Before the
New Hampshire Board of Medicine
Concord, New Hampshire

In the Matter of: **Docket # 16-07**

Kasey L. Dillon, PA
License No.: 0607

and

Edward J. Williams, MD
License No.: 9848
(Adjudicatory/Disciplinary Proceeding)

FINAL DECISION AND ORDER

Before the New Hampshire Board of Medicine ("Board") is an adjudicatory/disciplinary proceeding in the matter of Kasey L. Dillon, P.A.("Respondent Dillon" or "Ms. Dillon"), and Edward J. Williams, M.D. ("Respondent Williams" or "Dr. Williams") (collectively "Respondents").

Background Information
(Procedural History and Motions)

The Board commenced an investigation pursuant to RSA 329:17 and/or RSA 328-D:6 after receiving, on February 27, 2014, a copy of a Complaint filed in Strafford County Superior Court against the Respondents. The Complaint alleged that the Respondents were grossly negligent in the treatment of a patient and that their gross negligence resulted in patient harm. Given the information gathered during the investigation, including the response letters from the Respondents, the Board determined that the adjudicatory/disciplinary proceeding was necessary.

A Notice of Hearing was issued August 8, 2016, and served upon Respondents by certified mail, and upon Respondents' attorney, John D. Cassidy, Esquire. The Hearing was originally scheduled for March 1, 2017, but the Board granted a motion to reschedule filed by

Attorney Cassidy on December 12, 2016 and rescheduled the hearing for May 3, 2017. On February 22, 2017, Attorney Cassidy requested a prehearing conference; the Board held the prehearing conference on April 6, 2017. On April 10, 2017, Attorney Cassidy filed a second request to reschedule until the superior court trial naming the Respondents concluded. The hearing ultimately occurred on September 6, 2017, at 1:00 p.m. The specific issues to be determined at the Hearing included, but were not limited to, the following:

A. Whether on or about February 23, 2011, Respondent Dillon engaged in dishonest or unprofessional conduct or was negligent in practicing her profession or in performing activities ancillary to the practice of her profession during her treatment of K.H. and thereby failed to provide appropriate care in violation of RSA 238-D:6, IV; and/or

B. Whether on or about February 23, 2011, Respondent Williams displayed medical practice incompatible with the basic knowledge and competence expected of persons licensed to practice medicine or any specialty thereof; and/or engaged in dishonest or unprofessional conduct or was negligent in practicing medicine or performing activities ancillary to the practice of medicine during his treatment of K.H. and thereby failed to provide appropriate care in violation of RSA 329:17, VI (c) and/or (d); and

C. If the above allegations are proven, whether and to what extent Respondents should be subjected to one or more of the disciplinary sanctions authorized by RSA 329:17, VII, and/or RSA 328-D:7.

The members present included:

President Michael Barr, M.D.

Vice President Emily Baker, M.D.

Mark Sullivan, P.A.

Gilbert J. Fanciullo, M.D.

Daniel P. Potenza, M.D.

Frank B. Dibble, Jr., M.D.

The prosecution was represented by Hearing Counsel Attorney Michelle Heaton of the Administrative Prosecutions Unit ("APU") in the Office of the Attorney General. The Respondents were represented by John D. Cassidy, Esq., of Ficksman & Conley, LLP.

The following exhibits were introduced into evidence upon stipulation by the Parties and accepted into the record:

A. Wentworth-Douglas Hospital Emergency Room records for K.H. dated February 23 and 24, 2011.

B. Wentworth-Douglass Hospital SIRS Protocol.

C. Additional Wentworth-Douglass Hospital medical records for K.H. from February 24, 2011 to April 14, 2011.

D. Deposition transcript of Edward J. Williams, M.D., dated October 28, 2015.

E. Deposition transcript of Kasey L. Dillon, P.A., dated October 9, 2015.

F. Deposition Transcript of K.H., dated May 29, 2015.

G. Expert Disclosures for Michael J. VanRooyen, M.D. and Arron B. Waxman, M.D., Ph.D.

H. Trial Transcript of Michael J. VanRooyen, M.D., dated July 28, 2016.

I. Trial Transcript of Aaron B. Waxman, M.D., Ph.D., dated July 27, 2016.

J. Curriculum Vitae of Michael J. VanRooyen, M.D.

K. Curriculum Vitae of Aaron B. Waxman, M.D., Ph.D.

L. Trial Court's Order on K.H.'s Motion to set aside jury verdict.

M. Written Response of Kasey Dillon, P.A., dated June 27, 2014.

N. Written Response of Kasey Dillon, P.A., received August 1, 2014.

O. Written Response of Edward J. Williams, M.D., received July 1, 2014.

P. Written Response of Edward J. Williams, M.D., received August 12, 2014.

Q. Written Correspondence from counsel for Kasey Dillon, P.A., and Edward J. Williams, M.D., dated September 21, 2016.

R. Expert Opinion of Colin O'Brien, M.D.

S. Curriculum Vitae of Colin O'Brien, M.D.

The issue in this action revolves around whether Respondents did a proper work-up of the 40 year old patient on the evening of February 23, 2011. The patient presented to the emergency department with symptoms of vomiting, diarrhea, nausea and a cough and vitals of 96.8 degree temperature, Oxygen saturation of 93%, a pulse of 129 and blood pressure of 110/69. The complete blood count (CBC) results indicated a low white blood cell count (WBC) and 36% bands. The patient was treated for gastroenteritis, not given a chest x-ray, and discharged from the emergency department several hours after arrival, with a diagnosis of viral syndrome, and also given a cough suppressant. The patient returned to the emergency department the following evening and was diagnosed with bilateral pneumonia, acute respiratory distress syndrome (ARDS), pleural effusions, pneumothoraxes which required surgical intervention and a seven week hospitalization.

The crux of the case centers on whether the assumption that the patient had a viral illness without ruling out the possibility of pneumonia is consistent with medical practice that is compatible with the basic knowledge and competence expected of persons who practice emergency medicine.

Colin O'Brien, M.D. testified as Hearing Counsel's expert. He is currently employed as a staff physician at Southern New Hampshire Medical Center Emergency Department. He conducted an expert review of Respondents' treatment and diagnosis of the patient on behalf of the Medical Review Subcommittee ("MRSC") of the Board. He testified as to the results of his review, and provided his medical opinion regarding the work-up of the patient and indicated that given her presentation, labs and the onset of the symptoms five days prior indicated that a usual and customary septic work-up should have been completed. His testimony was that the signs of sepsis were there and should have been evaluated. The Board found his testimony to be forthright and credible.

Michael J. VanRooyen, M.D. testified on behalf of the Respondents. Dr. VanRooyen is board certified in emergency medicine, specializing in emergency room care, and is currently employed as the Chairman of the Department of Emergency Medicine at Brigham and Women's Hospital, and full professor at Harvard Medical School. His primary practice focuses on academic emergency medicine where he oversees the clinical practice and academic activity of Brigham's emergency department. Although the Board found Dr. VanRooyen to be a well-qualified and highly credentialed witness, the Board did not find his testimony as to the Respondents' treatment and diagnosis of K.H. compelling. Dr. Van Rooyen testified at length concerning his view that the Respondents complied with the standard of emergency department care in their treatment of the patient. His opinion centered on the patient's presentation and the low WBC being indicative of a viral illness. While Dr. Van Rooyen acknowledged that the elevated bandemia is most commonly associated with a bacterial process, he explained it could be associated with a viral process as well and he would not recommend a chest x-ray. He maintained that where the dominant complaint was gastrointestinal, and other lab tests showed

an elevated creatinine, it is not outside the realm of medical competence for a practitioner to fail to consider a pulmonary differential.

Respondent Kasey Dillon, P.A. is employed by Wentworth-Douglass Hospital and testified on her own behalf. The Board found that Respondent Dillon was well prepared to testify. However, the Board noted she was inconsistent throughout the investigative and trial process, and her testimony was not persuasive.

Respondent Edward Williams, M.D., is employed in the Emergency Medicine Department of Wentworth-Douglass Hospital by Seacoast Physicians Group and testified on his own behalf. The Board found that Respondent Williams was well prepared in his testimony, but given certain inconsistencies his testimony was not compelling.

Synopsis of Facts

On February 23, 2011, K.H. presented to the Wentworth-Douglass Emergency Room after being ill for five days with fever, chills, vomiting, diarrhea, and upper abdominal pains. At the time of presentation, K.H. had a temperature of 96.8, pulse of 129, respiratory rate of 20, blood pressure of 110/69, and pulse oximetry of 93%. Respondent Dillon reviewed the nursing assessment or triage findings prior to seeing K.H.

Respondent Dillon conducted a physical exam of K.H. and recorded normal findings in the medical record. Respondent Dillon recorded that K.H. presented with cough, chills, vomiting, diarrhea, myalgia and upper abdominal pains. Respondent Dillon noted that the patient's heart rate resolved to 80 during the examination. Initially, Respondent Dillon ordered a full metabolic panel, including a CBC, a urine analysis and urine dip; the urine analysis and urine dip were not completed. Respondent Dillon conferred with Respondent Williams and at Respondent Williams' behest ordered influenza and hepatitis tests. These came back negative prior to the

patient's discharge. Respondents did not order imaging or further studies prior to the patient's discharge.

The metabolic test included a CBC and Liver Function. Respondent Dillon recorded on K.H.'s chart that the CBC results were normal, and left other sections blank. Under the chemistries section of the chart, Respondent Dillon recorded only certain abnormal lab results including: creatinine 1.5, potassium 2.5, direct bilirubin 1.3, hepatitis panel negative, amylase normal, alkaline phosphatase normal, AST 1027, and ALT 939. However, she did not properly record K.H.'s lab results showing significant out of range values including: abnormal CBC results of a WBC 2.5, 36% bands, and 42% poly; and low values for glucose 52, carbon dioxide 17, and lipase <50. These specific abnormal results were not included on K.H.'s emergency room physician report.

Respondent Dillon ordered therapy for K.H. included administering two liters of intravenous normal saline (NS) and Zofran. Respondent Dillon documented that K.H. improved with this therapy. Respondent Dillon documented her diagnosis of K.H as being a gastrointestinal issue and viral syndrome. Respondent Williams testified that he agreed with Respondent Dillon's assessment that the test results were consistent with a gastrointestinal virus and that K.H. should be discharged. Respondent Dillon discharged K.H. with prescriptions for Tussionex, a cough suppressant, and Zofran for nausea, and gave further instructions to see her primary care physician for follow-up. At the time of discharge, K.H. had a pulse of 93, respiratory rate of 18, blood pressure of 106/73 and pulse oximetry of 98%. Respondent Dillon told K.H. to return if she had worsening symptoms. Both Respondents testified, and maintain, that an X-ray was not a necessary step in the treatment and diagnosis of K.H. on February 23, 2011. February 24, 2011, K.H. returned to Wentworth Douglass Hospital and was diagnosed

with pneumonia, impending respiratory failure, ARDS, and sepsis. K.H. remained hospitalized until April 14, 2011.

The record is unclear as to whether Dr. Williams actually ever examined the patient on the evening of February 23rd. As such it was left to a credibility determination as to this issue. The record likewise demonstrates an inconsistency as to whether Dr. Williams simply consulted with PA Dillon or whether there was an actual exam by the physician. In a letter received July 1, 2014, Dr. Williams indicates that he "discussed K.H.'s condition with [his] physician assistant, Kasey Dillon" and "[that] represented [his] only involvement in [K.H.'s] care." In a follow up letter received August 12, 2014, Respondent Williams again refers to his discussions with Respondent Dillon, but does not mention ever examining K.H himself. On October 28, 2015, Respondent Williams was deposed in the civil action and indicated that he did not recall actually examining the patient himself. Yet, at the hearing held before the Board Dr. Williams testified unequivocally that he examined the patient, despite a 6 year gap and treating countless patients over that 6 year period.

Likewise, the record presented to the Board regarding PA Dillon's review of the case reveals an inconsistency that is problematic. When responding to the Board investigator's initial inquiry on July 7, 2014 after receiving the civil complaint, PA Dillon reported the patient's CBC to be normal. This initial reaction was reiterated when Respondent Dillon was deposed on October 9, 2015, and testified that she did not record the CBC values because "the values were not clinically significant." Later in the deposition, however, she agreed that she failed to properly record the relevant data on the patient chart, and that she knew the results were abnormal. In a letter dated September 21, 2017 sent on behalf of the Respondents, their Attorney states that the July 7, 2014 letter was a mistake made by the attorney's staff, and not the Respondent's belief.

Finally, Respondent Dillon testified that she failed to properly review the July 7, 2014 letter before signing it.

Dr. VanRooyen testified that the treatment rendered to K.H. was appropriate, and in compliance with the standard of care, and that her symptoms were not suggestive of pulmonary process. He testified that in his medical opinion no further diagnostic testing was necessary. Dr. VanRooyen also testified generally that it was appropriate to discharge a patient who has a negative viral hepatitis panel and elevated liver enzymes if there is no indication the patient is unstable and there is no focal treatable illness that needs to be admitted. Specifically, he testified that K.H. did not meet the SIRS protocol.

Dr. VanRooyen stated that the Respondents complied with the standard of care and their medical decision making appeared to be sound. Dr. VanRooyen suggested that the information known by Respondents at the time was indicative of a viral infection. His testimony focused on the treatment given to the patient and her time in the emergency room showed the patient doing better, with her pulse and oxygen rate normalizing, her being rehydrated and showing no signs or symptoms of a dangerous situation. He did not believe that the patient's presentment included a suspicion of a bacterial infection, despite the abnormally low WBC, the bandemia or elevated liver function. He also testified that the pneumonia diagnosed on February 24, 2011 likely resulted from acute aspiration. Overall, he found that the Respondents' care of K.H. were appropriate to a reasonable degree of medical certainty based on what was within the record.

Expert Reviewer Colin O'Brien, M.D. was found to be credible by the Board. He indicated that in his medical opinion the standard of care was not met by the Respondents' treatment of K.H. on February 23, 2011. His testimony specifically noted that there is a need for "greater physician involvement with patients who are clearly very ill with multi-organ

dysfunction," that was not evident in his review. He further testified that K.H.'s report of five days of illness "should have raised enough concern for sepsis to justify a complete septic workup in the emergency department."

Dr. O'Brien opined that not only prudent medical care, but the standard of care, required that a chest x-ray be performed on K.H. given her symptoms because "to rely solely on a stethoscope to rule out pneumonia without obtaining a chest x-ray when there should be serious concern for pneumonia based on the history and abnormal blood work is not appropriate." He testified that "a low total WBC and a high band count are known to be associated with possible sepsis" and that these are factors "included in the SIRS scoring system" that is used to assess the possibility of sepsis. Dr. O'Brien further testified that to assume, as the Respondents did, that K.H. has ". . . a self-resolving viral illness without first performing the usual and customary septic workup places the patient at unacceptable risk of delay in diagnosis of sepsis and its causative disease process." Overall, he felt that Respondents should have ordered further studies to ensure that her infection was viral, not sepsis, and pneumonia was not a cause of her symptoms prior to discharging K.H. given the negative influenza and hepatitis tests, her abnormal CBC and liver functions, and five days of significant symptoms.

Analysis and Rulings of Law

The question of the diagnosis and treatment of K.H. on February 23, 2011 requires an analysis of the standard of care an Emergency Care Physician Assistant and/or Physician owes an emergency room patient with the following symptoms and test results: five reported days of fever, chills, cough, vomiting, diarrhea, and upper abdominal pains; a Complete Blood Count ("CBC") showing a WBC of 2.5, with 36% bands and 42% polys; a metabolic profile showing creatinine 1.5, AST 1027, ALT 939, and potassium 2.5; and glucose of 52, carbon dioxide of 17,

along with other abnormal test results. Based on the credible testimony of Dr. O'Brien, the Board finds the failure to interpret and record the studies properly, and order further studies and imaging, before discharging an emergency room patient with multiorgan dysfunction, constitutes an absence of care that demonstrates medical practice incompatible with the expectations of an Emergency Room physician assistant and/or physician. The Board accepts and finds credible the testimony of Dr. O'Brien when he testified that the failure to obtain further tests and imaging fell below the standard of care the Respondents owed K.H.

The Board realizes that complex clinical situations may become clear only in hindsight. However, the Board accepts as most compelling, Dr. O'Brien's testimony that a WBC of 2.5 and bandemia of 36%, along with the other results in the medical record, is evidence of a serious infection needing further studies. Dr. O'Brien's testimony regarding the inclusion of these factors on the SIRS scoring system as indicators of possible sepsis was significantly compelling to the board.

Kasey Dillon P.A.

Under RSA 328-D:6, IV the Board may take disciplinary action if it determines a physician assistant

> has engaged in dishonest or unprofessional conduct or has been grossly or repeatedly negligent in practicing his or her profession or in performing activities ancillary to the practice of his or her profession or any particular aspect or specialty thereof, or has intentionally injured a patient while practicing his or her profession or performing such ancillary activities.

RSA 328-D:6, IV

The Board determines that Respondent Dillon engaged in dishonest, unprofessional and reckless conduct in practicing her profession due to her failure to appropriately record data, interpret studies, and order additional studies needed to meet the standard of care in treating K.H. The

Board finds that a reasonable provider in Respondent Dillon's field would not have ignored the abnormal WBC and severe bandemia. Respondent Dillon's own witness, Dr. VanRooyen, testified that the bandemia could indicate bacterial infection, although he was adamant that viral infection was more likely.

Edward Williams, M.D.

Under RSA 329:17 VI the board may take disciplinary action against if it determines that a licensed physician

> (c) Has displayed a pattern of behavior which is incompatible with the basic knowledge and competence expected of persons licensed to practice medicine or any particular aspect or specialty thereof. [or]
>
> (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 specialty thereof, or has intentionally injured a patient while practicing medicine or performing such ancillary activities.

RSA 329:17, VI (c)(d).

Similar to the reasons stated above, Respondent Williams has displayed medical practice which is incompatible with the basic knowledge and competence expected of a person licensed to practice medicine. The Board finds that a reasonable provider in Respondent Williams' field would not have ignored the abnormal WBC and severe bandemia. Respondent Williams' own witness, Dr. VanRooyen, testified that the bandemia could indicate bacterial infection, although he was adamant that viral infection was more likely.

Additionally, it was practice incompatible, as Respondent Dillon's supervising physician, to appropriately ensure proper testing was ordered. Dr. Williams should have used the information provided to him by Respondent Dillon to determine the need to actually examine K.H. in the Emergency Room. His lack of recall about whether he physically examined K.H., and his failure to give closer observation of a patient with multiple-organ dysfunction, fell below

the standard of care owed to K.H. Furthermore, he should have considered the possibility that, given K.H.'s symptoms and the lab results, the infection was bacterial in nature and ordered further studies prior to discharging her.

Disciplinary Action

After making its findings of fact and rulings of law, the Board deliberated on the appropriate disciplinary action. 328-D:7, I ("The board, upon making an affirmative finding under RSA 328-D:6, may take disciplinary action in any one or more of the following ways. . ."); 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 these deliberations, the Board considered the mitigating factor that Respondents were without previous matters before this Board, having not been disciplined before or since this instant matter. However, the Board found this was outweighed by the Respondents' inconsistent testimony. Respondent Dillon was inconsistent in her testimony regarding K.H.'s February 23, 2011 abnormal CBC laboratory results. Respondent Williams was inconsistent in his testimony as to whether he actually saw K.H. on February 23, 2011. These issues indicate that perhaps there was an inability to see beyond the easy diagnosis of a "stomach bug" and confirm with a simple x-ray that there was a more serious underlying condition. Due to the facts delineated above the Board believes discipline is appropriate.

THEREFORE IT IS ORDERED that Respondent Dillon and Respondent Williams are hereby REPRIMANDED.

IT IS FURTHER ORDERED that this final Decision and Order shall become a permanent part of the Respondents' files, which are maintained by the Board as public documents.

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

BY ORDER OF THE BOARD*

DATED: 12/8/2017

Penny Taylor, Administrator
Authorized Representative of the
New Hampshire Board of Medicine

*Board members, David Conway, M.D. and Nina Gardner, Public Member, recused. Board member, John Wheeler, D.O., not participating.