BEFORE THE REVIEW COMMITTEE OF THE ARIZONA MEDICAL BOARD

In the Matter of **THOMAS J. RICK, M.D.** Holder of License No. 23545 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-20-0784A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR PROBATION**

The Review Committee of the Arizona Medical Board ("Board") considered this matter at its public meeting on December 1, 2021. Thomas J. Rick, M.D. ("Respondent"), appeared with legal counsel, Michael K. Goldberg, Esq., before the Review Committee for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(P). The Review Committee voted to issue Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

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 23545 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-20-0784A after receiving notification that Respondent's Hospital clinical privileges were suspended based on a finding that Respondent failed to recognize an incorrectly placed central venous catheter and subsequently revoked for failing to comply with the Hospital's remedial action plan.

4. On August 3, 2018, AJ a 75 year-old female presented to the Hospital for an elective L2-S1 posterior spinal fusion. Respondent was the anesthesiologist assigned to the case. Intraoperatively, invasive monitors were placed and used by Respondent consisting of a left radial arterial line and a right internal jugular central venous catheter, in addition to standard routine monitors. AJ experienced hypotension mid-procedure

unresponsive to IV fluid administration, as well as lack of response to IV doses of Ephedrine, Phenylephrine, Epinephrine, and calcium chloride. The surgical procedure was expedited and further IV therapies were given via peripheral IV access. AJ demonstrated intraoperative mixed respiratory and metabolic acidosis with hypoxemia on arterial blood gas analysis and was slow to emerge from the effects of anesthesia at the end of the surgical procedure. A CT scan of the head was negative for stroke. A chest CT scan showed a malpositioned right internal jugular central venous catheter with fluid in the mediastinum, compression of tracheal structures, bilateral pleural effusions with right greater than left, and complete collapse of the right lung. A right chest tube was subsequently placed with evacuation of 2500cc of fluid. AJ's post-operative course was uneventful and she was discharged to a skilled nursing facility on August 9, 2018.

5. The standard of care requires a physician to recognize and address a malpositioned central venous catheter Respondent deviated from this standard of care by failing to recognize the malpositioning of a central venous catheter used in anesthetic management.

6. Actual patient harm was identified in that the patient developed a massive right pleural effusion requiring chest tube placement. Additionally, the patient experienced intraoperative hemodynamic instability, hypoxemia, and metabolic abnormalities.

7. During a Formal Interview on this matter, Respondent testified regarding his recollection of the procedure at issue, including the indications for placement of a central line, and his technique for placement of the line. Respondent stated that he routinely transduces central lines, but does not normally document that in the record. Respondent testified regarding the sequence of events that occurred during the procedure. Respondent testified regarding his belief that the central line became misplaced when the patient was turned to the prone position. Additionally, Respondent was asked about the

lack of a comprehensive narrative in the medical record. Respondent stated that he would normally document pertinent occurrences in the 'remarks' section of the anesthesia record. He further stated that on occasion in the past he has created a summary in progress notes. Respondent testified that he began to have concerns that the central line had been misplaced mid-procedure, and agreed that he did not document that suspicion in the anesthetic record. Respondent stated that this was his first experience with a malpositioned central line during a procedure.

8. During that same Formal Interview, Review Committee members commented regarding the record and Respondent's testimony. Members recognized that the patient's prone positioning mid-procedure would have limited Respondent's options. However, Committee members also commented that, based on Respondent's testimony that he began to suspect the complication mid-procedure; he should have demonstrated greater urgency to take responsive action. Committee members additionally agreed that Respondent's documentation was deficient. Committee members ultimately voted in favor a disciplinary order for probation to complete relevant continuing medical education.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("Failing or refusing to maintain adequate records on a patient.").

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

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is placed on Probation for a period of six months with the following terms and conditions:

a. Continuing Medical Education

Respondent shall within 6 months of the effective date of this Order obtain no less than 10 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in an intensive, in-person course regarding medical recordkeeping and no less than 3 hours of CME in management of central line complications. Respondent shall within **thirty days** of the effective date of this Order submit his request for CME to the Board for pre-approval. Upon completion of the CME, Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure. The Probation shall terminate upon Respondent's proof of successful completion of the CME.

b. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED AND EFFECTIVE this 3rd day of February, 2022.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed this 3rd day of February, 2022 to:

Thomas J. Rick, M.D.
Address of Record

Michael K. Goldberg, Esq.
16427 North Scottsdale Road, Suite 200
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Attorney for Respondent

ORIGINAL of the foregoing filed this 3rd day of February, 2022 with:

Arizona Medical Board
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Michelle Fisher
Board staff