

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **TERRY R. MAXON, M.D.**

4 Holder of License No. **4717**
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-04-1108A

**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 December 7, 2005. Terry R. Maxon, M.D., ("Respondent") appeared before the Board with legal
9 counsel Suzanne Ogden 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. 4717 for the practice of allopathic
16 medicine in the State of Arizona.

17 3. The Board initiated case number MD-04-1108A after receiving notification of a
18 medical malpractice settlement involving Respondent's care and treatment of a sixty-eight year-
19 old female patient ("CM"). On February 19, 2001 CM presented to the emergency room at
20 Maryvale Hospital ("Hospital") complaining of rectal bleeding over a period of four to five days.
21 CM had a history of aortic stenosis. Respondent was called in to evaluate CM on February 20,
22 2001 and noted she was passing bloody stool at a fairly frequent rate, that she was rather pale,
23 and a little bit tachycardic. CM's hemoglobin fell from 10.3 to 8.1. Respondent recommended a
24 nuclear medicine study to determine the cause of bleeding. The physician performing the nuclear
25 medicine study aborted the procedure because CM was hemodynamically unstable. CM told the

1 nurse she had a panic attack during the study. CM later died after suffering a heart attack. In
2 Respondent's written response to the Board he noted CM's bleeding was active, but not brisk.
3 He also stated he was informed by the nurse that the nuclear medicine study was cut short by
4 CM's panic attack. Respondent also noted CM's bleeding had apparently slowed prior to her
5 death.

6 4. Respondent was asked his impression of CM when he first evaluated her.
7 Respondent testified his impression was that she was bleeding perhaps a little bit more
8 vigorously than when she came into the emergency room the night before. Respondent was
9 asked if his only order regarding CM was for the nuclear medicine study. Respondent testified he
10 also ordered a hemoglobin because she also had orders for morning and evening H and H and
11 he thought because maybe the bleeding had gotten a little bit more brisk, he would do one at that
12 time. Respondent was asked if at this time he knew CM's history of two previous episodes of
13 bleeding – one in August of 1999 at Maryvale where she was scoped and noted to have vascular
14 ectasia and cecal AV malformations and one in 1998 at another hospital where she required
15 transfusion. Respondent testified he was. Respondent was asked if this entered into his decision
16 as to how aggressively he would approach or treat CM. Respondent testified it certainly did and
17 he thought CM also had diverticulas so the issues were: (1) does she have bleeding now from
18 AVM's in the colon; (2) does she have bleeding from the left-sided diverticula; or (3) does she
19 have small bowel AVM's. Respondent noted this had never been established, was important to
20 establish, and affected how he treated her. Respondent was asked if he knew CM had
21 documented AVM's of the cecum. Respondent testified he did and she also had a blood pool
22 scan at previous hospitalization, but it did not demonstrate any site at that time.

23 5. The Board noted when Respondent ordered the radioactive scan to try to localize
24 the site of bleeding he had an understanding there must be a certain rate of bleeding for the scan
25 to be positive so it assumed Respondent thought CM was bleeding briskly enough that the scan

1 would be positive. Respondent was asked if he had an idea at what rate, in ccs per minute, a
2 person has to bleed in order for a scan to be positive and what that would amount to over a
3 twenty-four hour period. Respondent testified he has heard it is one-half to one cc per minute,
4 which would be a total of 1400 ccs of blood loss over twenty-four hours. Respondent was asked
5 to assume CM was bleeding at that rate for four or five days prior to presenting at the Hospital
6 and whether that would put her way behind the eight ball. Respondent testified that would be
7 about three units a day for six days, about eighteen units of blood, and a person does not have
8 that much. Respondent testified what happens is that the patient starts bleeding and stops.
9 Respondent noted typically you need three or four blood pool scans before there is a positive
10 result because the patient's bleeding stops about the time they are sent for the test. Respondent
11 noted if you look at CM's radiology report, which was dictated a day late, it suggests she had
12 stopped bleeding by the time she was down there, although it was not a complete scan.

13 6. Respondent was asked his recollection of what happened between CM and the
14 radiologist when she arrived for the scan. Respondent testified at the time he had no knowledge
15 whatsoever of what went on during the scan and did not even remember the nurse calling him.
16 Respondent testified if he knew the scan was not completed he would have told the nurse to
17 please wait for CM to start bleeding again and try to persuade her to go down and complete the
18 scan so he could figure out what the bleeding was. Respondent was asked if that meant he was
19 unaware at the time he ordered a bolus of 500 ccs of saline that CM's blood pressure had
20 dropped to seventy and her oxygen saturations to seventy-five percent while she was in the
21 scanner. Respondent testified he believes he was unaware. Respondent noted the nurse would
22 have told him, she might have given him those numbers, but then she gave him a current number
23 that was taken since CM had come back. Respondent noted if a patient is bleeding to death and
24 the blood pressure drops like that and you are returned to your room it does not immediately
25 return to normal. Respondent testified the 500 cc bolus was an order if CM started bleeding

1 briskly again and to send her to the scan with some sedation and extra fluid. The Board noted
2 the record only reflects an order to give a 500 cc bolus of normal saline. Respondent testified the
3 nurse was new and inexperienced and did not write orders well.

4 7. Respondent was asked if CM was given the bolus of saline. Respondent testified
5 she was not because, if you look at the graphic in the record, CM was not bleeding because the
6 nurse recorded CM had five black stools in the morning. Respondent was asked if he was aware
7 of CM's co-morbidities, specifically her severe aortic stenosis. Respondent testified he was
8 aware that she had significant chronic obstructive pulmonary disease and was still actively
9 smoking a pack and a half of cigarettes a day. Respondent also noted CM, probably because of
10 her aortic stenosis, was placed on beta blockers. Respondent testified CM was on sixty
11 milligrams of long-acting Inderal per day and this was continued at the time of her admission to
12 Hospital. Respondent testified beta blockers impair the heart's ability to respond to antienergetic
13 stimuli; basically she would not mount a rapid tachycardia, which would be the first sign a clinician
14 might see to appreciate that the bleeding is more than it might appear. Respondent testified the
15 presence of beta blockers may have removed the ability to monitor her or follow her by a
16 tachycardia. Respondent was asked if he heard anything else from the floor or from the nurses
17 between his phone call order of about 4:00 p.m. and the time CM arrested. Respondent testified
18 he did not and when he went to see CM the next morning he was told she had died.

19 8. Respondent was referred to CM's EKG in Hospital's records. The Board noted
20 there was a lot of LDH on the EKG and it could tell from the EKG that CM had an enlarged heart,
21 but more importantly noted inferiorly there was an ST segment depression. The Board noted it
22 was concerned with this depression in a woman who came in bleeding, who was on a beta
23 blocker and who was hypotensive and noted it would indicate CM was having a heart attack or at
24 least ischemia right then. Respondent was asked if this was something he looked at or was
25 aware of. Respondent testified he looked at the EKG. Respondent was asked if the inferior

1 changes mattered. Respondent testified he was not aware that you could call them acute, but he
2 did look at them. Respondent testified he thinks CM did have ischemic changes. The Board
3 noted they were pretty significant ischemic changes in a woman who had been bleeding for
4 perhaps five days. The Board noted when CM first presented her blood pressure was 150 and
5 her pulse was 91 then her blood pressure dropped in the emergency room to 106 over 58 and her
6 pulse stayed at 85 secondary to the beta blocker. Respondent was asked if he was aware of
7 these changes. Respondent testified he did not recall those changes. Respondent was asked if
8 he wrote the orders for 125 ccs an hour of normal saline. Respondent testified he had not, that
9 an intern who was following CM from the emergency room wrote those orders, but he may have
10 continued the orders during CM's stay. Respondent testified he looked at the IV rate because he
11 figured that was his department and it was about the rate he would do for somebody who was not
12 progressing rapidly downhill. Respondent noted he would disagree that is not holding orders,
13 particularly with heart disease and particularly with this kind of problem; very frequently these
14 people are over-hydrated. Respondent testified he has been called many times because the
15 patient is starting to have chest congestion from an IV rate of 125 an hour and he immediately
16 cuts it down.

17 9. Respondent was asked if he was concerned that CM's hemoglobin dropped from
18 ten to nine to eight. Respondent testified he misread the numbers because Hospital had just
19 changed the way it recorded these numbers from being read right to left to being read left to right
20 so he actually thought her hemoglobin went from eight to ten instead of ten to eight. Respondent
21 was asked if CM's feeling anxious could have been a sign of something other than anxiety, such
22 as ischemia or hypoxia. Respondent testified it could and he thought that is what happened to
23 her in the evening. Respondent was asked if medicating CM with Xanax, as indicated in the
24 orders, would be a good idea in this circumstance. Respondent testified CM was not medicated
25 with Xanax. Respondent noted there is an order for Ativan and an order for Xanax, but neither of

1 the drugs were given. Respondent testified the Ativan order was if CM started bleeding again
2 and she could be convinced to try to have the scan again. Respondent testified he did not tell the
3 nurse to do this as an order, he discussed it with her and she wrote it down as an order.
4 Respondent testified he did not order the Xanax, it was ordered by another physician and it was
5 not given either.

6 10. Respondent was asked if, with a patient who has possibly been bleeding for five
7 days, who has known heart disease, and aortic stenosis, would he have wanted to do a
8 colonoscopy or an EDG or something more aggressive. Respondent testified he would not.
9 Respondent testified he had the same EKG available from the previous hospitalization, he knew
10 she had a colonoscopy and he did not think doing a colonoscopy would really change what he
11 would do because you do not always accurately see where a patient is bleeding from with a
12 colonoscopy. Respondent noted nuclear medicine scans are not completely accurate either, but
13 repeated nuclear scans showing a site are what he has to rely on if eventually something is going
14 to be done. Respondent noted the frustration with these patients is that they are back time after
15 time after time and they are supported until the bleeding stops, which it almost always does within
16 a day or two as he tries to find out what is going on. Respondent noted eventually a physician,
17 maybe the GI physician, will decide maybe something should be done in conjunction with the
18 patient and considering her other problems. Respondent testified he was not CM's main GI
19 physician, but was covering that day.

20 11. Respondent was asked whether he would have had time to do the repeated
21 nuclear medicine scans he said may be required to find the source of the bleeding with CM
22 becoming hypotensive and unable to complete the scan. Respondent testified he believed
23 everyone was laboring under the conclusion that CM died from bleeding, but she did not.
24 Respondent also noted he did not know she had gotten hypotensive in x-ray and only got a call
25 after CM returned to the floor and she had normal values. The Board noted Respondent's

1 statement that CM did not die from bleeding and asked if she died of a heart attack. Respondent
2 testified she had. Respondent was asked if the blood loss CM suffered could have caused the
3 heart attack. Respondent answered "no." Respondent testified he thought possibly the fluids
4 they gave her may have influenced the heart attack. Respondent noted very often when he gets
5 some of these hemoglobins that are really low, he stops the fluids and is convinced the patient is
6 not bleeding anymore. Respondent testified the patients will be given some Lasix and the
7 hemoglobin will rise two grams just from that. Respondent noted it was certainly a load on CM's
8 ill heart if they miscalculated how much fluid to give her and overshot. Respondent testified there
9 was probably a good chance this was where the sensations of tightness in her chest and
10 shortness of breath came from shortly before she expired.

11 12. Respondent was asked to think of the coronary anatomy and where the aortic
12 valve is placed and how the coronary arteries come off right outside the aortic valve and if there is
13 not enough blood in the pump, the heart does not get enough perfusion. Respondent was asked
14 if it was correct that he did not think her having lost any blood could have contributed to that and
15 that she actually needed more not less. Respondent testified the issue is perfusion and what
16 patients need is adequate volume of blood to deliver the red cells to the tissues, the coronary
17 arteries and the brain. Respondent noted what happens when a patient is lying in the hospital is
18 that there is not anywhere near complete extraction of the oxygen and the patient can frequently
19 tolerate low hemoglobin and this is why when a patient comes in bleeding he makes sure they
20 have adequate volume so they have perfusion. Respondent noted this is what the IV rate of 125
21 was for.

22 13. Respondent was asked if this case changed his practice. Respondent testified it
23 had not and noted he has been doing this for thirty years and has never had a patient bleed to
24 death from lower GI bleeding. Respondent testified if someone bleeds to death it does not look
25 anything like CM's case – there is blood on the carpet, on the sheets, on the nurse, and there is

1 lots of melena all over the place. Respondent testified CM had stopped bleeding, her IV fluid kept
2 going at 125 ccs per hour, but her bleeding had stopped. Respondent was asked if he did not
3 think the blood loss CM suffered the days before and her underlying cardiac condition warranted
4 more aggressive care. Respondent testified he did not and he knows whether CM bled for four
5 days or ten days her hemoglobin was 10.3 before he even started diluting it with IV fluid.

6 14. Respondent was asked if pre-load was important in a patient with aortic stenosis in
7 terms of peripheral perfusion in bleeding coronaries. Respondent testified he guessed it was.
8 The Board noted Respondent testified he was more concerned about fluid overload versus fluid
9 underload and asked if in a patient who has aortic stenosis and LVH to show she correlates well
10 with aortic stenosis did he believe that high preload fluid levels would be important versus the
11 more dangerous lower volume on the preload side. Respondent testified he just wants to get it
12 right and asked the Board to remember there is an autopsy to look at and we are Monday
13 morning quarterbacking and see CM's lungs are full of fluid, she has a little bit too much preload
14 and has pulmonary edema. Respondent was asked if he thought the fluid given CM was a
15 significant amount of fluid for baseline fluid. Respondent testified CM could drink water and was
16 eating. Respondent was asked to confirm he was more concerned about overloading CM then
17 underloading her. Respondent testified he was just trying to get it right and you measure it by
18 having a good blood pressure, a reasonable pulse, and good oxygen saturation in a patient who
19 looks physically comfortable and if he started hearing wheezing or there were some changes in
20 those parameters he would adjust it accordingly.

21 15. Respondent was asked what happens to a patient's lungs during the code.
22 Respondent testified perhaps they maybe get edematous as well, but he was not sure.
23 Respondent directed the Board to the nurse's note before the code and the reason they asked for
24 Xanax was because CM was anxious and short of breath and wheezing – pulmonary edema.
25 Respondent testified he has been called on this fifty times, that the bleeding has stopped and the

1 nurse says "the bleeding has stopped and were still giving her an IV rate of 125 an hour. I think
2 we are getting fluid overload. I stopped it and gave her some Lasix, now I want an order."
3 Respondent testified he would give the nurse the order. Respondent noted this was common
4 practice for GI physicians.

5 16. Respondent was again asked about CM's hypotensive episode in nuclear
6 medicine. Respondent testified he did not think CM was hypotensive and he thinks she had
7 exactly what she said – a panic attack. Respondent was asked if he was saying a panic attack
8 caused CM's hypotension. Respondent testified he was. The Board noted it had never heard of
9 that before, that it had heard of vasovagal, but not a panic attack. Respondent testified CM called
10 it a panic attack, he calls it vasovagal. Respondent was asked if in the face of four or five days of
11 lower GI bleeding and in the face of ongoing continued bleeding as documented in the nurse's
12 notes with four or five episodes of bloody stools, he wants the Board to believe CM's becoming
13 hypotensive was secondary to a vasovagal response. Respondent testified he did. Respondent
14 was asked if he was aware the radiologist who was trying to perform the scan opened up CM's IV
15 fluids full force to bring her blood pressure up. Respondent testified if the radiologist was
16 concerned that CM was in shock from the bleeding he would not have just opened her IV he
17 would have sent her to the unit. The Board noted that was not the radiologist's decision and he
18 canceled the study appropriately when CM was unresponsive with a blood pressure of seventy,
19 sent her back to the floor, notified the nurse, who supposedly notified Respondent who then wrote
20 the order for 500 ccs of saline infusion. Respondent testified he did not write an order for 500 ccs
21 of saline. The Board noted the record reflects he did. Respondent testified the record is
22 incorrect.

23 17. Respondent was asked about his misreading the hemoglobin numbers and
24 thinking they had gone up. Specifically, Respondent was asked what he thought made it go up,
25 had he done a blood transfusion. Respondent testified he did not do a transfusion and a lot of

1 times he will see strange numbers one right after another that do not make sense and he does
2 not know why it happens, but it does. The Board noted it understood in a healthy patient who
3 does not have a GI bleed that the body makes up for it and the hemoglobin gets better, but CM
4 was sick, was bleeding. Respondent testified that clearly in this case the hemoglobin was falling,
5 just as he found. The Board noted Respondent had testified when he looked at the chart it had
6 gone up so that is why he was not alarmed as much. Respondent testified that was correct and
7 he thought if he had known it was not he does not think he would have done anything differently.
8 The Board noted that physiologically it does not make sense that hemoglobin would get better in
9 six to eight hours in a patient with a GI bleed for three or four days and no transfusion.
10 Respondent testified it does not make sense, but it happens and that is why the hemoglobin tests
11 are repeated.

12 18. Respondent was asked what he believed was the cause of CM's death.
13 Respondent testified he thought CM had an arrhythmia secondary to her aortic stenosis and he
14 did not know whether her little bit of extra fluid load had much, if anything to do with it or stress of
15 hospitalization, but he thought she had an arrhythmia and a cardiac death. Respondent was
16 asked if he thought the low hemoglobin had anything to do with it. Respondent testified it
17 absolutely did not. Respondent testified the records reflect CM had walked into her doctor's
18 office the year before with a hemoglobin of five. Respondent also noted he has patients walk into
19 his office or into the emergency room every month with hemoglobins of six. Respondent was
20 asked if he thought CM's rapid change in hemoglobin was different from a chronic low
21 hemoglobin. Respondent testified there are records from her office visits that show CM almost
22 never had a hemoglobin over eleven. Respondent was asked if he thought CM would have
23 benefited from blood or packed cells. Respondent testified CM would have gotten them before
24 she went home, but there was not a big necessity to transfuse her when her hemoglobin went to
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1 eight. Respondent testified he did not believe it mattered whether it was a chronic loss or acute
2 loss.

3 19. The standard of care required Respondent to recognize the seriousness of the GI
4 bleed and treat it in a timely and appropriate manner.

5 20. Respondent deviated from the standard of care because he did not recognize the
6 seriousness of the GI bleed and failed to treat it in a timely and appropriate manner.

7 21. Respondent's deviation from the standard of care eventually resulted in CM's
8 death.

9 **CONCLUSIONS OF LAW**

10 1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof
11 and over Respondent.

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

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

20 **ORDER**

21 Based upon the foregoing Findings of Fact and Conclusions of Law,

22 IT IS HEREBY ORDERED:

23 1. Respondent is issued a Letter of Reprimand for failure to properly monitor and treat
24 a patient with gastrointestinal bleeding eventually resulting in the death of the patient.

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RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

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

DATED this 9th day of February, 2006.



THE ARIZONA MEDICAL BOARD

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

ORIGINAL of the foregoing filed this 10th day of February, 2006 with:

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

Executed copy of the foregoing
mailed by U.S. Certified Mail this
10th day of February, 2006, to:

Suzanne Ogden,
Jones, Skelton & Hochuli, P.L.C.
2901 North Central Avenue – Suite 800
Phoenix, Arizona 85012-2703

1 Executed copy of the foregoing
mailed by U.S. this 10th day
2 of February, 2006, to:

3 Terry R. Maxon, M.D.
Address of Record

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Terry R. Maxon

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