BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

EDWARD J. HA, M.D.

Case No. MD-14-1045A

Holder of License No. 46688

ORDER FOR PROBATION AND
For the Practice of Allopathic Medicine
PRACTICE RESTRICTION; AND
In the State of Arizona.
CONSENT TO THE SAME

Edward J. Ha, M.D. ("Respondent"), elects to permanently waive any right to a
hearing and appeal with respect to this Order for Probation and Practice Restriction;
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 46688 for the practice of
allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-14-1045A after receiving notification
from a hospital that Respondent resigned his interventional cardiology privileges while the
hospital was investigating increased complications in his interventional cardiac
procedures.

4. An outside medical consultant ("OMC") reviewed the medical records for nine
patients whose cases were referred to the Board from the notifying hospital and found the
following deficiencies with respect to Respondent's treatment of three patients:

Patient M.M.

5. M.M., a 67 year-old female with a history of Crohn's disease, initially
presented to Respondent in consultation for a pericardial effusion. On April 10, 2014,
Respondent performed a pericardiocentesis. 1400cc of bloody drainage had been
removed when M.M. developed hypotension/tachycardia and respiratory
distress/hypovolemic shock, which required intubation. Respondent removed another
2000cc of fluid before he removed the catheter used for the pericardiocentesis. M.M.
required 6 units of PRBC's, 4 units FFP and 2 liters NS to get stabilized. In the intensive
care unit, M.M. was on phenylephrine and dopamine before she was gradually weaned off
pressors and the ventilator. M.M. was subsequently discharged in good condition.
6. The standard of care requires a physician who performs a pericardiocentesis
to recognize when he is not in the pericardial space and, if needed, to utilize
echocardiography to verify proper placement. Respondent deviated from this standard of
care by continuing to withdraw fluid from M.M. and failing to verify that he was in the
pericardial space, which he would have recognized if he had monitored the procedure with
simultaneous echocardiography.
7. Actual harm occurred to M.M. in that she developed hypovolemic shock.
8. There was the potential for harm in that M.M. could have required surgery to
stop the bleeding or M.M.'s death could have resulted.

Patient N.H.

9. N.H., a 76 year-old female, was diagnosed with severe aortic stenosis. On
March 20, 2014, Respondent performed cardiac catheterizations which consisted of a left
heart catheterization, left and right coronary angiograms, and left ventriculogram. N.H.
experienced chest pain and syncope post-catheterization. A STAT echocardiogram was
performed and was read as having aortic stenosis, normal LV function and no pericardial
effusion. Troponins were checked and noted to be elevated after the catheterizations.
10. On March 22, 2014, N.H. was taken to the operating room and reported to
have a pericardial effusion with non-clotting blood and evidence of early tamponade. The
aortic valve replacement was completed, but N.H. had difficulty weaning from the
cardiopulmonary bypass machine and an intra-aortic balloon pump ("IABP") was required
to wean N.H. off the bypass machine. N.H. was subsequently weaned off the pressors and
the IABP and she was extubated one day post-operatively. N.H. had paroxysms of atrial fibrillation post-operatively and was discharged on March 27, 2014.

11. The standard of care requires a physician to perform a left heart catheterization and left ventriculogram for proper indications. Respondent deviated from this standard of care by performing a left heart catheterization and left ventriculogram on N.H. without proper indications.

12. Actual harm occurred in that the left ventricle was perforated which resulted in a pericardial effusion.

Patient R.W.

13. R.W., a 56 year-old male, presented on May 30, 2014 with acute onset chest pain. Respondent discovered that the left anterior descending ("LAD") and right coronary artery ("RCA") had significant stenosis. Respondent first intervened upon the LAD with a stent, but found the proximal edge had "haziness" so he did not intervene further. Respondent then focused on the RCA. The first stent was deployed but had a dissection for which Respondent deployed multiple other stents to correct. Brisk flow in all coronaries was reported at the conclusion of these procedures.

14. R.W. experienced a sudden thrombosis of the RCA two days later. Respondent placed 3.5 diameter stents and used 2.0 and 2.5 mm balloons to reopen the RCA. R.W. also developed cardiogenic shock and acute respiratory failure requiring emergency intubation, which was described as traumatic, with probable aspiration. R.W. was on pressors and an IABP was placed.

15. On June 2, 2014, R.W. was noted to be improving with decreased dependence on pressors. The IABP was removed the following day, but R.W. became progressively agitated and experienced increased ST changes. On June 5, 2014, R.W. became hypoxic with ST elevation and was taken back to the catheterization lab where it was determined that the RCA was thrombosed. Respondent performed balloon angioplasty on the RCA during which a perforation of the posterior descending ("PDA")
branch occurred. Respondent made several attempts to stop the bleeding, including prolonged balloon inflations, which failed, and an attempt to completely occlude the PDA branch by placing a covered stent. The stent could not be placed or withdrawn, and was deployed more proximally. A wire was left in the mid-RCA which was ultimately coiled by an interventional radiologist due to ongoing bleeding. Respondent noted a pericardial effusion which did not demonstrate tamponade and did not require pericardiocentesis.

16. Over the next several days, R.W. continued to experience worsening abdominal distension and renal function, increasing size of the right ventricle with decreased function and blood pressure, episodes of bradycardia, mottling of the lower extremities, liver congestion and renal insufficiency. On June 8, 2014, the IABP was removed. On June 10, 2014, R.W. went into multi-organ system failure. The decision was made to make R.W. comfortable. R.W. had runs of ventricular arrhythmias and passed away that evening.

17. The OMC found that while there was no single defined event in Respondent’s treatment of R.W. that would be considered a deviation from the standard of care, there were several areas of concern regarding Respondent’s continued treatment of R.W.: First, regarding the initial procedure when Respondent stopped the LAD intervention, it would have been a better course for Respondent to investigate and/or fix the LAD dissection; the second ventriculogram on the RCA may not have been necessary; the technical problems Respondent experienced during the final ventriculogram and the justification for the procedure were not adequately documented; and, Respondent did not document any discussion about the possible management of multiple episodes of bradycardia and high degree AV block without a pacemaker.

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.").

c. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(II)("Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is placed on Probation with the following terms and conditions:

   a. Practice Restriction

      Respondent is prohibited from performing interventional cardiology until such time as he petitions the Board to lift the Probation and Practice Restriction and receives permission from the Board to resume the practice of interventional cardiology. Respondent shall submit quarterly reports to the Board regarding his compliance with the Practice Restriction. Additionally, the Board may request additional information from Respondent to monitor his compliance with the terms of Probation.

   b. Obey All Laws

      Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders

   c. Tolling

      In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of
d. Lifting of Probation/Practice Restriction

In the event Respondent wishes to resume the practice of interventional cardiology, he may petition the Board, in writing, to lift the Probation and Practice Restriction. Respondent's petition to lift the Probation and Practice Restriction will be placed on the next pending Board agenda, provided a complete submission is received by Board staff no less than 14 days prior to the Board meeting. Respondent's petition must demonstrate his ability to safely perform interventional cardiology. Prior to submitting his petition, Respondent shall complete training in interventional cardiology that is pre-approved by the Board or its staff. Respondent shall provide proof to the Board of his successful completion of the training. The Board has the sole discretion to determine whether Respondent can safely perform interventional cardiology or whether to take any other action that is consistent with its statutory and regulatory authority.

2. The Board retains jurisdiction and may initiate new action against Respondent based upon any violation of this Order. A.R.S. § 32-1401(27)(h).

DATED AND EFFECTIVE this 5th day of May, 2017.

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 any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

9. 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, prejudgment or other similar defense.
10. Any violation of this Order constitutes unprofessional conduct and may result in disciplinary action. A.R.S. §§ 32-1401(27)(t) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter.") and 32-1451.

11. Respondent has read and understands the conditions of probation.

[Signature]

(Edward Ha, M.D.)

DATED: April 20, 2017

EXECUTED COPY of the foregoing mailed this 5th day of May, 2017 to:

Edward J. Ha, M.D.
Address of Record

ORIGINAL of the foregoing filed this 5th day of May, 2017 with:

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

Board staff