BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **ELA M. TIMBADIA, M.D.** Holder of License No. **16679** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-06-0187A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 7, 2007. Ela M. Timbadia, M.D., ("Respondent") appeared before the Board with legal counsel John E. Drazkowski 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 after due consideration of the facts and law applicable to this matter. The Findings of Fact, Conclusions of Law and Order were issued by the Board on August 10, 2007. Thereafter, Respondent filed a Petition for Rehearing or Review ("Petition"). The Board granted the Petition for the limited purpose of editing paragraphs 17 and 18 of the Findings of Fact.

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. 16679 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-0187A after being notified of a malpractice settlement involving Respondent's care and treatment of a fifty-two year-old female patient ("CS") who was diagnosed with locally advanced breast cancer in Spring 2004. It was believed CS would benefit from pre-operative chemotherapy and she was referred to Respondent for placement of a chemotherapy subclavian Port-A-Cath. Respondent saw CS pre-operatively and discussed the planned procedure, options, and potential complications.

4. On April 22, 2004 Respondent attempted to place the Port-A-Cath. The operating room time for the procedure was three hours and five minutes. Respondent encountered difficulty placing the Port-A-Cath and converted from local anesthesia with conscious sedation to general anesthesia. Respondent believed the difficulty she experienced with the procedure was caused by either a venous anomaly or superior venacava syndrome. During the procedure Respondent attempted both left subclavian, left jugular and right subclavian approach before going back to the left subclavian and ultimately placing the catheter with a venoplasty and venacavagram. Post-operative x-rays were reported as demonstrating the catheter in satisfactory position.

5. CS subsequently received chemotherapy on April 30, 2004 and reported shortness of breath and chest pain. CS was referred back to Respondent and Respondent obtained an X-ray on May 6, 2004. The radiology report suggests there was no problem with the catheter, but did note a significant pleural effusion. CS underwent a second round of chemotherapy on May 21, 2004 and again complained of pain and shortness of breath. CS presented to the hospital and a May 21, 2004 CT scan demonstrated the Port-A-Cath crossing the midline from the left subclavian and terminating in the right pleural space. Also noted was a small to moderate pleural effusion with right lung atelectasis. CS underwent a thoracentesis of the pleural space followed by right tube thoracostomy with concomitant placement of a left jugular catheter and removal of the malpositioned subclavian catheter. The studies demonstrated CS had normal venous anatomy.

6. Respondent is a general and vascular surgeon and has completed seven or eight hundred similar procedures. In Respondent's operative report she documented "[superior] vena cava syndrome" rather than superior vena cava occlusion because she was not certain what was going on, she just had difficulty in negotiating the wire at the junction of the brachia cephalic vein to the superior vena cava. Respondent thought the potential causes of this difficulty were scarring from previous catheterizations, adenopathy in the mediastinum that could be compressing the area and not allowing the wire to go through the vein. When the wire stopped advancing

Respondent pulled it back and tried a softer wire, but it would coil. Respondent tried to inject dye through the syringe and could see it going beyond that point and it appeared there was a very narrow area that she needed to negotiate. At this point Respondent considered the possibility that CS might benefit from an alternate approach to infusion chemotherapy and claimed she called the oncologist during the procedure, but did not document any phone call in the operative report. Respondent maintained the call was documented elsewhere.

7. According to Respondent the oncologist asked her to try again because CS needed to get Adriamycin that had to be given in a centrally located catheter. At this point Respondent had the anesthesiologist convert the procedure to general anesthesia. Respondent subsequently gave up on the left subclavian approach and went over to the right, but got the same result. If there was a 100 percent occlusion and Respondent had pushed the wire through she could have perforated CS's superior vena cava and CS would have exsanguinated on the table. Respondent had injected dye and, although it was a very short stenotic area, there was a lumen to it and all she wanted to do was manipulate the wire to get through that area that was not completely occluded.

8. Whenever Respondent sees an obstruction or stenotic lesion she does have to cross it with different wires and she has done it in the past, not necessarily for a tumor patient, but sometimes because of stenosis secondary to scarring from previous catheters. Respondent would not ever attempt to try to negotiate a near total occlusion and CS's was approximately a 70 percent lesion. Respondent's earlier testimony was that she did not know what was occluding the vein. CS could have had a tumor mass invading the vein and continuing with the procedure could have caused her death.

9. Respondent encountered the same difficulty placing the wire in the right subclavian position and then attempted an internal jugular and then went back to the left subclavian. There is a certain point in time, weighing the benefits and risk to the patient, that it is

better to stop a procedure because of the risk to the patient. Respondent felt comfortable going on because she was able to negotiate the stenotic lesion and, once the dilator was past the stenotic lesion, she actually aspirated blood and made sure she was in the lumen. Respondent kept checking to make sure nothing was happening to CS and her vitals remained stable.

10. The most common complication of central line placement using subclavian approach is pneumothorax and Respondent has experienced this in the past. After Respondent tried on the left side she did not take an x-ray to make sure she had not collapsed CS's left lung before she went to the right because she was looking at it under fluoroscopy and she would have also seen a drop in her oxygen saturation and difficulty with the anesthesiologist ventilating CS if she developed a pneumothorax. Since Respondent attempted the procedure on both sides and CS got positive ventilation by general anesthetic she was at a much higher risk of developing a bilateral pneumothorax.

11. Respondent believed the catheter was in the appropriate position because she was able to get a normal aspiration of blood after placement. Subsequent events show that the catheter was in the right pleural space and Respondent maintained it migrated. If the catheter was in the superior vena cava and migrated out there would be a rather significant hemorrhage from rupture of the vessel from the large catheter migrating out.

12. As was her routine after insertion of any central venous procedure Respondent took an AP film after she believed she was in the superior vena cava. Even though she had difficulty placing the catheter Respondent did not get a two-dimensional lateral film because she did not want to send CS down to radiology – it was not something that could be done with a portable machine. Respondent normally uses a C-arm in the operating room. Respondent could get a lateral with the C-arm and did so in the operating room when she was inserting the catheter and injecting the dye. There are no C-arm films in the record. Respondent maintained the films were never captured or printed.

13. Respondent's earlier testimony was that she injected dye to verify placement of the catheter. On page 11 of the Baptist Hospital record containing Respondent's description of the procedure, one paragraph describes the dye use in detail. The next paragraph beginning "[a]t this point the glidewire was exchanged for an angled glidewire" indicates there were several attempts made to negotiate the area and when Respondent got past the area and got return blood flow she placed the catheter. Subsequent to that entry there is nothing indicating she verified with dye that she was indeed there. The record contains no further dye studies to show that the catheter was indeed beyond the purported obstruction. In subsequent paragraphs the only documentation that the catheter was in place was that the blood was freely aspirated.

14. Although Respondent maintained the catheter migrated distally and was in the vessel, the subsequent thoracic surgical consultation documents the "catheter appear[ed] to be traversing to mediastinum between the trachea and the esophagus" demonstrating the catheter was never in CS's central circulation. Also, in the dictation of the subsequent procedure to place the catheter there was no obstruction on any of the ultrasounds and the surgeon did not have any difficulty in placing the catheter.

15. The standard of care required Respondent to not make multiple attempts at placing a catheter in the face of procedural and possible anatomic abnormalities that she could not define.

16. Respondent deviated from the standard of care by making multiple attempts at placing a catheter in the face of procedural and possible anatomic abnormalities that she could not define.

17. The standard of care required Respondent to recognize the catheter was not correctly placed (was in the pleural space) when the patient had a pleural effusion and complications one week later.

18. Respondent deviated from the standard of care by not recognizing the catheter was not correctly placed when the patient had a pleural effusion and complications one week later.

19. CS received chemotherapy into the pleural space causing pain and requiring drainage. CS also required a second procedure to place a central line.

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 described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient of the public;") and A.R.S. § 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence or negligence resulting in harm to or the death of a patient.").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for failure to abandon the procedure to place a central catheter after multiple attempts in the face of possible anatomical abnormalities and for failure to recognize the central catheter was inappropriately placed

RIGHT TO APPEAL TO SUPERIOR COURT

Respondent is hereby notified that this Order is the final administrative decision of the Board and that Respondent has exhausted her administrative remedies. Respondent is advised

that an appeal to Superior Court in Maricopa County may be taken from this decision pursuant to Title 12, Chapter 7, Article 6.

DATED this 17th day of October, 2007.

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 18th day of October, 2007 with:

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

Executed copy of the foregoing mailed by U.S. Mail this 18th day of October, 2007, to:

John E. Drazkowski
Jardine, Baker, Hickman & Houston, P.L.L.C.
3300 North Central Avenue – Suite 2600
Phoenix, Arizona 85012-2504

Ela M. Timbadia, M.D.
Address of Record

_____