

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **JOHN S. TRUITT, M.D.**

4 Holder of License No. **21749**
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-05-0214A

**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 February 9, 2006. John S. Truitt, M.D., ("Respondent") appeared before the Board with legal
9 counsel E. Hardy Smith for a formal interview pursuant to the authority vested in the Board by
10 A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of
11 Law and 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. 21749 for the practice of allopathic
16 medicine in the State of Arizona.

17 3. The Board initiated case number MD-05-0214A after receiving a complaint
18 regarding Respondent's care and treatment of a 76 year-old female patient ("FP"). FP was
19 diagnosed and treated for breast cancer in 1991. Approximately ten years later FP developed
20 low back pain. FP presented to Respondent. Respondent diagnosed metastatic disease from
21 the original breast cancer. No x-ray studies or blood tests support a cancer diagnosis and
22 Respondent did not order a biopsy or recommend a second opinion to confirm recurrent cancer
23 before he initiated treatment. Between March 11, 2002 and March 25, 2002 Respondent treated
24 FP's twelfth thoracic vertebral body inclusive to the third sacral vertebral body with radiation
25 delivering 300 rads times ten (3,000 rads) at seven centimeters depth with a field measuring

1 fifteen centimeters wide by twenty-six centimeters long. Respondent also treated FP with femora,
2 aromosin and zometa. Future studies of FP never revealed a recurrence of cancer.

3 4. Respondent testified he treated FP in 2002 and at the time his practice was to
4 always, in the face of indeterminate studies, err on the side of the patient for treatment.
5 Respondent testified the studies finding FP's issues degenerative were indeterminate.
6 Respondent testified he would make sure the patient understood the risks and ramifications of
7 treatment and, if the benefits outweighed the risks, he would recommend treatment. Respondent
8 testified in 2004 he had a case before the Board very similar to this case where the Board found
9 there were indeterminate studies and issued Respondent a Letter of Reprimand for not obtaining
10 a tissue diagnosis. Respondent testified that since that time he has insisted on tissue diagnosis.
11 Respondent testified he admitted in retrospect FP most likely had degenerative change, but there
12 were multiple studies that were indeterminate for cancer. Respondent noted FP's tumor markers
13 had increased fifty percent during that time frame and her pain worsened dramatically.
14 Respondent testified if he made a major mistake it was that FP was hysterical and asking why he
15 was not helping her and he did not really have a good answer because he knew radiation could
16 alleviate her discomfort if indeed it was metastatic disease. Respondent testified FP's pain was
17 markedly improved within two weeks after treatment and has remained abated since that time.
18 Respondent testified after the 2004 Board action he would not treat a patient in this fashion
19 without confirmation because without biopsy confirmation he cannot form an adequate defense of
20 his actions.

21 5. Respondent testified he did not hide anything from FP and told her exactly what
22 was going on and explained everything in detail. Respondent testified as soon as the PET scan
23 was obtained he told her he did not think she had metastatic disease. Respondent testified he
24 had requested a PET scan at the time, and if it was able to be obtained, this never would have
25 occurred, but her insurance policy did not approve it. The Board asked if degenerative disease

1 gets better with radiation. Respondent testified it does, and arthritis, hemangiomas, and plantar
2 warts have been treated. Respondent testified radiation was very effective for bone pain.
3 Respondent testified the problem with degenerative change is radiation may not be a permanent
4 fix and when the inflammation recurs six months to one year later it can be painful and that is why
5 radiation is typically not used for degenerative change. The Board noted there was also risk.
6 Respondent testified there was a slight risk from any form of radiation and external beam
7 radiation is like x-rays or CAT scans in that respect. Respondent testified he has been treating
8 patients with radiation for sixteen years and not one ever got a second malignancy from radiation.

9 6. The Board asked if there was risk of skin damage or nerve damage with radiation
10 of the lower spine. Respondent testified the dosage administered to alleviate pain is below the
11 threshold of injury for the involved tissues. The Board asked Respondent if he was saying the
12 standard of care in 2002 was to treat suspected metastatic disease to the spine with radiation
13 therapy despite a negative MRI scan. Respondent testified it was an indeterminate state so the
14 possibility of metastatic disease was there. Respondent testified that when he trained from 1986
15 through 1989 he would sometimes treat patients who had negative diagnostic studies, so based
16 on his training, he would have to answer that he treated FP based on his previous training.
17 Respondent testified there are a number of physicians who would disagree with that philosophy
18 and say that a biopsy is needed, but you could also say that in metastatic disease in particular,
19 biopsies are not routinely obtained. Respondent testified biopsies are only obtained in the case
20 of an isolated lesion and where diagnosis has not yet been made or if it has been an extended
21 period of time before the unexplained lesion showed up.

22 7. The Board noted FP's records indicate FP developed low back pain sometime in
23 February 2001 and Respondent saw her in May 2001. The Board referred Respondent to FP's
24 March 19, 2001 MRI and asked him to read the radiologist's impression. Respondent testified the
25 impression was "Subtle focal extrusion with cephalad migration of disk material into the left

1 posterior paracentral aspect of the L3-4 intervertebral disk with cephalad migration with disk
2 material mildly effacing the left anterolateral aspect of the thecal sac at this level, see above
3 comments. Bulging L1-L2, L2-L3 and L3-L4 intervertebral disks, see above comments." The
4 Board asked if there was anything in this report that would lead Respondent to believe FP had a
5 metastatic tumor at that time. Respondent testified there was a bone scan that same day that
6 includes the interpretation of the MRI in which it states it was indeterminate. Respondent testified
7 in the MRI report, the way it is written, there is no suggestion of metastatic disease. The Board
8 noted Respondent did not perform radiation therapy until March of 2002. Respondent testified
9 when he saw FP in May 2001 he recommended she return in six months for a repeat MRI and
10 bone scan because he did not feel the studies at that time represented metastatic disease.

11 8. The Board directed Respondent to FP's February 27, 2002 MRI of the lumbar
12 spine and asked him to read the radiologist's impression. Respondent testified the impression
13 was "Rather marked degenerative changes seen within the lumbar spine which have intervally
14 increased in degree at the L2-L3 level, with more degenerative edema being seen involving the
15 inferior endplate of L2 and the superior endplate of L3. See above comments." The Board noted
16 the "above comments" were "comparison is made with this patient's previous MRI examination of
17 her lumbar spine dated 3-19-2001." Respondent was asked if there was anything in FP's
18 February 27, 2002 MRI report that suggested she has a metastatic tumor. Respondent testified
19 there was not. The Board asked Respondent why, one year after he first saw FP with a negative
20 MRI, after the radiologist compares both MRIs and sees only further degenerative changes, he
21 thought FP had a metastatic tumor and began to radiate her. Respondent testified one
22 contributing factor was FP's December 6, 2001 bone scan that stated the thoracic and lumbar
23 vertebral body remain indeterminate and the other contributing factor was FP's tumor markers
24 doubled from thirteen to nineteen – a roughly fifty percent increase in those markers that would
25 lead him to think something was going on.

1 9. The Board noted something may be going on, but it did not tell Respondent there
2 was something going on in the area of the spine he planned to irradiate. Respondent testified he
3 thought the MRI was suggestive of metastatic disease, but he thought the radiologist could
4 maybe make a comment about the reliability of MRI and other studies to determine metastatic
5 disease because sometimes with degenerative change, particularly vertebral collapse, it is almost
6 impossible to tell the difference between metastatic disease and tumor. The Board noted there
7 was no vertebral collapse in FP's case. Respondent testified he thought it was worsening at the
8 L2-L3, which was narrowing on the MRI and as he recalled it, there were both lytic and sclerotic
9 changes present. The Board noted the MRI scan report in relation to L2-L3 is talking about
10 intervertebral disc, not vertebral body collapse. Respondent testified if the Board looked at the
11 actual films it would see the vertebral bodies were distorted and did not have a normal
12 appearance. The Board noted when the radiologist compared the films he did not report that.
13 The Board asked Respondent if he was familiar with the radiologist who read the reports.
14 Respondent testified he was and he thought he was the best in the service and he respected his
15 opinion. The Board asked Respondent if the radiologist thought FP did not have metastatic
16 disease. Respondent testified the radiologist was uncertain and he thought it would probably be
17 degenerative change. Respondent testified he thought there were other studies that were
18 indeterminate and it was not a clear-cut case of absolute degenerative change and nothing else.

19 10. Respondent testified he made his error in treating FP by using his own
20 interpretation of the MRI, her symptomatology, and her laboratory studies to determine she had
21 metastatic disease. Respondent testified he persisted in this opinion until such time as a PET
22 scan was obtained seven or eight months later that showed it was probably not metastatic, but at
23 the time he was fairly certain it was metastatic. The Board noted Respondent was the only
24 physician who was convinced it was metastatic and in all the other tests done no one else was
25 convinced and, in fact, they said just the opposite – that FP had degenerative disease.

1 Respondent testified a patient he treated after the 2004 Board action had an MRI that was
2 suspicious, indeterminate, and he obtained a CT-guided new biopsy that came back as fibrous
3 tissue. Respondent testified he sent this patient to a neurosurgeon for a second opinion per the
4 Board's previous recommendation and a second CT-guided biopsy came back as fibrous tissue.
5 Respondent testified this was in the face of an MRI that said degenerative change. Respondent
6 testified the neurologist did not want to do an open biopsy because of the previous CT-guided
7 biopsy he believed it was not possible that the patient had metastatic disease. Respondent
8 testified he disagreed and the neurosurgeon did an open biopsy that proved the patient had
9 metastatic disease. Respondent testified he thinks he made an error in FP's case and he thought
10 in retrospect in light of the PET scan and other studies he was wrong and he should have
11 obtained a biopsy for a second opinion.

12 11. The Board asked Respondent if he discussed the X-ray, MRI findings, and rising
13 tumor markers with a medical oncologist before he decided to treat FP. Respondent testified he
14 could not recall. The Board asked if it was something Respondent would normally do.
15 Respondent testified most likely he would. The Board asked if the amount of radiation FP
16 received would have short-term or long-term detriment to FP's spine or the surrounding
17 structures. Respondent testified there was a certain threshold of injury for radiation to tissues
18 and it depends on which tissues the Board was talking about, but 3,000 Centigrade of radiation is
19 below that threshold and he has never in sixteen years seen an article stating 3,000 Centigrade
20 of radiation is detrimental to any organ system. Respondent testified he has changed his method
21 of treatment and he regrets treating FP without further evaluation, but at the same time, the
22 treatment he administered was very effective at alleviating her discomfort and there were no ill
23 effects.

1 must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102.
2 Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a
3 petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35)
4 days after it is mailed to Respondent.

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

7 DATED this 6th day of April, 2006.



THE ARIZONA MEDICAL BOARD

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11 By *T.C. Miller*
12 TIMOTHY C. MILLER, J.D.
Executive Director

13 ORIGINAL of the foregoing filed this
14 7th day of April, 2006 with:

15 Arizona Medical Board
16 9545 East Doubletree Ranch Road
17 Scottsdale, Arizona 85258

18 Executed copy of the foregoing
19 mailed by U.S. Mail this
20 7th day of April, 2006, to:

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22 Chandler & Udall, LLP
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25 John S. Truitt, M.D.
Address of Record

J.S. Truitt