

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **ROY R. GETTEL, M.D.**

4 Holder of License No. 11015
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-04-0859A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND ORDER**

(Decree of Censure & Probation)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting
8 on October 7, 2005. Roy R. Gettel, M.D., ("Respondent") appeared before the Board
9 with legal counsel Jack Redhair for a formal interview pursuant to the authority vested in
10 the Board by A.R.S. § 32-1451(H). The Board voted to issue the following findings of
11 fact, conclusions of law and order after due consideration of the facts and law applicable
12 to this matter.

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 No. 11015 for the practice of allopathic
17 medicine in the State of Arizona.

18 3. The Board initiated case number MD-04-0859A after receiving notification
19 of a medical malpractice settlement involving Respondent's care and treatment of a forty-
20 five year-old female patient ("BR"). On November 19, 2001 BR fell off a stool at home
21 and sustained a trimalleolar fracture of her right ankle. BR was seen and evaluated in
22 the emergency room of Kino Community Hospital and was admitted. On November 20,
23 2001 Respondent evaluated BR. Respondent's consult mentions BR's history of
24 rheumatoid arthritis and osteoporosis. Respondent does not mention the state of BR's
25 soft tissues or the neuromuscular status of the right ankle and foot. Respondent did not

1 document any general orthopedic examination. Respondent described the fracture as a
2 complex trimalleolar fracture, with the posterior malleolus consisting of ten percent of the
3 articular surface. Respondent's notes indicate the talus is sitting laterally and would erode
4 the distal tibial articular surface causing severe arthritis if surgery was not performed.
5 (The records indicate the talus had slightly displaced medially, not laterally). Respondent
6 discussed the risks of surgery with BR and she consented to surgery.

7 4. On November 20, 2001 Respondent performed an open reduction and
8 internal fixation. Respondent's records contain no mention of a tourniquet to provide
9 hemostasis. According to the operative report Respondent used a lateral approach to
10 identify the fibula fracture and fixed it with a one-third tubular plate, just proximal to the tip
11 of the fibula. The post-operative radiographs however show it as considerably more
12 proximal. Respondent approached the medial malleolar fracture from the medial side
13 and fixed it with a single screw. The intra-operative radiographs revealed proximal
14 migration with the first screw and Respondent changed it. Respondent closed the
15 wounds and applied a dressing and short leg cast. Respondent's records indicate the
16 post-operative radiographs "demonstrated a near anatomic relocation of the medial and
17 lateral malleoli."

18 5. BR was discharged on November 23, 2001. The discharge instructions are
19 not available, but page two of the disclosure statement contains orders of weightbearing
20 as tolerated on the short leg cast. BR presented to Respondent on November 26, 2001.
21 Respondent noted the cast to be "smelly" and removed it. Respondent replaced the cast
22 with a "moon boot." Respondent noted BR's alignment and orientation were considered
23 good, but he did not obtain radiographs. Respondent allowed BR to "slightly weightbear."
24 BR next presented to Respondent on December 7, 2001. Respondent removed her
25 sutures and noted the wounds were benign. Respondent did not obtain radiographs, but

1 planned to in two weeks. BR was again seen on December 21, 2001. Respondent
2 interpreted radiographs as showing a slight amount of varus and allowed BR to weight
3 bear. However, the radiographs show no change from the pre-operative deformity.

4 6. BR presented to Respondent again on January 4, 2002 concerned with the
5 redness of her wounds. Respondent notes that healing is progressing normally and
6 suggests BR apply Vitamin E on the wound. Respondent saw BR on January 18, 2001.
7 Radiographs demonstrate a varus malunion of the ankle. BR complained of pain and
8 tenderness around her ankle with numbness in the distribution of the sural nerve that
9 Respondent attributed to the injury. The radiographs show the fibular plate is prominent
10 laterally. Respondent recommended hardware removal and manipulation with repeat
11 fixation to avoid arthritis. Respondent performed the second surgery on February 1,
12 2002. Without mention of a tourniquet, Respondent removed the plate and screws.
13 Respondent manipulated the fracture and the position apparently improved, but there are
14 no confirming radiographs. Respondent's postoperative handwritten note describes
15 twenty-two degrees of residual varus, but Respondent's dictated note describes seven
16 degrees of varus.

17 7. BR was discharged on February 5 and next seen by Respondent on
18 February 22. Respondent prescribed a corrective brace and Achilles stretching
19 exercises. Respondent also mentioned the possibility of future surgery. BR next
20 presented to Respondent on March 22, 2002. Respondent noted pain, tenderness and
21 swelling in BR's ankle. Respondent recommended a dome distal tibial osteotomy and
22 swimming and cycling for exercise. BR presented to another physician ("Physician #2")
23 for a second opinion. Physician #2 recommended delaying any additional intervention
24 until BR's lateral wound healed. BR then presented to another physician who evaluated
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1 her for a two centimeter opening in her lateral wound and was concerned about bone
2 infection. BR underwent a debridement on June 9, 2003.

3 8. Respondent testified BR's fracture was one of the most difficult fractures he
4 has ever seen. Respondent stated that BR had osteoporosis, rheumatoid arthritis, hand
5 deformities and arm deformities so her weightbearing could not be altered because she
6 did not have the upper extremities to control the weightbearing. Respondent testified in
7 his initial description he said her talus had laterally displaced, but it was medially
8 displaced. Respondent stated this was an error in his notes. Respondent testified BR's
9 fracture was not only medially displaced, but it had compressed the tibial plafond, or
10 upper portion of the tibia, so that there was a sixteen degree varus alignment of the distal
11 tibial surface, a vertical fracture through the medial malleolus, and a fracture through the
12 lateral malleolus at the level of the mortise of the ankle. Respondent testified his choices
13 were to do a very complex operation that would bring the plafond back down in some way
14 and then graft under it with BR's own bone from her iliac crest and support the structure
15 of the distal tibial epiphysis.

16 9. Respondent testified his attempt to repair the fracture was to put two
17 screws across the medial side and to support the lateral side. Respondent testified one
18 screw penetrated the ankle so he had to remove that screw and put a second screw
19 above it. Respondent testified he tried to do as simple a procedure as possible because
20 with BR's rheumatoid arthritis, healing is not good and the complexity of grafting under
21 that and the failure of that potentially osteoporotic bone made it so that it was just not a
22 possible solution to the problem. Respondent testified he had every piece of equipment
23 available to him to do a complex procedure, but he chose to do the simplest thing he
24 could. Respondent testified he thought BR could tolerate the sixteen degrees of varus
25 and he got the ankle mortise absolutely symmetric, even though it was in varus the

1 medial malleolus aligned with the talus, the plafond aligned with the talus, and the fibula
2 aligned with the talus. Respondent addressed the criticism that he did not get an x-ray in
3 the intervening time between the initial surgery and late December, but the x-rays did not
4 show any change. Respondent testified the weightbearing, the cast, the wound
5 problems, every aspect of the fracture care that could be criticized did not show any
6 change in the fracture alignment between the time of the first surgery and the second set
7 of x-rays taken on December 21 and it was sixteen degrees on both views.

8 10. Respondent testified that by January 19th it began to shift and went to
9 twenty degrees and by February 22 went to twenty-two degrees. Respondent testified
10 the increase in malorientation of BR's fracture was such that he felt he should try to do
11 something to manipulate it back to position, at least back to sixteen degrees and maybe
12 even better. Respondent testified on the second surgery he went in and took the plate
13 out of the lateral side and took out the two screws from the medial side and tried to
14 manipulate the fracture over with his hands. Respondent testified at the same time he
15 had the medial side open he put a Cobra plate on the inside where he can fix it proximally
16 into the tibia and use the plate maybe to structurally press on the medial structures to try
17 to get a more valgus inclination to the fracture. Respondent testified that having put that
18 on and then checking the x-ray there was no difference. Respondent noted the fractures
19 had healed and the manipulation of the fracture was impossible so he tried bracing and
20 proposed the reconstruction of her distal tibia to get it back into a neutral alignment with
21 an external fixator, dome osteotomy, but BR declined.

22 11. Respondent was asked when he noticed BR's fracture was complex and
23 uncommon. Respondent testified he noticed it right at the time, especially in surgery
24 when the first screw he put in went across the mortise and BR was so osteoporotic that
25 the compression of the plafond into the bone, unlike a tibia plateau fracture, did not show

1 any compression of bone. Respondent was asked if he recognized the plafond was
2 intact or not intact when he looked at the preoperative x-rays. Respondent testified the
3 plafond was intact, just pushed out and not as though it was fractured in the subchondral
4 bone or the bone underneath the joint on the medial side. Respondent was asked if his
5 opening comment was that the reason why this went on to further varus was that the
6 plafond was not intact. Respondent testified it was intact, but got compressed into varus,
7 more on the medial side than on the lateral side. Respondent was asked to explain how
8 if the plafond was intact it could be pushed up into varus. Respondent testified it was so
9 osteoporotic it just bent from the medial side and crushed up into the subchondral bone
10 of the osteoporotic bone at the anterior medial aspect of the tibia.

11 12. Respondent was asked if this meant the plafond was not intact.
12 Respondent testified the plafond is a structure of the distal tibia and there was a fracture
13 through the back, which was ten percent on the surface, so there was that fracture of the
14 plafond, but in the front it had bent, which is a type of fracture, and it had compressed up
15 into the medial aspect of the distal tibia. The Board noted the reason why the status of
16 the plafond is important is because Respondent mentioned it was part of the reason the
17 fracture was complex and questioned when Respondent recognized it was or was not
18 intact. Respondent testified it was intact except for the ten percent fracture in the back
19 and the torus-type fracture of the medial aspect that it allowed it to bend up into the
20 varus. Respondent was asked if "intact, except" makes it not intact. Respondent agreed
21 it was not intact.

22 13. Respondent was asked why BR's fracture was particularly difficult.
23 Respondent testified it was because of the varus inclination of the tibial plafond.
24 Respondent was asked how the tibial plafond can go in varus if it was not intact.
25 Respondent testified the whole plafond is shoved into varus and compressed up against

1 the subchondral bone on the medial side and intact is pressed into varus. Respondent
2 was asked if it was his contention that the plafond is still intact, just compressed.
3 Respondent testified the plafond was intact, and compressed with a ten percent posterior
4 fracture and a torus-type fracture on the side that allowed the whole plafond to be pushed
5 up into varus. Respondent was asked if he recognized this preoperatively. Respondent
6 stated he recognized it preoperatively, perioperatively, and postoperatively. Respondent
7 was asked why then did he allow BR to weightbear. Respondent testified he had no
8 option and with BR's osteoporosis if he let her stay in bed for six weeks to allow the
9 fracture to heal in sixteen degrees of varus he did not think she would have much bone
10 left. Respondent stated he chose to provide stimulation to the bone through
11 weightbearing. Respondent was asked if he made this choice even at the risk of causing
12 further deformity. Respondent testified he hoped BR would not suffer further deformity
13 with the internal support and the cast and it would maintain what she had.

14 14. The Board directed Respondent to his operative report from the date of
15 surgery and noted it did not mention anything about accepting varus deformity, but his
16 first postoperative note with x-ray mentions the deformity. Respondent was asked if that
17 suggested a change in the intervening time or did it suggest there was not any note of it
18 at the time of surgery, particularly since Respondent testified there was no change in two
19 months. Respondent stated he misspoke and he should have said one month. The
20 Board noted Respondent's operative note suggested anatomic alignment. Respondent
21 testified the way he looked at the x-rays in the operating room was that the ankle mortise
22 was reconstituted – the medial malleolus was up against the talus, the plafond was down
23 against the talus, and the lateral malleolus was against it. Respondent stated he had
24 reconstituted the ankle mortise and that is the anatomic part of what he spoke about in
25 the operative report. Respondent was asked if he believed BR bearing her 150 pound

1 weight on two screws in osteoporotic bone was acceptable. Respondent testified with
2 the cast and pain BR had she could not put all of her weight down and, if she did, it
3 certainly would have confounded the problem with osteoporosis.

4 15. Respondent was asked if he felt he took the right course of action knowing
5 what he now knows about BR's further deformity and further collapse. Respondent
6 testified it is a continuum of treatment – to get the ankle mortise together, not do too
7 much that would cause wound problems or infection, and then try to separate, to get the
8 sixteen degrees back down to maybe thirteen or seven degrees if he could manipulate
9 the ankle over in the second procedure. Respondent testified he thought the third, with
10 an external fixator and minimal open dome of the tibia to get the varus out with the
11 normal ankle mortise, and get her perfectly lined back up into neutral alignment would
12 have protected BR from the arthritis that subsequently ensued.

13 16. Respondent was asked if he believed it was within the standard of care in
14 an osteoporotic rheumatoid patient to allow weightbearing immediately after surgery.
15 Respondent testified he thought he had to allow some weightbearing otherwise you
16 would get distraction of the cast by carrying the leg around. Respondent stated one way
17 or another BR would have had to put weight down on the leg and he could not prevent
18 that from happening. Respondent was asked if his instruction would be to weightbear as
19 tolerated or to minimally weightbear. Respondent testified his instruction was to
20 weightbear as tolerated because it was necessary for BR since her upper extremities
21 could not take the weight off her leg.

22 17. Respondent was asked the standard of care for weightbearing with this type
23 of fracture in a patient who did not have osteoporosis or rheumatoid arthritis.
24 Respondent testified it would be to do less, to do sort of a touchdown weightbearing.
25 Respondent was asked if with BR it was within the standard of care to allow her to do

1 more weightbearing. Respondent testified it was the only type of care, the necessary
2 type of care because she could not relieve the weightbearing and could not unload the
3 leg. Respondent testified he could possibly have used a Hoya lift, but then he would
4 have ended up with cast distraction and more osteopenia and more osteoporosis. The
5 Board asked Respondent if the standard of care in a rheumatoid patient is to allow
6 weightbearing as tolerated from the very beginning after the fracture. Respondent
7 testified the optimal would be to do less weightbearing, but the necessity of BR's case
8 required more weightbearing. The Board again asked Respondent what he believed was
9 the standard of care for weightbearing in a patient with rheumatoid arthritis and with
10 osteoporosis after a severe ankle fracture. Respondent testified it would be to approach
11 weightbearing tolerance because there would be less initially, and more as she was able
12 to tolerate it.

13 18. Respondent was asked if after removing the screw that was intra-articular
14 there was any improvement or any change in the alignment of the fracture or did he just
15 remove the screw and place another. Respondent testified the two screws were
16 removed and another screw put in. Respondent was asked if there was any change in
17 alignment of the fracture when he put in the second screw. Respondent testified there
18 was not. Respondent was asked the standard of care for fracture alignment.
19 Respondent testified the goal is to get the fracture as close to anatomic as possible.
20 Respondent was asked if there were any criteria in the medical literature suggesting what
21 is and is not acceptable in terms of fixation of the alignment. Respondent testified that in
22 every single patient it becomes very individual and very much predictable, but if you look
23 at BR's ankle mortise, it is back, it is just set in sixteen degrees of varus so from an
24 anatomic standpoint the mortise is okay. Respondent stated everyone thinks you can put
25 a plate or separate screw or something on the medial side to bring the plafond down, but

1 you would have to actually get in and move the plafond down and put the bone graft in
2 underneath it and this is an incredibly extensive operation.

3 19. Respondent was asked if he was prepared to do the bone graft at the time
4 of BR's surgery. Respondent testified when he goes into surgery he is prepared to do
5 what he needs to do and he needs to take care of what the problem is. Respondent was
6 asked if he took care of BR's problem. Respondent testified he believed he did initially
7 because he did not violate her iliac crest and did not put a huge operation on the medial
8 side to pull that down and he did not cause what could have been a very complicated
9 series of events with possible leg loss and infection. Respondent was asked if he met
10 the goals of surgery in BR's case, specifically, did he restore the anatomy and alignment.
11 Respondent testified the ankle mortise was restored and the alignment is in two forms,
12 one is ankle mortise and it was intact, the tibular varus was still in varus at the time of
13 surgery.

14 20. Respondent was asked to answer either "yes" or "no" as to whether the
15 alignment and anatomy were restored. Respondent testified the anatomy was and the
16 alignment was not. Respondent was asked if he was saying the standard of care was to
17 accept sixteen degrees of malalignment for a fracture at time of surgery. Respondent
18 testified it would not normally, but in BR's case it was. Respondent was referred to his
19 note of November 20, 2001 where it appears his clear preoperative plan was to try and
20 prevent degenerative arthritis by bringing the ankle into anatomic alignment. Respondent
21 was asked if he accomplished this plan. Respondent testified he did not bring the
22 tibiotalar alignment into anatomic alignment, but he did not think he fell below the
23 standard of care and did the best he could do under the circumstances.

24 21. Respondent was asked if putting a screw into the fracture site for a
25 transverse fracture of the lateral malleolus is below the standard of care. Respondent

1 testified he thought you can cross it and to him the ankle mortise looked good and the
2 fibula was not the cause of the problem. Respondent was asked if he felt the posterior
3 malleolus, the plafond, was depressed initially. Respondent testified it was not and it was
4 mostly the anterior plafond, the anterior medial. Respondent testified he thought the
5 whole plafond went up, but he thought it went up more anteriorly than posteriorly.
6 Respondent was asked if one screw medially would hold BR's type of comminuted
7 trimalleolar fracture with plafond involvement. Respondent testified it normally would not
8 and that is why he initially put in two, but once he got the one screw in it is almost
9 impossible to figure out where a second screw would go without pulling the medial
10 malleolar segment up more. Respondent testified the one screw held the medial
11 malleolar fragment in place and still maintained the mortise, two millimeters separation all
12 the way around the ankle mortise.

13 22. Respondent was asked if one screw would be sufficient in a normal healthy
14 woman for this type of fracture on the medial side. Respondent testified it would not.
15 Respondent was asked why then in an osteoporotic rheumatoid patient he settled for just
16 one screw and did not put a buttress plate or Cobra plate or something medially to hold it
17 better. Respondent testified the mortise was perfect and the fibula was at fifteen or
18 sixteen degrees and the plafond was tipped up. Respondent was asked if he would put
19 even partial weightbearing on BR, with the fixation he achieved. Respondent testified
20 with the osteoporosis if he did not do weightbearing BR would lose bone. Respondent
21 was asked if his concept of weightbearing to prevent osteoporosis was correct with bone
22 of this quality, with very poor fixation. Respondent testified if he let the cast hang on the
23 foot there would be deformity and he had to stimulate the bone to heal and continue to
24 create bone. Respondent testified even if he put a buttress plate on the medial side with
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1 the plafond tipped fifteen degrees there was no way to correct it unless he pulled down
2 and put grafting or some sort of cement underneath.

3 23. Respondent was asked why his notes did not reflect BR's prolonged (three
4 to four months) wound problems. Respondent testified the wounds were not as much his
5 concern, the inclination and the varus orientation was. Respondent noted his effort was
6 to stay away from the wounds in the final operation and try to bring BR back into valgus
7 with a dome osteotomy. Respondent stated he was concerned about BR's wounds and
8 was diligent to take care of them, but he did not think they were as serious a problem.
9 Respondent was asked the optimal time to perform such an operation on BR who he
10 knows is at risk for having wound problems and poor skin problems with her rheumatoid
11 disease and possible immunocompromise. Respondent testified the optimal time would
12 be within the first twenty-four to forty-eight hours and if not and there were wound blisters
13 or fracture blisters and lots of swelling he would wait three or four weeks.

14 24. Respondent was asked his experience in treating a trimalleolar fracture by
15 open reduction and internal fixation. Respondent testified it is a fairly common fracture
16 for an orthopedist doing any kind of emergency work and he probably saw one or two a
17 month and treated them with surgery. Respondent was asked if he ever considered
18 consulting with another physician, especially since he realized this was a complex
19 situation. Respondent testified he was one of three orthopedic surgeons in town at the
20 time and he did not think another physician would add much.

21 25. The standard of care required Respondent to restore the anatomy and
22 alignment when repairing BR's fracture.

23 26. Respondent deviated from the standard of care because he failed to restore
24 BR's anatomy and alignment.

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1 gross negligence, repeated negligence or negligence resulting in harm to or death of a
2 patient").

3 **ORDER**

4 Based upon the foregoing Findings of Fact and Conclusions of Law, IT IS
5 HEREBY ORDERED that:

6 1. Respondent is issued a Decree of Censure for negligently performing open
7 reduction and internal fixation of an ankle resulting in malposition.

8 2. Respondent is placed on probation for five years subject to the following
9 terms and conditions:

10 A. Respondent's practice is restricted in that he may not perform
11 orthopedic surgeries requiring open reduction and internal fixation.

12 B. Respondent shall submit quarterly declarations under penalty of
13 perjury on forms provided by the Board, stating whether there has been compliance with
14 all conditions of probation. The declarations shall be submitted on or before the 15th of
15 March, June, September and December of each year, beginning on or before March 2006.

16 C. In the event Respondent should leave Arizona to reside or practice
17 outside the State or for any reason should Respondent stop practicing medicine in
18 Arizona, Respondent shall notify the Executive Director in writing within ten days of
19 departure and return or the dates of non-practice within Arizona. Non-practice is defined
20 as any period of time exceeding thirty days during which Respondent is not engaging in
21 the practice of medicine. Periods of temporary or permanent residence or practice outside
22 Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary
23 period.

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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 his 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 12th day of December, 2005.



THE ARIZONA MEDICAL BOARD

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

ORIGINAL of the foregoing filed this 12th day of December, 2005 with:

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

Executed copy of the foregoing
mailed by U.S. Certified Mail this
12th day of December, 2005, to:

Jack Redhair
Chandler, Tullar, Udall & Redhair
33 North Stone Avenue – Suite 2100
Tucson, Arizona 85701

Roy R. Gettel, M.D.
Address of Record