

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **ALLEN D. SLOAN, M.D.**

4 Holder of License No. 17481
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Case No. MD-14-1665A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND ORDER FOR LETTER
OF REPRIMAND**

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on
8 April 6, 2016. Allen D. Sloan, M.D. ("Respondent"), appeared with legal counsel, Dan
9 Cavett, before the Board for a Formal Interview pursuant to the authority vested in the
10 Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of
11 Law and Order after due consideration of the facts and law applicable to this matter.

12
13 **FINDINGS OF FACT**

14 1. The Board is the duly constituted authority for the regulation and control of
15 the practice of allopathic medicine in the State of Arizona.

16 2. Respondent is the holder of license number 17481 for the practice of
17 allopathic medicine in the State of Arizona.

18 3. The Board initiated case number MD-14-1665A after receiving notification of
19 a malpractice settlement arising out of Respondent's care and treatment of a 62 year-old
20 female patient ("DM") alleging failure to recognize a complication and failure to report on
21 the patient's condition.

22 4. On August 7, 2013, DM was scheduled to undergo a first right toe
23 amputation due to gangrene. DM had a prior history of coronary artery bypass graft,
24 chronic renal failure with dialysis, insulin therapy for diabetes mellitus, morbid obesity,
25 hypertension and anemia with hematocrit under 30%. Respondent provided anesthesia

1 for the procedure. He assessed DM as ASA IV, indicating a perceived risk of death under
2 anesthesia. During the procedure, DM's heart rate decreased to 40 beats per minute, then
3 increased to about 60 beats per minute with oxygen saturations of 93%. DM's pulse
4 oximetry tracing flatlined with a heart rate between 40 and 60 beats per minute and a
5 normal sinus rhythm. While compressions were performed for five to ten minutes, DM
6 suffered an anoxic brain injury. DM did not regain consciousness and remained ventilator
7 dependent until she died two months later.

8 5. The standard of care requires a physician to timely recognize a life
9 threatening condition of the patient and initiate resuscitation, and to obtain complete past
10 medical history for non-emergency surgery. Respondent deviated from this standard of
11 care by delay or failure to recognize the patient's life threatening condition, failure to
12 initiate resuscitative efforts, and failure to obtain complete past medical history for non-
13 emergency surgery.

14 6. During a Formal Interview on this matter, Respondent testified that he was
15 unaware that DM had pulmonary hypertension and severe mitral valve regurgitation.
16 Respondent further testified that if he was aware, he would have cancelled the surgery, as
17 both of these conditions require much more careful preparation before considering putting
18 a patient to sleep. Respondent testified that even though the malfunctioning blood
19 pressure cuff caused difficulty with direct monitoring of the patient's blood pressure, he
20 was reassured by the readings of the plethysmograph tracing, despite not having a blood
21 pressure reading that could be charted.

22 7. Respondent also testified that he had never previously had a patient that
23 required up to seven doses of a presser such as phenylephrine or epinephrine in
24 concurrence with the inability to obtain a blood pressure. Respondent agreed that the
25 amount of presser required was uncommon. At the time, Respondent believed it would be

1 helpful for the surgery to continue in order to allow DM's body catecholamines to raise the
2 blood pressure. Respondent stated that it was only after the surgery stopped that DM
3 experienced a sudden cessation of circulation.

4 8. With regard to the manual anesthesia record, Respondent testified that the
5 record was filled out in the ICU after the surgery was over. Respondent stated that just
6 before he left and transported the patient to the ICU he took basic data with blood
7 pressure, pulse rates off the recording that was present in the anesthesia monitor, but he
8 forgot to make recordings of the BCO2 and forgot to put that in the record.

9 9. Board members agreed that although the case was fairly complicated, the
10 failure to obtain a full past medical history was troubling with a non-emergent surgical
11 procedure.

12 **CONCLUSIONS OF LAW**

13 1. The Board possesses jurisdiction over the subject matter hereof and over
14 Respondent.

15 2. The conduct and circumstances described above constitute unprofessional
16 conduct pursuant to A.R.S. § 32-1401(27)(q) ("Any conduct or practice that is or might be
17 harmful or dangerous to the health of the patient or the public.").

18 19 **ORDER**

20 IT IS HEREBY ORDERED THAT:

21 1. Respondent is issued a Letter of Reprimand.
22

23 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

24 Respondent is hereby notified that he has the right to petition for a rehearing or
25 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

1 petition for rehearing or review must set forth legally sufficient reasons for granting a
2 rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after
3 date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed,
4 the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

5 Respondent is further notified that the filing of a motion for rehearing or review is
6 required to preserve any rights of appeal to the Superior Court.

7 DATED AND EFFECTIVE this 3rd day of June, 2016.

8 ARIZONA MEDICAL BOARD

9
10 By Patricia E. McSorley
11 Patricia E. McSorley
12 Executive Director

13 EXECUTED COPY of the foregoing mailed
14 this 3rd day of June, 2016 to:

15 Dan Cavett
16 Cavett & Fulton PC
17 6035 E Grant Road
18 Tucson, AZ 85712
19 Attorney for Respondent

20 ORIGINAL of the foregoing filed
21 this 3rd day of June, 2016 with:

22 Arizona Medical Board
23 9545 E. Doubletree Ranch Road
24 Scottsdale, AZ 85258

25 Mary Bobe
Board Staff