Medical Consultant Report and Summary

Re: [redacted] **M.D. (Case MD-09-**[redacted]
Date: May 24, 2009 **Medical Consultant:** [redacted]

1. **Detailed (Chronological) Analysis:** On Tuesday March 10, 2009, at 8:50 in the morning a ten year old female, JM, was brought by her mother to the [redacted] clinic in Queen Creek. JM was seen by [redacted], PA-C. JM was reported to have sustained an injury to her R leg/hip some three days prior. JM was experiencing more pain in the extremity and spiked a fever of 104F per mother's complaint (103F as noted in the record) the early morning prior to presenting. No other source of fever, outside the painful extremity, is suggested by either the patient or the provider in her report. Mother reported that the area of concern was swollen to the size of a fist and extremely hot to the touch. PA [redacted] took a history which was consistent with the above events. PA [redacted] performed a physical exam, which revealed no source other than the leg/groin for JM's fever. JM's vital signs were noted as follows: Temperature (tympanic) 100.4, blood pressure 103/94, and a pulse of 146. The exam describes: **"*gait: affected by a leg limp, tenderness noted in the R groin, erythema and warmth along the medial superior right thigh.*"** A complete blood count and a sedimentation rate were ordered, with the results expected in about one working day. PA [redacted] working differential included: ***"unspecified infective arthritis, pelvic area and thigh."*** The discharge diagnosis was: ***"leg pain and fever unspecified."*** JM was discharged home with prescriptions of Keflex (antibiotic) and Tylenol with codeine (narcotic pain preparation). There was no documentation as to whether the PA discussed this case with the physician that was in attendance.

   JM's mother called the clinic the next day and again several times in the ensuing week to check on laboratory data, which was unavailable. No return calls were made to JM and her mother. JM again spiked a fever and was having more complaints with her leg on Thursday March 19. As she was traveling, JM was brought to [redacted] Hospital in Oklahoma. There, the diagnosis of cutaneous abscess was made and the lesion was incised and drained. The wound grew Streptococcal Pyogens and a prescription for Bactim was issued. After using a second Bactrim prescription by her primary physician, the infection seems to have resolved. No long term sequela has been reported by this series of events.

   On March 28, **18 days after having her blood drawn at** [redacted] JM's mother received a call telling her that JM's white count was extremely elevated with a white count of 29,000 and 89% polymorphic neutrophils.

   Dr. [redacted] **is the supervising physician for PA** [redacted]**. As well he is the medical director for the** [redacted] **clinic.**

   In his response to the Board, Dr. [redacted] states the following: ***"After reviewing the chart I can state that the patient did not present with an obvious abscess or source of infection."***

   He further states: "***Even in retrospect, based on the initial patient presentation of March 10, 2009 I doubt a different approach taken by the Physicians Assistant would have resulted in a significantly different outcome.***

2. **Proposed Standard(s) of Care:** The standard of care in running a medical practice is to have in place the necessary means for the prompt reporting of critically abnormal lab values. Further, the standard when utilizing a PA is to have in place a system that will direct the more potentially unstable patients to the care of the physician on duty. As well, as a supervising physician, Dr. [redacted] is entrusted with adequate chart review and supervision of the PA in his charge.

3. **Deviation from the Standard of Care:** Dr [redacted] deviated from the standard by not having an adequate system in place to follow up on critical lab values. Further, he is below the standard in his chart review of the PA in his charge. It was clear to JM's mother, PA [redacted] (who examined the patient) and this OMC that the source of JM's infection was her groin/leg area.. How Dr. [redacted] can review this same set of facts and find: ***"After reviewing the chart I can state that the patient did not present with an obvious abscess or source of infection."*** This analysis seems questionable at best. Further, Dr [redacted] is below the standard in not having in place a system which directs the more critical patients to the physician on duty, rather than the PA.

4. **Actual Harm Identified:** The actual harm was in the delay in reviewing the critically high white count in JM. This most likely led to a worsening of her cutanous abscess.

5. **Potential Harm Identified:** The potential harm in this case is very worrisome to this OMC. In this particular case, a missed septic joint or necrotizing fasciitis would have potential life long consequences, including possible amputation and even end-organ damage and death. In a broader sense, Dr. [redacted] lack of insight into the severity of the clinical picture, even in retrospect, is frankly, disquieting at best. The constellation of high fever (103-104F), limp, erythema and tenderness in the groin, severely elevated pulse and white count should serve as an alarm for immediate intervention.

6. **Aggravating Factor(s):** As noted above, Dr. [redacted] lack of insight into the potential seriousness of this presentation, even retrospectively, is very aggravating. As well, the apparent lack of any meaningful follow-up with this patient after numerous phone calls deserves mention here. Not recognizing and reporting a critically high white count **for 18 days** stands as an aggravating factor.

7. **Mitigating Factor(s):** Dr. [redacted] spends a good deal of time in his response elucidating the fact that there was a systems change occurring in his practice with the use of electronic medical records. He feels that this was the source of the delay in obtaining timely lab values. As well, in using his PA, the doctor never met or examined JM on her clinic visit.

8. **Consultant's Summary: Dr. [redacted] was below standard in not assuring that critical lab values were reported in a timely fashion. He has further fallen below the standard by not recognizing the potential critical nature of the presentation of JM and in not adequately supervising the PA after the fact.**

9. **Records Reviewed:**

[redacted] clinic record	3/10/2009
JM Complaint	4/1/2009
Board Notice	4/6/2009
Dr. [redacted] response	4/16/2009
[redacted] Hospital records	3/19/2009 and 3/21/2009
Office visit [redacted] DO	4/10/2009

[redacted] May 24, 2009

Print Name Date