BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

MICHAEL R. TRIMBLE, M.D.

Holder of License No. 33104
For the Practice of Allopathic Medicine
In the State of Arizona.

Case No. MD-16-1101A
ORDER FOR LETTER
OF REPRIMAND; AND
CONSENT TO THE SAME

Michael R. Trimble, M.D. ("Respondent") elects to permanently waive any right to a
hearing and appeal with respect to this Order for a Letter of Reprimand; admits the
jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order
by the Board.

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 number 33104 for the practice of
allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-16-1101A after receiving notification of
a malpractice settlement regarding Respondent's care and treatment of a 62 year-old
female patient ("IV") alleging failure to diagnose extent of existing condition, failure to
recognize complications during procedure, and failure to promptly transfer to a higher level
of care.

4. On December 18, 2012, IV presented for a consultation with Respondent for
recurrent reflux and dysphagia and a history of a Nissen fundoplication procedure in 2002.
Subsequently, a barium swallow test was performed and Respondent diagnosed IV with
Type III hiatal hernia. An endoscopy was performed for confirmation of diagnosis and
assurance of the status of the esophagus and stomach. The study confirmed that the
previous fundoplication was intact.
5. On February 13, 2013, Respondent performed surgery on IV to reduce the hernia and redo the gastric wrap. Post-operatively, IV's status included hypoxia, acidosis, tachycardia, and hypotension. There was no documentation that IV was seen by Respondent that evening.

6. On February 14, 2013, IV had improved mildly but remained hypoxic. That afternoon and evening, IV deteriorated with sepsis, continued hypoxia and hypotension. IV was transferred to the ICU where she was intubated, started on pressors and arterial monitoring with fluid resuscitation. Respondent also performed an endoscopy.

7. Subsequently, IV was transferred to a different hospital, where she underwent total gastrectomy, blind pouch esophagus, and feeding tube jejunostomy.

8. The standard of care required Respondent to reduce the stomach from the chest prior to attempting to fix the hiatal hernia. Respondent deviated from this standard of care by failing to reduce the stomach from the chest prior to attempting to fix the hiatal hernia.

9. The standard of care required Respondent to convert to an open operation when difficulty arises during a laparoscopic procedure. Respondent deviated from the standard of care by failing to convert to an open operation when difficulty arose during the laparoscopic procedure.

10. The standard of care required Respondent to treat hypoxia. Respondent deviated from the standard of care by failing to treat hypoxia.

11. The standard of care required Respondent to transfer a patient to a higher level of care or request assistance during the operation. Respondent deviated from the standard of care by failing to timely transfer the patient to a higher level of care or request assistance during the operation.
12. Actual patient harm was identified in that the patient became acidotic and hypoxic and her stomach became ischemic. The patient subsequently underwent total gastrectomy and blind pouch esophageal resection with debilitating results and will likely also require a third operation to use either colon or small bowel to connect the esophagus to the duodenum.

13. There was the potential for patient harm in that IV is at risk for cardiac complications of her sepsis from the first operation as well as the cardiac stress from the two subsequent operations required to fix the complications of the first. Also, the hypoxia experienced by IV can have long term effects on all organs.

CONCLUSIONS OF LAW

a. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

b. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q)("Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

DATED AND EFFECTIVE this 1st day of February, 2018

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Executive Director
CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.
7. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

8. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgetment or other similar defense.

9. **Respondent has read and understands the terms of this agreement.**

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MICHAEL R. TRIMBLE, M.D.

DATED: 12/28/2017

EXECUTED COPY of the foregoing mailed this 20th day of December, 2017 to:

Michael R. Trimble, M.D.
Address of Record

ORIGINAL of the foregoing filed this 1st day of February, 2017 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

1740 W Adams St
Suite 4000
Phoenix, AZ 85007

Board staff