

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **JOSEPH A. CAPLAN, M.D.**

4 Holder of License No. 14750  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona.

Board Case No. MD-05-0427C

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

(Letter of Reprimand)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on  
8 October 12, 2006. Joseph A. Caplan, M.D., ("Respondent") appeared without legal counsel  
9 before the Board for a formal interview pursuant to the authority vested in the Board by A.R.S. §  
10 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and  
11 Order after due consideration of the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

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

15 2. Respondent is the holder of License No. 14750 for the practice of allopathic  
16 medicine in the State of Arizona.

17 3. The Board initiated case number MD-05-0427C after being notified of a medical  
18 malpractice settlement paid on Respondent's behalf regarding his care and treatment of a  
19 seventy-four year-old male patient ("JR"). JR presented to the hospital on February 23, 2003  
20 complaining of shortness of breath on exertion and was admitted to telemetry with a diagnosis of  
21 Congestive Heart Failure ("CHF"). George Kam Wong, M.D. read a February 24, 2003  
22 echocardiogram as noting mild to moderate enlargement of the left atrium and right ventricle,  
23 severe global hypokinesis of the left ventricle with akinesis of the anteroseptal wall and an  
24 ejection fraction of twenty-five percent. Dr. Wong performed a cardiac catheterization and  
25

1 angiography on February 26, 2003. Dr. Wong was unable to evaluate the valve and planned a  
2 second angiography.

3 4. At 0130 on February 27, 2003 JR complained of 10/10 abdominal pain and he had  
4 tachycardia, tachypnea and falling hemoglobin. JR's internist was notified and he ordered pain  
5 medication, a repeat hemoglobin and a GI consult. At 0415 JR's blood pressure fell to 58/40 and,  
6 when nursing staff was unable to reach the internist, they called Dr. Wong. Dr. Wong declined to  
7 address the problem because he was not on-call and instructed the staff to call Respondent, his  
8 colleague who was on-call. Respondent ordered fluid resuscitation and a CT of the abdomen, but  
9 did not go to the hospital until 0915. The CT scan was completed at 0610 and JR was  
10 transferred to intensive care per Respondent's orders at 0615. The CT scan showed a large  
11 retroperitoneal bleed. Staff made brisk resuscitative efforts to revive JR, but he died a few hours  
12 later. The autopsy showed a seventy-five percent left anterior descending lesion.

13 5. Respondent testified he has been in practice for twenty-one years, has done  
14 approximately 10,000 coronary procedures, and is not unfamiliar with retroperitoneal hematoma.  
15 Respondent testified there are many aspects about JR's care that could have been better and he  
16 is not claiming he played no role in JR's care. Respondent testified there were a lot of issues  
17 regarding the nursing communication as far as timely obtaining the CT scan or even calling him  
18 with the results of the CT scan. Respondent was Chief of Cardiology at the hospital for the last  
19 ten years and he used this case as an opportunity to create a nursing protocol for groin  
20 management and to look at various quality assurance issues regarding nursing communication to  
21 minimize the morbidity and mortality associated with retroperitoneal hematoma, a complication  
22 you cannot get away with even in the best of hands.

23 6. After Dr. Wong performed the cardiac catheterization and angiography  
24 Respondent and Dr. Wong had a conversation about the hemodynamic aspects of JR's case and  
25 there was a question as to whether JR had critical aortic stenosis that could not be deduced from

1 the data Dr. Wong had obtained. Dr. Wong did not tell Respondent JR had atrial fibrillation or  
2 that he was anticoagulated. When Respondent left the hospital at 5:00 p.m. he knew JR came to  
3 the hospital with heart failure, was cathed, the cath revealed incomplete hemodynamic data, and  
4 he needed to find out the anatomy to see which surgical procedure was appropriate. Dr. Wong  
5 did not tell him he had difficulty in creating hemostasis in the groin after the cath – that the angio  
6 seal did not hold. Respondent next heard about JR when he got the call from the telemetry nurse  
7 at 4:30 a.m. that JR's blood pressure was very low. Respondent does not go to the hospital for  
8 every patient who is hypotensive because many of them are having a vasovagal reaction.  
9 Respondent started with the simplest of things first and then elevated his level of intensity as the  
10 situation required.

11 7. When the nurse called Respondent about JR he did not connect JR with his earlier  
12 conversation with Dr. Wong about a patient and all he recalled was that he was told JR was  
13 markedly hypotensive after a cath earlier in the day. Respondent testified his initial reaction was  
14 to order a CT scan, have the nurses give fluids, and call him back to tell him what happened.  
15 Respondent testified he takes his job extremely seriously and has given 110 percent every day  
16 for the last twenty-one years and will continue to do so until the day he retires. Respondent  
17 testified the breakdown in communication occurred at this point because he expected the nurses  
18 to get back to him after the CT scan and after giving the fluids to update him on JR's status, but  
19 he just got a phone call at 6:10 a.m. that JR was not responding and, after being told the CT scan  
20 was not done, he instructed them to move JR to intensive care. Respondent testified he was  
21 never told JR had severe abdominal pain or that the nurses were unsuccessful in contacting the  
22 internist – he was only told JR was hypotensive. Respondent testified he got another call thirty to  
23 forty minutes later telling him JR's blood pressure came up to around 110 over 70 and he was  
24 feeling better. At that time Respondent was thinking JR had suffered a vasovagal episode or  
25 transient episode of hypotension.

1           8.       On the intensive care intake note the nurse wrote that the right groin was firm and  
2 bruising and there was right abdominal bruising. Respondent was called and he ordered two units  
3 of fresh frozen plasma ("FFP"). Respondent testified he did not know and was never told JR had  
4 been anticoagulated and ordered the FFP shooting from the hip thinking there was some type of  
5 coagulopathy. Respondent testified there are many different forms of retroperitoneal hematoma  
6 and most resolve or stabilize without any intervention. Respondent testified the patients like JR  
7 who have hemodynamic collapse are the patients that usually have a spontaneous  
8 retroperitoneal bleed and it could be related to an arterial or venous puncture. Respondent  
9 testified when a patient has a spontaneous severe retroperitoneal hematoma, there is nothing a  
10 physician can do. Respondent testified he regretted not going in and seeing JR, but believed that  
11 given the severity and nature of the hemodynamic collapse in JR, it would not have changed  
12 things at all.

13           9.       The Board asked how Respondent emergently treated a retroperitoneal  
14 hemorrhage. Respondent testified there are different forms of retroperitoneal hemorrhage, most  
15 of which are self-limiting and the ones that produce hemodynamic collapse are usually of two  
16 varieties – the first being from arterial or venous puncture where you can clearly see on a CT  
17 scan a track of blood that leads to the retroperitoneal space and the second being spontaneous  
18 where the patient is just bleeding. Respondent testified in JR's case it probably was a  
19 spontaneous retroperitoneal hematoma from anticoagulation or from something going amiss.  
20 Respondent testified with massive hemodynamic collapse all he can do is resuscitate as best as  
21 he can with fluid and blood and get a surgeon involved. Respondent stated a surgeon will not get  
22 involved without having some idea that the diagnosis is correct and the surgeon needs to know  
23 whether to approach from the groin or just open the abdomen. Respondent testified it is very  
24 difficult to treat when there is a hemodynamic collapse and, in his years of practice, he knows of  
25 only one patient who survived a hemodynamic collapse from an arterial rupture because the CT

1 scan was done promptly and the surgeon was able to identify the track coming from the posterior  
2 aspect of the common femoral artery and suture it.

3 10. Respondent testified there were multiple things that could have been done to  
4 possibly prevent JR's ultimate demise, the first of which would have been proper communication  
5 between the nurses and himself. Respondent stated he had no idea JR was on Lovenox and had  
6 been on Coumadin and, had he been told right at the outset, things may have been different – he  
7 may have assumed the worst. Respondent stated he did order the CT scan right away, but he  
8 had no idea JR in fact had a retroperitoneal hematoma. The Board asked Respondent the  
9 standard of care for taking care of a patient who has severe hypotension. Respondent testified  
10 the standard is to administer fluids and the other things he did. The Board asked if the standard  
11 also required assessing the patient. Respondent agreed it did, but stated that at 4:30 in the  
12 morning, the initial assessment is done by the nursing staff, and the second line of defense is  
13 going in to see the patient and he regrets he did not. Respondent testified he did not believe it  
14 was below the standard of care to not go in to see every patient who is hypotensive.

15 11. The Board asked if there was a difference in a hypotensive patient who has a  
16 systolic pressure of 90 versus 70 versus 50 versus 30 and the response he would give.  
17 Respondent testified there was. The Board confirmed JR's systolic pressure on the first phone  
18 call was reported to Respondent as 58 and asked if that represented a mild situation, a moderate  
19 situation, or a severe situation. Respondent testified it could have turned out to be any of the  
20 three and that is why he started off with giving fluids. Respondent testified he was not aware  
21 there was a significant drop in hematocrit of 15 points. The Board asked if he considered, in  
22 addition to running the IV fluid bolus, ordering a blood count, a coag profile, and typing and  
23 crossing JR for blood. Respondent testified this did not occur to him at 4:30 that morning. The  
24 Board asked whether Respondent asked the nurse questions to try to elicit from her any other  
25

1 possible etiologies that could have been contributing to the hypotension other than vasovagal.

2 Respondent testified he did not and regrets that he did not.

3         12. The Board asked Respondent the protocol when he cross-covered for Dr. Wong.  
4 Respondent testified generally call began at 5:00 p.m. and the sign-off was in the morning, but  
5 not at any particular time. The Board reminded Respondent of the conversation he had with Dr.  
6 Wong regarding the fact that JR needed an additional cardiac catheterization and asked when  
7 that conversation took place. Respondent did not recall, but remembered it took place in the cath  
8 lab because he reviewed the films with Dr. Wong. Respondent testified Dr. Wong made no other  
9 comment about JR's clinical situation and there was no other conversation between him and Dr.  
10 Wong after the film review and before he assumed call. When Respondent discussed the case  
11 with Dr. Wong it was about a patient, not specifically identified as JR and, when he got the phone  
12 call, he did not make the association that the patient he was being called about – JR – was the  
13 patient he and Dr. Wong had discussed earlier. Respondent and Dr. Wong stopped cross-  
14 covering for each other several months after JR's death for multifaceted reasons, including JR's  
15 case.

16         13. The Board asked if Respondent was concerned about hypotension in a critical  
17 aortic stenosis patient – is this a perfusion problem for the coronaries when there is a significantly  
18 low afterload and probably no preload if indeed his diagnosis of vasovagal was correct.  
19 Respondent testified with critical aortic stenosis it is a serious problem that may lead to death  
20 instantly, but at 4:30 in the morning he had no idea JR was a patient with aortic stenosis and  
21 knew only JR had a cath. Respondent thanked the Board for the opportunity to appear before  
22 them.

23         14. The standard of care required Respondent to obtain JR's past medical history and  
24 timely manage the severe and known complication of a cardiac catheterization that history would  
25 have revealed.



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

2 Respondent is hereby notified that he has the right to petition for a rehearing or review.  
3 The petition for rehearing or review must be filed with the Board's Executive Director within thirty  
4 (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review  
5 must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103.  
6 Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a  
7 petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35)  
8 days after it is mailed to Respondent.

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

11 DATED this 7<sup>th</sup> day of December, 2006.



12 THE ARIZONA MEDICAL BOARD

13 By *T.C. Miller*  
14 TIMOTHY C. MILLER, J.D.  
15 Executive Director

16 ORIGINAL of the foregoing filed this  
17 8<sup>th</sup> day of December, 2006 with:  
18 Arizona Medical Board  
19 9545 East Doubletree Ranch Road  
20 Scottsdale, Arizona 85258

21 Executed copy of the foregoing  
22 mailed by U.S. Mail this  
23 8<sup>th</sup> day of December, 2006, to:

24 Joseph A. Caplan, M.D.  
25 Address of Record

*J. M. Caplan*