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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of
GEORGE KAM WONG, M.D.
Holder of License No. **21765**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-05-0427A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER**
(Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on October 12, 2006. George Kam Wong, M.D., ("Respondent") appeared with legal counsel Andrew Rosenzweig before the Board for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
2. Respondent is the holder of License No. 21765 for the practice of allopathic medicine in the State of Arizona.
3. The Board initiated case number MD-05-0427A after being notified of a medical malpractice settlement paid on Respondent's behalf regarding his care and treatment of a seventy-four year-old male patient ("JR"). JR presented to the hospital on February 23, 2003 complaining of shortness of breath on exertion and was admitted to telemetry with a diagnosis of Congestive Heart Failure ("CHF"). Respondent read a February 24, 2003 echocardiogram as noting mild to moderate enlargement of the left atrium and right ventricle, severe global hypokinesis of the left ventricle with akinesis of the anteroseptal wall, and an ejection fraction of twenty-five percent. Respondent performed a cardiac catheterization and angiography on

1 February 26, 2003. The left main ostial had a forty to fifty percent lesion and Respondent did not
2 mention a left anterior descending lesion ("LAD"). Respondent was unable to evaluate the valve
3 and planned a second angiography.

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

14 5. Respondent testified his initial assessment of JR was very significant regarding the
15 CHF at his age with hypertension. Respondent was extremely concerned about the valvular
16 problem and a coexisting coronary artery disease. Respondent was highly suspicious the
17 echocardiogram underestimated the valve and, with that in mind, he urgently conducted coronary
18 angiogram. After the angiogram Respondent had a high suspicion there was a left main ostial
19 lesion, which can potentially cause a fatal outcome, and for that reason and after a few
20 unsuccessful attempts to try to cross the valve, he decided, for JR's safety, to stop the procedure
21 and get a second opinion from Dr. Caplan. Respondent testified it is vitally important to make the
22 diagnosis to recommend to JR whether he needed bypass surgery, valve replacement, or both.
23 Respondent noted the mortality of either bypass surgery or valve replacement alone is one to two
24 percent, but it increases to ten percent if the procedures are combined so it is extremely
25

1 important to make an accurate diagnosis to recommend future management. Respondent had
2 spoken to Dr. Caplan about JR's condition.

3 6. JR's past medical history included atrial fibrillation, hypertension and he was
4 anticoagulated on Coumadin. Respondent agreed a transvalve grading of 80 in light of an EF of
5 twenty to twenty-five percent was significant and would make him more worried about severe
6 aortic stenosis versus moderate. Respondent testified the discrepancies with his clinical
7 judgment and discrepancies of the echo finding, and the estimation of the valve area, is why he
8 chose not to believe the finding and to verify it. Respondent stated echocardiogram sometimes is
9 not as reliable for the assessment of aortic valve severity and that is why there is a fallback to
10 cardiac catheterization. Respondent testified there is an estimation of at least twenty to twenty-
11 five percent between the gradient obtained by cardiac catheterization compared with the
12 estimation of an echo report and this was the issue.

13 7. Respondent testified the risks for developing a major complication post-cath
14 include the age of the patient, renal failure, hypertension, and previous stroke. Respondent
15 agreed giving anticoagulants increased the risk for developing a major complication and noted it
16 is controversial whether the patient should be taken off anticoagulants with any procedure
17 because of the worry of the benefit of thromboembolism and stroke versus the risk of bleeding
18 has to be balanced. The Board asked the risk of stroke in a patient in afib who is not
19 anticoagulated. Respondent testified that compared to a patient without atrial fibrillation over one
20 year there is a six percent increase in risk or 600 percent increase in risk of thromboembolism
21 when the patient is in chronic atrial fibrillation versus the patient in sinus rhythm. The Board
22 asked how Respondent managed JR's anticoagulation around the cath line. Respondent testified
23 he considers the INR anywhere between 1.6 to 1.8 a reasonable anticoagulation state to benefit
24 the patient from bleeding and at the time he did JR's angiogram it was between 1.6 and 1.8 so he
25 was relatively comfortable to go ahead with an invasive procedure at that time.

1 8. Respondent did not order any follow-up INRs or PTs on the same day because the
2 result was not going to change in minutes or hours and, if anything, the INR would go down as
3 time went by without giving further Coumadin. The Board asked how Respondent obtained
4 hemostasis at the puncture site when he withdrew the sheath. Respondent testified if the patient
5 has been anticoagulated with an INR above 1.8 he would like to use a mechanical means like a
6 thrombin plug or angio seal so he can actually plug the puncture site with a thrombin and, if for
7 whatever reason that does not perform, he will exert manual pressure for as long as possible to
8 obtain adequate hemostasis. With JR the angio seal was not successful because the plug was
9 not able to totally seal off the hole and there was oozing and Respondent applied manual
10 pressure and there was no further bleeding before JR left the cath lab.

11 9. The Board asked if Respondent left any orders for the floor nurses to check the
12 right groin area. Respondent testified the routine protocol is that every patient will be checked
13 every fifteen minutes for two hours and then every hour subsequent to that for another two hours.
14 The Board asked how much activity JR was allowed to do. Respondent testified the first two
15 hours is total bed rest and after two hours, if there was no evidence of bleeding, JR would be
16 allowed to sit up. After another two hours if there is still no evidence of bleeding, he could
17 ambulate slowly and JR did get out of bed. The Board noted JR went back to the floor and twelve
18 hours later developed 10 out of 10 right abdominal pain, became tachypneic, his pulse rate went
19 up and the nurses called the internist who ordered a GI consult, pain medication, and repeat
20 blood work in the morning. For three hours there was no activity and the nurses documented
21 JR's blood pressure was dropping and JR was restless and they called the internist again at
22 about 4:20 a.m. and, when the answering service did not pick up, they called Respondent.

23 10. The Board asked who was responsible for treating the patient who just had a
24 procedure – the physician who performed the procedure (Respondent) or the person on-call who
25 does not know the patient (Dr. Caplan). Respondent testified either physician who got the phone

1 call should initiate immediate action. Respondent got the phone and did not initiate immediate
2 action, but "turfed" the case to Dr. Caplan. Respondent testified when the nurses called him that
3 morning the nurse identified herself and said she was calling about a patient of his, but at that
4 time he told her Dr. Caplan was on-call and she should call him and she said she would.
5 Respondent had no recollection of obtaining any information regarding JR's situation, nor did the
6 nurse tell him about the severity of JR's condition so he had no way of making a remote diagnosis
7 and if he knew the information, he would have initiated immediate action and went in immediately
8 to manage the patient. When the nurses called Respondent they documented a blood pressure
9 of approximately 56 over 35 and it appears from the nurse's notes that information was relayed to
10 Respondent. Respondent testified he did not get that information and, if he had, he would have
11 been extremely concerned and would have done something immediately.

12 11. The nurse was worried, JR was in pain, and was hypotensive post-cath, but there
13 is no documentation anyone was looking at the groin. The Board asked if Respondent would be
14 worried about a patient when he received a call at 4:30 a.m. Respondent agreed, but stated he
15 needed to have the information in order to be worried or not and, unfortunately, he did not receive
16 the information. Accordingly, he was unable to worry and initiate any action. Respondent stated
17 any patient, whether his or not, with a blood pressure of 50 is a very critical situation and he
18 would remember distinctly if he had known that information. Respondent acknowledged he did
19 not ask the nurse any questions – he testified he answered the phone, the nurse told him who
20 she was without any other information. The Board asked if Respondent could have simply asked
21 the nurse for more information. Respondent testified that in retrospect he wished he would have
22 asked the nurse questions.

23 12. Respondent described the sign-out procedure to other physicians noting in
24 general, unless he is worried about a patient who might get into trouble, he will mention to the on-
25 call doctor what he might anticipate and, with JR at 5:00 p.m., there was no evidence he was

1 heading for any problems so he did not specifically mention him to Dr. Caplan. Respondent
2 noted however because he did get a consent with Dr. Caplan to arrange the angiogram for the
3 next day he did tell him about his concerns for JR – the aortic stenosis and left main ostial lesion.
4 Respondent could not recall if he told Dr. Caplan JR was anticoagulated, but did recall telling him
5 about atrial fibrillation. Respondent was called by Dr. Caplan between 7:00 and 7:30 a.m. and
6 was told JR was not doing well at all and he arrived at the hospital between 8:30 and 9:00.

7 13. The Board asked how Respondent has changed his practice since JR's case.
8 Respondent testified he learned a lot from this tragic case and has remorse about how he could
9 have done it differently. Respondent testified he has tried to construct the whole scenario over
10 and over again to see if there is any alternative that he would have done differently to prevent the
11 complication, which is potentially reversible, and really believes if he would have known the
12 information he would have done things differently. Respondent stated he has become more and
13 more vigilant and actually calls the nursing staff to confirm the patient is okay. The Board asked if
14 Respondent's procedure for anticoagulation, pericatheter, and catheterization has changed.
15 Respondent testified it was individualized and if the patient has high risk potential for embolism
16 he will anticoagulate the patient and be as careful as possible, but if he thinks the bleeding is
17 higher, he will definitely either stop the anticoagulation or reverse the anticoagulation before he
18 does the invasive procedure.

19 14. Respondent's orders for JR were that if his INR was greater than two, the nurses
20 were to give two units of FFP precath. The Board asked if Respondent ever rechecked the INR
21 before catheterization to see how much impact the FFP had. Respondent testified he did and
22 noted if the INR is anything over 2.0 and if JR did receive FFP it is mandatory to repeat it to make
23 sure enough FFP is given to bring the INR down to a comfortable level. Respondent testified that
24 once the FFP is given and the second reading of INR is obtained the anticoagulation level at that
25 time would maintain and would not show up again. The Board asked if Respondent was aware of

1 what happened to JR's INR. Respondent testified he did not give the FFP, therefore, he takes
2 the face value of 1.8. JR had FFP before he went to the cath lab and his INR went up to 2.9 – so
3 the FFP did not have the desired impact for as long as Respondent wanted. The Board asked
4 how this changed JR's risk of developing a complication. Respondent testified it would definitely
5 increase the risk of bleeding, but JR did receive Lovenox afterwards and it potentially would make
6 his blood thinner, and in a patient with CHF with liver congestion, potentially it would produce less
7 clotting factors and may potentially increase the bleeding and change the INR. Respondent
8 noted when he gives Lovenox he does not have to check INR.

9 15. The Board was concerned that no one looked for reasons for the bleed even
10 though JR was anticoagulated before a cath was done. Respondent had a difficult time with the
11 angio seal obtaining hemostasis and no additional lab work was ordered until another physician
12 ordered it the next morning and JR developed severe symptoms. The Board directed
13 Respondent to his post-op preprinted orders and noted it did not see where Respondent ticked off
14 on the site of the insertion of the catheter about putting pressure or watching for bleeding. The
15 Board asked if this was a concern or did he just sign off and the post-catheterization nurses are
16 aware of all the standard orders. Respondent testified everyone in the lab understood the
17 procedure quite well and he does not discharge a patient from the cath lab until he is satisfied the
18 groin is comfortably relieved and the bleeding has stopped. The Board noted Respondent's
19 concern that he could not put the plug in properly and asked when he got the phone call in the
20 middle of the night was that a concern for him and did he bother to ask the nurse why she was
21 calling. Respondent testified he wished he would have asked the nurse what the problem was,
22 why she was calling, but unfortunately he did not have the information to even alert him there was
23 a major problem.

24 16. The CT report showed a large retroperitoneal hematoma on the right side and the
25 Board asked if there was an actual perforation posteriorly of the vessel – was there a technical

1 problem that created a perforation causing JR to lose this much blood. Respondent testified he
2 has to assume with any kind of hemorrhage, especially after a procedure, that it is related to the
3 puncture; however, he remembers he did not mention that he had any difficulties in getting to the
4 artery. Respondent also stated there was no bleeding anteriorly where the puncture site was so
5 he has to assume the hemorrhage is from the posterior side of the femoral artery that would track
6 up and this is one of the reasons the groin did not show any extensive evidence of bleeding. The
7 Board asked if Respondent experienced any technical difficulties while actually performing the
8 catheterization. The Board noted it was trying to understand where the perforation happened that
9 allowed the patient to bleed so massively into the retroperitoneal space. Respondent testified in
10 the autopsy the doctor did not notice any posterior puncture site where the exit of the blood is and
11 it is not unreasonable to assume the bleeding has to be from the posterior even though the
12 puncture hole was not discovered at autopsy. Respondent testified sometimes there is
13 spontaneous retroperitoneal hemorrhage in an atherosclerotic artery and again he has to assume
14 the bleeding is either related to the procedure, or is a spontaneous bleed, especially if the patient
15 is on anticoagulation.

16 17. The Board asked if Respondent recalled anything unusual about the performance
17 of JR's catheterization – did he encounter any element of obstruction that presented technical
18 difficulties for him. Respondent testified JR's catheterization was relatively straightforward.
19 Respondent testified he put the arterial sheath into the femoral artery and that poses no evidence
20 of any obstruction or tearing or dissection of the artery that he could recall.

21 18. The Board noted it seemed that whether Respondent was on-call or not he would
22 have asked specific questions to find out the clinical status of JR – his patient – and asked why
23 he did not elicit more information or go in to see JR. Respondent testified he has many regrets
24 about JR's case and if he could turn back the clock he would have asked the nurse questions, but
25 unfortunately he did not have the information. The Board asked if Respondent currently performs

1 cardiac catheterizations and, if so, what would he do if he received a call about a current patient
2 like he did in JR's case. Respondent assured the Board he would not go back to sleep and would
3 ask as many questions as he needed until he is absolutely sure the patient is safe. The Board
4 confirmed Respondent's recollection about the call from the nurse was that she called, identified
5 herself and said she was calling about JR, that Respondent told her he was not on-call, and that
6 was the end of the conversation.

7 19. The standard of care requires the physician to ask appropriate questions about the
8 patient and his status and to follow-up on a critically ill patient.

9 20. Respondent deviated from the standard of care because did not ask appropriate
10 questions about the patient and his status and failed to follow-up on a critically ill patient.

11 21. JR died from a complication of cardiac catheterization.

12 **CONCLUSIONS OF LAW**

13 1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof
14 and over Respondent.

15 2. The Board has received substantial evidence supporting the Findings of Fact
16 described above and said findings constitute unprofessional conduct or other grounds for the
17 Board to take disciplinary action.

18 3. The conduct and circumstances described above constitutes unprofessional
19 conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice which is or might be
20 harmful or dangerous to the health of the patient or the public") and 32-1401(27)(ll) ("[c]onduct
21 that the board determines is gross negligence, repeated negligence or negligence resulting in
22 harm to or the death of a patient").

23 **ORDER**

24 Based upon the foregoing Findings of Fact and Conclusions of Law,
25

1 IT IS HEREBY ORDERED:

2 Respondent is issued a Letter of Reprimand for failure to ask appropriate questions and
3 follow-up on a critically ill patient.

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

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

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

14 DATED this 7th day of December, 2006.



16 THE ARIZONA MEDICAL BOARD

17 By [Signature]
18 TIMOTHY C. MILLER, J.D.
19 Executive Director

20 ORIGINAL of the foregoing filed this
8th day of December, 2006 with:
21 Arizona Medical Board
22 9545 East Doubletree Ranch Road
23 Scottsdale, Arizona 85258

24 Executed copy of the foregoing
25 mailed by U.S. Mail this
8th day of December, 2006, to:

1 Andrew E. Rosenzweig, Esq.
2 Olson Jantsch & Bakker, PA
3 7243 N. 16th St.
4 Phoenix, Arizona 85020-7250

5 George Kam Wong, M.D.
6 Address of Record

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