BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MIGUEL A. ARENAS, M.D.** Holder of License No. 33383 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-19-0265A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR LETTER OF REPRIMAND**

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 6, 2020. Miguel A. Arenas, M.D. ("Respondent"), appeared with legal counsel, Tom Slutes, Esq., before the Board for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order for Letter of Reprimand 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 33383 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-19-0265A after receiving a complaint regarding Respondent's care and treatment of a 60 year-old female patient ("PK") alleging failure to recognize and diagnose perforated colon; failure to timely obtain emergency hospital transfer; and improper performance of diagnostic colonoscopy with subsequent death.

4. PK was referred to Respondent for a diagnostic colonoscopy after she was discovered to have biopsy proven omental adenocarcinoma and her treating provider suspected a colorectal primary. PK presented to Respondent's office on May 23, 2018 and saw a Nurse Practitioner who scheduled her for a colonoscopy the next day.

5. On May 24, 2018, PK presented to a Surgery Center for the colonoscopy performed by Respondent. The colonoscopy was difficult and limited due to a sigmoid stricture. Respondent started with a pediatric colonoscope and tried for eleven minutes to traverse the sigmoid stricture. Respondent subsequently attempted to pass a smaller scope for another seven minutes, but still could not advance the scope past the stricture and therefore the procedure was terminated. A small polyp was removed but no obvious tumor was visible.

6. Post-operatively PK was agitated, confused, and hypoglycemic with pain ten out of ten on the pain scale. PK's abdomen was firm and distended. Respondent was notified by nursing staff of the PK's tight abdomen.

7. At 1033, PK was transferred to the Hospital. PK was lethargic with a distended, firm abdomen. The ED physician described PK to be acutely ill, drowsy, and in pain. The ED physician's physical examination showed a tense distended tympanic abdomen; and floppy paralysis of legs, absent sensation, mottling from waistline down, and feet are ice.

8. At 1336, an abdominal CT scan showed "findings of a presumed of colonic perforation resulting in a massive amount of pneumoperitoneum resulting in a presumed tension pneumoperitoneum. This caused marked collapse and compression of the abdominal aorta...absence of flow within the iliac arteries".

9. At 1359, the patient was seen by Respondent in the pre-operative area of the Hospital. In his physical examination, Respondent noted PK had a distended tender abdomen. Respondent made note of CT findings of a massive amount of pneumoperitoneum with marked collapsed and compression of abdominal aorta, and absent flow in iliac arteries. Respondent's diagnoses were metastatic peritoneal adenocarcinoma, abdominal pain, constipation, and severe colonic stricture. Respondent

noted that "patient has bowel perforation and will need emergency surgery. Poor overall prognosis".

10. At 1422, PK underwent emergency surgery with a post-operative diagnosis of perforated transverse colon with colonic content in peritoneum, infracted transverse, descending colon, ischemic small bowel, diffuse abdominal carcinomatosis, and frozen pelvis with tumor. The family elected comfort care and PK expired. The death certificate listed the cause of death as colonic perforation following diagnostic colonoscopy.

11. The standard of care requires a physician to recognize and appropriately treat post-operative complications. Respondent deviated from this standard of care by failing to recognize and appropriately treat post-operative complications of a colonoscopy.

12. Actual patient harm was identified in that the patient died of multi-organ failure brought on by colonic perforation and pneumoperitoneum, as the result of an attempted colonoscopy.

13. During the course of the Board's investigation, Respondent reported changes to his practice protocols intended to improve patient safety and overall communication between care providers.

14. During a Formal Interview on this matter, Respondent testified that the patient was stable and able to move her lower extremities when he saw her, and opined that the patient's change in condition occurred during her transport to the Hospital. When asked about nursing documentation indicating that the patient was assessed prior to transfer and was unable to feel her leg and the legs were observed to be mottled, Respondent stated that there was a communication breakdown between him and the nurse who completed the assessment. Respondent stated that he did not assess the patient's lower extremities. Respondent stated that the basis for transferring Patient PK to the Hospital was to allow the patient to undergo a diverting colostomy. In response to a

Board member's inquiry, Respondent noted that he performed ten cases on the day of PK's procedure. Respondent additionally testified regarding the changes to his practice regarding patient transfer and communication protocols. Respondent further expressed his condolences to PK's family for the outcome of this case.

15. During that same Formal Interview, Board members commented regarding the discrepancy between Respondent's testimony and the documentation. Board members further expressed concern regarding how well Respondent would be capable of monitoring PK's recovery given the number of cases performed that day. Board members noted that nursing documentation indicated that Respondent was informed of the patient's condition, and expressed concern regarding Respondent's assertion that the perforation occurred after PK was transferred to the Hospital. Board members recognized the remedial action undertaken by Respondent. However Board members agreed that Respondent remained accountable for the patient's case.

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 issued a Letter of Reprimand.

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 8th day of April ,2020.

ARIZONA MEDICAL BOARD

By Kristina Judson for
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed this 8th day of April, 2020 to:

Tom Slutes, Esq.
Slutes, Sakrison & Rogers, P.C.
4801 East Broadway Boulevard Suite 301
Tucson, Arizona 85711
Attorney for Respondent

ORIGINAL of the foregoing filed this 8th day of April, 2020 with:

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

Michelle Robles
Board staff