BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **THOMAS PETERS, M.D.** Holder of License No. **9582** For the Practice of Medicine In the State of Arizona.	Board Case No. MD-01-0641 **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 13, 2003. Thomas Peters, M.D., ("Respondent") appeared before the Arizona Medical Board ("Board") with legal counsel, Kimberly Kent, for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). After due consideration of the facts and law applicable to this matter, the Board voted to issue the following findings of fact, conclusions of law and order.

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 No. 9582 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-01-0641 after receiving a complaint regarding hip replacement surgery Respondent performed on a 32 year-old female patient ("DP") on July 10, 2000. DP reported that she followed all of Respondent's post-surgical instructions and when she returned to see him ten days after the surgery she informed him that she was experiencing pain. According to DP, Respondent instructed her to start bearing weight. DP's condition worsened and Respondent referred her for an arthrogram. After viewing the arthrogram Respondent informed DP that her pain might

be the result of soft tissue in between the joint and that he wanted to perform a repeat replacement.

4. On September 8, 2000, DP sought a second opinion and another physician ("Physician") informed her that the femoral head of the replacement appeared slightly larger than the native head that was removed. Physician informed DP that if her pain became severe and disabling they could discuss a second procedure. On October 4, 2000, DP returned to Physician with continued complaints of severe and disabling pain. On October 9, 2000, Physician performed a second surgery and placed a new ball joint and removed a previously placed Sampson rod.

5. The Board's medical consultant opined at the formal interview that Respondent fell below the standard of care because when he viewed the initial post-operative x-rays he did not recognize that the prosthetic head was too large for the acetabulum. The medical consultant also noted that he was unaware of any soft tissue that could be in the acetabulum that would have caused DP's pain.

6. Respondent testified that DP's case was a particularly unusual and difficult case involving a younger person with avascular necrosis and he elected to utilize a surface replacement in conformance with the standard of care for a young patient. Respondent noted that the case was complicated by the presence of a Sampson rod that was placed when DP was an adolescent and was the etiology of her avascular necrosis.

7. Respondent testified that he sized the prosthetic component by direct measure of the femoral head, with the size being determined by a caliper technique that took the least diameter of the diameters of the femoral head and converting that to the prosthesis. Respondent noted that he attempted for an hour and a half to extract the Sampson rod, but was unable to do so. Respondent stated that the prosthesis had to be truncated in the engineering department at the hospital. Respondent noted that the

implantation, the trial reduction of the head of the femur, was performed under direct vision. Respondent also stated that concentric reduction appeared to be obtained after two trials and with the final implantation. Respondent stated that closure was performed in the usual fashion and the soft tissues about the femoral head were reapproximated and DP was turned from a lateral position to a supine position and transferred to recovery.

8. Respondent noted that post-operative x-rays indicated that the femoral component appeared to be perched on the rim of the acetabulum rather than being deeply protruding into the rib into the edge of the acetabulum. Respondent stated that he felt this was a labrum of the lip or the rim around the acetabulum being infolded and soft tissue of the capsule that was redundant having also been infolded. Respondent stated that this was not obvious or present at the time of the reduction in the lateral position while the wound was still open. Respondent stated that he elected to allow DP the opportunity to weight bear to see if it represented infolded soft tissue or hematoma and to see if the prosthesis would reduce.

9. Respondent testified that in his training and experience the larger femoral head size is usually chosen to provide more satisfactory rim contact, rather than a smaller size that might intrude into the bony pelvis and become unstable or produce unusual wear in the dome of the acetabulum. Respondent stated that the standard for this procedure requires a direct measure of the femoral head and that the later discrepancy is certainly an issue, but is not readily explainable by the technique employed at surgery.

10. Respondent testified that his plan of treatment for avascular necrosis patients who have already been treated with conservative care (non-steroidals and anti-inflammatory medications) depends on the head involvement and the patient's age.

Respondent stated that if there is mild involvement he is more inclined to do a core depression.

11. Respondent noted that he has done surface replacements on patients only once every six years – approximately three or four in his years of practice. Respondent stated that DP's surface replacement was the last one he had done and he may not do another or he may choose to do one in a different fashion. Respondent testified that he believed younger patients are better off if treated with a standard total hip arthroplasty with a hard bearing.

12. Respondent testified that he elected the surface replacement for DP because of the presence of the Sampson rod. Respondent testified that when he tried to extract the Sampson rod he could get it out through the trochanter only about three or four centimeters and the bow of the femur was such that he could not move the rod any further without potentially breaking the femur. Respondent stated that he could have done an episiotomy of the femur, but the length that would be required to get to the bow of the femur would be excessive, so he felt that an episiotomy was not prudent. Respondent instead elected to leave the rod in place and complete the surface replacement.

13. Respondent stated that once he realized he could not put the stem across, he truncated the terra stem on the table himself, measuring it directly and then he sent it to the engineering department for the corners to be rounded out.

14. Respondent was asked if the post-operative x-rays bothered him because he said that intra-operatively he was able to reduce the hip and it was well contained, but on these x-rays this was not the case, because if there was anything in the acetabulum he could not have reduced the hip. Respondent stated that he assumed based on the amount of edema in the area that it possibly represented a capsular interposition and his

approach was to do a clinical trial of weight bearing to get DP mobilized. Respondent stated that moving DP from a lateral position to a supine position could have made it subluxate from intra-operative to post-operative. Respondent stated that DP appeared to have the normal amount of post-operative discomfort.

15. Respondent was asked if it raised a red flag for him that the hip was subluxed because one of DP's legs appeared longer than the other. Respondent stated that on DP's visit when the leg appeared longer he did not have her x-rays until after the visit and the radiology report stated that there was essentially a normal relationship to the bony pelvis and no problems were observed. Respondent stated that when the x-rays were available, DP had already had the arthrogram and the diagnosis had been made that there was a discrepancy in size or interposition of the soft tissue and the recommendation had been made for re-exploration.

16. Respondent stated that in hindsight what may have happened is that the caliper technique may have been inaccurate or the reading off of the caliper may have been inaccurate at the time of measurement.

17. Respondent was asked to explain how it was possible to have concentric reduction and then have a post-operative film like the one in DP's case. Respondent stated that he could not explain it based upon what he saw in surgery other than the change in the region such that soft tissue interposition may have occurred or a hematoma. Respondent was asked how there was a possibly of dislocation or interposition of tissue, since DP's procedure was not a standard total hip replacement. Respondent stated that it was his working hypothesis that something had changed and interposition occurred during repositioning or an amount of bleeding had occurred from the acetabulum. Respondent did acknowledge that in his twenty-five years of practice he had never seen a hip dislocate or tissue appear the way it did in DP's case.

18. Respondent was asked to explain his thinking when post-surgery DP had complaints of sciatica coupled with a leg length discrepancy. Respondent stated that he believed DP's symptoms were more related to his having spent a significant portion of the surgery trying very vigorously to extract the Sampson nail.

19. The standard of care required Respondent to use the proper size femoral head when performing a hip replacement surgery and to recognize the problem immediately after surgery and, having failed to do so and that time, when DP presented repeatedly after surgery with pain and a leg length discrepancy.

20. Respondent's conduct was unreasonable in that, given the standard of care, he did not use the proper size femoral head when performing hip replacement surgery and he failed to recognize the problem immediately after surgery and when DP presented repeatedly after surgery with pain and a leg length discrepancy.

21. DP was harmed because the she was required to undergo repeat hip replacement surgery.

CONCLUSIONS OF LAW

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

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances above in paragraphs 5 through 21 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(24)(q) "[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the pubic."

ORDER

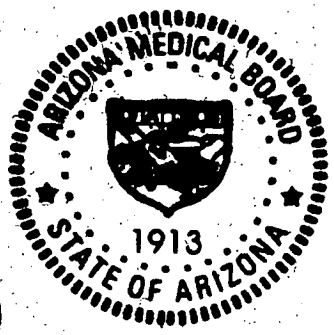
Based upon the foregoing Findings of Fact and Conclusions of Law, IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for improper performance of hip replacement surgery and improper follow-up care resulting in harm to the patient.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing or review must be filed with the Board's Executive Director within thirty days after service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a rehearing or review. Service of this order is effective five days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five 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 this 14th day of May, 2003.



ARIZONA MEDICAL BOARD

By _____
BARRY A. CASSIDY, Ph.D, PA-C
Executive Director

ORIGINAL of the foregoing filed this 14th day of MAY, 2003 with:

The Arizona Medical Board
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