Before the
New Hampshire Board of Medicine
Concord, New Hampshire 03301

In The Matter Of: **Docket No.: 11-03**
W. Michael Todd, M.D.
License No.: 12360
(Adjudicatory/Disciplinary Proceeding)

FINAL DECISION AND ORDER

Before the New Hampshire Board of Medicine ("Board") is an adjudicatory/disciplinary proceeding in the matter of W. Michael Todd, M.D. ("Respondent" or "Dr. Todd").

Background Information:

In November 2009, the Board received a complaint alleging that the Respondent failed to treat F.M.'s major alcohol withdrawal when F.M. presented to the emergency room. On February 4, 2011, the Board issued a Notice of Hearing, scheduling a hearing for April 6, 2011. On April 14, 2011, the hearing was rescheduled to July 6, 2011. On June 20, the Notice of Hearing was amended to cite RSA 329:17 (b) and (c) rather than RSA 329:17 (c) and (d).

On Wednesday, July 6, 2011, at 1:00 p.m., the Board commenced with the adjudicatory/disciplinary hearing in the above captioned matter. Board members present[1] were:

Nick Perencevich, Physician Member, Presiding Officer
Robert Andelman, Physician Member, President
Louis Rosenthall, Physician Member
John Wheeler, Physician Member
Mark Sullivan, Physician Assistant Member
Gail Barba, Public Member
Edmund Waters, Jr., Public Member
Robert Cervenka, Physician Member

The prosecution was represented by Hearing Counsel Attorney Jason Reimers of the Administrative Prosecutions Unit ("APU") of the Office of the Attorney General and Jessie Maihos, law student, pursuant to Supreme Court Rule 36. The Respondent was represented by W. Kirk Abbott, Jr. of Sulloway & Hollis, PLLC.

[1] These same Board members also deliberated voted on this Final Decision and Order, except for Dr. Perencevich who was not present for the final vote.

Narrative Findings of Fact:

The following exhibits were introduced into evidence and accepted into the record:

- The Parties' Joint Medical Records Submission – Black binder
- Hearing Counsel's exhibits: 1, 3, 4, 5, 6[2].
- The Respondent's exhibits: A through E.

The parties also submitted written closing summation memoranda.

Mary Valvano, M.D., an ER physician from Concord Hospital, testified for the Hearing Counsel. Dr. Valvano is an expert in emergency medicine. The Board found Dr. Valvano to be direct, forthright and credible. The Board further found Dr. Valvano to be articulate, candid and persuasive.

Jeannine Zwoboda, Fred M.'s sister, also testified for the Hearing Counsel. The Board found Ms. Zwoboda articulate and credible.

The Respondent, W. Michael Todd, M.D., an ER physician from Catholic Medical Center ("CMC"); Theodore Benzer, M.D., an ER physician from Massachusetts General Hospital ("MGH"); and Mark Josephs, M.D., an ER physician from Exeter Hospital, testified for the Respondent. The Board found these physicians likewise to be direct, forthright and credible. Drs. Benzer and Jospephs are experts in emergency medicine.[3]

In light of the testimony and exhibits, the Board finds the following facts:

On or about August 14, 2009, Fred M. fell and broke his humerus (upper arm) bone and his arm was placed in a sling.[4] Fred M. was a veteran and on August 25 he went to the Manchester VA where the treating provider questioned the origin of the fall.[5] It appears that within the differential diagnosis the treating provider may have included that Fred M. fell as a result of a seizure and ordered some tests to determine whether the fall was the result of a seizure.[6] The treating provider

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[2] Hearing Counsel's exhibit 6 is the parties joint medical records submission.
[3] See Exhibit B (Josephs' CV); Exhibit C (Benzer's CV).
[4] Tr. 18; R. 2, 5, 16.
[5] Tr. 18; R. 2, 5. There was unreliable information that the fall was a result of a seizure. R. 2.
[6] Tr. 18-19, 142.

ordered a CT scan[7] of Fred M.; the August 26 CT scan results were negative.[8] The treating provider also ordered an EEG.[9]

It appears that the Manchester VA does not have the capability of performing an EEG at its Manchester facility,[10] so Fred M.'s EEG was scheduled for September 4, 2009 at the Jamaica Plains VA, located near Boston, Massachusetts.[11] Fred M. lived in Ossipee, New Hampshire without transportation.[12] The plan for September 4th was that the Daughters of American Veterans ("DAV") was going to pick Fred M. up at his home in Ossipee and drive him to the Manchester VA; then the Manchester VA would have transported Fred M. to the Jamaica Plains VA for the EEG.[13]

On the morning of September 4, 2009, when the DAV arrived at Fred M.'s house to fetch him, Fred M.'s friend told them that Fred M. had had a seizure[14] that morning.[15] The DAV proceeded to drive Fred M. to the Manchester VA urgent care.[16] Fred M. arrived at the Manchester VA at 7:54 a.m. and at 8:25 Fred M. had another seizure.[17] This seizure was witnessed by medical personnel.[18],[19] The VA medical personnel administered 5 milligrams of Valium for the seizure.[20] Shortly thereafter, at 8:59 a.m. the VA medical personnel administered an additional 2 milligrams of Valium for Fred M.'s agitation/restlessness.[21]

From the Manchester VA Urgent Care, Fred M. was transported to Catholic Medical Center ("CMC") in Manchester.[22] Despite the 7 milligrams of Valium in his system, Fred M. arrived at CMC

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[7] Tr. 16-19. A CT (computed tomography) scan is a test that makes detailed pictures of the structures inside one's body with the use of x-rays.
[8] Tr. 18.
[9] An EEG (electroencephalogram) is a test that measures the electrical activity of one's brain. Tr. 16.
[10] R. 36.
[11] Tr. 16.
[12] Tr. 16-20, 170-72.
[13] Tr. 19-20.
[14] 1st seizure of the day.
[15] Tr. 19; R. 2.
[16] Tr. 19-20.
[17] Tr. 20-21; R. 2-3, 36.
[18] R. 2-3. This seizure was documented as a grand mal seizure in the medical record. R. 2-3.
[19] **2nd seizure of the day.**
[20] R. 36; Tr. 22, 26.
[21] Tr. 22; 121.
[22] Tr. 22.

at 9:26 a.m with elevated blood pressure and an elevated heart rate.[23] The Respondent was the emergency room ("ER") physician at that time.[24]

The Respondent conducted a physical exam of Fred M.[25] Notably, the Respondent conducted only a cursory neurological exam despite the fact that Fred M. was at the CMC ER due to an onset of seizures.[26] Due to the paucity of the Respondent's notations in Fred M.'s medical records, it is unclear whether the 'history and physical' exams were deficient or whether the Respondent's documentation thereof was deficient.[27] Where medical record documentation is such an integral part of medical providers 'history and physical' exams, the Board must assume that where the medical record is lacking, the 'history and physical' exams were likewise lacking. Despite his review of a nurse's neurological exam notes, the Respondent's notes are lacking an appropriately detailed neurological exam of Fred M.[28]

Approximately forty-five minutes after Fred M. arrived at CMC, at 10:19 a.m., he had another seizure.[29],[30] This seizure was witnessed by CMC medical personnel including a nurse and the Respondent.[31] The Respondent prescribed an additional 5 milligrams of Valium for the seizure.[32] The Respondent's note, which was entered nearly two hours later at 12:09 p.m., states: [33]

> soon after arrival the pt had what was likely another small seizure where he did not lose consciousness or have any tremors but was not responsive to voice and his eyes were deviated to the right and was followed by approx 15 minutes of a mild post-ictal appearing period. Pt given an additional 5 mg valium with good effect.

This was the totality of the Respondent's note of this event.[34] A nurse's note at 10:22 a.m. further states that seizure pads were put on Fred M.'s bed; seizure pads are usually placed so that patients do not injure themselves if they have another seizure.[35]

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[23] R. 12; Tr. 23-26.
[24] Tr. 16; R. 12-19.
[25] R. 13; Tr. 29.
[26] Tr. 29-40; R. 12-19.
[27] R. 12-19.
[28] Tr. 29-40; R. 13.
[29] Tr. 40-43; R. 15-16.
[30] **3rd seizure of the day** (2nd witnessed by medical personnel).
[31] R. 15-16.
[32] Tr. 42; R. 15-16.
[33] R. 15; Tr. 42.
[34] R. 15; Tr. 42-45.
[35] Tr. 43-44; R. 17.

At 10:48 a.m., the Respondent wrote Fred M. a prescription for Librium.[36] One half-hour after Fred M.'s third seizure, at 10:49 a.m., the Respondent wrote out Fred M.'s discharge instructions.[37] There is no documentation showing that the Respondent ever even considered admitting Fred M.[38] There is documentation showing that the Respondent telephoned Fred M.'s sister concerning discharge at 11:13 a.m.[39] There is also documentation that the Respondent made a request to the VA to transport Fred M home.[40]

At 11:15 a.m., when the nurse went into Fred M.'s room to administer the Librium,[41] she witnessed Fred M. having another seizure.[42],[43] The Respondent prescribed another 5 milligrams of Valium for the seizure.[44] Whereas the Respondent does not dispute that he knew about this fourth seizure, the Respondent made no documentation of this seizure in Fred M.'s medical record.[45] In fact, the next nursing entry in Fred M.'s medical record, at 11:58 a.m. states: "awaiting to hear back from the va for ride to ossepee (sic)."[46] At 12:09 p.m. another call was placed to the VA to fetch Fred M.[47] The Respondent's notes for this time state: "The patient will be discharged."[48] The Respondent called Fred M.'s sister to come pick Fred M. up from CMC.[49]

Fred M. was eventually discharged at 2:53 p.m. when his sister arrived from Ossipee.[50] Rather than fill the prescriptions provided upon discharge at a commercial pharmacy, Fred M.'s sister drove to the Manchester VA, where prescription medications are provided to veterans at a significantly reduced rate.[51] While waiting for the medications at the Manchester VA, Fred M. had

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[36] Tr. 45; R. 15. Librium (generically clordiazepoxide) is a type of benzodiazepine sedative medication.
[37] R. 18; Tr. 46-48.
[38] R. 12-19; Tr. 48.
[39] R. 17
[40] R. 17
[41] As noted above, which the Respondent prescribed at 10:48.
[42] R. 17; Tr. 49-50.
[43] **4th seizure of the day** (3rd witnessed by medical personnel).
[44] R. 17; Tr. 50. In total, Fred M. had received a total of 17 milligrams of Valium that morning. Tr. 55.
[45] R. 12-19; tr. 51-52.
[46] R. 17; Tr. 53.
[47] Tr. 53; "2nd call to the va looking for ride to ossipee; pt awake and alert aware of pf plan; the va now says they are unable to pick up pt and so we will call the sister." R. 17 (semicolons added).
[48] Tr. 55; R. 16.
[49] Tr. 175.
[50] R. 17; Tr 58-59.
[51] R. 24; Tr. 178-79.

another seizure before 4:00 p.m.[52],[53] At that time, Fred M. was transported to Concord Hospital.[54] Fred M. was admitted through the ER and was transferred to the Intensive Care Unit.[55] Fred M. developed status epileptcus[56], psychosis, dementia, and encephalopathy.[57] After approximately two weeks, his care was changed to comfort measures only and Fred M. died.[58]

Analysis

There is little doubt (by the Respondent at the time and by the Board at present) as to why these seizures were occurring. Fred M. was a chronic alcoholic – a heavy steady drinker. He drank at least 9 to 12 beers on a daily basis – he even did so on the day before.[59] But Fred M. was under strict orders by his physician to stop drinking to enable a more accurate reading of his EEG.[60] So at some time on September 3, 2009, Fred M. ceased drinking.[61] Though Fred M. may have known that he intended to resume drinking later in the day on September 4 (the medical record is devoid of any reference of his willingness to quit drinking)[62], physiologically his body reacted to the abrupt withdrawal of alcohol. Alcohol related seizures are a common and known reaction to this.[63] When Fred M. presented to the ER, with a history of only two seizures that very morning, the Respondent may well have been correct to diagnose him with mild alcohol withdrawal.

Subsequent to the seizure observed by the Respondent (Fred M.'s third seizure of the day), the Respondent did not change his diagnosis and did not add anything to the differential. The Respondent's response was to prescribe 5 mg of Valium. The Respondent prescribed Librium to help Fred M. withdraw from alcohol. Exactly one half hour after Fred M.'s third seizure, the

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[52] Tr 59; R. 1-2, 22.
[53] 5th seizure of the day.
[54] Tr. 60; R. 45 et al.
[55] R. 63; Tr. 61.
[56] Status epilepticus is continuous seizures during which there is no full recovery to normal neurological state without seizures within a certain time period. Tr. 61-62.
[57] Tr. 61; R. 45-310.
[58] Tr. 61.
[59] R. 2; Tr. 126 (answers by Dr. Valvano: "Q. If you look at the fifth line down starting on the right, it says, 'Yesterday had two six-packs (12 ounces.)' That's a description of his normal alcohol intake on September 3rd, correct? A. It's a description that he usually drinks one and a half to two six-packs a day and that that day he report having two six-packs."
[60] Tr. 124, 137, 266.
[61] R.2; Tr. 126-27.
[62] R.; Tr. 138, 186-87.
[63] See detailed discussion below.

Respondent wrote Fred M.'s discharge papers. There is no notation in the record that Fred M., however, should be observed for 4 to 6 hours before the actual discharge. There is no note that the medical staff at the hospital should wait until the effect of the medication wore off. To the contrary, the medical record is replete with the Respondent's multiple attempts discharge Fred M.

At the hearing, the Respondent testified that his workstation was located a short distance outside Fred M.'s room.[64] He testified that the room was located right behind his back when he was at his computer.[65] He stated that despite not documenting his further rounding on Fred M., he did see the patient at various times.[66] The Board finds this testimony self-serving and lacks credibility. This finding is bolstered by the evidence in the medical record that when Fred M. had another seizure, the Respondent did not re-enter Fred M.'s room at that time, nor at any other time thereafter.

After Fred M.'s 4th seizure, the Respondent prescribed 5 mg Valium. Notably, this was Fred M.'s 3rd such dosage of the day. Again, the Respondent did not document a concern to wait for the patient's reaction when the medication wore off before discharging him. The Respondent did not physically re-evaluate the patient, he did not consider any diagnostic tests, he did not re-evaluate his differential diagnosis. In fact, the Respondent did not document anything at all in Fred M.'s medical record about the 4th seizure. Rather, he again sought to discharge this patient by calling and/or having the staff call for the patient's ride.

Rosen's

Hearing Counsel introduced a chapter from a book on emergency medicine. Exhibit 1. Specifically, it was chapter 183 entitled "Alcohol-Related Disease," from the book 'Rosen's Emergency Medicine.' Exhibit 1. Although the book itself states that its purpose is not to define the standard of care,[67] it appeared that each of the medical witnesses accepted that this book is

[64] Tr. 235.
[65] Tr. 205, 235.
[66] Tr. 235.
[67] Tr. 102.

recognized as an authoritative text in emergency medicine and relevant to the present matter.[68] The Board finds this chapter to be an authoritative reference for the purposes of this proceeding.

> ■ **Alcohol Withdrawal Syndrome**
> ...
> **Clinical Features**
> *The withdrawal syndrome may occur any time after the blood alcohol starts to fall. Therefore, only a reduction, not the abrupt cessation, of ethanol intake may result in withdrawal.*
> *The withdrawal syndrome usually develops 6 to 24 hours after the reduction of ethanol intake and lasts 2 to 7 days. The alcohol withdrawal state ranges from mild withdrawal with insomnia and irritability to major withdrawal with diaphoresis, fever, disorientation, and hallucinations.*

Rosen, p. 2377.

As stated above, Fred M. presented to the Respondent's ER at 9:26 a.m. on September 4. He had not had a drink since some point the previous day, which resulted in the abrupt cessation of alcohol and the presumption is that Fred M.'s blood alcohol level fell. While it is unknown at what time Fred M. stopped drinking on September 3rd,[69] his presentation at CMC was clearly between 6 and 24 hours after such cessation.[70] What is less clear, is where Fred M.'s state was in the range from mild withdrawal to major withdrawal when he was at CMC from 9:26 a.m. to 2:53 p.m.

The Respondent has been charged with "failing to diagnose major alcohol withdrawal and appropriately care for Fred M." At the hearing, there was much controversy between the parties about the degree of withdrawal. The Respondent failed to document sufficient information for the Board to find, by a preponderance of the evidence, what Fred M.'s state of alcohol withdrawal was at the relevant timeframe. Accordingly, the Board is unable to make an affirmative finding that the Respondent "fail[ed] to diagnose major alcohol withdrawal."[71] Notwithstanding this inability, this allegation includes, in its following clause, a charge that the Respondent committed professional misconduct by failing to appropriately care for Fred M. on September 4th. As further explained below, a diagnosis of major vs. mild withdrawal is irrelevant. The Respondent's care, as briefly

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[68] Tr. 70-72 (Dr. Valvano); Tr. 231 (Dr. Todd); Tr. 256, 259-60 (Dr. Benzer); Tr. 273-76 (Dr. Josephs).
[69] Tr. 28.
[70] Tr. 28.
[71] Tr. 131-32 (Dr. Valvano).

outlined in the subparagraphs of paragraph 5 of the Notice of Hearing and as evidenced at the hearing, was inappropriate.

> **Management**
> ...
> **Treatment Plan**
> *The alcohol withdrawal syndrome should be promptly recognized and treated. Treatment is necessary (1) to provide relief from anxiety and hallucinations; (2) to halt progression to major withdrawal and withdrawal seizures. ...*
> **Pharmacologic Intervention**
> *Patients suffering from alcohol withdrawal should receive pharmacologic intervention along with supporting care. ...*
> **Emergency Department and Outpatient Approaches**
> *Rapid, aggressive control of alcohol withdrawal is crucial. The cornerstone of treatment is a benzodiazepine. Lorazepam is preferable because of its previously discussed qualities.*
> ...
> *Patients remain under observation or are admitted until the manifestations of withdrawal do not progress after the effects of the benzodiazepine have dissipated.*
> ...

Rosen, p. 2378-79.

As to the Respondent's treatment plan of Fred M., alcohol withdrawal was recognized when the Respondent personally saw the third seizure and prescribed 5 mg of Valium. While it is unclear whether Fred M. was suffering from anxiety at CMC, he did not start suffering from hallucinations until after he was discharged. Clearly, the Respondent's treatment (a total of 10 mg of Valium and 25 mg of Librium) was inadequate to "halt progression to major withdrawal and withdrawal seizures."[72] As to the Respondent's pharmacologic intervention in Fred M.'s care, in addition to the two low doses of Valium after the two CMC witnessed seizures, the Respondent prescribed the "cornerstone treatment [of] benzodiazepine" when he prescribed 5 mg Valium after each seizure and the 25 mg of Librium. The administration of this latter dose was delayed due to the Respondent's fourth seizure. The Respondent failed the patient in his 'ED and Outpatient Approach' as Fred M. did not remain under observation for a sufficient amount of time (as more fully discussed below).

[72] As evidenced from the later medical records from the VA and Concord Hospital. Tr. 22, 44 et seq.

The Respondent likewise failed Fred M. as the latter was not "admitted until the effects of [the Valium and Librium] had dissipated" and "the manifestations of withdrawal d[id] not progress."[73]

> ■ **Alcohol-Related Seizures**
> *Among the many medical problems related to alcohol abuse, the differential diagnosis and management of seizures are one of the most challenging and controversial. Patients presenting to the ED with seizures should be questioned about alcohol intake. In 20 to 40% of seizure patients presenting to an ED, the seizures are related to alcohol use or abuse….*
> *Alcohol may act in one of several ways to produce seizures in patients with or without underlying foci: (1) by its partial or absolute withdrawal after a period of alcohol intake; …*

Rosen p. 2379.

There is no doubt, based upon the testimony and evidence that Fred M.'s alcohol-related seizures were produced by an absolute withdrawal after a period of alcohol intake.[74]

> **Alcohol Withdrawal Seizures**
> …
> *Seizures occurred 6 to 48 hours after the cessation of drinking [in a study on 241 alcohol abusers with seizures]. … Sixty percent experienced multiple seizures within a 6 hour period. However, data suggests seizure recurrence can be reduced to 3% with lorazepam administration following the initial seizure. … Regardless, first-time seizures and partial seizures warrant an evaluation for intracranial pathology.*
> …
> **Patients Presenting with a Normal Neurological Exam**
> **New-Onset Alcohol Related Seizures**
> *Patients with new-onset ARS should be thoroughly evaluated. This includes alcoholics who claim to have had seizures but for whom no documentation or an appropriate workup is available. Metabolic disorders, toxic ingestion, infection, and structural abnormalities should be considered. Laboratory and radiographic testing including electrolytes, blood urea nitrogen, creatinine, glucose, anticonvulsant levels, and brain CT scan may be necessary. …*
> *If the initial physicial exam, imaging studies, and laboratory tests are within normal limits, patients who remain seizure free and symptom free with no sign of withdrawal after 4 to 6 hours of observation may be discharged. These criteria may be difficult to meet; therefore, admission may be considered.*

Rosen p. 2378-80.

As stated above, Fred M. fell and broke his humerus sometime in mid-August, about two to three weeks before the date in question. Fred M.'s medical record, which was available to the

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[73] Rosen, p. 2379; Tr. 56.
[74] R. 13, 15; Tr. 229

Respondent at the time, states that a friend said that the fall may have resulted from a seizure.[75] There was no medical evidence that it had been a seizure[76] nor was there any evidence suggesting that if it were, it was in any medical way related to the September 4th seizures. Specifically, there was no appropriate workup available aside from a CT scan that was 10 days old. The EEG that was scheduled for that day had not been performed. The September 4th seizures must have been considered as first-time seizures warranting an evaluation for intracranial pathology.[77] The Respondent did not repeat a CT scan after this new onset ARS; moreover, the Respondent did not have Fred M. undergo the EEG at CMC, though he was scheduled for one elsewhere that very morning.

The Respondent's attorney makes much ado of the fact that Fred M. was observed for 3 hours and 38 minutes[78] after the fourth seizure, and while that was technically outside the timeframe of "4 to 6 hours" that Rosen requires, he states that another 22 minutes would not have differed the outcome – as Fred M.'s next seizure occurred 4 hours and 43 minutes later.[79],[80] This math misses the point entirely. For while one might "ignore" the first seizure – which was not observed by medical personnel or treated, one cannot discount the second seizure – which was both observed by medical personnel and treated with a total of 7 mg Valium. Even if one were to "ignore" the first two seizures and only count the CMC seizures, Fred M. was observed for an hour before he was found to be seizing again. Thus, pursuant to Rosen's, even if the Respondent had considered as within normal limits Fred M.'s physical exam (which was poorly documented[81] and not necessarily normal[82]); the imaging studies (the old CT scan and the lack of EEG[83]); and the laboratory tests (surprisingly never performed[84]), Fred M. did not remain seizure free after 4 to 6 hours of observation from the 'first

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[75] R. 2 (VA notes: "His sister states at the time that his friend thought he had a seizure associated with the fall however the sister was not sure this was the case.")
[76] Tr. 142
[77] Tr. 76-78, 139-40.
[78] Tr. 83 (4th seizure at 11:13; discharge at 14:53).
[79] R 17, R.22 (4th seizure at 11:13; 5th seizure at 15:56).
[80] Respondent's Written Closing Summation, p. 7
[81] Tr. 29-38.
[82] Tr. 59.
[83] Tr. 78.
[84] Tr. 87.

CMC' seizure. Yet, based upon the medical record, the Respondent did not consider admission for Fred M.[85]

> ■ **Admission Guidelines and Disposition**
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> ...
>
> *Unfortunately, many managed care and Medicaid plans limit or do not cover inpatient detoxification. In choosing medical versus psychiatric admission, a medical illness usually takes priority.*

Rosen, p. 2391.

As stated above, Fred M. had medical insurance coverage, while it is unknown whether it limited or did not cover detoxification, there is no indication in the medical record that Fred M. was even interested in detoxification.

> **Seizures**
> *Patients experiencing their first ARS may be admitted. Admission allows initiation of drug therapy, diagnostic evaluation, and continued monitoring of the patient's status. However, the alcoholic patient with a first-time ARS may be discharged to a suitable social situation when (1) the patient's alcohol withdrawal is mild and easily controlled either by supportive care or with low-dose benzodiazepines; (2) the diagnostic workup, including a head CT san, is unremarkable; (3) the patient has had less than two seizures; and (4) the patient has been observed to be alert and oriented, with normal vitals signs, physical examination, and laboratory studies, during the 6 hours since the last seizure, and appropriate outpatient follow-up can be ensured.*

Rosen, p. 2391.

(1) Fred M.'s alcohol withdrawal was not controlled with low-dose benzodiazepines. Between 8:35 am and 10:21 am, he was given 12 mg of Valium. Subsequent to his 11:13 am (4th) seizure, he was given 5 mg more (17 mg total) in addition to 25 mg Librium. (2) The diagnostic workup was too deficient (no labs, no EEG, old CT, and insufficient physical) to make a proper determination of whether or not it was remarkable.[86] Fred M. had more than two seizures, he had four that morning – three observed by medical personnel. (4) Fred M. was 'observed' for only 3 hours and 38 minutes from the 4th seizure - 2 **hours** and 22 minutes shy of "the 6 hours since the last seizure." Accordingly, Fred M. did not meet any of the guidelines for discharge.

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[85] Tr. 48.
[86] Tr. 85-88.

Patients with a documented history of ARS can be discharged if they have no more than two ARSs during a 6-hour period with a lucid interval between seizures and are observed to be sezure free and at baseline mental and physical status for at least 6 hours after their last ARS. Three to five brief, self-limited seizures may occur with alcohol withdrawal seizures. Nevertheless, admission for patients with two or more seizures is advised because of the potential for deterioration to status epilepticus. This is especially appropriate in the malnourished, immunocompromised, homeless, or noncompliant alcoholic patient.

Rosen, p. 2391.

Even if the Board were to agree with the Respondent that the mid-August fall constituted a documented history of ARS, on the morning of September 4th Fred M. did not have a 6-hour period between seizures. Rather, Fred M. had four separate seizures within a 6-hour period. Yet remarkably, the Respondent did not consider admission or prolonged observation (i.e. six hours from the last seizure or until the effects of the medication had dissipated).

Patients with partial seizures or focal neurologic findings on physical examination require admission unless these findings have been previously documented. … Status epilepticus or recurrent seizures during observation in the ED indicate a lack of seizure control also requiring hospitalization.

Rosen, p. 2391.[87]

Fred M. had recurrent seizures. The third and fourth such seizures occurred in the ER of CMC. This conclusively indicated a lack of seizure control which required Fred M.'s hospitalization.

On September 4, 2009, the Respondent did not appropriately care for Fred M. when he failed to conduct and/or document a detailed neurological exam of Fred M.; when he ordered Fred M.'s discharge within a half hour after the third seizure; when he failed to conduct/order sufficient diagnostic testing; when he did not observe Fred M. for a sufficient length of time after the medication dissipated; and when he did not admit Fred M. to hospital. [88]

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[87] See also Tr. 163.

[88] Tr. 280 (Questions by Dr. Perecevich, Answers by Dr. Josephs): "Q: I have a question for you, Doctor. Based on your review of the materials that were available, do you have any concerns about the reliability or unreliability of this patient? I mean, he apparently stopped drinking in preparation for an EEG test. We heard testimony earlier in the day from his sister about his long time troubles with alcohol. He had four seizures in 12 hours and he's being sent home with at least some possibility that he might resume drinking again. And you mentioned it was a close call. A. And I agree with you. It was a close call. It was not the optimum by any means. Q. Not the optimum.... A. Discharge plan."

Rulings of Law:

Applicable Laws:

- RSA 329:17, VI states in pertinent part:

> The board, after hearing, may take disciplinary action against any person licensed by it upon finding that the person: ...
> (c) Has displayed medical practice which is incompatible with the basic knowledge and competence expected of persons licensed to practice medicine or any particular aspect or specialty thereof.
> (d) Has engaged in dishonest or unprofessional conduct or has been grossly or repeatedly negligent in practicing medicine or in performing activities ancillary to the practice of medicine or any particular aspect or specialty thereof, or has intentionally injured a patient while practicing medicine or performing such ancillary activities.

As to subsection (c), the questions before the Board are: (1) whether the Respondent failed to diagnose major alcohol withdrawal and/or (2) whether the Respondent failed to appropriately care for Fred M. on September 4, 2009. If the Board finds that the Respondent so failed in either of these, it must next ask: whether this failure was incompatible with the basic knowledge and competence expected of an emergency room physician.

In light of the testimony presented, the Board has not found that Fred M. was necessarily suffering from major alcohol withdrawal as opposed to minor alcohol withdrawal. The Board has, however, found that the Respondent did not appropriately care for Fred M. in the emergency room that fateful day. The Board finds that the Respondent's failure to observe Fred M. for at least 6 hours from his last seizure and/or admit Fred M. to the hospital on September 4, 2009 was incompatible with the basic knowledge and competence expected of an emergency room physician.

As to subsection (d) the question before the Board is whether the Respondent's care of Fred M. was grossly negligent. There is no statutory definition of 'gross negligence,' in New Hampshire. The New Hampshire Supreme Court has not defined this term in this context. The Board of Medicine, however, is a uniquely composed body created by the legislature to decide cases alleging misconduct violations against physicians and physician assistants. "Like other administrative bodies

whose jurisdiction is limited to particular types of cases,"[89] the standard of determining what constitutes 'gross negligence' is uniquely within the competence of this Board.

To define this standard, the Board borrows an analogy from the commerce world where the courts have fashioned a test to determine whether one's acts are grave, the courts have looked to the reaction of those who are genuinely familiar with the venue of the act. 'The Rascality Test' requires a plaintiff who is bringing a claim under the Consumer Protection Act to show "that the defendant's acts attainted a level of rascality that would raise an eyebrow of someone inured to the rough and tumble of the world of commerce."[90] In the present venue, the majority of the members on the Board of Medicine are professionals who are "inured to the rough and tumble world" of medicine. A showing of 'gross negligence,' however, requires more than lifting of any one of these commissioners'/practitioners' eyebrows; it requires them to give a collective pause and exclamation of dismay. "Rough and tumble" in this context means that death is often a natural, unavoidable and inescapable occurrence. Hence, a patient's death, even under the care of the most skillful and attentive physician or surgeon does not necessarily give this Board a pause and exclamation, like it would a family member or a lay person.

From the testimony and exhibits, it appears that Fred M.'s ultimate demise was inevitable. The Board finds that it was not the Respondent's care, or lack thereof, that caused Fred M. to so decompensate. There is no way to now know what would have happened, in the short term, on that fateful day of September 4, had the Respondent cared differently for Fred M. and/or had admitted him. However, based upon the testimony and medical record, Fred M. was not a well man, either due to his chronic alcoholism or otherwise, and the Board therefore finds that if the Respondent's failures hastened Fred M.'s deteriorations, they did not do so by much.

The Board appreciates the insight given from each of the well-respected experts' testimony.[91] The Board has the luxury of judging after the fact and not during the quick decision making in the ER; and though the Respondent testified that if a patient came to his ER with the

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[89] Appeal of Beyer, 122 N.H. 934, 940 (1982).
[90] Beer v. Bennett, 160 N.H. 166, 1__ (2010) (citation omitted); see also Barrows v. Boles, 141 N.H. 382, 390 (1996).
[91] Specifically Tr. 131-32 (Dr. Valvano); Tr. 267 (Dr. Benzer); Tr. 280 (Dr. Josephs).

same presentation he would not act differently; and although the Board wishes he would consider whether longer observation or admittance might be prudent on another occasion, the Board finds that Respondent's care of Fred M. did not rise to the level of gross negligence.

Rulings:

The Board makes the following findings by a preponderance of the evidence:

1. In accordance with paragraph 6A of the Notice of Hearing ("NOH"), the Board finds that the Respondent engaged in professional misconduct by failing to ~~diagnose major alcohol withdrawal and~~ appropriately care for Fred M., 'display[ing] medical practice which is incompatible with the basic knowledge thereof," in violation of RSA 329:17, VI(c).

2. In accordance with paragraph 6B of the Notice of Hearing ("NOH"), the Board finds that the Respondent was not grossly negligent in his care of Fred M.; thus he was not in violation of RSA 329:17, VI(d).

Disciplinary Action:

After making its findings of fact and rulings of law, the Board deliberated on the appropriate disciplinary action. RSA 329:17, VII ("The board, upon making an affirmative finding under paragraph VI, may take disciplinary action in any one or more of the following ways:..."). In this deliberation, the Board considered the mitigating factors that the Respondent has been forthcoming and cooperative throughout the Board's investigation and without previous matters before this Board.

Based upon the above and based upon the unique facts of this case, including the Board's empathic understanding of "working in the trenches," i.e. the difficulty in making several potentially life-altering decisions in quick succession, the Board has voted to impose relatively light discipline as follows:

IT IS ORDERED that the Respondent is Reprimanded.

IT IS FURTHER ORDERED the Respondent to meaningfully participate in a program of four (4) hours of continuing medical education in the area of alcoholic and substance abuse patients. These hours shall be in addition to the hours required by the Board for renewal of licensure and shall be completed

within six (6) months from the effective date of this Order. Within fifteen (15) days of completing these hours, the Respondent shall notify the Board and provide written proof of completion.

IT IS FURTHER ORDERED that this Final Decision and Order shall become a permanent part of the Respondent's file, which is maintained by the Board as a public document.

IT IS FURTHER ORDERED that this Final Decision and Order shall take effect as an Order of the Board on the date an authorized representative of the Board signs it.

*\BY ORDER OF THE NEW HAMPSHIRE BOARD OF MEDICINE

Date: 10/6/11

Kathryn M. Bradley
(Signature)

Kathryn M. Bradley
(Print or Type Name)
Authorized Representative of the
New Hampshire Board of Medicine

*\ Amy Feitelson, M.D., Board member, recused.