BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **LUIS A. PIEDRAHITA, M.D.** Holder of License No. 34023 For the Practice of Allopathic Medicine In the State of Arizona.	**Case No. MD-18-1230A** **ORDER FOR DECREE OF CENSURE; AND CONSENT TO THE SAME**

Luis A. Piedrahita, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for a Decree of Censure; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 34023 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-18-1230A after receiving a complaint on December 31, 2018, alleging potential impairment while practicing medicine. The complaint additionally alleged that Respondent had been arrested for domestic violence and possession of drug paraphernalia on October 20, 2018.

4. On October 20, 2018, Respondent was charged with domestic violence related misdemeanors. Respondent states that the charges did not involve physical contact or injuries. Respondent failed to report the charges to the Board within ten working days pursuant to A.R.S. § 32-3208. Respondent subsequently entered into a deferred prosecution agreement on the charges as filed in the County Consolidated Justice Court. As part of his agreement, Respondent completed remedial programs for domestic violence, parenting and substance abuse and successfully completed a series

of random toxicology tests. On May 1, 2020 the charges were dismissed with prejudice following Respondent's successful completion of the deferred prosecution agreement.

5. On January 2, 2019, the Executive Director issued Respondent an Interim Order for Bodily Fluid and Hair Testing and Interim Order for Physician Health Program ("PHP") Assessment. On January 7, 2019, Respondent disclosed that he had tested positive for an illicit substance in a drug screen conducted during the course of a family court case. On January 8, 2019, Respondent entered into an Interim Consent Agreement for Practice Restriction prohibiting Respondent from engaging in the practice of medicine while the matter was pending Board review.

6. Respondent subsequently entered into inpatient treatment in a Board-approved facility ("Facility") on January 17, 2019. Respondent was discharged with staff approval on February 15, 2019. Based on Respondent's progress during treatment and his discharge diagnoses, the Facility recommended completion of an intensive, outpatient treatment program, monitoring and compliance with recommendations for aftercare.

7. On April 17, 2019, Respondent enrolled in an intensive outpatient treatment program ("IOP"). On June 27, 2019, Respondent graduated from the IOP.

8. On July 15, 2019, Respondent submitted a request to lift the Interim Practice Restriction. Respondent's request was denied, pending completion of a post-treatment PHP assessment to determine his safety to practice.

9. On July 31, 2019, Respondent was issued an Interim Order for a PHP Post-Treatment Assessment. On August 13, 2019, Respondent presented for the assessment. The PHP Assessor expressed concern with his apparent non-compliance and recommended that Respondent undergo a comprehensive inpatient evaluation and other testing for further clarification of whether he is safe to practice medicine Respondent failed to complete the evaluation and testing as requested by the PHP Assessor.

10. During the course of the Board's investigation, Board staff obtained Respondent's employment records from the Orthopedic Institute where Respondent was

employed ("Employer"). The Employer documented concerns regarding professionalism and performance that ultimately led to his suspension of clinical privileges on September 12, 2018 and termination from the practice on September 26, 2018. Respondent denies that he was impaired while practicing medicine, and the Employer did not report Respondent's conduct to the Board.

11. A Medical Consultant ("MC") reviewed two of Respondent's patients' charts.

Patient AR

12. AR was an 88 year-old male with a past medical history of Alzheimer's dementia with behavioral disturbance, bipolar disorder, coronary artery disease, and hypertension. On October 25, 2017, AR presented to the Hospital after a fall while ambulating with his walker and complained of left hip, knee, and neck pain. The Hospital diagnosed AR with an intertrochanter hip fracture. Respondent, the on call orthopedic surgeon, was notified by emergency room staff at approximately 2:30 p.m.

13. On October 27, 2017, Respondent completed his consultation and surgery was performed later the same day. Respondent states that Wednesday, October 25 was a surgery day for him and the patient had taken Plavix, a blood thinner, which increases the risk of bleeding. Respondent also states that a hospitalist was managing the patient's post-operative anticoagulation. On October 29, the patient's family transferred him to hospice. On October 30, 2017, AR expired. According to the Discharge Summary, the patient tolerated the surgery well but his postoperative course was complicated by delirium and then aspiration, a pulmonary embolus, and he developed respiratory failure.

Patient NM

14. NM was a 67 year-old female who had a fall in her home. On January 30, 2016, NM presented to the Hospital and sustained a right intertrochanteric fracture. The initial hip x-ray was interpreted by a radiologist as revealing a right intertrochanteric fracture with extension into a lobular lucency in the medial femoral neck region; the

fracture was described as probably pathologic. Respondent was consulted and planned to operate on NM the following day.

15. On January 31, 2016, Respondent examined NM and described the hip x-rays as revealing a displaced femoral neck fracture and he performed a hemiarthroplasty on the patient at approximately 3:30 p.m. the same day.

16. On December 1, 2016, NM fell again and sustained a periprosthetic fracture to her right femur. A different orthopedic surgeon interpreted NM's x-rays as revealing subsidence and loosening of the femoral implant and performed a revision arthroplasty and plated the femoral shaft fracture. Intraoperatively, the subsequent surgeon found the implanted femoral stem to be 'grossly loose'. Respondent states that no loosening was noted before the patient's subsequent fall and that a periprosthetic fracture is a known potential complication of any hip replacement.

Deviations from the Standard of Care

17. The Board's MC identified deviations in Respondent's postoperative care and management of both AR and NM, including failure to timely visit AR and failure to adequately monitor both patients. Respondent states that a surgeon would have been on call to evaluate AR over the weekend. Respondent also states that patient NM was advised at her four month follow-up visit to return as needed and she did not return until she was reinjured.

18. Additionally, the MC found that Respondent deviated from the standard of care for patient NM by failing to identify a bony lesion and its associated pathologic fracture.

19. The MC identified potential harm for both AR and NM, including the potential lost opportunity for earlier intervention to address post-operative complications. Respondent states that hospitalists were managing AR's anticoagulation and medical comorbidities.

20. On February 20, 2020, Respondent allowed his license to expire.

1 **CONCLUSIONS OF LAW**

2 a. The Board possesses jurisdiction over the subject matter hereof and over
3 Respondent.

4 b. The conduct and circumstances described above constitute unprofessional
5 conduct pursuant to A.R.S. § 32-1401(27)(a) ("Violating any federal or state laws or rules
6 and regulations applicable to the practice of medicine."). Specifically, Respondent's
7 conduct violated A.R.S. § 32-3208(A) ("A health professional who has been charged with a
8 misdemeanor involving conduct that may affect patient safety or a felony after receiving or
9 renewing a license or certificate must notify the health professional's regulatory board in
10 writing within ten working days after the charge is filed.").

11 c. The conduct and circumstances described above constitute unprofessional
12 conduct pursuant to A.R.S. § 32-1401(27)(f) ("A pattern of using or being under the
13 influence of alcohol or drugs or a similar substance while practicing medicine or to the
14 extent that judgment may be impaired and the practice of medicine detrimentally
15 affected.")

16 d. The conduct and circumstances described above constitute unprofessional
17 conduct pursuant to A.R.S. § 32-1401(27)(r) ("Committing any conduct or practice that is
18 or might be harmful or dangerous to the health of the patient or the public.").

19 e. The conduct and circumstances described above constitute unprofessional
20 conduct pursuant to A.R.S. § 32-1401(27)(s) ("Violating a formal order, probation, consent
21 agreement tor stipulation issued or entered into by the board or its executive director under
22 the provisions of this chapter.").

23 f. The conduct and circumstances described above constitute unprofessional
24 conduct pursuant to A.R.S. § 32-1401(27)(oo) ("Refusing to submit to a body fluid
25 examination or any other examination known to detect the presence of alcohol or other

drugs as required by the board pursuant to section 32-1452 or pursuant to a board investigation into a doctor of medicine's alleged substance abuse.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Decree of Censure.

DATED AND EFFECTIVE this 6th day of January, 2023

ARIZONA MEDICAL BOARD

By ______________________
Patricia E. McSorley
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent in this Order are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent

are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

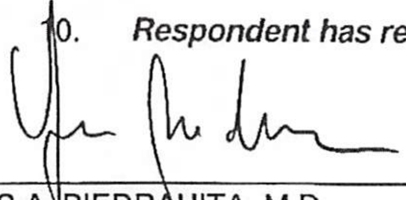
6. Notwithstanding any language in this Order, this Order does not preclude in any way any other State agency or officer or political subdivision of this state from instituting proceedings, investigating claims, or taking legal action as may be appropriate now or in the future relating to this matter or other matters concerning Respondent, including but not limited to, violations of Arizona's Consumer Fraud Act. Respondent acknowledges that, other than with respect to the Board, this Order makes no representations, implied or otherwise, about the views or intended actions of any other state agency or officer or political subdivisions of the State relating to this matter or other matters concerning Respondent

7. Upon signing this agreement and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

9. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

10. ***Respondent has read and understands the terms of this agreement.***



LUIS A. PIEDRAHITA, M.D.

DATED: 12/13/2022

EXECUTED COPY of the foregoing mailed
this 6th day of January, 2023 to:

Luis A. Piedrahita, M.D.
Address of Record

Christopher J. Smith, Esq.
Smith Law Group
Davis House
262 North Main Avenue
Tucson, Arizona 85701
Attorney for Respondent

ORIGINAL of the foregoing filed
this 6th day of January, 2023 with:

Arizona Medical Board
1740 West Adams, Suite 4000
Phoenix, Arizona 85007

Board staff