

1 artery was lacerated during the procedure and suffered a rapid blood loss of 250ml. The
2 anesthetic record shows that ED's blood pressure dropped to 55/40 with a pulse rate of
3 60. ED's blood loss was replaced almost entirely with intravenous fluids. A small amount
4 of cell saver blood was administered and ED developed a very low blood count.

5 5. After gaining control of the bleeding, the surgeon discussed the situation with
6 Respondent and the operating room nurses. The surgeon explained that the artery repair
7 would be difficult, and ordered a cell saver to collect shed blood, and requested
8 Respondent to induce burst suppression. The total blood loss was recorded as 2000ml.
9 Respondent had infused approximately 5 liters of crystalloid, 250ml of albumin, and 250ml
10 of blood from the cell saver. With ED unconscious and his breathing significantly impaired,
11 Respondent administered naloxone to reverse the effects of sedation. ED did not awaken,
12 but resumed breathing on his own. Prior to leaving the recovery room, Respondent
13 documented ED's vitals to include a blood pressure of 110/60 and a pulse rate of 80. In
14 the recovery room, Respondent ordered only a unit of blood, a measurement of blood
15 glucose and oxygen as needed. The blood glucose order was for on admission and then
16 "ad lib" starting at 19:00. The blood sugar at 19:05 was 300 mg/dL. There was no
17 response to this measurement for another 15 minutes until another physician ordered
18 insulin. There were no other orders for electrolytes, EKG, chest film, platelet count, arterial
19 blood gases. Respondent attempted to reverse ED's obtundation and evaluated his
20 neurological status only after the surgeon and a consulting physician raised the issue, ED
21 was transferred to another hospital for further care. On January 18, 2007, ED developed
22 increased intracranial pressure and died.

23 6. The standard of care requires a physician to order O-negative blood
24 immediately and draw a sample for crossmatching when large blood loss is anticipated
25 during surgery; to use an ancillary IV, piggyback into the main IV as close to the vein as

1 possible; to protect the patient against hypercarbia in a patient with a possible significant
2 ischemic brain injury; and to manage the patient's care in the PACU.

3 7. Respondent deviated from the standard of care by failing to immediately
4 order O-negative blood and draw a sample for crossmatching, by adding narcotics to the
5 main IVs rather than establishing a separate IV; by failing to protect ED against
6 hypercarbia; and by failing to manage ED's care in the PACU.

7 8. There was potential for exacerbation of an ischemic injury to the brain due to
8 Respondent's failure to immediately order O-negative blood and failure to prevent
9 postoperative hypercarbia.

10 9. A physician is required to maintain adequate legible medical records
11 containing, at a minimum, sufficient information to identify the patient, support the
12 diagnosis, justify the treatment, accurately document the results, indicate advice and
13 cautionary warnings provided to the patient and provide sufficient information for another
14 practitioner to assume continuity of the patient's care at any point in the course of
15 treatment. A.R.S. §32-1401(2). Respondent's medical records were inadequate because
16 he inappropriately entered information into the record prior to the actual events and failed
17 to write a detailed post-anesthesia note.

18 CONCLUSIONS OF LAW

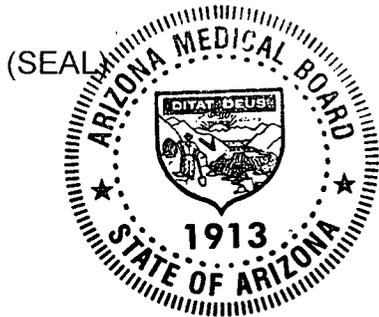
19 1. The Board possesses jurisdiction over the subject matter hereof and over
20 Respondent.

21 2. The conduct and circumstances described above constitute unprofessional
22 conduct pursuant to A.R.S. § 32-1401(27)(e) (“[f]ailing or refusing to maintain adequate
23 records on a patient.”) and A.R.S. §32-1401(27)(q) (“[a]ny conduct or practice that is or
24 might be harmful or dangerous to the health of the patient or the public.”).

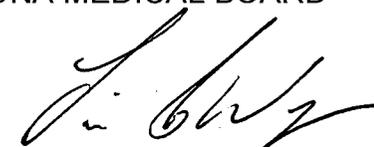
25 ORDER

1 IT IS HEREBY ORDERED THAT Respondent is issued a Letter of Reprimand.

2
3 DATED AND EFFECTIVE this 9TH day of FEBRUARY, 2016.



ARIZONA MEDICAL BOARD

6
7 By 
8 Lisa S. Wynn
Executive Director

9 **CONSENT TO ENTRY OF ORDER**

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

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

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

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

21 5. All admissions made by Respondent are solely for final disposition of this
22 matter and any subsequent related administrative proceedings or civil litigation involving
23 the Board and Respondent. Therefore, said admissions by Respondent are not intended
24 or made for any other use, such as in the context of another state or federal government
25 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or
any other state or federal court.

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

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

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

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

14 10. Any violation of this Order constitutes unprofessional conduct and may result
15 in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation,
16 consent agreement or stipulation issued or entered into by the board or its executive
17 director under this chapter") and 32-1451.

18
19 
20 _____
MARK J. TRENTALANGE, M.D.

DATED: 01/18/2011

21 EXECUTED COPY of the foregoing mailed
22 this 10th day of February 2010 to:

23 Mark J. Trentalange, M.D.
24 Address of Record

25 ORIGINAL of the foregoing filed
this 10th day of February 2010 with:

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

3 
4 Arizona Medical Board Staff

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