agreed that an Advisory Letter is an appropriate outcome. Dr. Beyer opined that the lapse in the medical records is a serious issue but that it has been mitigated by completed the CME. Dr. Krahn commented that the physician could have signed off this patient's care following the weekend which could have worsened the outcome and recognized the physician's decision to stay with the patient.

**MOTION: Dr. Artz moved to issue an Advisory Letter for inadequate documentation. While the licensee has demonstrated substantial compliance through rehabilitation or remediation that has mitigated the need for disciplinary action, the board believes that repetition 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. Krahn, Dr. Artz, Ms. Bain, Dr. Beyer, Dr. Gillard, and Ms. Jones.**
**VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

## GENERAL BUSINESS

### G. DISCUSSION REGARDING DEBRIEFING ON COMMITTEE PROCESSES

Dr. Krahn commented that these microphones are tricky. Dr. Krahn acknowledged Ms. Jones service to Committee B.

### H. ADJOURNMENT

**MOTION: Ms. Bain moved for adjournment.**
**SECOND: Dr. Beyer.**
**VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Dr. Artz, Ms. Bain, Dr. Beyer, Dr. Gillard, and Ms. Jones.**
**VOTE: 6-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.**
**MOTION PASSED.**

The meeting adjourned at 2:22 p.m.

Raquel Rivera

Raquel Rivera, Interim Executive Director