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<tr><td>STATE OF COLORADO
COLORADO MEDICAL BOARD

HEARINGS PANEL A

1560 Broadway, Suite 1350
Denver, CO 80202</td><td rowspan="2">▲ COURT USE ONLY ▲

CASE NUMBER:
ME 2012-0002</td></tr>
<tr><td>IN THE MATTER OF DISCIPLINARY PROCEEDINGS REGARDING THE LICENSE TO PRACTICE MEDICINE IN THE STATE OF COLORADO OF JOSE SALVADOR CRUZ-MARTINEZ, M.D., LICENSE NO. 23403</td></tr>
<tr><td colspan="2">FINAL BOARD ORDER</td></tr>
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THIS MATTER comes before Hearings Panel A on the parties' exceptions to Administrative Law Judge Matthew E. Norwood's January 16, 2013 initial decision in the above captioned matter. Having reviewed the initial decision, exceptions, and administrative record; having heard oral argument by the parties; and being fully informed in the premises, the Board now enters this final order.

PROCEDURAL BACKGROUND

Jose Salvador Cruz-Martinez, "Respondent," is a psychiatrist, medical license number 23403. This case concerns Respondent's treatment of a developmentally disabled young man at Parkview Medical Center ("Parkview") in Pueblo, Colorado. This young man, "the Patient," died while in the Respondent's care during October of 2007.

A hearing was held before the ALJ on December 3-6, 2012. On January 16, 2013, the ALJ issued the initial decision that is the subject of this final order. The ALJ found that Respondent's treatment of the Patient failed to meet generally accepted standards of medical practice and that he engaged in unprofessional conduct pursuant to C.R.S. § 12-36-117(1)(p) with respect to the following aspects of the Patient's care:

1. Benzodiazepine withdrawal;
2. Extrapyramidal side effects;
3. Dehydration;
4. Seizures;
5. High sodium levels; and
6. Neuroleptic malignant syndrome.

The ALJ ordered that Respondent's license to practice medicine be revoked.

On March 18, 2013, both parties filed exceptions to the ALJ's initial decision. Oral arguments were held before Hearings Panel A on May 15, 2013.

STANDARD OF REVIEW

"As a state agency with statewide territorial jurisdiction, the Board's actions are governed by the State Administrative Procedure Act, sections 24-4-101 to -108, 10A C.R.S. ...." *State Bd. Of Med. Exam'rs v. McCroskey*, 880 P.2d 1188, 1193 (Colo. 1994). Section 24-4-105(15)(b) of the Act provides the standard under which the Board reviews the initial decision:

> The findings of evidentiary fact, as distinguished from ultimate conclusions of fact, made by the administrative law judge or the hearing officer shall not be set aside by the agency on review of the initial decision unless such findings of evidentiary fact are contrary to the weight of the evidence.

"As this section makes clear, the Board's ability to review and to set aside an ALJ's finding turns on whether the finding is one of 'evidentiary' or 'ultimate' fact." *McCroskey*, 880 P.2d at 1193.

"The distinction between evidentiary facts and ultimate conclusions of fact is not always clear." *Id.* "In general, however, evidentiary facts are the detailed factual or historical findings upon which a legal determination rests." *Id.* "In contrast, findings of ultimate fact involve a conclusion of law, or at least a mixed question of law and fact, and settle the rights and liabilities of the parties." *Id.* "Unlike evidentiary facts, ultimate conclusions of fact usually are phrased in the language of the controlling statute or legal standard." *Id.*

"A finding of evidentiary fact cannot be set aside by the Board on review of an ALJ's decision unless the finding is contrary to the weight of the evidence in the record." *Id.* Determinations as to credibility may not be disturbed. *Samaritan Inst. v. Prince-Walker*, 883 P.2d 3, 10 (Colo. 1994). Additionally, it is the role of the ALJ, and not the Board, to resolve conflicts in evidence. *Board of Dental Examiners v. Micheli,* 928 P.2d 839, 841 (Colo. App. 1996).

"Although an ALJ's finding of evidentiary fact may not be altered by the Board if supported by the evidence, the Board is not precluded from drawing a different ultimate conclusion therefrom." *Colorado State Bd. Of Med. Examiners v. Hoffner*, 832 P.2d 1062, 1067 (Colo. App. 1992). The "Board can substitute its judgment for that of the ALJ with respect to an ultimate conclusion of fact ... so

long as the Board's finding has a reasonable basis in law and is supported by substantial evidence in the record." *McCroskey*, 880 P.2d at 1193 (citations omitted). "Substantial evidence is probative, credible, and competent evidence that warrants a reasonable belief in the existence of a fact without regard to contradictory evidence or inference." *Colorado State Bd. Of Med. Examiners v. Ogin*, 56 P.3d 1233, 1237 (Colo. App. 2002).

"The board is afforded great discretion in determining the appropriate sanction for unprofessional conduct, and its determination must be upheld on review unless it bears no relation to the conduct, is a gross abuse of discretion, or is manifestly excessive in relation to the needs of the public." *Id.* at 1240. "In this regard, a reviewing court may not substitute its judgment for that of the board as to what constitutes appropriate sanctions." *Id.*

FINDINGS OF EVIDENTIARY FACT

Background

1. The Respondent was licensed to practice medicine by the Board in 1980. The Respondent has completed a residency in psychiatry at the University of Nebraska but is not board certified. He does not currently have privileges at any hospital.

2. The Patient was male, born in October of 1982. In August of 2007 the Patient was 5'10" and 225 lbs. He was developmentally disabled with autism and

attention deficit hyperactivity disorder. He was at age three or four developmentally and knew about 60 words. He had a history of seizure disorder throughout his life.

3. On August 7, 2007, the Patient was placed at the Pueblo Regional Center ("PRC"). During his entire stay at PRC, the Patient received .5 mg. of benzodiazepine two times a day.

4. On October 27, 2007, the Patient flipped over a fence at PRC twice and landed on his head both times. He then ran across the street and had to be restrained. He would not calm down, an ambulance was called and he was taken to Parkview, a hospital in Pueblo, that same day.

5. As of October 27, 2007, the Patient was strong, in good physical condition, but overweight.

<u>October 27, 2007.</u>

6. At the Parkview emergency room the Patient was examined and treated by Dr. Robert MacDonald, IV, a Board-certified emergency medicine physician. At the time of admission his sodium level and other vital signs were within normal ranges and he was not demonstrating any seizure-like activity. However, the Patient had to be restrained and was sedated with the antipsychotic Haldol.

7. The Patient was later transferred to Parkview's psychiatric unit, 2 North. On the Patient's admission to the psychiatric unit, Respondent continued Haldol but discontinued benzodiazepines.

8. After admission, the Patient exhibited signs of benzodiazepine withdrawal. The Respondent did not seriously consider benzodiazepine withdrawal and did not make any related documentation.

9. Upon admission, Respondent also ordered that the Patient's vital signs be taken twice a day. The Patient's vital signs were charted only once on October 27.

October 28, 2007.

10. Entries on the Patient's chart:[1]

a. **6:20 a.m.**, by Thomas Cabral, RN: "Patient difficult to redirect most times. He was in his room drinking several glasses of water. We had to take the cup away because he kept filling it from the sink in his room and downing the water. ...."

b. **2:42 p.m.**, by Neva Deschner, Clinical Therapist: "Patient continues to exhibit seizure like activity; sometimes arching his back and becoming very stiff, turning almost purple in the face. Nursing noted some of the behavior may be related to psychoactive medications. ...."

c. **6:20 p.m.**, by Martha Perez, Clinical Therapist: "Patient refuses to respond to redirection and appears to get attention by standing up and then trying to fall to the ground. Patient did hold his breath several times and stiffen his body. ...."

11. The Patient's vital signs were only charted once on October 28.

October 29, 2007.

12. Entries on the Patient's chart:

a. **3:38 a.m.**, by Julianne White, RN: "Patient making classic signs of seizure activity. I.e.: clicking noises with his mouth, grinding of his

[1] All quotations from chart notes have medical abbreviations spelled out.

teeth, patient shaking head back and forth: Patient also making aimless movements of his extremities. Patient also does respond when staff says, "[patient's first name] stop" ... Noted patient's verbal noises become louder when staff making statement about his behaviors, actions, and verbal noises. Patient continues to be awake with said above noises, movements. Patient refuses to get onto the bed and continues to lie on the floor. ...."

b. **8:14 a.m.**, by Laura Chapman, RN: "Over last 24 hours: patient not eating much but is taking fluids fairly well. He is showing some seizure like activity (grunting noises, teeth grinding, some incontinence, stiffened muscles, hyperextended neck and back, aimless large muscle movements) breath holding, diaphoresis and self injury (biting his lip and finger). Sometimes able to be distracted from these behaviors, sometimes not. ... All of the above reported to Dr. Cruz via chart report."

c. **9:20 a.m.**, by Respondent: "Patient continues displaying psychosomatic symptoms in order to get attention from staff. Nevertheless, pseudoseizures are mingled with perhaps mixed partial seizure activity but we been seeing patient responding to distraction and some of the symptoms subsided when pop drinks or fluids are given to him. He will continue on close medical observation."

13. As of October 29, 2007, Respondent did not document his thinking about extrapyramidal side effects and was not thinking about these conditions.

14. As of October 29, 2007, the Respondent did not consider that the Patient was suffering seizures in a serious way and he did not document any such consideration, despite his 9:20 a.m. entry on the Patient's chart.

15. The psychiatric unit was not a safe place to treat a patient suffering from seizures, who could aspirate stomach contents and suffocate.

16. The Patient's vital signs were not charted on October 29.

<u>October 30, 2007.</u>

17. At **7:30 a.m.**, the Patient had a fever of 101.6 degrees Fahrenheit and a low pulse of 54. Nurse Chapman contacted the hospitalist to notify her of the change in temperature to 101.6 degrees because treatment for this falls into the medical side of patient care on the psychiatric unit.

18. At **8:35 a.m.**, Respondent was physically present at Parkview and had access to the information concerning the 101.6 degree fever. He ordered the discontinuation of Haldol and the giving of Cogentin for extra pyramidal symptoms.

19. At **9:10 a.m.**, Joanne Smiley, a nurse practitioner, ordered "push fluids," indicating that she was concerned about dehydration.

20. At **4:00 p.m.**, the Patient had a fever of 99.7 degrees despite receiving Tylenol.

21. At some time prior to **6:05 p.m.**, Respondent had spoken to the patient's parents. The patient's father is an orthopedic surgeon. The patient's father asked the Respondent about neuroleptic malignant syndrome (NMS). The Respondent told him that the nurses would look for rigidity.

a. NMS is an exceptionally rare condition, but potentially life-threatening reaction to the use of almost any of a group of antipsychotic drugs or major tranquilizers (neuroleptics).

b. The key symptoms of NMS are: 1) muscular rigidity after exposure to dopamine blocking agents, 2) fever, 3) altered mental status and 4) unstable vital signs. At this time, the Patient was displaying the following signs and symptoms: 1) muscular stiffness, 2) altered mental status, 3) he was intermittently tachycardic and bradycardic, 4) he was hypertensive, 5) he had an elevated respiration rate and 6) diaphoresis (sweating). The patient was also suffering from urinary incontinence.

c. The muscular rigidity in NMS can wax and wane, but can also become quite extreme to the point of "lead pipe rigidity." This describes muscles so stiff that a limb is like a lead pipe. At least some of the Patient's documented abnormal movements were extrapyramidal symptoms from his antipsychotic medications.

d. The muscular rigidity of a patient suffering NMS is severe and does not respond to Cogentin, but extrapyramidal symptoms do respond to Cogentin. The Patient's muscular rigidity positively responded when he was given Cogentin.

e. NMS causes muscle damage, which can be detected by the creatine kinase test.

f. NMS is a medical emergency and results in the death of 10-20% of the persons diagnosed with it. Early diagnosis is crucial.

22. The Respondent did not seriously consider NMS and did not order a creatine kinase test.

23. At **6:05 p.m.**, Respondent ordered by telephone an electrolyte panel and a complete blood count ("CBC").

24. At **7:04 p.m.**, the lab reported the results to Tom Cabral, RN. The results included a sodium level of 169 mmol/l. This is a dangerously high sodium level and is "hypernatremia." This high of a sodium level cannot be safely treated in a psychiatric unit. An ICU was the proper place for the Patient, where his cardiovascular and respiratory status could have been monitored, his airway protected, and he could have been rehydrated.

25. By **7:10 p.m.**, the high sodium level was communicated to the Respondent. In addition, the Patient's father called the Respondent at home

around the time of the sodium level of 169 mmol/l. to make sure there was some sort of communication and to establish a more reliable plan of care.

26. The Respondent did not treat the high sodium level as an emergency and did not contact another physician. Instead, Respondent told nurse Hannula to contact the "hospitalist," Nurse Smiley.

27. Nurse Hannula contacted Nurse Smiley per the Respondent's instructions and informed her of the test results. Nurse Smiley attempted to rehydrate the patient with intravenous fluid. The extent to which Nurse Smiley was supervised by a physician is not disclosed by the evidence.

28. The Respondent did not document any consideration of the possibility of dehydration.

<u>**October 31, 2007.**</u>

29. At **2:10 a.m.**, the Patient was not breathing and a "cor-zero" was called.

30. At **2:49 a.m.**, the Patient could not be revived and was pronounced dead. The Patient died from either dehydration and hypernatremia or NMS.

31. Over the course of his hospitalization at Parkview the Patient's cognitive functioning decreased as did his purposeful actions such as eating and drinking. He was agitated and engaged in self-injurious behavior. The Patient's presentation changed over the course of his hospitalization and different aspects of

his condition declared at different times. Almost all of the Patient's signs and symptoms could be attributed to multiple different medical conditions.

Expert Testimony

32. Claudia L. Clopton, M.D., presented expert opinion that Respondent's care of the Patient fell below the standard of care. Alan S. Fine, M.D., presented the expert opinion that Respondent's care of the Patient met the standard of care. Both Dr. Clopton and Dr. Fine are board certified psychiatrists. In weighing the testimony of the two experts, the ALJ found Dr. Clopton's more compelling.

Subsequent Discipline of Nurse Smiley

33. The Colorado Nursing Board has reviewed Nurse Smiley's care. It issued her a letter of admonition stating, in pertinent part: "your failure to realize how serious this situation was, delayed intervention by an appropriately skilled health care provider and may have compromised this patient's condition and outcome."

APPLICABLE LAW

Both parties question the standard of care applied by the ALJ. After reviewing the initial decision, the parties' exceptions, and the legal authority cited in the initial decision and exceptions, the Hearings Panel sets for the following law to be applied in determining the ultimate findings:

1. The Colorado legislature, through the Colorado Medical Practice Act, has granted the Hearing Panel authority to discipline medical licenses for a

practitioner's unprofessional conduct. C.R.S. § 12-36-118. The definition of unprofessional conduct includes any act or omission which fails to meet generally accepted standards of medical practice. C.R.S. § 12-36-117(1)(p).

2. Compliance with the generally accepted standards of medical practice requires a practitioner to exercise the same degree of knowledge, skill, and care as exercised by other physicians in the same field of medicine during the same time period in question. *State Bd. of Med. Exam'rs v. McCroskey*, 880 P.2d 1188, 1194 (Colo. 1994).

3. Stated differently, a practitioner's standard of care must be objectively reasonable in light of all the facts and circumstances. *Id.* at 1195. The accepted standard of medical practice is not determined by the customary or prevailing practice in a community or by what a respectable minority of physicians would do. *Id.*

4. Both parties agree that the Supreme Court's decision in *McCroskey* sets forth the applicable standard of care.

ULTIMATE FINDINGS

The ALJ found that Respondent violated the generally accepted standard of medical practice when he did not adequately: 1) monitor and treat benzodiazepine withdrawal; 2) consider extrapyramidal side effects, dehydration, seizures, and NMS; or 3) oversee the Patient's medical care, including treating the Patient's high sodium levels as an emergency and transferring the Patient to an ICU. The

Respondent challenges these findings. The determination of whether a practitioner met the generally accepted standard of medical practice is an ultimate finding. *State Bd. of Med. Exam'rs v. McCroskey*, 880 P.2d 1188, 1196 (Colo. 1994).

1. The Patient presented with various indications of withdrawal; dehydration, seizures, high sodium levels, and fever. All of these symptoms were red flags that the Patient required urgent medical assessment/evaluation as well as care not available on the psychiatric unit.

2. Based on a review of the entire record and the parties' exceptions, the Board finds that the Respondent violated the generally accepted standard of medical practice by not conducting appropriate testing, asking appropriate questions, monitoring his own orders for vital signs, and ensuring that the Patient was transferred to the ICU or another unit where appropriate medical attention was available.

3. The ultimate care of the Patient fell to the Respondent. Faced with the Patients' symptoms, it was below the generally accepted standard of medical practice for the Respondent to entrust the Patient's care to the hospitalist. If the Respondent was unsure of the specific medical attention required by the Patient, he should have either obtained additional physician input or transferred the Patient to a medical unit of higher intensity.

SANCTION

1. In determining the appropriate disciplinary action, the Hearings Panel must first consider sanctions that are necessary to protect the public. C.R.S. § 12-36-118(5)(g)(III). This is in accordance with the purpose of the Colorado Medical Practice Act to protect the citizens of Colorado from the unqualified and improper practice of the healing arts. C.R.S. § 12-36-102. The Panel may also consider Respondent's prior disciplinary record. C.R.S. § 12-36-118(5)(g)(V).

2. Any discipline must be in the form of a letter of admonition, probation, suspension for a definite or indefinite period, or revocation of Respondent's license to practice. C.R.S. § 12-36-118(5)(g)(III). The Hearings Panel is authorized to impose conditions on Respondent's practice, including: (a) taking courses of training or education as may be needed to correct deficiencies found in his practice; (b) review or supervision of Respondent's practice as may be necessary to determine the quality of his practice and to correct deficiencies therein; and (c) restrictions on the nature of Respondent's practice to assure that he does not practice beyond the limits of his capabilities. *Id.*

3. It is critically important for a doctor to recognize when a patient is in need of medical treatment, as was required by the Respondent here. Recognizing the need for such treatment is one of the primary responsibilities of a doctor, even if the doctor in question is not qualified to provide the treatment. Until such time as the Respondent is adequately trained to recognize when additional care is necessary, his license is suspended.

4. Respondent's license shall remain suspended pending review by the Center for Personalized Education for Physicians ("CPEP"), which shall set minimum education requirements that must be completed, known as the "CPEP Assessment". If Respondent is found to be substantially lacking in an area as demonstrated by the CPEP Assessment, that area must be satisfactorily addressed before Respondent may return to the probationary practice detailed below.

5. Upon completion of the CPEP Assessment and upon approval from the Board, the Respondent's license will be reinstated on a probationary basis for at least one year, but no more than eighteen months, for the purpose of correcting the educational needs determined by the CPEP Assessment.

6. During the one-year probationary period, the Respondent's practice must be overseen by a monitoring supervisor, nominated by CPEP and approved by the Board, who will report Respondent's progress to the Board on a monthly basis, due no later than 10 days after the end of each month.

7. Upon successful completion of the probationary period as determined by CPEP and the Board, and the submission of at least 12 progress reports evaluated as successful by the Board approved monitoring supervisor, the Respondent may petition the Board to have his Colorado medical license be reinstated, under the terms and conditions to be established by the Board.

THIS FINAL BOARD ORDER is hereby effective upon signature. Any party adversely affected or aggrieved by any agency action may commence an action for

judicial review before the Court of Appeals within forty-five (45) days after such action becomes effective. Reference Sections 24-4-106(11) and 12-36-119, C.R.S.

SO ORDERED this 11th day of July, 2013.

FOR THE COLORADO MEDICAL BOARD
HEARINGS PANEL A

Kyle Kittredge PA-C
Member

[signature] D.O.
Member

Lynn Parry MD
Member

Member

Member

Member