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12 **BEFORE THE ARIZONA MEDICAL BOARD**

13 In the Matter of:
14 **DEBORAH LYN AARON, M.D.**
15 Holder of License No. 22495
16 For the Practice of Allopathic
17 Medicine In the State of Arizona,
18 Respondent.

19 NO. MD-00-0310
20 MD-00-0535 ..
21 MD-02-0732

22 **CONSENT AGREEMENT FOR LETTER
23 OF REPRIMAND**

24 **CONSENT AGREEMENT**

25 RECITALS

26 In the interest of a prompt and judicious settlement of the above-captioned matter before the Arizona Medical Board (Board) and consistent with the public interest, statutory requirements and responsibilities of the Board and under A.R.S. § 41-1092.07(F)(5) and A.R.S. § 32-1451(F), Deborah Lyn Aaron, M.D. ("Respondent"), holder of License No. 22495 for the practice of allopathic medicine in the State of Arizona., and the Board enter into the following Recitals, Findings of Fact, Conclusions of Law and Order ("Consent Agreement") as the final disposition of this matter.

1. Respondent has read and understands this Consent Agreement as set forth

1 herein, and has had the opportunity to discuss this Consent Agreement with an attorney or
2 has waived the opportunity to discuss this Consent Agreement with an attorney.
3 Respondent voluntarily enters into this Consent Agreement for the purpose of avoiding the
4 expense and uncertainty of an administrative hearing.

5 2. Respondent understands that she has a right to a public administrative hearing
6 concerning each and every allegation set forth in the above-captioned matter, at which
7 administrative hearing she could present evidence and cross-examine witnesses. By entering
8 into this Consent Agreement, Respondent freely and voluntarily relinquishes all right to such
9 an administrative hearing, as well as all rights of rehearing, review, reconsideration, appeal,
10 judicial review or any other administrative and/or judicial action, concerning the matters set
11 forth herein. Respondent affirmatively agrees that this Consent Agreement shall be
12 irrevocable.

13 3. Respondent agrees that the Board may adopt this Consent Agreement or any
14 part of this agreement, under A.R.S. § 32-1451(F). Respondent understands that this
15 Consent Agreement or any part of the agreement may be considered in any future
16 disciplinary action against her.

17 4. Respondent understands that this Consent Agreement does not constitute a
18 dismissal or resolution of other matters currently pending before the Board, if any, and does
19 not constitute any waiver, express or implied, of the Board's statutory authority or
20 jurisdiction regarding any other pending or future investigation, action or proceeding.
21 Respondent also understands that acceptance of this Consent Agreement does not preclude
22 any other agency, subdivision or officer of this state from instituting other civil or criminal
23 proceedings with respect to the conduct that is the subject of this Consent Agreement.

24 5. All admissions made by Respondent in this Consent Agreement are made
25 solely for the final disposition of this matter, and any related administrative proceedings or
26

1 civil litigation involving the board and Respondent. This Consent Agreement is not to be
2 used for any other regulatory agency proceedings, or civil or criminal proceedings, whether
3 in the State of Arizona or any other state or federal court, except related to the enforcement
4 of the Consent Agreement itself.

5 6. Respondent acknowledges and agrees that, upon signing this Consent
6 Agreement and returning this document to the Board's Executive Director, Respondent may
7 not revoke her acceptance of the Consent Agreement or make any modifications to the
8 document, regardless of whether the Consent Agreement has been issued by the Executive
9 Director. Any modification to this original document is ineffective and void unless mutually
10 approved by the parties in writing.

11 7. Respondent understands that the foregoing Consent Agreement shall not
12 become effective unless and until adopted by the Board and signed by its Executive
13 Director.

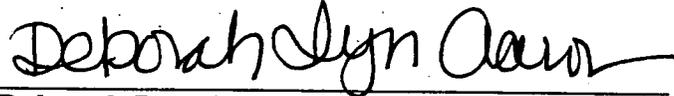
14 8. Respondent understands and agrees that if the Board does not adopt this
15 Consent Agreement, she will not assert as a defense that the Board's consideration of this
16 Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

17 9. Respondent understands that this Consent Agreement is a public record that
18 may be publicly disseminated as a formal action of the Board, and shall be reported as
19 required by law to the National Practitioner Data Bank and the Healthcare Integrity and
20 Protection Data Bank.

21 10. Respondent understands that any violation of this Consent Agreement
22 constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(25)(r)([v]iolating a formal
23 order, probation, consent agreement or stipulation issued or entered into by the board or its
24 executive director under the provisions of this chapter) and may result in disciplinary action
25 pursuant to A.R.S. § 32-1451.

1 ACCEPTED BY:

2 DATED: February 12, 2004

3
4 

5 Deborah Lyn Aaron, M.D.

6
7  03.04.2004

8 Richard H. Rea, Esq.
9 Attorney for Respondent

10 **FINDINGS OF FACT**

11 By stipulation of the parties, the following Findings of Fact, Conclusions of Law and
12 Consent Order are entered for final disposition of the matters described therein. Respondent
13 acknowledges that sufficient evidence exists for the Board to make the following Findings
14 of Fact:

- 15 1. This Complaint and Notice of Hearing are prepared, and these proceedings are
16 instituted, under A.R.S. §§ 32-1451 and 41-1092, *et seq.*
- 17 2. The Arizona Medical Board ("Board") is the duly constituted authority for licensing
18 and regulating the practice of allopathic medicine in the State of Arizona.
- 19 3. Deborah Lyn Aaron, M.D. ("Respondent") is the holder of License No. 22495 for the
20 practice of allopathic medicine in the State of Arizona.

21 **Case No. MD-00-0310**

- 22 4. On October 25, 1999, the Board received notice from Respondent's medical
23 malpractice insurance carrier of a settlement of a lawsuit filed by LM against
24 Respondent arising from her treatment.
- 25 5. On May 6, 1997, Respondent admitted Patient LM, a 36 year old male with a history

- 1 of severe gastrointestinal reflux disease, to Scottsdale Memorial Hospital-North for
2 a laparoscopic anti-reflux procedure, referred to as fundoplication or "Nissen"
3 procedure. This procedure involves suturing the fundus of the stomach completely
4 or partially around the gastroesophageal junction by use of a laparoscope, an
5 instrument that allows viewing inside of the body by use of fiber optics.
- 6 6. LM had undergone previous medical treatment for his condition that had not been
7 successful.
- 8 7. The surgery started at approximately 1:00 o'clock p.m. Respondent performed a
9 laparoscopic Toupet procedure, a variation of fundoplication, which is a partial
10 attachment of the stomach edge to the esophagus and repair of hiatal hernia. During
11 the procedure, the lining of the lung was perforated resulting in a partial collapse of
12 the left lung. Respondent ordered x-rays and inserted a chest tube. The surgery was
13 completed at 8:45 o'clock p.m. and LM was taken to recovery.
- 14 8. Respondent encountered difficulty during the surgery because of fogging of the
15 laparoscope lenses; problems with the insufflator and problems with maintaining the
16 pneumoperitoneum necessary to perform the operation. The insufflator delivers gas
17 into the body cavity to provide an open space at the site of the laparoscopy. This
18 induction of gas into the cavity is called pneumoperitoneum.
- 19 9. At approximately 11:00 o'clock p.m. nursing staff notified Respondent that the
20 patient was experiencing pain, an increased pulse rate of 142 and that fluid was
21 drained from patient's left chest.
- 22 10. On May 7, 1999, at 7:30 o'clock a.m., Respondent inquired of the nursing staff about
23 patient's condition and was told that he was still experiencing pain, that dark red
24 drainage had come from the chest tube, high pulse rate, shallow respiration and
25 swelling.

- 1 11. Over the next two days, LM continued to have excessive drainage, pain, shallow
2 breathing and increased pulse rates. Chest x-rays showed no abnormal fluid or air.
3 Respondent ordered an x-ray with oral contrast material. That x-ray, taken at 4:30
4 o'clock p.m. on May 8, 1997, indicted a perforation of the left lateral wall of the
5 esophagus above the diaphragm into the pleural space, the membrane that surrounds
6 the lungs.
- 7 12. At that time, Respondent contacted another physician, Adalberto C. González, for a
8 thoracic surgery consult. Dr. Gonzalez did not see LM until 9:00 o'clock a.m. the
9 following day.
- 10 13. Dr. Gonzalez attempted a primary repair of the perforation, but because of the length
11 of time that had elapsed since the perforation occurred, the repair failed and he
12 conducted a second surgery to repair LM's esophagus. Following that surgery, LM
13 developed a subhepatic abscess, which required further surgical intervention.
- 14 14. Respondent did not meet the standard of care when she failed to terminate the
15 fundoplication procedure upon experiencing problems with the laparoscope and
16 problems administering the gas into the area; failed to timely recognize that she had
17 perforated the esophagus; and, failed to appreciate the seriousness of the problem
18 post-surgery.

19 **Case No. MD-00-0535**

- 20 15. On February 10, 2000, the Board received notice from Respondent's medical
21 malpractice insurance carrier of a settlement of a lawsuit filed by KR against
22 Respondent alleging medical malpractice and negligence.
- 23 16. On March 17, 1997, Patient KR, a 46 year old female, was admitted to Scottsdale
24 Memorial Hospital North with an extensive history of abdominal surgical procedures
25 to undergo an exploratory abdominal laparotomy and possible replacement of a mesh
26

- 1 previously used to correct an abdominal hernia.
- 2 17. Respondent had first seen KR in March, 1997 when she complained of upper
3 abdominal pain and recurrent adhesions. KR had a medical history that included
4 several abdominal surgical procedures, the most recent being the removal of suture
5 granulomas and repair of a recurrent abdominal hernia in 1994. At least one of the
6 previous repairs required the use of a large Gore-Tex (soft plastic) mesh.
- 7 18. In May, 1996, Respondent performed an exploratory abdominal laparotomy on KR.
8 At that time, she noted a significant area of scarring and dense adhesions in the right
9 upper quadrant as well as multiple adhesions between adjacent loops of small bowel
10 and other areas. Respondent was able to cut the adhesions without complications.
- 11 19. In February, 1997, KR returned to Respondent complaining of bloating and pain,
12 chronic diarrhea and nausea. Respondent examined her and ordered an upper
13 gastrointestinal study. The study was negative except for post-operative changes
14 involving the terminal ileum and proximal colon.
- 15 20. KR returned to Respondent on March 10, 1997, indicating that she was pretty
16 uncomfortable and getting worse. KR indicated that she wanted to undergo another
17 exploratory laparotomy. Respondent explained the risks of the surgery, but did not
18 give any instructions regarding a pre-operative bowel preparation.
- 19 21. On March 17, 1997, KR was admitted for the surgery. No pre-operative bowel
20 preparation was noted or ordered. A pre-operative bowel preparation is indicated in
21 a patient with a history of known dense adhesions and previous right colon resection
22 wherein the dissection may well involve the colon.
- 23 22. During the surgery, Respondent found that the colon was found to be densely fixed
24 to the Gore-Tex mesh. There was colon injury during the dissection, a colotomy--an
25 opening of the un-prepped colon. Respondent stated the opening was minimal, but
26

- 1 a technician present at the surgery described the hole in the colon.
- 2 23. The bacterial count is very high in an un-prepped bowel and thus the contamination
3 of the peritoneal cavity from such a colotomy would be severe.
- 4 24. Respondent placed a sheet of seprafilm over the Gore-Tex patch in the face of gross
5 contamination. Respondent had not used the product before.
- 6 25. Postoperatively, KR displayed a severe fever, difficulty breathing, increased pulse
7 rate, profuse sweating, hypotension and diminished oxygen saturation of the blood.
- 8 26. Respondent called in an infectious disease specialist for consultation at the end of the
9 second day after the surgery.
- 10 27. Respondent's progress notes at 36 hours after the surgery indicates drainage and early
11 wound infection, again confirming severe intra-abdominal soiling. KR's blood tests
12 indicated systemic reaction to severe infection, with a white blood cell count at 6,500.
13 A chest x-ray suggested aspiration pneumonia and the consultant changed the
14 antibiotics and the temperature came down, but never to normal.
- 15 28. Respondent's progress notes during this time did not reflect the severity of KR's
16 condition.
- 17 29. On the 4th day after the surgery, KR's temperature again spiked upwards. The
18 infectious disease consultant requested a CT scan of the abdomen to locate a source
19 for the infection. Respondent cancelled the CT because it would "not be helpful
20 simply because of the degree of anticipated post-op changes."
- 21 30. On the 5th day after surgery, Respondent noted improvement and advanced KR's
22 diet. A repeat chest x-ray showed no pneumonia.
- 23 31. On the 6th day after surgery, one antibiotic was stopped. Respondent recorded that
24 KR's abdominal discomfort was better. Her temperature was still elevated and the
25 wound was the same. The diet was advanced.

- 1 32. On the 7th day after surgery, the infectious disease consultant noted the white blood
2 count to be 16,000 and noted that KR had significant abdominal pain. He ordered
3 a CT scan of the abdomen to search for an intra-abdominal source for the continued
4 infection.
- 5 33. The scan showed pelvic accumulations of fluid which were tapped by a radiologist
6 using CT guidance with catheter placement for drainage. The fluid was "murky and
7 full of debris" as recorded by the radiologist. KR's treatment continued for intestinal
8 infection.
- 9 34. Respondent continued to attempt to feed KR by mouth in spite of evidence of an ileus
10 and omitted placing a nasogastric tube to relieve the gastric distention.
- 11 35. At about 11:00 p.m. on Saturday night, Respondent learned that a white cell scan
12 showed localized uptake over the mesh. Respondent changed antibiotics and
13 considered removing the mesh. However, the surgery was delayed for thirty-three
14 hours over the weekend. Respondent attempted to add a bowel prep.
- 15 36. The mesh was removed on March 31, 1997, two weeks after the original surgery.
16 This surgery also resulted in a massive small bowel resection, leaving the patient with
17 approximately five feet of residual small bowel, because there was evidence of long-
18 standing peritonitis rendering the small bowel fragile and easily damaged.
- 19 37. After this surgery, KR continued to have fevers, required incubation and respiratory
20 support, with evidence of multi-organ failure and development of a small bowel
21 fistula (an abnormal passage).
- 22 38. Respondent was asked to leave the care of KR by the family and, despite subsequent
23 heroic efforts, KR died on April 25, 1997.
- 24 39. Respondent fell below the standard of care by:
- 25 a. failing to order a bowel preparation before the initial surgery.
- 26

- 1 b. persisting in the surgery when it became necessary to dissect the colon way
2 from dense adhesions.
- 3 c. failing to recognize the apparent signs of sepsis (infection) post-operatively
4 and addressing them according to accepted standards.
- 5 d. failing to promptly order a CT scan and cancelling one ordered by the ID
6 consultant.
- 7 e. failing to promptly return the patient to surgery when sepsis continued and
8 there was evidence of intra-abdominal source of infection.

9 **Case No. MD-02-0732**

- 10 40. On November 13, 2002, the Board received information that disciplinary action had
11 been taken against Respondent by the Alaska State Medical Board (ASMB) for
12 inappropriate prescribing of controlled substance medications to an individual with
13 whom she maintained a close personal relationship but did not have a
14 physician/patient relationship. An investigation was opened.
- 15 41. The ASMB found that between April 3, 2001 and January 6, 2002, Respondent wrote
16 one prescription for fifty Roxicet tablets, a Schedule II controlled substance
17 medication and four prescriptions for one hundred fifteen tablets of Lorazepam, a
18 Schedule IV controlled substance medication for an individual with whom
19 Respondent was involved in a personal relationship but was not being treated by
20 Respondent as a patient.
- 21 42. Respondent entered into a Memorandum of Agreement with ASMB in which she
22 admitted to the facts. The Board imposed a five year probation, a \$5,000 fine, with
23 \$4,500 suspended and a reprimand.

24 **MITIGATING CONSIDERATIONS**

- 25 43. Since Arizona first licensed Respondent to practice medicine and surgery in Arizona,
26

1 Respondent continued to hold an active Arizona license.

2 44. Respondent actively practiced medicine and surgery in Idaho from February 1998
3 until November 1999. In Idaho, Respondent had no Board disciplinary action and
4 no medical lawsuits filed against her.

5 45. Respondent actively practiced medicine and surgery in Alaska from November 1999
6 to the present. Other than the memorandum of Agreement referenced in paragraphs
7 40, 41 and 42 of this Consent Agreement, in Alaska Respondent had Board
8 disciplinary actions and no meritorious medical lawsuits filed against her. On
9 October 23, 2003, the Alaska State Medical Board voted unanimously to release
10 Respondent from all provisions of the Memorandum of Agreement Respondent
11 entered into with the State of Alaska.

12 46. The Arizona Medical Board received a written statement from a Dr. Newman, a
13 senior General Surgeon in Alaska who has been in unique position to evaluate Dr.
14 Aaron's surgical technique, surgical judgment and post-operative care. On a variety
15 of surgeries, he assisted Dr. Aaron in the operating room and directly observed her
16 surgical technique. He directly observed her practice in the emergency room and on
17 the wards. He also directly observed Dr. Aaron's exercise of medical judgement on
18 post-operative care.

19 47. Dr. Newman receives information about the procedures all hospital surgeons perform
20 and the results of those procedures. He verified that Dr. Aaron performed hundreds
21 of procedures, including dozens of successful laparoscopic procedures and dozens
22 of successful open abdominal procedures. He verified that Dr. Aaron's patients enjoy
23 post operative results well within expectations.

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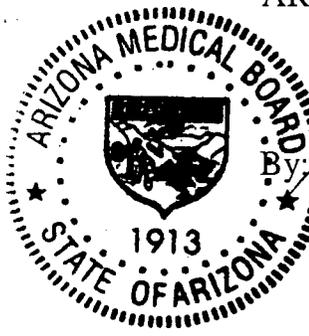
1 medication without establishing a physician patient relationship. She has demonstrated
2 remediation that has mitigated the need for disciplinary action.

3 2. Respondent, Deborah Lyn Aaron, M.D., the holder of License No. 22495, is
4 hereby issued an Letter of Reprimand for unprofessional conduct arising from MD-00-0535
5 for falling below the standard of care by failing to appreciate the risks of surgery pre-
6 operatively; failing to terminate the surgical procedure when she recognized complications;
7 and failing to appropriately treat the patient post-operatively.

8 DATED AND EFFECTIVE this 15th day of APRIL, 2004.

10 ARIZONA MEDICAL BOARD

11 (SEAL)



12 By Barry A. Cassidy
13 Barry A. Cassidy, Ph.D., P.A.-C.
14 Executive Director

16 Original of the foregoing filed this
17 16th day of April, 2004, with:

18 Arizona Medical Board
19 9545 E. Doubletree Ranch Road
20 Scottsdale, Arizona 85258

21 COPY of the foregoing mailed by U.S.
22 Certified Mail this 16th day
23 of April, 2004, to:

24 Deborah Lyn Aaron, M.D.
25 P.O. Box 6775
26 Ketchikan, Alaska 99901
Respondent

COPIES of the foregoing mailed
this 16th day of April, 2004, to:

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16 Planning and Operations

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