BEFORE THE BOARD OF MEDICAL EXAMINERS

IN THE STATE OF ARIZONA

In the Matter of **JOSE PADILLA, M.D.** Holder of License No. **25251** For the Practice of Medicine In the State of Arizona.	Board Case No. MD-01-0143 **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

This matter was considered by the Arizona Board of Medical Examiners ("Board") at its public meeting on December 6, 2001. Jose Padilla, M.D., ("Respondent") appeared before the Board with legal counsel Peter Akmajian, for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(I). 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. 25251 for the practice of medicine in the State of Arizona.

3. The Board initiated case number MD-01-0143 after being informed by the Arizona Department of Health Services that it conducted an unannounced on-site inspection at Sierra Vista Regional Medical Center ("Medical Center"). The inspection was in response to a complaint regarding Respondent's care of an 84 year-old male patient ("Patient").

4. Patient presented to Medical Center for treatment after having fallen several times over a two-week period. Respondent diagnosed a fractured left hip and admitted Patient to Medical Center on September 13, 2000, with plans to perform an open reduction of the fracture the following day.

5. During the surgical procedure, Respondent used a noncannulated screwdriver to insert a lag screw driving a previously placed guide wire up through the acetabulum into the pelvis and out of Respondent's view. Intraoperative x-rays on the AP view showed that the guide had penetrated the acetabulum and entered the ilium. Respondent took no action, despite the x-rays.

6. Patient was discharged from Medical Center on September 17, 2000, and was to receive further care and physical therapy at Northern Cochise Community Hospital ("Community") in Wilcox, Arizona. While at Community, Patient began to develop fevers, decreased hemoglobin and hematocrit, and an increased white blood count. An abdominal x-ray showed that a Steinmann pin had not been removed after surgery and was in Patient's pelvis.

7. Patient was transferred back to Medical Center on September 19, 2000. While at Medical Center, another surgeon ("Surgeon") removed the pin in pieces and performed a colostomy. Patient continued to deteriorate postoperatively. Patient developed sepsis and was appropriately treated with antibiotics.

8. On October 10, 2000, Surgeon, assisted by Respondent returned the Patient to surgery to determine the source of the infection, but was unsuccessful. Patient expired later in the day. The cause of death was determined to be myocardial infarction and severe lung damage along with necrosis of the liver and focal ischemia to the small bowel.

9. At the formal interview before the Board Respondent testified that he used a C-arm for the surgery and did both AP and lateral views. Respondent also testified that he elected to do an open reduction and use the cannulated lag screw. According to Respondent he put the Steinmann pin in and got a good reduction and the Steinmann pin was entering into the acetabulum to support the femoral head at four or five millimeters.

10. Respondent noted that at least half of the Steinmann pin was sticking out of from the lateral aspect of the femoral shaft. Respondent then proceed to ream the pin and took the reamer out. At this time half the pin was sticking out. Respondent then applied the screw with a screwdriver onto the Steinmann pin.

11. Respondent testified that although it was not reflected in the records, he turned to the technician that handed him the instrument and noted that it did not look right. According to Respondent, he was assured that it was correct. Respondent then testified that what he thought was the screwdriver was actually the extractor.

12. Respondent testified that the instrument had been handed to him in one piece, the screw on the screwdriver with the locking mechanism. Respondent testified that he then put the lag screw over the Steinmann pin up to about four millimeters shy of the femoral surface. Respondent testified that he then went ahead and took off the locking mechanism, handed it to the technician behind him and took a picture to confirm where the screw was.

13. According to Respondent he was unaware that a locking mechanism was in the screwdriver. In response to a query from the Board, Respondent testified that he saw the lag screw going over the pin into the head.

14. Respondent testified that he had the picture from immediately beforehand of the Steinmann pin in good position and he did not recognize at that point that the

Steinmann pin was being driven by the locking mechanism. Respondent did not move the C-arm proximately to see that the Steinmann pin had been driven into the pelvis.

15. Respondent testified that he did not notice that the guide pin had been driven out of his view. According to Respondent, he may have assumed that the pin came out in the screwdriver.

16. Respondent testified that he saw the intraoperative X-rays, but did not recognize that the pin was beyond the acetabulum. The pin appeared to be where Respondent had placed it.

17. Respondent testified that he at no point has denied making a mistake in not catching the guide pin going out of his view. Respondent stated that he was handed the wrong instrument. Respondent noted that he is currently the Chair of the Department of Surgery at the institution where he is on staff and has instituted a new policy that all guide pins are accounted for after surgery.

18. Respondent also testified that the pin perforated the inferior portion of the rectum and then lodged into the opposite side of the pelvis in the ilium. According to Respondent, at the second surgery there was no focus of infection at this site; there was no focal infection at the hip; and the wound and rectum were well healed.

CONCLUSIONS OF LAW

1. The Board of Medical Examiners of the State of Arizona 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, 6, 8, 14 and 16 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(q) "[a]ny conduct or

practice which is or might be harmful or dangerous to the health of the patient or the public."

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 negligence in the operative care of a patient.

RIGHT TO PETITION FOR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing must be filed with the Board's Executive Director within thirty (30) 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. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing 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 is required to preserve any rights of appeal to the Superior Court.

DATED this 7th day of February, 2007.

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

By Claudia Foutz
CLAUDIA FOUTZ
Executive Director

ORIGINAL of the foregoing filed this 7th day of FEBRUARY, 2007 with:

The Arizona Board of Medical Examiners
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Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Certified Mail this
7th day of February, 2007, to:

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Executed copy of the foregoing
mailed by U.S. Mail this
7th day of February, 2007, to:

Jose Padilla, M.D.
1951 Frontage Road
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Copy of the foregoing hand-delivered this
7th day of February, 2007, to:

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