

1 the diagnosis of cocaine abuse of a single episode. Two years of monitoring was
2 recommended by Respondent's evaluators.

3 6. On April 8, 2014, Respondent entered into an Interim Order for PHP
4 Participation. On December 22, 2014 and December 30, 2014, Respondent submitted
5 consecutive dilute urine drug screen tests. Based on these test results, PHP scheduled
6 Respondent for a PEth test on January 6, 2015. Respondent did not take the PEth test.
7 Respondent has stated that he no longer wanted to undergo testing as required by his
8 Interim Order. The information was then presented to the investigative staff, the chief
9 medical consultant and the lead Board member who all agreed that an interim consent
10 agreement to restrict Respondent's practice was appropriate.

11 7. Respondent entered into an Interim Practice Restriction on January 27,
12 2015. On March 30, 2015, Board staff received a report from the PHP Contractor stating
13 that Respondent had resumed compliance with the monitoring program. The PHP
14 Contractor's recommendation at that time was that Respondent continue to be monitored
15 under the previous interim consent agreement, with no credit for the two months of non-
16 compliance. Respondent's practice restriction was subsequently vacated on April 10,
17 2015.

18 8. During the course of the Board's investigation, the Board requested that a
19 Medical Consultant ("MC") review seven patient charts from the Hospital. Of the seven
20 patients' charts reviewed, the MC identified a deviation from the standard of care in six
21 cases, as well as medical recordkeeping concerns.

22 9. Patient SS, a 75 year-old female, was admitted to the Hospital in December
23 of 2013. SS presented with stroke-like symptoms and was found to have evidence of
24 carotid disease on a duplex study. A computed tomography angiography ("CTA") showed
25 only moderate findings, and Respondent performed a carotid endarterectomy. SS did not

1 have any untoward outcome. SS's patient records contain no documentation to support
2 that Respondent or his Physician Assistant saw the patient in follow up.

3 10. Patient LR, a 72 year-old male with significant chronic kidney disease,
4 presented to the Hospital with vertigo and dizziness. He was seen by neurology and
5 cardiology, and initially it was felt that he may have had an inner ear problem. A brain MRI
6 showed bilateral frontal infarcts. CTA and magnetic resonance angiography ("MRA")
7 showed a potential left internal carotid artery dissection. Respondent saw LR and felt that
8 angiography was appropriate to make a definitive diagnosis, which confirmed the
9 dissection. Respondent elected to proceed the following day with stenting of the carotid
10 dissection. LR developed crushing subdural chest pain. He had a coronary angiogram that
11 demonstrated an aortic dissection. LR was stabilized, became septic, and ultimately, he
12 was taken to the operating room ("OR") for emergency surgery. LR was hypotensive and
13 expired in the OR due to the dissection. Respondent did not dictate the operative report for
14 ten days after the procedure, and Respondent failed to appropriately document in LR's
15 chart.

16 11. Patient MM, a 65 year-old female, was admitted to the Hospital after
17 presenting with symptoms consistent with a stroke. She was found to have significant
18 carotid disease as well as incidental aneurysms. On February 6, 2014, Respondent
19 performed a carotid endarterectomy with significant intraoperative issues. Respondent's
20 operative note mentioned ulcerative plaque eroding through the posterior wall of the
21 carotid artery, which Respondent was unable to repair. As a result, Respondent surgically
22 occluded the carotid artery. MM sustained a significant stroke and resultant hemiplegia.
23 The MC opined that other methods could have been attempted when the carotid could not
24 be primarily repaired, such as a patch graft or some form of an interposition graft.

25

1 12. Patient TY, an 81 year-old female, presented on December 21, 2013 with a
2 subarachnoid hemorrhage. She was found to be in a critical neurologic state and
3 intubated. Initially, Respondent elected to treat TY with expectant management. However,
4 TY improved neurologically and Respondent elected to endovascularly treat the
5 aneurysm. The procedure was performed on December 25, 2013 and was complicated by
6 a thrombus in the carotid artery extending to the middle cerebral artery and anterior
7 cerebral artery. As a result, TY sustained a major stroke and expired on December 27,
8 2013. The MC stated that Respondent should not have first angiographically studied the
9 non-ruptured aneurysm, which subjected TY to a lengthier procedure with increased risk of
10 stroke. The MC also stated that Respondent's overall daily notes were not detailed with
11 respect to the plan and discussion with the patient's family.

12 13. Patient RB1, a 35 year-old male, sustained a burst fracture of his L1
13 vertebrae and a fracture of his L2 vertebrae with disc herniation after a fall. Respondent
14 diagnosed the fracture and took RB1 to surgery for laminectomy and posterior spinal
15 fusion. The hardware was not placed appropriately, as some of the screws were
16 misplaced.

17 14. Patient RB2, a 55 year-old male, was found to have a C7 facet fracture.
18 Based on imaging studies, Respondent placed RB2 in a rigid cervical orthosis, with which
19 RB2 was non-compliant according to the medical records. X-rays later revealed a new
20 subluxation at C6-C7, which was not present previously. RB2 presented to the emergency
21 department with complaints of arm pain and numbness. A CT scan showed evidence of
22 the fracture, with new findings of a disc herniation. Respondent did not order a new MRI
23 as suggested by the radiologist. Respondent took RB1 to the OR for a posterior cervical
24 decompression with a posterior cervical instrumented fusion. The initial plan was to place
25 lateral mass screws. However, due to the fracture on the right side, Respondent placed a

1 right C7 pedicle screw. A CT scan that was ordered by the chief of staff revealed the
2 hardware to be malpositioned.

3 15. The standard of care required a physician to follow up with the patient in the
4 postoperative setting. Respondent deviated from the standard of care by failing to follow
5 up with SS postoperatively.

6 16. The standard of care for a patient with stage III chronic kidney disease
7 requires a physician to treat the patient with medical management. Respondent deviated
8 from the standard of care by failing to treat LR with medical management and proceeding
9 with surgical stenting, placing LR at risk due to the dye load.

10 17. The standard of care in the event that the patient's carotid cannot be
11 primarily repaired requires a physician to attempt other methods including graft prior to
12 sacrificing the carotid artery via occlusion. Respondent deviated from the standard of care
13 by occlusion of MM's carotid artery without first attempting other methods such as patch or
14 interposition graft when the carotid could not be primarily repaired.

15 18. The standard of care requires a physician to avoid aggressively treating an
16 elderly patient with aneurysmal subarachnoid hemorrhages as they have notoriously bad
17 outcomes with mortality rates over 60%. Respondent deviated from the standard of care
18 by angiographically studying the non-ruptured aneurysm first, subjecting TY to a lengthier
19 procedure with increased risk of stroke.

20 19. The standard of care requires a physician to appropriately place the patient's
21 hardware. Respondent deviated from the standard of care by failing to appropriately place
22 RB1's hardware.

23 20. The standard of care requires a physician to order an MRI when properly and
24 appropriately recommended by the radiologist. Respondent deviated from the standard of
25 care by failing to obtain an MRI when RB2 presented with new neurologic symptoms.

1 21. Patient LR expired. Patient MM sustained a significant stroke and resultant
2 hemiplegia. Patient TY sustained a major stroke from the procedure, resulting in her
3 demise. Patient SS could have suffered a major cerebral vascular accident, hemorrhage,
4 or death. Patient RB1's retroperitoneal hematoma could have resulted from the misplaced
5 screws. Inappropriately placed hardware can potentially cause neurologic or vascular
6 injury or lack of solid fusion. In the case of patient RB2, potential harm includes the failure
7 of the hardware, and the potential failure to fuse adequately. Additionally, patient RB2
8 could potentially have persistent neurologic deficits due to an unrecognized herniated disc.

9 22. Respondent presented for a comprehensive physician assessment at the
10 University of California San Diego Physician Assessment and Clinical Education ("PACE")
11 Program on April 6-8, 2015. On July 7, 2015, the Board received the report from
12 Respondent's PACE assessment. The PACE evaluators expressed concern regarding
13 Respondent's ability to safely and independently practice as an endoscopic neurosurgeon.
14 Specifically, the PACE report identified specific procedures that Respondent was safe to
15 practice independently, specific procedures that Respondent could perform under
16 supervision of a proctor for a period of time, and specific procedures that are beyond
17 Respondent's current scope of practice. PACE also recommended that Respondent
18 complete a fitness-for-duty neuropsychological evaluation. The information from PACE
19 was then presented to the investigative staff, the chief medical consultant and the lead
20 Board member who all agreed that an interim consent agreement to partially restrict Dr.
21 Horton's clinical practice was appropriate. Dr. Horton entered into an Interim Consent
22 Agreement for Practice Restriction which was executed on July 13, 2015.

23 23. Respondent underwent the neuropsychological evaluation on August 19 and
24 20, 2015. The evaluator found within a reasonable degree of neuropsychological certainty
25 that Respondent's overall neuropsychological functioning is in the normal range. It was

1 noted that, although signs of low normal information processing speed and motor
2 functioning are concerning given Respondent's occupational specialty, the pattern does
3 not indicate a significant functional impairment that would prevent him from performing his
4 duties as a physician in a manner conducive to public safety.

5 24. On October 26, 2015, The PHP Contractor provided a letter to the Board
6 recommending that Respondent's abuse track monitoring be terminated based on his
7 compliance since his reentry into the PHP program.

8 **CONCLUSIONS OF LAW**

9 a. The Board possesses jurisdiction over the subject matter hereof and over
10 Respondent.

11 b. The conduct and circumstances described above constitute unprofessional
12 conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate
13 records on a patient.").

14 c. The conduct and circumstances described above constitute unprofessional
15 conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct that is or might be harmful or
16 dangerous to the health of the patient or the public.").

17 d. The conduct and circumstances described above constitute unprofessional
18 conduct pursuant to A.R.S. § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent
19 agreement or stipulation issued or entered into by the board or its executive director under
20 this chapter.").

21 **ORDER**

22 IT IS HEREBY ORDERED THAT:

- 23 1. Respondent is issued a Letter of Reprimand.
24 2. Respondent is placed on Probation for a period of five (5) years with the
25 following terms and conditions:

1 **a. Practice Restriction**

2 Respondent's practice in the State of Arizona is restricted as follows:

3 Respondent's independent endovascular neurosurgery practice shall be limited to
4 craniotomy for trauma, spinal decompression (laminectomy or anterior cervical
5 decompression and fusion ("ADCF")), craniotomy for simple, supratentorial tumor,
6 ventriculoperitoneal shunt, diagnostic cerebral angiography and mechanical thrombectomy
7 for large vessel ischemic stroke.

8 Prior to performing any of the following procedures, Respondent shall obtain a
9 Board-approved proctor ("Proctor") to monitor a minimum of five cases each. Respondent
10 shall not perform these procedures independently until the Proctor certifies to the Board
11 that Respondent no longer requires proctoring. This applies to the following: carotid
12 endarterectomy, carotid stenting, coil embolization of intracranial aneurysm, clip ligation of
13 aneurysm, liquid embolic embolization of arteriovenous malformation ("AVM") and
14 instrumented spinal fusion.

15 Respondent is prohibited from performing the following procedures as the primary
16 surgeon: craniotomy for AVM resection, any pediatric neurovascular case, extracranial-
17 intracranial bypass and complex aneurysm treatment.

18 Respondent may request, in writing, early release and/or modification from the
19 terms of this Practice Restriction prior to the expiration of this Order. The Executive
20 Director, Lead Board Member and the Chief Medical Consultant have the discretion to
21 determine whether it is appropriate to release Respondent from the terms of this Practice
22 Restriction.

23 **b. Chart Reviews**

24 Board staff or its agents shall conduct chart reviews, at Board staff's discretion, to
25 monitor Respondent's compliance with the terms of the Practice Restriction. Based upon

1 the chart review, the Board retains jurisdiction to take additional disciplinary or remedial
2 action.

3 3. Prior to the termination of Probation, Respondent must submit a written
4 request to the Board for release from the terms of this Order. Respondent's request for
5 release will be placed on the next pending Board agenda, provided a complete submission
6 is received by Board staff no less than 14 days prior to the Board meeting. Respondent's
7 request for release must provide the Board with evidence establishing that he has
8 successfully satisfied all of the terms and conditions of this Order, and is safe to practice
9 any procedures for which Respondent remains under Practice Restriction. The Board has
10 the sole discretion to determine whether all of the terms and conditions of this Order have
11 been met or whether to take any other action that is consistent with its statutory and
12 regulatory authority.

13 4. This Order supersedes any and all Consent Agreements previously entered
14 into by Respondent and the Board regarding this matter.

15 5. The Board retains jurisdiction and may initiate new action against
16 Respondent based upon any violation of this Order. A.R.S. § 32-1401(27)(r).

17 DATED AND EFFECTIVE this 3rd day of December, 2015.

18
19 ARIZONA MEDICAL BOARD

20
21 By Patricia E. McSorley
22 Patricia E. McSorley
23 Executive Director
24
25

CONSENT TO ENTRY OF ORDER

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

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

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

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

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

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

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

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

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

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

13 11. *Respondent has read and understands the conditions of probation.*

14 
15 _____
16 TRISTRAM G. HORTON, M.D.

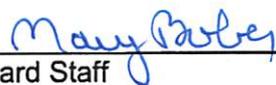
DATED: November 11, 2015

17 EXECUTED COPY of the foregoing mailed
18 this 3rd day of December, 2015 to:

19 Robert J. Milligan
20 Milligan Lawless, PC
21 505 N 40th Street Suite 200
22 Phoenix, AZ 85015
23 Attorney for Respondent

24 ORIGINAL of the foregoing filed
25 this 3rd day of December, 2015 with:

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



Board Staff