James S. Hawkins, M.D., FAAOS

Arizona Spine Care - 5655 N. 4th Street, Phoenix AZ 82012

Date: September 6th, 2022

Arizona Medical Board

Re: [redacted]

Dear Board Members,

I have been requested to review the malpractice case of [redacted] versus Pitt and give my professional medical opinion. The case has brought onto Dr. Pitt involving several items of accusation regarding appropriate care of the patient/plaintiff and now likely under the reviewed by the Arizona Medical Board that wish to address. The accusations put forth by the plaintiff include: inappropriate surgery, to this point was the level of attempted fusion surgery at cervical two three already fused, the possibility of the experienced esophageal tear complication, Dr. Pitt handling of the complication in a timely and efficient manner and lasty the appropriateness of the case to be performed at a surgery center. These accusations stem from Dr. Pitt's surgery with [redacted] on August 5th, 2016.

First about my training and experience. I am a board certified, fellowship trained orthopedic spine surgeon practicing here in the valley for the past 17 years. I have cared for patients in my own private practice, Arizona Spine Care from 2005 to 2018 and went on to start and be the director for the spine program at the Phoenix VA Medical Center full time from 2016 to current. While at the VA I have expanded my teaching roles to include Associate Clinical Faculty, Mayo Clinic Scottsdale and Associate Clinical Faculty, University of Arizona Medical School. I have recently, joined OrthoArizona and am back in private practice.

My association with Dr. Duane Pitt is that of a spine surgeon colleague and investment partner. During my years in the valley, we have had the expected crossover of patients and conversations regarding care as happens from time to time and have always found Dr. Pitt to have sound surgical plans and provide caring and a complete care for his patients. Professionally, we are investment partners in the Minimally Invasive Spine Surgery Center of Paradise Valley, although due to my commitments at the VA, I have not operated at that surgery center since 2017.

The first question and a key point is the appropriateness of surgery for the fusion of C2-C3 for the patient. In reviewing the x-rays of 3/22/2016, I can see an arthritic C2-3 segment, with kyphotic deformity in a previously operated on, anteriorly and posteriorly, cervical spine. The facet joints are ankylosed primarily on the right but the joint space in each is still visualized. There is mild but incomplete anterior osteophyte noted at C2-3 contributed to the kyphotic position of the segment. The CT scan of 6/21/2016 is also reviewed by this physician and again does not show the fusion at C2-3 prior to Dr. Pitts surgery. Preoperative symptoms for this patient can be many given her previous surgeries, but if a main complaint could be attributed to the arthritic facet joints and kyphotic position of her cervical spine then this would coincide with the painful segment at C2-C3.

The next points involve the unfortunate esophageal tear. This is rare but well know potential complication of an anterior approach to the cervical spine with an occurrence of approximately .1 - .3 percent. If encountered, it is important to recognize the problem as soon as possible and act on it to minimize potential future complications. Dr. Pitt, thankfully noted the tear in the esophagus, repaired the tear, diverted any oral intake, sought appropriate consultation from an Ear Nose and Throat (ENT) specialist and transferred the patient to a higher level of care. These are the appropriate actions that a surgeon should do if they encounter such an event. One of my patients experienced a small esophageal tear in anterior approach to the cervical spine to remove a large osteophyte pressing on the esophagus several years ago and I approached the complication is the same fashion. My patient went on to do well but did require a diverting feeding tube for several weeks while the repair healed.

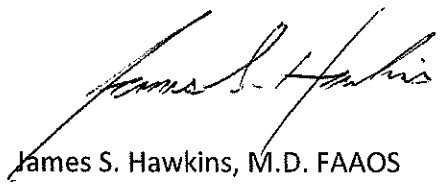
The last point of accusations involves the use of a surgery center for this spine surgery. Performing anterior cervical decompression and fusion surgeries in surgery centers has been done and evaluated extensively for the past 10 years. The primary reasons are to eschew potential complications and time constraints when performing these typical outpatient procedures in larger hospitals. For myself included, given the backup of the main OR at the VA over the past years I routinely take my single and even two level ACDF's to a surgery center as outpatient procedures. It is important that the surgery center performs these types of cases, the surgeon has the training and experience, and that there is main hospital that the patient can be transferred to if there is a need for admission. Using a surgery center is done to enhance patient care and improve patient experience. This case did have a higher potential to be more challenging with the previous surgeries in the same region, but it was not outside the standard of care or community practice.

In reviewing the case for the noted key questions these are my findings. I feel Dr. Pitt met the standards of care for this surgery. He had an extensive experience with and evaluation of the patient over the years and underwent an indicated surgery after a lengthy time but failed non

operative course. The patient was taken to surgery center for a case that was routinely done there and where Dr. Pitt had extensive experience. The unfortunate esophageal tear that was discovered during surgery was addressed immediately and appropriately at the time and then the patient transferred to a higher level of care.

Thank you for you time in reading this letter. I am available for any questions or further information as circumstances require.

Sincerely,



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