BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MICHAEL S. MCGRATH, M.D.** Holder of License No. 51004 For the Practice of Allopathic Medicine In the State of Arizona.	**Case No. MD-17-0084A** **ORDER FOR LETTER OF REPRIMAND AND PRACTICE RESTRICTION; AND CONSENT TO THE SAME**

Michael S. McGrath, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for a Letter of Reprimand 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 51004 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-17-0084A after receiving notification from the National Practitioner's Data Bank stating that Respondent's clinical privileges at a Hospital had been summarily suspended. The Board also received notification from a second Hospital stating that Respondent had voluntarily refrained from exercising his privileges pending a review into his practices.

4. Board staff obtained three patient charts from each Hospital for Medical Consultant ("MC") review.

Patient SW

5. This is a 62 year-old male with advanced degenerative osteoarthritis of the left him. Respondent performed an uncemented left total hip replacement utilizing an anterior approach. The anesthesiologist record indicates the procedure took 3½ hours.

6. The standard of care requires a physician to acquaint the operating room staff with the planned procedure prior to its onset, especially in such instances where the staff had not previously performed an anterior hip replacement. Respondent deviated from the standard of care in the case of patient SW by failing to acquaint the operating room staff with the planned procedure prior to its onset.

7. There was the potential for patient harm in the case of SW in that Respondent took more than twice as long to perform an uncomplicated uncemented total hip arthroplasty performed through an anterior approach, which should have taken an actual operating time of up to one hour and thirty minutes.

Patient SH

8. This 50 year-old woman had a torn acetabular labrum and a completely avulsed and retracted gluteus medius tendon. Respondent performed an arthroscopic repair of the retracted torn gluteus medius tendon and the procedure and the procedure took seven hours to complete. Respondent chose not to convert the procedure from arthroscopic to an open procedure.

9. The standard of care requires a physician to recognize that his persistence in attempting an arthroscopic repair of an avulsed gluteus medius tendon is not in the patient's best medical interest. Respondent deviated from the standard of care in the case of patient SH by failing to recognize that his persistence in attempting an arthroscopic repair of an avulsed gluteus medius tendon was not in the patient's best medical interest.

10. There was the potential for patient harm in the case of SH in that the markedly prolonged anesthesia time could have led to metabolic and physiologic complications, and that was an increased risk for postoperative infection.

Patient TE

11. This 340 lb., 61 year-old man with a body mass index of 44.4 had degenerative arthritis of the left hip. Respondent performed an elective left total hip arthroplasty utilizing an anterior approach using a 4-inch surgical incision. The procedure took 9½ hours to complete. During the procedure, TE sustained a displaced fracture of the lesser trochanter, which is a known potential complication of the procedure. Respondent did not have all of the instrumentation on hand to repair the fracture, and there was an approximately 3 hour delay while the instruments were brought in, washed and sterilized for use. Respondent's operative note does not include any mention that there was a long delay while instruments were procured from outside of the hospital. Respondent's operative report documented that the operation was one continuous event, with Respondent noting that the lesser trochanter had fractured and displaced, that a long modular stem would be needed to bypass the fracture, and that the fracture was reamed up to a 15 mm reamer.

12. The standard of care requires a physician to perform proper preoperative planning, which would reveal that a surgical approach other than a direct anterior incision might have been a better choice in a morbidly obese male with a BMI of 44.4 with degenerative arthritis of the left hip, and should result in the recognition that a longer anterior incision would be necessary in order to have proper exposure of the hip joint and sufficient room for manipulation of the hip in such an obese patient. Respondent deviated from the standard of care in the case of patient TE by attempting to perform a total hip arthroplasty on a morbidly obese male through a 4 inch incision and by failing to make certain that the hospital had available the various types of instruments that might be required in the surgical treatment of the types of complications generally associated with an anterior approach.

13. Patient TE experienced actual harm in that he sustained a displaced fracture of the lesser trochanter during the performance of the total hip arthroplasty through an anterior approach. In addition, TE sustained a left peroneal nerve palsy with left foot drop and anesthesia about the left foot and ankle as well as along the left leg. He also had evidence of hypovolemic shock and acute kidney injury as result of the excessively long operating time.

Patient NC

14. This 24 year-old male patient was admitted to the Hospital for removal of screws from his right femur, placed six months earlier during a repair of a fracture to the right femoral shaft by insertion of retrograde femoral intramedullary rod with two interlocking screws. X-rays showed that the fracture had healed, but NC was experiencing pain and snapping of the iliotibial band overlying the screw heads.

15. Respondent performed outpatient surgery to remove the screws under local anesthesia accompanied by monitored anesthetic sedation and with fluoroscopic control because the patient had not been fasting ("NPO"). The procedure took an hour and 15 minutes and included an intraoperative x-ray to verify location of the screws.

16. The standard of care for performing a simple hardware removal for a patient who had not been fully NPO requires a physician to postpone the procedure until it could be done under general anesthesia, and to enlist the services of another orthopedic surgeon to assist. Respondent deviated from the standard of care in the case of patient NC by failing to postpone the procedure or to enlist the assistance of another orthopedic surgeon when he discovered that the procedure would have to be performed under local anesthesia.

17. There was the potential for patient harm in the case of patient NC in that the procedure should have been completed in approximately half the time of Respondent's surgery and the intraoperative x-ray was unnecessary.

Patient RP

18. This 47 year-old woman of relatively thin body habitus, had a tear of the right hip acetabular labrum along with hypertrophic bony spurring which had apparently been treated unsuccessfully by a right hip arthroscopic procedure a year earlier. Respondent performed a right hip arthroscopy, debridement and repair of the labral tear, and debridement of several intra-articular bony spurs. Respondent took six hours to perform the actual arthroscopic procedure, including one hour and ten minutes for him to have the patient positioned, prepped, and draped prior to the start of the procedure.

19. The standard of care requires a physician to enlist the services of another orthopedic surgeon who has had operative experience in the techniques involved in the planned procedure to assist during the surgery. Respondent deviated from the standard of care in the case of patient RP by failing to recognize preoperatively that his surgical experience in the performance of the procedure was apparently minimal and that he needed the services of a second orthopedic surgeon, who had operative experience and training in the technique, to act as his surgical assistant.

20. There was the potential for patient harm in the case of patient RP in that the markedly prolonged anesthesia time could have led to metabolic and physiologic complications and made postoperative infection more likely.

Patient DB

21. This 79 year-old female with a history of multiple medical problems including osteopenia and obesity, was noted to be having severe pain despite undergoing more conservative treatments for her condition, including hip injections, physical therapy,

medication management and activity modification. Respondent performed a left hip total arthroplasty via an anterior approach with a four inch incision. Subsequently, a postoperative x-ray showed that there was a non-displaced femoral fracture beginning immediately adjacent to, and extending inferiorly from the tip of, the femoral component. When Respondent re-operated on the patient later that night, he found that the fracture extended proximally to the greater trochanter which was partially displaced.

22. The standard of care for the performance of a left hip total arthroplasty via an anterior approach in a morbidly obese, elderly osteopenic female patient with a high BMI requires a physician to recognize preoperatively that a longer incision would be required in order to obtain good exposure without applying excessive force and/or stress on the bony and soft tissue structures during the procedure, and to obtain additional images in the event of a post-procedure fracture to clarify the precise nature and extent of the fracture. Respondent deviated from the standard of care in the case of patient DB by attempting an anterior approach total hip arthroplasty through a 4 inch incision on an obese osteopenic patient, and by failing to obtain additional images when notified of the post-procedure fracture, which would have clarified the precise nature and extent of the fracture.

23. DB experienced actual harm in that she experienced a femoral fracture extending proximally to the greater trochanter which was partially displaced.

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)(e)("Failing or refusing to maintain adequate records on a patient.").

c. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(r)("Committing 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.

2. Respondent is placed on a Practice Restriction for a minimum period of three years as follows:

a. Practice Restriction

Respondent's license to practice medicine in the State of Arizona is restricted in that he shall not engage in the practice of orthopedic surgical procedures during the effective period of this Order.[1]

In order to ensure compliance with the terms of this Practice Restriction, Board staff or its agents may conduct periodic chart reviews or obtain written declarations from Respondent regarding compliance with this Order, at the discretion of Board staff. Respondent shall bear all costs associated with any chart reviews.

[1] This Practice Restriction does not prohibit non-surgical orthopedic examinations not requiring an incision using instruments.

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. Modification/Termination

This Order shall not be modified or terminated except upon Respondent's affirmative request. Respondent must submit a written request to the Board for termination from or modification of the terms of this Order. Respondent's request for termination or modification will be placed on the next pending Board agenda, provided a complete submission is received by Board staff no less than 30 days prior to the Board meeting.

Respondent may request modification of this Order if necessary to allow him to engage in an education or residency training program. The Board has the sole discretion to determine whether a modification is appropriate based on the information provided by Respondent and the program to which he has applied.

Any request for termination must provide the Board with evidence establishing that he has successfully satisfied all of the terms and conditions of this Order and is safe to resume engaging in the practice of orthopedic surgery.

The Board has the sole discretion to determine whether all of the terms and conditions of this Order have been met or whether to take any other action that is consistent with its statutory and regulatory authority, including continuing or modifying this order, or ordering any combinations of evaluations or examinations the Board determines is appropriate based on the facts and evidence available to the Board at the time of the request. The Board may require Respondent to engage in additional education and/or remediation including practice monitoring, chart reviews and/or requiring Respondent to

utilize a proctor for a period of time prior to returning to the unrestricted practice of orthopedic surgery in the State of Arizona.

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

DATED AND EFFECTIVE this 14th day of June, 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 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)(s) ("[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 acknowledges that, pursuant to A.R.S. § 32-2501(16), he cannot act as a supervising physician for a physician assistant while his license is restricted.

12. ***Respondent has read and understands the conditions of this Order.***

DATED: 5/25/18

MICHAEL S. MCGRATH, M.D.

EXECUTED COPY of the foregoing mailed this 10th day of June, 2018 to:

Calvin Raup
Calvin L. Raup, PLLC
335 E Palm Lane
Phoenix, AZ 85004
Attorney for Respondent

ORIGINAL of the foregoing filed this 16th day of June, 2018 with:

Arizona Medical Board
1740 West Adams, Suite 4000
Phoenix, Arizona 85007

Mary Bailey
Board Staff