Arizona Medical Board

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FINAL MINUTES FOR BOARD REVIEW COMMITTEE A MEETING
Held on Wednesday, June 4, 2025
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.R., F.A.S.T.R.O.
Laura Dorrell, M.S.N., R.N.
R. Screven Farmer, M.D.
Gail Guerrero-Tucker, M.D., M.P.H., F.A.A.F.P., D.A.B.F.M.

GENERAL BUSINESS

A. CALL TO ORDER
Chairman Figge called the Committee's meeting to order at: 10:17 a.m.

B. ROLL CALL
The following Committee members were present: Dr. Figge, Dr. Bethancourt, Ms. Dorrell, Dr. Farmer and Dr. Guerrero-Tucker.

ALSO PRESENT
The following Board staff participated in the meeting: Raquel Rivera, Interim Executive Director; Nicole Samaradellis, Investigations Manager and Michelle Robles, Board Operations Manager. Seth Hargraves, Assistant Attorney General ("AAG") was also present.

C. OPENING STATEMENTS
Chair Figge 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 meeting.

E. APPROVAL OF MINUTES

- April 1, 2025 Review Committee A Minutes

  MOTION: Dr. Guerero Tucker moved to approve the April 1, 2025 Review Committee A Minutes.
  SECOND: Farmer
  VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Ms. Dorrell, Dr. Farmer and Dr. Guerrero-Tucker.
  VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
  MOTION PASSED.

LEGAL MATTERS

F. FORMAL INTERVIEWS
1. MD-24-0689A, CHARLES MATLIN M.D., LIC. #13975
   Mr. Hall counsel was present and Dr. Matlin appeared via Zoom.

Board staff summarized that the Board initiated case number MD-24-0689A after receiving notification of a malpractice settlement regarding Dr. Matlin's care and treatment of a 64 year-old female patient ("LB") alleging improper performance of a diaphragmatic hernia repair. On June 16, 2022, LB underwent a laparoscopic cholecystectomy with reduction of a diaphragmatic hernia for biliary dyskinesia performed by Dr. Matlin. The Board's Medical Consultant ("MC") reviewed the case and determined that Dr. Matlin deviated from the standard of care by improperly performing a diaphragmatic hernia repair. The MC stated that tacking devices should never be used on the diaphragm as they expose the intra-thoracic organs to the points of the diaphragmatic tacks. The MC stated that Dr. Matlin had no way to visualize the thoracic surface of the diaphragm from a laparoscopic view within the abdomen; therefore, the tacks were placed without being able to see if they protruded through the other side of the diaphragm. SIRC noted that the MC found that Dr. Matlin deviated from the standard of care by using tacking devices on the diaphragm during a laparoscopic diaphragmatic hernia repair resulting in injury to the patient, an additional cardiac procedure and a longer recovery time. The MC further noted that the manufacturers of such devices clearly state that they should not be used on the diaphragm because of the risk of such injury. SIRC observed that in his response, Dr. Matlin defended his surgical technique and claimed that he was never informed that using the tacking devices on the diaphragm was contraindicated and that "off label" usage was justified in this case. SIRC recognized Dr. Matlin's significant prior Board history and acknowledged that he reported being retired. However, SIRC noted that his Arizona license does not expire until November 2026. SIRC stated that due to the egregious complication identified for the care rendered in 2022, as well as Dr. Matlin's refusal to take responsibility for the complication, SIRC recommended a Decree of Censure. SIRC further recommended that Dr. Matlin be offered a permanent practice restriction prohibiting him from practicing medicine until he undergoes a competency evaluation.

Mr. Hall provided an opening statement and requested that the Committee reject SIRC's recommendation. Mr. Hall quoted the MC who stated that Dr. Matlin appears to be well trained and thoughtful, made excellent intraoperative decisions with the exception of the choice of the tacking device and that Dr. Matlin recognized the problem promptly and made the appropriate referral. The MC concluded that Dr. Matlin is competent, and has undoubtedly saved the life of countless patients over the years. Mr. Hall opined that Dr. Matlin is not a physician who should be placed on a permanent practice restriction until he undergoes a competency evaluation. Mr. Hall argued that the manufacturer's statements do not establish the standard of care. Surgeons establish what is reasonable and what is the standard of care for a surgeon. Dr. Matlin had used them previously to his knowledge in these types of repairs, and he submitted literature, showing that other surgeons had used these types of tacks in this type of procedure. Mr. Hall argued that there is no reasonable basis to effectively take Dr. Matlin's license away from a surgeon who has practiced in Arizona

During questioning, Dr. Matlin informed the Committee that he's done repairs of the diaphragmatic plication and over the years he's done trauma and had traumatic diaphragmatic injuries with repairs. In this particular case, we did not expect to find this hernia. It was believed to be biliary dyskinesia, and this was an intraoperative finding, that was a surprise but explained the symptoms. It warranted repair because there was an incarcerated colon there and at the time he debated whether to suture or to tack. Dr. Matlin stated that he had extensive experience using the Ethicon tacker and he erroneously thought he could control its depth of penetration. Dr. Matlin explained that when he contemplated putting the suture blindly in the diaphragm, with the heart beating like that, he felt that it was more dangerous to try to anchor sutures that use a taker. Dr. Matlin disagreed with the idea that he did not recognize that this was an error. He understood that the tacker created this problem and that he could not control the depth of penetration enough to prevent it from injuring the heart. Dr. Matline stated that he thought he was choosing the path that was going to be the safest. With regards to considering going to an open procedure, Dr. Matlin stated that he felt confident that he could secure

this laparoscopically. Dr. Matlin noted that this was an older woman and her diaphragm probably isn't that thick. Placing a suture in the diaphragm and anchoring it would have required going pretty deep into that muscle to secure a patch to that area. Dr. Matlin opined that it would have been dangerous. Dr. Matlin stated that he failed to take into account that even if he got the tacks in, if there was a slight edge protruding, later it could have injured the heart. Dr. Matlin agreed that an off label warning is a red flag but he weighed the risks and in hindsight it was probably the wrong decision. Regarding his past Board history, Dr. Matlin stated that the advisory letters mostly pertain to documentation and noted that he had a case of a temporal artery biopsy. Dr. Matlin explained that his Arizona license afforded him the opportunity for emergency credentialing where he is living now in times of crisis. Dr. Matlin clarified that he is not sure what gave the impression that he didn't take responsibility but that he tried to explain his decision making.

In response to a Board member query, Board staff commented that the length of that tack is 6.7 millimeters, and it is not prohibited to use it around the area of the diaphragm where there is no urgency to the heart or major vessel. So, it is not the use of that tack on some diaphragmatic area, it is where he used it that is the problem and a question of judgment and awareness of where you are when you perform that surgery. Board staff noted that the diaphragmatic thickness in that area is two millimeters.

Dr. Farmer commented that SIRC recommended a Decree of Censure and that one of the factors was the presence of advisory letters. Dr. Farmer asked Board staff to explain the rationale for the Decree of Censure.

Board staff explained that SIRC was concerned at the combination of judgment and technical issues. Board staff stated that it was the spectrum of judgment and technical issues was a reason for signification discussion and concern for Dr. Matlin's practice.

Dr. Matlin commented that the advisory letters span 15 years, where he's done thousands of procedures in that time frame. Dr. Matlin opined that to categorize this as having a technical issue or judgment issues is overreaching and excessive in its response. Dr. Matlin stated that not every decision he's ever made has been correct but the vast majority of the time he's made good decisions, did procedures correctly and the patient outcome was excellent. To put this together and say he's not a competent physician is inappropriate.

Mr. Hall provided a closing statement, and stated that this is not a case of a physician reporting that they have retired to get out of discipline. Dr. Matlin has established residency in a foreign country. Mr. Hall stated that a permanent practice restriction until he completes a competency evaluation is unwarranted and is not supported by the evidence. Mr. Hall argued that the MC concluded that Dr. Matlin is competent to continue practicing. Mr. Hall stated that that a Decree of Censure and a permanent practice restriction is not warranted in this case.

Board staff commented that SIRC did consider Dr. Matlin's prior Board history, as well as the last Letter of Reprimand. As progressive discipline, the Decree of Censure was recommended.

Dr. Figge stated that sometimes there are multiple letters of reprimand but the next step would be a decree of censure, then suspension and then revocation. So there is a progression of severity of discipline but it doesn't mean it's progressive just because there was a letter of reprimand.

Mr. Hall spoke in favor of an advisory letter and even CME.

MOTION: Dr. Farmer moved for a finding of unprofessional conduct in violation of A.R.S. § 32-1401(27)(r).
SECOND: Dr. Guerrero-Tucker.

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

Dr. Farmer opined that this rises to the level of disciplinary action and agreed with SIRC that the use of tacks, especially in an anatomic zone at issue, was an egregious violation and especially given the very clear warnings and that anatomy involved. Dr. Farmer commented that he is debating whether a Letter of Reprimand or a Decree of Censure is appropriate. It seems that the physician does accept responsibility. The previous Board history can be considered for a Decree of Censure. Dr. Farmer opined that this does not rise to the level of a Decree of Censure and the MC noted that the rest of the care was competent and that the complication was followed up on. Dr. Farmer expressed concern regarding the practice restriction and further evaluation as to competency. The Committee had extensive discussion regarding whether a practice restriction was warranted and what the terms of that restriction would be.

MOTION: Dr. Farmer moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and Probation with Practice Restriction. Dr. Matlin shall be prohibited from practicing medicine for the duration of his licensure in Arizona. The physician shall not request termination of the Practice Restriction without providing proof of having undergone a competency evaluation with a Board approved facility. Dr. Matlin shall comply with any recommendations from the evaluation, subject to approval by the Board or its staff. In the event that the physician requests termination of the Practice Restriction and he has not completed the previously ordered competency evaluation, the Board may require any combination of other examinations and/or evaluations in order to determine whether or not Dr. Matlin is safe to practice medicine and the Board may continue the Practice Restriction or take any other action consistent with its authority including modification of the Practice Restriction in order to facilitate the return to practice.
SECOND: Dr. Bethancourt

Dr. Figge spoke against the motion given the amount of time that has gone by since the previous board history. This was an egregious outcome and the physician recognized the outcome and acted appropriately and emergently sent the patient somewhere to get care and the patient did well. Dr. Figge spoke in favor of a Letter of Reprimand but spoke against the restriction. Dr. Guerrero-Tucker also spoke against the motion and opined that given the MC's review this does not seem to be a competency problem. This was an error in judgment at the time of the surgery, which the doctor has acknowledged.

VOTE: The following Committee members voted in favor of the motion: Dr. Bethancourt and Dr. Farmer. The following Committee members voted against the motion: Dr. Figge, Ms. Dorrell and Dr. Guerrero-Tucker.
VOTE: 2-yay, 3-nay, 0-abstain, 0-recuse, 0-absent.
MOTION FAILED.

MOTION: Dr. Farmer moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand.
SECOND: Dr. Bethancourt.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Ms. Dorrell, Dr. Farmer and Dr. Guerrero-Tucker.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

G. FORMAL INTERVIEWS

1. MD-19-0351A, MD-20-0068A, NADER M. HADDAD, M.D., LIC. #41193

Dr. Haddad was present with Counsel Cody Hall and Michelle Donovan.

Board staff summarized that Case MD-19-0351A was initially reviewed at the June 10, 2021 Board meeting and returned to have a second MC review the case prior to requesting a competency evaluation. The case involved a 35 year old who presented to

Dr. Haddad for infertility evaluation. She had a history of PCOS. An ultrasound revealed fibroids, laboratory studies were done and note that Clomid and Dexamethasone were to be used. The patient developed significant side effects reportedly from the Dexamethasone which she informed Dr. Haddad about and one week later she was admitted with aortic valve endocarditis requiring a valve replacement. Nine months later, the patient was seen by the physician with heavy bleeding while on Coumadin. An HGB in the office was 9 and the physician offered her an IUD if cardiology approved. Five days later, the bleeding continued and the patient called requesting to be seen by a different physician. She was admitted, required 4 units of PRBCs, underwent a D&C and thermoablation with improvement. The second MC's evaluation agreed with the initial one, with findings of violations of the standard of care including: Failure to describe location of myomas and no RBO, Failure to evaluate male factor early in the workup which could change a plan of care for infertility, failure to provide operative or pathology notes and endometriosis was not documented, failure to properly evaluate bleeding in a patient on Warfarin. Medical records were also found to be inadequate by both MCs. Case MD-20-0068A resulted from a malpractice settlement. It was also reviewed by two MC's. The obstetrical patient presented at 39 weeks with spontaneous rupture of membranes. The pregnancy was significant for symmetrical intrauterine growth restriction. Labor ensued with occasional Category II fetal heart rate tracings noted. When the patient was 9 cm, variables were present and Dr. Haddad reported offering the patient a scalp electrode and intrauterine pressure catheter but these were declined. The patient became complete and started pushing. Dr. Haddad ordered Pitocin at this time to enhance the contractions in spite of the decelerations. The tracing was broken up though late decelerations with overshoots were suggested. Dr. Haddad identified the tracing to be a Category I tracing though the second MC found that this interpretation was probably based on the maternal heart rate recorded rather than the fetal heart rate which could not be accurately monitored. Delivery occurred approximately one hour later with Apgars of 2/2/6/7 and a cord pH of 6.78. The infant developed seizures and cerebral palsy. Medical records were again an issue in this case. Dr. Haddad underwent a competency evaluation in May/June 2022. The findings were that he was safe to practice without educational intervention.

Mr. Hall provided an opening statement regarding Case MD-19-0351A and noted that some of the medical consultant's criticisms have been fully rebutted or even withdrawn, and it is not recognized in the SIRC report. SIRC continues to state in its discussion that the MC #2 found that Dr. Haddad fell below the standard of care when he prescribed Clomid instead of letrozole. That MC submitted a supplemental response in January of 2020, in which she said this was no longer a concern after Dr. Haddad's response. Mr. Hall stated that SIRC relied on these MC reviews and reached the conclusion that the quote, "widespread nature of the deviation raised concerns with regard to Dr. Haddad's overall fund of knowledge and his ability to be regulated." SIRC pressed for a competency evaluation which Dr. Haddad challenged. A competency evaluation for a sole practitioner is very costly, takes a lot of time and puts a burden on his patients who he cannot see while he is undergoing the competency evaluation. Dr. Haddad eventually agreed to go to the competency evaluation, and Dr. Haddad passed the competency evaluation with the highest possible rating of pass category one. This evaluation reflected that Dr. Haddad demonstrated excellent performance in most, if not all, areas measured and is consistent with safe practice and competency, with no significant deficiencies noted. Dr. Haddad had to demonstrate his documentation skills as part of the evaluation and PACE also reviewed 25 random charts from his practice. There were no deficiencies noted in charting in those charts. Mr. Hall opined that the 2019 complaint does not warrant a letter of reprimand.

Ms. Donovan provided an opening statement regarding case MD-20-0068A and noted that electronic fetal monitoring is not an exact science. It shows the beat-to-beat variability of the baby's heart from which you can draw some assumptions about oxygenation. The two MCs read the strips differently. In fact, this is a widely known phenomenon called intra-observer and inter-observer variability, that has been studied by ACOG and is actually discussed in practice. What's notable in this particular case as well

is that the 1st MC to review this case found that the strip showed fetal tachycardia with decelerations with pushing. The MC did not disagree that there was moderate variability. The second MC was the first person to say this is a mom, this isn't a baby. Ms. Donovan stated that in addition to the bedside clinicians, Dr. Haddad, the nurses, the charge nurses, everybody else on the floor, the six excerpts in the underlying case and the first MC, none of them felt that this strip was fetal. Yet the alleged misinterpretation of this strip is the reason for SIRC to recommend a Letter of Reprimand. Ms. Donovan argued that the Board cannot meet its burden of proof to show that Dr. Haddad, by clear and convincing evidence, is guilty of unprofessional conduct.

Dr. Haddad provided an opening statement and opined that he met the standard of care and informed the Committee of how he documents his notes and acknowledged that there is always room for improvement with regard to documentation.

Regarding the reading of the strip, Dr. Haddad still believed that he had the advantage of being at the bedside with the patient and reading the tracing. He was able to correlate everything happening on the strip live and feels that he made the right decision at that moment. Dr. Haddad stated that he did not feel the need to push hard for the fetal scalp electrode ("FSE") since it wad declined since the retracing was reassuring. In retrospect, Dr. Haddad stated that he would push harder toward an FSE. Regarding his documentation of VR, PCOS is considered to be chronic medical condition and they do not challenge the diagnosis. This patient had all the clinical symptoms of PCOS. Dr. Haddad opined that the hole chart is where you would find the information of the diagnosis. Dr. Haddad explained the timeframe for the Clomid prescription and that the used it exactly as the American College of OBGYN recommends. Dr. Haddad opined that the Dexamethasone has nothing to do with her infective endocarditis, and eventually the patient was found to have a patent foramen ovale with a bicuspid aortic valve. She had a dental procedure, and one of the MCs stated that the patient having an infective endocarditis under my care is not a harm that was done by me. Dr. Haddad further stated that the Dexamethasone was not the reason for her fever. With regard to a stat pelvic exam or pap smear not being done, Dr. Hadad explained that he's dealt with this patient's abnormal bleeding for a long period of time. When the patient walked into the office that day she was offered a pelvic exam and she declined. The visit allowed him to evaluate her and she was hemodynamically stable. The patient had no symptoms of acute blood loss, anemia, no chest, pain, no palpitations, no fatigue and no shortness of breath. Dr. Hadad stated that it is only with the benefit of hindsight that he would know that this patient would need emergency surgery in four days.

In closing, Mr. Hall requested dismissal of the case or at most an Advisory Letter for documentation. Mr. Hall noted that the medical care in these two complaints occurred years apart.

In closing, Ms. Donovan stated that a Letter of Reprimand is excessive and requested that the case be dismissed or at most an Advisory Letter issued.

Board staff commented that on MD-19-0351A, the physician stated that the patient refused a pelvic exam. This wasn't documented, but in the notes he offered her a pap smear which would be inappropriate when the patient is heavily bleeding, so it seems more that she declined the pap smear rather than the pelvic, which would have been appropriate to evaluate the bleeding. In regard to MD-20-0068A and the tracing, staff agreed that the tracings can be read in different ways. The description of variability was used by the attorney. The issue is variability. When the heart rate starts at 120, even what they had suggested doesn't go from 60 to 80, and that's not normal variability. The second MC stated that if you're unable to evaluate the tracing, you need to intervene and deliver the baby.

MOTION: Dr. Guerrero-Tucker moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(e) in both cases.
SECOND: Dr. Bethancourt.

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

Dr. Guerrero-Tucker opined that this rises to a level of Advisory Letter due to documentation. Dr. Guerrero-Tucker commented that this doctor has not thought of the fact that when you're in a group practice, anyone's going to pick up the chart and they need to know what you're thinking. He's not putting in what he's thinking. He doesn't coalesce that in his notes, in a way for anyone to understand.

MOTION: Dr. Guerrero-Tucker moved to issue an Advisory Letter for inadequate documentation. 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. Bethancourt.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Ms. Dorrell, Dr. Farmer and Dr. Guerrero-Tucker.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

H. FORMAL INTERVIEWS

1. MD-22-0724A, MD-23-0788A, GEORGE K. MYO, M.D., LIC. #42034
   Dr. Myo was present with counsel Cody Hall.

   Board staff summarized that cases MD-22-0724A and MD-23-0788A came to the attention of the Board because of a complaint against Dr. Myo, regarding the care and treatment of patient RR and SB. RR was 55-year-old who underwent a reverse total shoulder arthroplasty on November 3, 2020 by Dr Myo at Mountain Vista Medical Center. Post-operatively, RR required limited pain medication but described pain extending into the right forearm; he initially utilized a sling less than recommended. RR progressed quickly in physical therapy (PT) but continued to describe significant, achy, right forearm pain. X-ray interpretations indicated appropriate hardware placement. On February 2, 2021, RR presented to Dr. Myo's office and was seen by a PA. RR reported an approximate one-week history of swelling and increased pain in the region of the incision. The PA described a 3 x 2cm region that was fluctuant, tender, and warm. Diffusely the shoulder was painful, but the established range of motion (ROM) was maintained. The PA documented that he aspirated 8cc of serosanguinous fluid without evidence of purulence. RR was placed on Keflex 500 mg. On February 5, 2021, RR presented to Casa Grande Medical Center (CGMC) for shoulder pain. An MRI was negative for evidence of abscess and the patient was started on Bactrim and Keflex was discontinued. The aspirate's culture revealed the presence of Cutibacterium acnes. On February 9, 2021, RR underwent a right shoulder irrigation and debridement of the skin, fascia, and soft tissue performed by Dr. Myo. The operative report noted that the abscess was superficial. Gram stain revealed only WBCs but the specimen didn't meet the lab's criteria for acceptability for culture. Subsequently, the patient was seen 7 times by the PA for various problems including drainage, loss of range of motion, fluid collection. At one point, the PA suspected a hematoma and recommended massaging the region. On April 29, RR presented to Dr. Myo's office and was seen by a PA for follow-up. RR reported that the shoulder and forearm achiness had returned and he lost ROM secondary to pain. The PA restarted Ciprofloxacin and discussed the possibility of implant removal. On May 18, 2021, RR presented to Dr. Myo's office for follow-up. Dr. Myo noted RR's pattern of improvement when taking antibiotics and worsening symptoms when not. RR's ROM had decreased significantly though there were no outward signs of infection. Dr. Myo recommended removal of all shoulder implants and an irrigation and debridement procedure. On June 1, 2021, RR underwent right TSA removal and placement of antibiotic spacer. A wound VAC was placed due to excessive drainage at the surgical site. RR was discharged per his request on 30 days of IV antibiotics to be followed by home health on June 6, 2021. There were other visits because of issues with the wound

VAC and recurrent fluid accumulation which was drained by radiology. Dr Myo later mentioned a possible revision surgery but RR did not return to his care. A staph bacterial strain in the shoulder was identified a few months later and the patient had lost much of his shoulder motion in the interim. A revision shoulder arthroplasty was performed elsewhere approximately one year after the primary arthroplasty. The Board's MC reviewed the case and determined that Dr. Myo deviated from the standard of care by failing to adequately evaluate and treat post-operative infections and failing to appropriately supervise advanced practice providers (APP) resulting in delayed treatment. The MC stated that once the Cutibacterium and Pseudomonas cultures were final, there was a delay in switching medications to the most effective antibiotic regimen. The MC observed that Dr. Myo's PA had repeated post operative encounters with the patient; however, the physician should have evaluated the patient who had recurrent infections at an operative site containing foreign bodies. The MC noted that Dr. Myo's medical record keeping was inaccurate to a degree that it could seriously affect patient care. MD-23-0788A came to the attention of the board because of a complaint against Dr. Myo regarding the care rendered to patient SB. SB was a 76 year old who had a shoulder replacement performed by Dr. Myo on April 26, 2022 without unexpected findings or complications. A reverse TSA was placed, with removal of the previously placed metal suture anchor in the greater tuberosity, and a biceps tenodesis. A thigh muscle biopsy was also performed at the request of her neurologist. The patient was discharged from the hospital on POD #1. SB had significant pain postoperatively and continued to have significant pain and limited motion over several months after the surgery due to an undiagnosed tuberosity fracture. In February 2023, SB obtained a second opinion where the fracture was identified. On May 15, 2023, it was documented by Dr. Stevens that she does have a greater tuberosity fracture that may have been intraoperative or postoperative, and there appears to be impingement on the bony fragment with abduction. It was decided to proceed with revision surgery with tuberosity fragment excision versus repair. On June 15, 2023, she underwent revision surgery with Dr. Stevens at Oro Valley Medical Center. The operative report documents findings of a chronic greater tuberosity fracture. The fracture fragment was debrided and repaired and the surgery was felt to be uncomplicated. The MC reviewed the case and cited multiple deviations from the standard of care. Including not recognizing a displaced greater tuberosity fracture or an axillary nerve neuropraxia. He failed to document the presence of the fracture on x-rays post-operatively. The MC stated that the fracture was visible on the post operative x-rays reviewed by Dr. Myo and his PA's in subsequent post-op office visits. The MC opined that a board-certified orthopedic surgeon should have recognized a tuberosity fracture and that it was a contributor to the patient's continued pain. The MC also expressed concern that SB was only evaluated by APPs prior to the day of surgery. Dr. Myo did not see or examine the patient before the day of surgery. In his response to the board, he stated that, "If there was any fractured bone that had to be removed, it likely came from her fall in 9/22". SIRC considered MD-22-0724A and MD-23-0788A together. SIRC found it mitigating that in MD_22-0724A, the wound infection did not become evident until three months after surgery and the MRI obtained at that time demonstrated that there was no hardware infection. However, when the post-operative symptomatology suggestive of infection did not resolve and more aggressive treatment was required, Dr. Myo should have evaluated the patient instead of or in addition to an APP, which SIRC found aggravating. SIRC noted that in MD-23-0788A, the MC was critical of Dr. Myo's preoperative and post operative surgical care, SIRC agreed that Dr. Myo should have seen and documented the surgical plan thoroughly with the patient and that a visit just prior to surgery is not the standard of care. SIRC stated that Dr. Myo should have recognized the tuberosity fracture and discussed with patient post operatively and subsequent office visits that this could have been a contributor to the patient's continued pain. SIRC found it aggravating that it was not until approximately ten months later, after SB sought a second opinion that she received the appropriate treatment to help alleviate pain. SIRC observed that in both cases the MC's noted a possible lack of communication between Dr. Myo and his APPs, which may have contributed to the deviations from the standard of care.

Mr. Hall provided an opening statement and noted that SIRC considered whether a non-disciplinary resolution was appropriate for these cases and acknowledged that when considered individually, case MD-22-0724A may not rise to the level of discipline based on findings related to documentation and communication. Mr. Hall argued that there is not clear and convincing evidence of unprofessional conduct and requested non-disciplinary action.

Dr. Myo provided an opening statement and informed the Committee that his main PAs were fresh trainees out of school, and he did not let them have autonomy over decisions until several months. They were trained to deal with patients exactly the way he would treat the patient. They also know that he has to hear about any post-operative patients that deviate from normal post-operative course, and usually that means these patients are then scheduled to be seen by him, which both of these patients were. They discussed the patient their concerns with Dr. Myo. Both of the patients in question today were specifically seen postoperatively by him because they had postoperative courses that deviated from the norm. Dr. Myo explained that he is the only surgeon in the office, and that is made plainly obvious by his staff and mid-levels. He personally meets with all preoperative patients at minimum before surgery. No pre-op staff would let a patient roll back to the OR without the surgeon discussing the risks and benefits of surgery with a patient and to sign a consent form. Dr. Myo provided literature on Reverse Total Shoulder Arthroplasties and noted that it is a surgery with significant issues post-operatively. Dr. Myo noted that he treated RR for a long time, and is glad that after we treated his infection he was able to get a follow-up surgery. SB had a fall during her care, and he was also biopsying her for a possible general muscle problem. Dr. Myo opined that her main problem was an axillary nerve palsy, which he told her frequently.

During questioning, Dr. Myo explained that if there are any concerns the PAs will contact him and twice a week, he's in the office to discuss cases with them as well. Dr. Myo informed the Committee that his area of specialty is upper extremities but that he can do lower extremity traumas. He does not do spinal surgeries and will refer them to colleagues. Regarding SB, Dr. Myo explained that post-operatively he did not see a bone fragment and going back he did see a small sliver, but he would not have done anything with it. Even the Tucson physician could not say whether or not she would have done anything. Dr. Myo noted that none of the views showed that the fragment was within the components. Dr. Myo explained why he thought it was an auxiliary nerve palsy instead of an impingement. He obtained an EMG and confirmed with a neurologist. He recommended her to follow-up on it since she was moving to Tucson. Regarding RR, Dr. Myo explained how his infection may have progressed in such an unusual manner and provided two pieces of literature on infections. Dr. Myo confirmed that both of his PAs operate under sterile procedures. Dr. Myo stated that his PAs contact him constantly and are the reason he can practice at other locations. Dr. Myo confirmed that he speaks to them daily and is in the office two to three times a week. Dr. Myo agreed that he could document better, especially for complex patients, he should document his thought process.

Dr. Figge inquired if there were any complaints regarding the PAs.

Board staff confirmed that a complaint was not filed against the PAs.

Dr. Myo explained that he is the only physician in his clinic and when a patient schedules an appointment, they will see a PA but if they request to see him they will schedule that. Dr. Myo noted that fragments are not uncommon, and he tries to take out as minimally as possible to get the implant in.

Mr. Hall provided a closing statement and argued that this does not rise to the level of discipline and that Dr. Myo appropriately supervises his PAs. Mr. Hall requested dismissal or an Advisory Letter.

Dr. Myo stated that he knows RR very well and that if he says there was not adequate coercion, then he knows that it's not true. His PA had said RR was having a problem and Dr. Myo explained that he said to get him into the office as soon as possible but noted that it still took two weeks.

During deliberations, Dr. Figge commented that there is a reason a complaint comes to the Board but listening to the physician today there are mitigating factors. There were issues with how things evolved regarding communication and regarding the bone fragment, there was still potential harm.

MOTION: Dr. Figge moved for findings of unprofessional conduct in violation of A.R.S. §§ 32-1401(27)(e), (r) and (jj) for both cases.
SECOND: Dr. Bethancourt.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Ms. Dorrell, Dr. Farmer and Dr. Guerrero-Tucker.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

Dr. Figge opined that this does not rise to the level of discipline. There was also a recommendation by SIRC for a CPEP course and CME for records. However, with the discussion today, Dr. Figge stated that he is unsure if the courses will make a difference. The physician has heard the Board's concerns and will change things going forward.

MOTION: Dr. Figge moved to issue an Advisory Letter for lack of documentation, potential lack of supervision of physician assistants and potential for patient harm. 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. Bethancourt.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Ms. Dorrell, Dr. Farmer and Dr. Guerrero-Tucker.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 0-absent.
MOTION PASSED.

I. FORMAL INTERVIEWS

1. MD-23-0639A, DANIEL I. SHAPIRO, M.D., LIC. #20700
   Dr. Shapiro was present with counsel Jay Fradkin.

Board staff summarized that case MD-23-0693A was brought to the Board on July 5, 2023 through a report of malpractice settlement. The MC's detailed report read as follows: The patient was originally seen for consultation on 11/11/2021 for her abdomen. She was diagnosed with lipodystrophy and diastasis of the infra and supra abdominal area. It was recommended to her that she have abdominoplasty with liposuction of the anterior flanks. On 12 / 06 /2021, the patient underwent abdominoplasty with liposuction of the lateral abdomen. She was kept overnight for observation and was discharged on 12/07 /2021, and scheduled for office follow-up in five days. On 12/ 09/ 2021 the patient's husband contacted Dr. Shapiro and informed him she was suffering from nausea, inability to have a bowel movement and that she could not eat over the last three days. It was felt that the most likely reason was constipation from narcotic pain medication. The recommendation was to decrease the narcotic intake and use magnesium citrate to relieve the constipation. Subsequently the patient was evaluated at the emergency department at the Mayo Clinic Scottsdale, where she was diagnosed with an ileus. She was admitted to the hospital and a nasogastric tube was placed and she was started on intravenous antibiotics. Over the next several days her condition deteriorated, and she was noted to have tachycardia and a rising WBC count. A CT scan that was performed indicated that there was a bowel perforation present. On 12/16/21, the patient underwent an exploratory laparotomy. She was found to have three serosal tears in the small intestine, a tear in the mesentery of the small intestine and a through and through perforation of the small intestine. The tears in the serosa, or outer lining, of the small

intestine were repaired, as was the tear in the mesentery. The perforation of the small intestine required a resection of the injured area of the small intestine and reanastomosis of the small intestine, meaning reconnection of the small intestine after removal of the injured section of the small intestine. These injuries were felt to be iatrogenic. The patient recovered from the emergency exploratory laparotomy and was discharged from the hospital on 12/26/21. The patient apparently experienced a difficult recovery from the laparotomy, requiring home rehabilitation visits. SIRC noted that the MC determined that Dr. Shapiro deviated from the standard of care by failing to recognize a significant injury to the small intestine during the performance of an abdominoplasty. SIRC observed that the MC concluded that this was not a common complication of liposuction or abdominoplasty, in general, and proper precautions and techniques were described yet at least one of the surgical instruments penetrated the abdominal muscle wall causing the significant injury. SIRC reviewed the licensee response and noted his statement; that he accepted full responsibility for the complication. However, in his supplemental response, Dr. Shapiro reported that a resident had actually performed the surgery under his supervision. SIRC expressed concern that there was no mention of the resident in the operative report or paperwork from the facility. SIRC agreed with the medical consultant that Dr. Shapiro's deposition, under oath, clearly states he performed the surgery. SIRC also noted that Dr. Shapiro's narrative response indicates that he performed the procedure without any mention of a resident until the supplemental response. SIRC recognized the actual harm that occurred to the patient and considered Dr. Shapiro's new disclosure of a fourth year resident performing the procedure as an aggravating factor; in the light of this statement not being supported in the records, deposition, and initial response reviewed.

Mr. Fradkin provided an opening statement and stated that Dr. Shapiro did not make a false statement to the Board. Dr. Shapiro's practice is to have residents with him all the time. Mr. Fradkin stated that this case is a singular case of an unfortunate, albeit rare, complication, that does not rise to the level of disciplinary action.

Dr. Shapiro apologized if it appeared that he made a misleading statement in his second response to the Board. Dr. Shapiro stated that he informs his patients that there will be a resident involved in the care. Dr. Shapiro stated that he takes responsibility for it. Dr. Shapiro stated that he is still the surgeon of record and out of habit he doesn't include them in his operative summary. They're listed on the nursing notes. Dr. Shapiro confirmed that the patient know they're involved throughout the whole process. With regards to the technical misadventure, Dr. Shapiro stated that he still cannot explain it. It could have happened from the tumescent cannula. It could have happened from the liposuction cannula if it happened. Dr. Shapiro explained that he can't retrospectively examine them, but if it happened on the left side of the patient, it was probably his doing, and if it was on the right side, it was the Resident with him helping them. Dr. Shapiro stated that he has done a lot of liposuction cases without a problem so this was a really horrible thing to happen.

During questioning, Dr. Shapiro confirmed that the patient knew that there was going to be a plastic surgeon resident involved.

Dr. Bethancourt noted for the record that there is no mention of the surgical resident in the surgical note.

Dr. Shapiro confirmed that he does the surgical note.

Dr. Bethancourt reiterated that there is no mention of the resident in the consent, the documentation or the operation note.

Dr. Shapiro noted that there are a couple of documents that he provided, one from the Surgery Center, that actually has the resident listed as the assistant and then another on their consent form that has assistance by any associated staff that the surgeon choses. Dr. Shapiro explained that it is an elective aesthetic surgery practice and the patients

know that a resident is involved. Dr. Shapiro agreed that if there is a lack of documentation it is his error but stated that the residents are a big part of the patient's experience. Dr. Shapiro noted that there is a general consent agreement that includes the risk of a visceral complication. Dr. Shapiro stated that the patients know the resident is with him, because his relationship with them is quite intimate before, during and after surgery. Dr. Shapiro stated that if there's a lack of documentation it is his error but it is not intentional and is not out of omission.

Dr. Farmer commented that you can be deceptive by not saying something and leaving out material facts. It's not that different from being deceptive by stating something that's erroneous. Dr. Farmer opined that there is a huge gap in common understanding of consent, common understanding of documenting, you know the reality of what happened. These are people who are actually doing a consequential part of the procedure.

Dr. Shapiro explained that he is there every step of the way, and his hand is next to theirs. Yes, they are assisting and they're doing some of the surgery but he still has the responsibility as the surgeon. Regarding the penetrating the viscera, Dr. Shapiro explained that the patient had a pretty protuberant abdomen and suspected there was some attenuation there. Dr. Shapiro suspected that it happened at the Costal margin right below the rib, but he doesn't know. Dr. Shapiro stated that the only thing he was trying to provide with his supplemental response was figuring out what possibly could have happened. It could have happened anywhere but one would think that the plane would be very clear, and it's a radial three-dimensional kind of structure. It is not completely flat. Dr. Shapiro explained that he looked at the OP reports, and there was no reference to anatomical difficulty, or anything that he could see. Dr. Shapiro explained there are two parts of the procedure, and he specifically does not perform liposuction in the central abdomen as not to affect the perfusion of the central abdominal tissue. Dr. Shapiro stated that he only suctions in the lateral anterior abdomen and suspects that whatever happened, it happened when the tumescent was being put in. That's a very small cannula as opposed to the liposuction cannula that is larger gauge.

Mr. Fradkin provided a closing statement and noted that there is an intraoperative surgical record indicating the resident was also in the OR. Mr. Fradkin noted that Dr. Shapiro had one advisory letter in 2001. Mr. Fradkin requested that this not rise to the level of discipline.

During deliberations, Dr. Bethancourt stated that he does not believe that the physician was trying to knowingly deceive the Board and opined that the violations of A.R.S. §§ 32-1401(27)(u) and (kk) as recommended by SIRC can be taken out.

MOTION: Dr. Bethancourt moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(e), (r) and (jj).
SECOND: Dr. Guerrero-Tucker.
Dr. Farmer stated that he understands the view of taking the §§ 32-1401(27)(u) and (kk) violations off but opined that SIRC is correct that during the deposition he stated under oath that he performed the surgery, which we know is not the case. The physician contradicted himself and spoke in favor of the (u) and (kk) violations based on the record and testimony. Dr. Figge stated that he understands both opinions and is on the fence. Dr. Guerrero-Tucker agreed with the motion and commented that she disagreed with leaving the residents off the documents and that it was a mistake, it is the physician's responsibility for the surgery. Dr. Figge noted that the physician stated that this is a very hands-on approach and the physician didn't even think of not taking responsibility. Dr. Farmer noted that it is clear that the resident is doing a substantive part of the procedure, and it is not documented or made available to the patient. Dr. Farmer found it concerning that he made a statement that he did the procedure and then later stated that he did not.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Ms. Dorrell and Dr. Guerrero-Tucker. The following Committee member voted against the motion: Dr. Farmer.
VOTE: 4-yay, 1-nay, 0-abstain, 0-recuse, 0-absent.

MOTION PASSED.

Dr. Bethancourt opined that this does not rise to the level of discipline.

MOTION: Dr. Bethancourt moved to issue an Advisory Letter for failing to properly perform an abdominoplasty, for inadequate medical records and for inadequate supervision of a resident. 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. Dorrell.
VOTE: The following Committee members voted in favor of the motion: Dr. Figge, Dr. Bethancourt, Ms. Dorrell and Dr. Guerrero-Tucker. The following Committee member abstained: Dr. Farmer.
VOTE: 4-yay, 0-nay, 1-abstain, 0-recuse, 0-absent.
MOTION PASSED.

GENERAL BUSINESS

J. DISCUSSION REGARDING DEBRIEFING ON COMMITTEE PROCESSES

There was no discussion.

K. ADJOURNMENT

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

The meeting adjourned at 2:43 p.m.

Raquel Rivera

Raquel Rivera, Executive Director