BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of
NATHAN R. BEGET, M.D.
Holder of License No. 40782
For the Practice of Allopathic Medicine
In the State of Arizona.

Case No. MD-15-1195A
ORDER FOR LETTER OF
REPRIMAND; AND CONSENT TO THE
SAME

Nathan R. Beget, 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 40782 for the practice of
allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-15-1195A after receiving notification
from a surgical facility stating that Respondent, an anesthesiologist, had his privileges
suspended after review of a patient care related event that occurred on August 25, 2015
involving patient C.C., a 52 year-old female who presented for an elective face and brow
lift.

4. Respondent induced anesthesia to C.C. at approximately 8:13 a.m. on the
morning of her surgery. When the surgeon began to inject Lidocaine around C.C.'s face,
which can be painful, Respondent began injecting propofol on a regular basis during the
local injection and supplemented it with fentanyl boluses. Based on C.C.'s medical
records, it appears that Respondent administered at least 200mg of propofol and 100mg of
fentanyl during this time.
5. During the first 2 – 3 hours of the surgery, C.C. was responding more than usual and Respondent administered regular boluses of propofol and fentanyl. Based on C.C.’s medical records, it appears that Respondent administered approximately 2000mg of propofol and 500mg of fentanyl during this time period.

6. Respondent noted in C.C.’s medical records that C.C. experienced short periods of apnea which caused the pulse oximetry readings to decrease and also lower than usual pulse oximetry readings after injecting propofol.

7. Respondent recognized that he was using significantly more propofol and fentanyl during the 2 – 3 hour time period after the surgery began. Because a portion of the procedure involved the use of an endoscope which is painful, Respondent requested the surgeon to inject C.C. with additional Lidocaine. C.C. continued to respond and reach for her face in response to the painful stimulus.

8. At approximately 11:30 a.m., C.C. unexpectedly and violently reached towards her face and nearly sat up. Respondent gave C.C. a 50mg dose of propofol; however, C.C.’s pulse oximetry readings began to fall and her heart rate dropped. C.C.’s color became blue around her mouth. Respondent placed a laryngeal mask airway, but C.C.’s pulse oximeter readings and heart rate continued to drop.

9. The surgery was halted and Respondent elected to intubate C.C. After intubation, a full code was called. C.C. was given atropine, an epinephrine IV and chest compressions. Respondent used a video laryngoscope to determine whether the endotracheal tube was properly positioned and realized that the intake tube was still connected to the nasal oxygen tubing and not the anesthesia circuit, which resulted in not getting a CO2 reading. After two rounds of chest compressions, C.C.’s heart rate started to increase. Respondent claims that C.C.’s heart rate and blood pressure returned to reassuring levels and that the whole episode transpired within approximately 3 – 5 minutes of coding.
10. The surgeon and Respondent agreed that C.C. would spend the night in the hospital, which Respondent believed was precautionary only. Respondent and the surgeon also discussed the options of whether C.C.'s surgery should be continued or the extensive excision closed or that C.C. should be transported to a higher level of care hospital. They elected to proceed with the surgery but not perform the endoscopic brow lift. At the same time, arrangements were made to transfer C.C. to a higher level of care hospital. The surgery took approximately 2 hours and 45 minutes to complete.

11. After C.C. was brought to the recovery room, her vital signs were stable with minimal chin lift required. After Respondent gave a report to the PACU staff, he went to participate in a short surgical case with the same surgeon. During the second surgery, the PACU nurses reported to Respondent that C.C. did not appear to be waking up from the anesthesia normally and needed a nasal airway because her breathing was obstructed without constant airlift. Respondent evaluated C.C. and concurred that her emergence was abnormal and she started to demonstrate seizure-like activity. Respondent inquired about the status of C.C.'s transport to the hospital and was informed that a transport team had not been called to the surgery center. Respondent immediately instructed the staff to call for transport.

12. Subsequent to C.C.'s transfer, Respondent received a call from the intensive care physician at the hospital who reported that C.C. had suffered profound brain damage with a very poor prognosis. The intensive care physician planned to institute immediate hypothermia therapy.

13. C.C. expired on September 3, 2015. The discharge diagnosis included diffuse anoxic encephalopathy related to the outpatient cardiac arrest; recurrent seizures related to global brain injury; cardiomyopathy ejection fraction 45-50% likely related to the cardiac arrest; and, abnormal troponin levels consistent with myocardial infarction.
14. The Board finds that the standard of care requires a physician to switch to another form of anesthesia when the original plan is not working and the patient continues to react to painful stimuli despite greater than normal amounts of propofol and fentanyl. The Board finds that Respondent deviated from this standard of care by failing to switch to another form of anesthesia when the original plan was not working and by administering increasing dosages of propofol and fentanyl when C.C. continued to respond to painful stimuli, leading to apnea, airway obstruction and hypoxia.

15. The Board finds that the standard of care requires a physician to send a patient who has had a code with chest compressions to a hospital with a higher level of care as soon as possible. The Board finds that Respondent deviated from this standard of care by failing to make arrangements immediately to transfer C.C. to the nearest hospital for a higher level of care.

16. The Board finds that the standard of care requires a physician to stay with a patient who has had a code and manage the transfer to a hospital to ensure that there is no miscommunication between the facilities. The Board finds that Respondent deviated from this standard of care by electing to participate in another surgery case instead of staying with C.C. in the recovery room to facilitate her transfer.

17. The Board finds that the standard of care requires the use of a disposable end tidal monitor CO2 detector to identify that an endotracheal tube is placed correctly in the trachea. The Board finds that Respondent deviated from this standard of care by failing to use a disposable end tidal CO2 device to determine proper endotracheal tube placement, which would have quickly determined if the initial intubation was in the trachea or the esophagus and could have prevented a delay in delivering oxygen to C.C.

18. The Board finds that actual patient harm was identified in that by Respondent persisting to do the case under MAC anesthesia and administering up to what appears to be 2000mg of propofol and 500 mg of fentanyl, C.C. became apneic, had airway
obstruction for a prolonged period and became hypoxic. Hypoxia caused C.C. to have a
code arrest, necessitating cardiac compressions.

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 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 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, prej udgment or other similar defense.

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

   [Signature]

   DATED: 3/29/2017

   NATHAN BEGET, M.D.
EXECUTED COPY of the foregoing mailed this 5th day of May, 2017 to:

Jim C. Goodwin
J. Goodwin Law, PLLC
1616 North Litchfield Road, Suite 140
Goodyear, AZ 85395
Attorney for Respondent

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

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

[Signature]
Board staff