BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

RONALD SALIK, M.D.

Holder of License No. **25392**
For the Practice of Medicine
In the State of Arizona.

Board Case No. MD-01-0454

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

(Letter of Reprimand)

This matter was considered by the Arizona Medical Board ("Board") at its public meeting on August 7, 2002. Ronald Salik, M.D., ("Respondent") appeared before the Board with legal counsel, Phil Grant, 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. 25392 for the practice of medicine in the State of Arizona.

3. The Board initiated case number MD-01-0454 after receiving notification of the settlement of a medical malpractice action involving Respondent's care and treatment of an 11 year-old male patient ("F.R.").

4. On December 31, 1997 F.R., who had a known history of asthma and prior hospitalizations was transported by ambulance to University Medical Center ("Medical Center") in Tucson, Arizona. Respondent, with the assistance of a third year resident ("Resident"), assessed F.R. F.R. had become apneic upon arrival and was transferred to

a hospital gurney. F.R. was intubated by Resident, bagged and masked with 100 percent oxygen.

5. F.R. went into cardiac arrest and was resuscitated. During the resuscitation the endotracheal tube was found in the esophagus and F.R. had to be re-intubated. F.R. was transferred to a pediatric intensive care unit and was later determined to have suffered bilateral uncal herniation due to diffuse swelling consistent with anoxic brain injury from prolonged resuscitation.

6. The Board's Medical Consultant stated that his review of the records indicated that F.R. was initially intubated at a time when his pulse oxygen was decreasing, but he had not coded. The Medical Consultant also noted that while F.R. was intubated 100 percent oxygen was provided and there was considerable improvement in his condition. The Medical Consultant stated that a few moments later when F.R.'s condition deteriorated neither Respondent nor Resident recognized that the deterioration was caused by the dislodgment of the endotracheal tube. The Medical Consultant noted that the dislodgment was subsequently discovered and F.R. was re-intubated, but the records indicate an interval of 15 minutes during which F.R. was without oxygen.

7. At the formal interview Respondent testified that F.R. was an asthmatic child who arrived at the emergency room in extremis and required intubation. Respondent noted that the question was how long F.R. was extubated during the time that he coded. Respondent noted that the person responsible for timing the code did not enter the room until the middle of the code and probably charted on a napkin or towel and transferred the notes later. Respondent testified that there were a number of nurses in the room trying to do a bunch of things at the same time and there was a lot of confusion. Respondent maintained that the Board really should not pay attention to the times noted

because in the emergency room hospital staff is trying to save someone's life and it is quite different and far more chaotic than one would believe.

8. According to Respondent, the charting nurse charted two minutes of time from when the extubation was noted until F.R. was re-intubated so he has trouble with the 15-minute timeframe noted by the Medical Consultant. Respondent noted that it has never been his practice to have something like this happen and it not be recognized. Respondent stated that it has been his testimony throughout this matter that he does not see where the discrepancy of 15 minutes came from.

9. Respondent was asked if he had created a medical record of his interaction with F.R., his findings and the sequence of events, independent of that dictated by Resident. Respondent stated that he did not dictate a separate summary and was advised by Medical Center risk management that it was best that there be one dictation. Respondent was asked if it was standard practice in a residency program for the attending physician on a bad case to do a separate dictation. Respondent stated that it is not common practice to do so and that at Medical Center they had just, within the last two years, started dictating records of admissions. When it was noted that this case was dictated, but it occurred more than two years ago, Respondent stated that he decided to have Resident dictate this case because he knew that if there was a hand-written record for a case that was probably going to go to court it would be more confusing than having a dictated record that everyone could read. Respondent noted that he recognized there were significant problems with F.R.'s case and that he had received advice to not do any independent documentation of the events.

10. Respondent testified that F.R. was intubated by the rapid sequence technique at 6:08 and that F.R. had already arrested at the time he was intubated. Respondent testified that he started bagging F.R., called for RSI drugs and shortly

thereafter F.R. was intubated. Respondent was asked why F.R. was given a sedative when he had already arrested and was unresponsive and pulseless. Respondent testified that F.R. had decortic-like activities and that drawal was tight, so to intubate him would have been very difficult. Respondent testified that the RSI drugs, especially for an asthmatic child were not readily available. Respondent noted that Resident did the intubation with a 6.5 oral tracheal tube that was cuffed. Respondent was asked what Resident did after the tube was placed to assure it was placed correctly. Respondent testified that Resident held the tube because intubation respiratory staff had not yet arrived and Respondent listened for bilateral breath sounds. Respondent noted that a Capnometer CO2 monitor that fits on the tube that changes color was used. Respondent was asked if there was any documentation of whether the color had changed and stated that he did not know of any one document. Respondent stated that in hindsight it is important to document, and that to be thorough would require documenting that you saw a color change indicating that you were through the vocal chords and saw the tube go through the cords without a problem.

11. Respondent agreed that the standard of care with Capnometry is to confirm tube placement within the first 15 seconds. Respondent also agreed that Resident's documentation became his documentation. Respondent stated that an x-ray was ordered to confirm tube placement but the x-ray staff was outside the room because F.R. was deteriorating. Respondent stated that although x-rays often are used to immediately confirm tube placement it depends on the patient and what is going on at the time. Respondent stated that a tube placement is confirmed when the patient starts to stabilize and you see the tube go through the cords. Respondent noted there was also Capnometry and that it was optimal if you have enough time to allow x-ray to get into the room and do the film.

12. The medical records reviewed by the Board indicate that F.R. was intubated at 6:08. The records suggest that this was a rapid sequence intubation for a patient who had not arrested. The nursing notes say F.R. became pulseless and asystolic at 6:14 and was re-intubated at 6:29. Respondent maintains that the times indicated in the records are incorrect and that there was not a fifteen-minute interval from when F.R. became pulseless and when he was re-intubated. Respondent stated that it was not his practice to sit and watch a patient deteriorate and not check the tube.

13. Respondent failed to properly supervise and monitor Resident's provision of respiratory support to F.R.

14. The medical records of F.R.'s care contain many discrepancies regarding times noted and the Board cannot determine the period of time that F.R. was without oxygen. Respondent's testimony regarding the times as he remembers them is credible and believable.

15. The medical record of F.R.'s care is erratic and disappointing and devoid of any independent notes made by Respondent's.

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 6, 9, 10, and 13 through 15 constitute unprofessional conduct pursuant to A.R.S. § § 32-1401 (24)(e) "[f]ailing or refusing to maintain adequate records on a patient;") 32-1401(24)(ii) ("[l]ack of or inappropriate direction, collaboration or direct supervision of a medical assistant or a

licensed, certified or registered health care provider employed by, supervised by or assigned to the physician."

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 failure to document the respiratory support of a critically ill patient and failure to adequately supervise a resident.

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 3rd day of October, 2002.

ARIZONA MEDICAL BOARD

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

ORIGINAL of the foregoing filed this 3rd day of October, 2002 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 3rd day of October, 2002, to:

Philip Grant
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Executed copy of the foregoing mailed by U.S. Mail this 3rd day of October, 2002, to:

Ronald Salik, M.D.
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Copy of the foregoing hand-delivered this 3rd day of October, 2002, to:

Christine Cassetta
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