BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **WILLIAM M. JACOBSEN, M.D.** Holder of License No. 21620 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-22-0694A, MD-21-0984A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR LETTER OF REPRIMAND AND PROBATION**

The Arizona Medical Board ("Board") considered this matter at its public meeting on October 9, 2024. William B. Jacobsen, M.D. ("Respondent"), appeared before the Board for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order for Letter of Reprimand and Probation after due consideration of the facts and law applicable to this matter.

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 21620 for the practice of allopathic medicine in the State of Arizona.

MD-21-0984A

3. The Board initiated case number MD-21-0984A after receiving a complaint regarding Respondent's care and treatment of a 31 year-old female patient ("CC") alleging inadequate post-operative care and treatment, inappropriate placement of silicone implant(s) without consent, and failure to properly perform a breast augmentation and lift.

4. On March 26, 2021, CC presented to Respondent's office for a breast augmentation consultation. CC requested a D+ cup size. On examination, CC was noted to have breast ptosis with parenchymal involution. Respondent recommended a breast augmentation with vertical mastopexy. Respondent discussed the risks, alternatives, and

benefits of the vertical mastopexy. Instructions were given to CC on how to perform breast massage with the implants in place.

5. On May 27, 2021, Respondent performed a bilateral submuscular breast augmentation with saline implants, bilateral vertical mastopexy, and excision of bilateral benign nevi from the left dorsal hand and right face on CC at a Hospital. Prior to the procedure, Respondent obtained informed consent from CC using a consent document for saline filled implants. After closure of the breast, the right side appeared to be smaller and softer. The incision was opened and a defective valve was found. An equivalent size and shape saline implant was not available, so a 155 ml smooth Mentor silicone gel high-profile implant was placed.

6. On May 28, 2021, CC contacted Respondent's office to report pain and swelling in her right breast.

7. On June 2, 2021, Respondent informed CC that an emergent evacuation of an apparent post-operative hematoma was necessary. CC presented to the Hospital and on examination, CC had a very high painful right breast with very little bruising, and the left breast appeared to be completely deflated. Respondent's operative report noted that CC underwent an evacuation of a 20ml hematoma of the left breast, removal of a ruptured saline Mentor implant in her left breast, and reimplantation with a Mentor high-profile smooth 450 mL silicone gel breast implant. Additionally, Respondent performed an evacuation of a 40 ml right breast hematoma, removal of the intact right breast Mentor implant, and replacement with a Mentor high-profile smooth 450 mL silicone gel breast implant.

8. On June 8, 2021, CC presented to Respondent's office for post-operative follow-up. Respondent noted a contracture of CC's pectoralis on the right side.

9. During the course of the Board's investigation, Respondent provided a written narrative describing his informed consent process and a copy of the informed consent document utilized for silicone gel implants.

10. Respondent did not provide the silicone gel informed consent document to CC prior to either the May 27 or June 2 procedures

11. The standard of care requires a physician to obtain adequate informed consent prior to surgery. Respondent deviated from this standard of care by failing to obtain appropriate informed consent for gel implants prior to implantation during CC's second surgery. The Medical Consultant ("MC") who reviewed Respondent's care and treatment of CC noted that it was unclear from the documentation whether there was an intraoperative rupture to the implant or whether the implant was defective. The MC observed that the use of a gel implant could have been avoided if a backup saline implant was available.

12. Actual patient harm was identified in that the patient's breast augmentation was performed with one saline breast implant and one silicone gel implant.

MD-22-0694A

13. The Board initiated case number MD-22-0694A after receiving a complaint regarding Dr. Jacobsen's care and treatment of a 58 year-old female patient ("LC") alleging failure to properly perform breast reconstruction and mastectomy resulting in multiple subsequent infections and surgeries; failure to advise of risks of procedures; failure to obtain informed consent; inadequate post-operative care, treatment, and communication; inadequate post procedure instructions, and false representation of board certification status.

14. On April 13, 2021, LC presented to Respondent's office for consultation. LC reported that a needle biopsy had identified adenocarcinoma in her left breast. An MRI

showed a second lesion in the left breast. LC was aware that a lumpectomy was a potential option but she wanted to have bilateral mastectomies with immediate reconstruction, rather than a delayed reconstruction. LC had implants in place from a prior breast augmentation.

15. On May 12, 2021, Respondent performed a bilateral total mastectomy with an immediate non-nipple sparing mastectomy on LC.

16. On May 20, 2021, LC contacted Respondents office reporting that the area around her left arm was tingling, warm, and swollen. Respondent reviewed photos sent by LC and noted some fluid under the arm, a lymphocele.

17. On May 21, 2021, LC presented to Respondent's office for drainage of the lymphocele and Respondent drained an additional 20ml of fluid.

18. On June 1, 2021, LC presented to Respondent's office for follow-up. Respondent placed 120ml of saline into the expander on the left and drained an 80ml periprosthetic seroma.

19. On June 7, 2021, LC contacted Respondent via text and reported that her left breast incision had opened and that she was bleeding. Respondent scheduled LC for surgery the same day. Respondent excised the injured skin edges, removed the expander, and replaced it with a new expander.

20. On June 15, 2021, LC presented to Respondent's office for follow-up. Respondent drained a small amount of seromatous fluid and prescribed a course of antibiotics.

21. On July 6, July 13, and July 23, 2021, Respondent injected 120ml of saline into the expander.

22. On July 25, 2021, LC's husband contacted Respondent reporting that her incision had opened again. He described that pus was leaking from the open incision. He

related that the breast was hot; and that LC had a fever. Respondent prescribed a course of antibiotics and scheduled LC for surgery the next day.

23. On July 26, 2021, Respondent performed a removal of the left breast implant with irrigation and debridement. Respondent noted that the incision was intact; however, the issue was quite thin and effaced. Cultures were sent for analysis and showed positive for Methicillin Resistant Staph Aureus ("MRSA") with heavy growth. Respondent ordered IV Vancomycin and Levaquin. LC stayed in a Recovery Care Center for three days.

24. On July 28, 2021, Respondent performed the placement of an implant in the left breast. Respondent placed 1000mg of vancomycin in the pocket before implant placement.

25. On July 30, 2021, LC presented to Respondent's office for follow-up. Respondent prescribed Rifampin, Clindamycin, and Bactrim.

26. On August 4, 2021, LC texted Respondent to advise him that she was having diarrhea and was sick to her stomach. Respondent noted that LC had no signs or symptoms consistent with colitis.

27. On August 6, 2021, LC presented to Respondent s office for follow-up. LC was concerned that she had a C. difficile infection. Respondent noted that LC's presentation was not consistent with a C. difficile infection.

28. On August 20, 2021, LC presented to Respondent's office for follow-up. Respondent removed the sutures. Respondent noted that LC's breasts looked symmetrical and well balanced for her body habitus. This was LC's last visit with Respondent.

29. Subsequently, LC sought care with a secondary surgeon to address complications of delayed wound healing and MRSA related surgical site infection of the left

breast. LC underwent a breast implant explantation on September 25, 2021, followed by reconstruction on March 10, 2022.

30. The standard of care requires a physician to wait a full three months after a periprosthetic infection and implant removal before proceeding with any revision surgeries in order to allow adequate time for healing. Respondent deviated from the standard of care by proceeding with an implant-based breast reconstruction revision in the presence of a periprosthetic infection.

31. The standard of care requires a physician to properly perform a mastectomy. Respondent deviated from the standard of care by improperly performing a bilateral mastectomy.

32. There was actual patient harm in that LC developed a MRSA related postoperative infection. There was potential for patient harm in that LC was at risk for a c difficile infection from antibiotic use.

33. During a Formal Interview on this matter, Respondent testified regarding his informed consent process and the May 27, 2021 procedure performed on CC. Respondent testified that normally he has backup implants available, but that he did not have one that day. Respondent testified that when he noticed the leak he had to decide whether to take out the leaking implant and stop the procedure, take out both implants and leave the patient without any augmentation or to utilize the silicone gel implant that was available. Respondent testified that he chose to utilize the silicone gel implant. Respondent recognized that it would have been ideal to discuss the intraoperative decision with CC's fiancé who was in the waiting room, but could not recall if he was aware that family was present with CC prior to the procedure. Respondent further testified that with regard to the second procedure, he should have changed the consent form for CC based on his preoperative evaluation of CC.

34. With regard to Patient LC, Respondent testified about his decision to perform both the reconstruction and mastectomy portions of the procedure, when he does not normally perform mastectomies in his practice. Respondent testified that he does perform mastectomies for non-cancer patients, and had previously performed mastectomies for cancer patients when he was practicing as a general surgeon. Respondent testified that it can be difficult for cancer patients who have implants at the time of diagnosis to find a surgeon to perform the procedure. Respondent testified that he referred LC to a general surgeon to obtain coordination of care, but the surgeon wanted to only provide conservative care and LC was insistent on obtaining a mastectomy with reconstruction.

35. Respondent testified that he felt it best to perform a left axillary superficial lymphadenectomy rather than a sentinel node or complete axillary dissection because he was unsure that the lymph node could be identified adequately due to LC's previous augmentation. When asked about his decision to place tissue expanders on the left side during the initial procedure rather than a replacement implant, Respondent testified that there was not enough space on the left side, due to LC's lower pole cancer. Respondent stated that the lower and superior flaps were not adequate to give LC the same volume as her previous implants.

36. Respondent testified regarding his decision to replace the implant two days after the removal and debridement on July 26, 2021, Respondent testified that his approach was non-standard but acceptable. Respondent testified that he gave LC the option to use a tissue expander for a period of time, and that she chose to proceed with the replacement. Respondent stated that there is a trend towards salvaging infected prostheses and that he has taken this approach as a general surgeon with other types of surgeries including aortografts. The Board's Chief Medical Consultant noted that this approach is more justifiable with a patient whose life is at risk from a bleeding major

vessel, but not with a patient like LC. In LC's case, the Chief Medical Consultant agreed with the MC's conclusion that this decision was a significant deviation from the standard of care.

37. When asked to explain why he did not evaluate LC for a c difficile infection on August 6, 2021, Respondent stated that he did not feel that she met the criteria for c difficile at the time.

38. During that same Formal Interview, Board members commented regarding Respondent's care of LC, and agreed that while an aortograft may need to be kept in place, the standard of care for a fragile patient with significant infection requires removal. Board members noted that Respondent's documentation did not reflect his rationale for the deviation or appropriate counseling to the patient.

39. Board members also commented that the consent issues for Patient CC were significant, in that CC signed a consent form for a saline implant, did not sign a consent form for silicone gel implants that were actually used, and the consent for the second procedure did not accurately reflect the procedure that was performed. Board members further commented that the records did not accurately reflect the discussion with Patient CC prior to the second procedure.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. 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.").

3. 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 Probation for a period of six months with the following terms and conditions:

a. Continuing Medical Education

Respondent shall within 6 months of the effective date of this Order obtain no less than 10 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in an intensive, in-person/virtual course regarding medical recordkeeping and no less than 6 hours of Board staff pre-approved Category I CME in the treatment of post-operative wound infection. Respondent shall within thirty days of the effective date of this Order submit his request for CME to the Board for pre-approval. Upon completion of the CME, Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure. The Probation shall terminate upon Respondent's proof of successful completion of the CME.

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.

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)

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he/she has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED AND EFFECTIVE this ____16th _____ day of ____December_____, 2024.

ARIZONA MEDICAL BOARD

By Patricia Mcsorley
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing
mailed this 16th day of December, 2024
to:

William M. Jacobsen, M.D.
Address of Record

ORIGINAL of the foregoing filed
this 16th day of December, 2024 with:

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

Michelle Robles
_____
Board staff