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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of  
**ARTHUR T. WOLFF, M.D.**  
Holder of License No. 43894  
For the Practice of Allopathic Medicine  
In the State of Arizona.

Case No. MD-14-0957B  
**ORDER FOR LETTER OF  
REPRIMAND; AND CONSENT  
TO THE SAME**

Arthur T. Wolff, M.D. ("Respondent"), elects to permanently waive any right to a hearing and appeal with respect to this Order for a Letter of Reprimand; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

**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 number 43894 for the practice of allopathic medicine in the State of Arizona.
3. The Board initiated case number MD-14-0957B after receiving a complaint regarding Respondent's care and treatment of a 60 year-old male patient ("TM") alleging that propofol was not administered according to Southern Arizona VA Health Care System ("SAVAHCS") protocol, resulting in the patient's death.
4. On March 9, 2014, TM was admitted to the VA Medical Center for lethargy and worsened chest pain for one month. TM reportedly had left a hospital earlier that day against medical advice. TM's urine drug screen was positive for opiates and methamphetamines. Over the following 24 hours, TM became agitated with a Clinical Institute Withdrawal Assessment ("CIWA") score of 19. TM was being followed by the non-teaching hospitalist on the ward, given medication to help calm him, and a sitter was placed at his bedside.

1           5.     On March 11, 2014, TM became increasingly agitated with a CIWA score of  
2 26, and was evaluated by cardiology and psychiatry specialists. TM's agitation progressed  
3 and he was transferred to the intensive care unit for airway protection monitoring and  
4 nursing care. Multiple "Code Greens" were called overnight and into the following morning  
5 for TM's combative and threatening behavior.

6           6.     On March 12, 2014, TM's care was assumed by the internal medicine  
7 teaching service, and he remained somnolent and intermittently combative in four point  
8 restraints. IV access was problematic as TM was pulling out his IV lines and foley catheter,  
9 and he required IV medications to help sedate and calm him.

10          7.     On March 13, 2014, TM's CIWA score was 19 with worsened agitation. The  
11 following day, TM remained in the intensive care unit and began to improve. IV access  
12 continued to be troublesome with three attempts to place an IV overnight.

13          8.     On March 15, 2014, additional attempts were made at placing an IV in the  
14 morning. TM was unable to safely take medication orally, but was less combative. Per the  
15 resident physician's progress note, the plan was to hold off on line placement and continue  
16 to monitor TM. The attending physician was unable to supervise the resident for the  
17 necessary procedures, and Respondent was asked to supervise, which he agreed to do.  
18 The resident physician obtained verbal consent for central line access and lumbar  
19 puncture from TM's medical power of attorney. Respondent witnessed the consent. The  
20 consent stated that moderate sedation would be used for both procedures.

21          9.     After the consent was obtained on March 15, 2014, Respondent attempted a  
22 central line placement with the resident physician, and the nurse present. Respondent  
23 used Local lidocaine, and placed the line using 5mg of IV diazepam, 25mg IV Benadryl,  
24 and 9.75mg of aripiprazole. TM was moving during the procedure. Venous blood gas was  
25 obtained at the time of line placement, and a pharmacy consult was obtained for initiation

1 of Precedex. Due to TM's heart failure, it was felt that this medication was contraindicated  
2 and therefore discontinued. The resident physician elected to use propofol for sedation.  
3 Respondent admitted that he knew that propofol was being used however; he was not  
4 immediately available to monitor the effects of the sedation.

5 10. Two hours later, a chest x-ray confirmed that the line placement was too far  
6 and the line was pulled back by 2cm. Nursing staff documented the initiation of propofol at  
7 5mcg/kg/min in anticipation of the lumbar puncture procedure. Twenty minutes later,  
8 propofol was increased to 10mcg/kg/min. After an additional twenty minutes, propofol was  
9 increased to 20mcg/kg/min. The lumbar puncture attempt was abandoned. TM's oxygen  
10 saturation became difficult to obtain via pulse oximetry and propofol was discontinued.

11 11. The oncoming nurse performed a head-to-toe assessment of TM, who was  
12 noted to have agonal breathing with respirations of 6. An internal medicine intern  
13 answered the page for an available physician, and observed at TM's bedside that his heart  
14 rate was in the 20s without a blood pressure and no measurable pulse oximetry. The  
15 physician subsequently contacted the attending to pronounce expiration of the patient.

16 12. The standard of care required Respondent to adequately monitor the use of  
17 propofol with only a trainee/resident and nurse present; to be immediately present to  
18 monitor the use of the medication and its effects; to provide the appropriate level of  
19 supervision indicated by the acuity of the clinical situation; to adequately supervise a  
20 resident physician during the use of a respiratory and CV depressant by the resident  
21 physician in the intensive care unit setting for a procedure without direct monitoring and  
22 support; and to directly supervise the ongoing use of propofol when the procedure is  
23 aborted.

24 13. Respondent deviated from the standard of care by the unmonitored use of  
25 propofol with only a trainee/resident physician and nurse present; by failing to be



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**ORDER**

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

DATED AND EFFECTIVE this 8<sup>th</sup> day of October, 2015.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley  
Patricia E. McSorley  
Executive Director

**CONSENT TO ENTRY OF ORDER**

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended

1 or made for any other use, such as in the context of another state or federal government  
2 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or  
3 any other state or federal court.

4 6. Upon signing this agreement, and returning this document (or a copy thereof)  
5 to the Board's Executive Director, Respondent may not revoke the consent to the entry of  
6 the Order. Respondent may not make any modifications to the document. Any  
7 modifications to this original document are ineffective and void unless mutually approved  
8 by the parties.

9 7. This Order is a public record that will be publicly disseminated as a formal  
10 disciplinary action of the Board and will be reported to the National Practitioner's Data  
11 Bank and on the Board's web site as a disciplinary action.

12 8. If any part of the Order is later declared void or otherwise unenforceable, the  
13 remainder of the Order in its entirety shall remain in force and effect.

14 9. If the Board does not adopt this Order, Respondent will not assert as a  
15 defense that the Board's consideration of the Order constitutes bias, prejudice,  
16 prejudgment or other similar defense.

17 10. *Respondent has read and understands the terms of this agreement.*

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ARTHUR T. WOLFF, M.D.

DATED: 09/17 '15

21 EXECUTED COPY of the foregoing mailed  
22 this 8<sup>th</sup> day of October, 2015 to:

23 Chris Smith  
24 Smith Law Group  
25 Davis House  
262 North Main Ave  
Tucson AZ 85701  
Attorney for Respondent

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ORIGINAL of the foregoing filed  
this 8<sup>th</sup> day of October, 2015 with:

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

May Patel  
Board Staff