



THE COMMONWEALTH OF MASSACHUSETTS
DIVISION OF ADMINISTRATIVE LAW APPEALS
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MALDEN, MA 02148

JAMES P. ROONEY
ACTING CHIEF ADMINISTRATIVE MAGISTRATE.

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June 6, 2023

Julian N. Robinson, M.D.
Chairperson of the Board
Board of Registration in Medicine
178 Albion St., Suite 330
Wakefield, MA 01880

Re: Board of Registration in Medicine v. John Shackelford, D.O.
DALA Docket No. RM-20-0424

Dear Dr. Robinson:

Enclosed is the Administrative Magistrate's Recommended Decision in the above-captioned matter.

By copy of this letter, parties are advised that in accordance with the provisions of 801 CMR 1.01 (11)(c)(I), they have thirty (30) days to file with the Board of Registration in Medicine written objections to the Recommended Decision.

Sincerely,

A handwritten signature in black ink that reads "James P. Rooney".

James P. Rooney
Acting Chief Administrative Magistrate

JPR/mbf

Enclosure

cc: Paul R. Cirel, Esq.
Karen A. Robinson, Esq.
Debra Stoller, Esq. ✓

COMMONWEALTH OF MASSACHUSETTS
Division of Administrative Law Appeals

BOARD OF REGISTRATION IN
MEDICINE,
Petitioner,

Docket No. RM-20-0424

v.

JOHN SHACKELFORD, D.O.,
Respondent.

Appearance for Petitioner:

Karen Robinson, Esq.
Board of Registration in Medicine
Wakefield, MA 01880

Appearance for Respondent:

Paul Cirel, Esq.
Todd & Weld, LLP
Boston, MA 02110

Magistrate:

Eric Tennen

Summary of Recommended Decision

The Respondent treated Patient A at an urgent care facility. Unfortunately, she passed away a few days later from streptococcus pneumonia, which the Respondent had neither tested for nor diagnosed. The Board alleges Respondent's conduct fell below the standard of care because he failed to appreciate Patient A's susceptibility to a serious infection and should have done testing to rule it out. However, the Board failed to carry its burden of proof. Although the Board's expert was well-qualified and gave a plausible opinion, Respondent's expert was more credible. Accordingly, even though the results were tragic, the Respondent's conduct was within the standard of care.

RECOMMENDED DECISION

On October 8, 2020, the Board of Registration in Medicine (“Board”) issued a Statement of Allegations seeking to discipline John Shackelford, D.O. (“Respondent”). The Board referred the matter to the Division of Administrative Law Appeals (“DALA”), requesting DALA to make recommended findings of fact and necessary conclusions of law. The Respondent filed an answer to the Board’s allegations, admitting some facts but denying misconduct.

The matter was assigned to a DALA magistrate, who held a hearing over the course of three days in 2021. The magistrate admitted 15 exhibits and excluded one (which has been marked ID A). The Board called the Respondent and Dr. Andrew Angel, M.D. as witnesses.¹ The Respondent called Michael Jones, Esq. and Dr. Steven Van Dam. Following the hearing, the parties submitted closing briefs. After the matter was submitted, the hearing magistrate became unavailable to issue a decision. The matter was reassigned to me. *See* 801 Code Mass. Regs. § 1.01(11)(e). The parties agreed I could decide the matter based on the existing record: the exhibits and the recordings of the hearing (including transcripts).

This is a close case. It revolves around one factual dispute—did the Respondent’s conduct fall below the standard of care. That determination, in turn, can be resolved only by

¹ On the third day of hearings, the Board called Dr. Jerald Reisman as a witness; he was testifying virtually. Dr. Reisman had drafted an expert affidavit in 2017 as part of a medical malpractice case against the Respondent. (Exhibit 12.) Unfortunately, there were several technological difficulties that delayed the testimony by almost 30 minutes.

Dr. Reisman began by saying he could not recall the case in “complete detail.” Then Dr. Reisman, understandably frustrated, complained about the meeting being a “disaster”; he did not have time for it since he had only scheduled one hour and it was clearly not going to end soon. He lamented he was doing it for free. He was angry over the situation and would not reschedule. His testimony abruptly ended without finishing his direct or a single question of cross-examination. The Board indicated it would simply rely on his affidavit. I place no weight on Dr. Reisman’s testimony, other than to note his demeanor. I address the import of his affidavit *infra*.

assessing the credibility of opposing expert opinions. Although it is not standard practice to detail testimony that I do not credit, I nevertheless lay out the competing evidentiary claims by each witness. This will assure the parties that I have carefully considered all the evidence while also setting forth the foundation for my credibility determinations.

FINDINGS OF FACT

Based on the testimony and the exhibits, I make the following findings of fact. In doing so, I am deviating from the usual practice of only recounting:

1. The Respondent is board-certified in internal medicine. He has been licensed to practice medicine in Massachusetts since 2004. (Stipulated facts.)
2. The allegations revolve around the Respondent's care for Patient A. (Statement of Allegations.)
3. Patient A was a 41-year-old woman. She had a pacemaker. In 1993, she was in a motor vehicle accident that required her to have her spleen removed, otherwise known as a splenectomy. (Stipulated facts.)
4. Patient A visited an urgent care clinic, Health Express in Pembroke, MA, on October 2013 where the Respondent treated her. (Stipulated facts.)
5. Her temperature that day was 97.7 and her respiration rate was 18 breaths per minute, both recorded as normal. (Stipulated facts.)
6. The medical records show her "chief complaint" as fever, rash and diarrhea. (Stipulated facts.)
7. The "history of present illness" section included the following symptoms: very cold upper and lower extremities for a week, rash to her face, burning, aching, tingling, weakness, and diarrhea. (Stipulated facts.)

8. The “skin and soft tissue exam” section included the following symptoms: “mottle blue and white with a little red on pressure very cool to palp, mottle area of hands and feet looks like red/white and blue tender to palp.” (Stipulated facts.)
9. Ultimately, the Respondent diagnosed the Patient with Raynaud’s disease and sent her home with instructions to contact her doctor, go to an emergency room (“ER”), or return to the clinic if her condition did not improve, or if it worsened. (Stipulated facts.)
10. After leaving the clinic, Patient A’s health deteriorated, but she did not contact a doctor, an ER or any other health care provider. (Stipulated facts.)
11. She passed away a few days later from streptococcus pneumonia. (Stipulated facts; Exhibit 1.)
12. Around 2015, Patient A’s estate sued the Respondent for malpractice. (Exhibit 4.)

The Respondent’s Testimony

13. The Respondent had recently begun working at Health Care Express when he treated Patient A. (Respondent testimony.)
14. Before the Respondent treated her, Patient A met with the intake medic who recorded some preliminary data. (Respondent testimony.)
15. The intake paramedic documents the “chief complaint.” (Respondent testimony.)
16. Patient A’s blood pressure was 130/72, her pulse was 76, and her pulse oximetry was 99%. Those measurements are considered within normal limits. (Respondent testimony; Exhibit 6.)
17. The medical record noted Patient A “had tried” over the counter (“OTC”) medications, but she was not taking them currently. (Respondent testimony; Exhibit 6.)
18. The Respondent understood that to mean she had not taken any medications of any kind

- within a day prior to coming in. (Respondent testimony.)
19. It is important to know whether a patient has taken any kinds of medications because that could impact blood pressure, pulse, temperature, respiration, and other vital signs. (Respondent testimony.)
20. Whether she took any medication was also potentially significant because some OTC medications can reduce fever. (Respondent testimony.)
21. Patient A also complained of sore joints and stiffness, which can be symptoms of an infection. (Respondent testimony.)
22. Patient A reported she had these symptoms for a week. (Respondent testimony; Exhibit 6.)
23. This was significant to the Respondent because he would expect someone without a spleen who had an infection to present differently: “in other words, when I see her and her vital signs are perfect, then the likelihood of infection is—with these vital signs is extremely low.” (Respondent testimony.)
24. Patient A also denied having a sore throat or any problems with her cardiac and pulmonary systems; she was urinating normally. An affirmative answer acknowledging problems with any of these symptoms could have been consistent with an infection. (Respondent testimony.)
25. After going through these questions, the Respondent conducted a physical examination. The physical examination confirmed she was alert and comfortable and her systems (*e.g.*, throat, lungs, etc.) were “normal,” consistent with her answers. (Respondent testimony.)
26. In short, according to the Respondent, nothing recorded by the intake paramedic, reported by the patient, or physically observed by the Respondent was consistent with an

- infection, let alone pneumococcal or streptococcal pneumonia. (Respondent testimony.)
27. In the Respondent's experience, patients with pneumonia do not have pulse oximetry of 99%, a temperature of 97.7, a respiration rate of 18 breaths per minute, or blood pressure of 130/72 mm Hg. (Respondent testimony.)
28. The only remarkable finding of his examination was her skin. She had red, white, and blue on her extremities. Her hands and cheek bones were a little red on pressure and cool and slightly tender on palpation. (Respondent testimony.)
29. That rash was consistent with Raynaud's Syndrome. Specifically, the "malar" rash on her cheekbones indicated it was probably Secondary Raynaud's Syndrome. (Respondent testimony.)
30. Raynaud's syndrome is a disorder of the blood vessels in the hands and feet. (Exhibit 6.)
31. It is not a life-threatening condition. (Respondent testimony.)
32. There are tests available to confirm the presence of Secondary Raynaud's Syndrome; the Respondent did not perform those on Patient A. (Respondent testimony.)
33. There are also environmental conditions that can precipitate Secondary Reynaud's Syndrome; but the Respondent did not inquire about those. (Respondent testimony.)
34. The Respondent was aware the patient did not have a spleen. (Respondent testimony.)
35. Spleens help fight infection. Persons without a spleen have a greater risk of infections. Spleens also neutralize or weaken bacteria that cause pneumonia. Therefore, without a spleen, an infection like pneumonia is more life-threatening. (Respondent testimony.)
36. The Respondent did not order any blood tests nor send her to a hospital. (Respondent testimony.)
37. Instead, the Respondent sent Patient A home with oral and written instructions to contact

her doctor, go to an ER, or return to the clinic if her condition did not improve, or if it worsened. (Stipulated facts; Respondent testimony.)

38. He also told her that she needed a work-up for Raynaud's, which required bloodwork. (Respondent testimony.)

Andrew Angel, M.D.²

39. Dr. Angel testified as an expert for the Board.
40. Dr. Angel is board-certified. He practices internal medicine and primary care. (Angel testimony.)
41. In his opinion, the Respondent deviated "very significantly" from the standard of care. (Angel testimony.)
42. With respect to Patient A's use of OTC medications, he agreed there was an inconsistency in the record—that the history of present illness said she had tried OTC medications, but the intake said she had not. (Angel testimony.)
43. He agreed one interpretation of that inconsistency could mean Patient A did not take any OTC that day but did in the past. However, in his opinion, that would not be a fair reading of that inconsistency. (Angel testimony.)
44. Given her chief complaints, and some additional symptoms, Dr. Angel would have been concerned about a possible infection. (Angel testimony.)
45. Any doctor should have been particularly concerned, given Patient A's splenectomy, because the spleen protects from infections. Absence of a spleen thus increases risk of bacterial infections. (Angel testimony.)

² I do not ultimately credit Dr. Angel's opinion that the Respondent's conduct fell below the standard of care. I nevertheless summarize the basis and reasoning for his opinion.

46. History of a “splenectomy” was a “flashing red light” for someone not feeling well. It was the most important factor in this presentation. (Angel testimony.)
47. The pacemaker was also significant because it controls the heartrate. However, Dr. Angel was unclear, or did not know, whether that meant her heartrate would have otherwise been irregular here, but the pacemaker covered that up. (Angel testimony.)
48. Nevertheless, whether or not Patient A’s pacemaker was working properly would not have affected whether she showed signs of an infection. (Angel testimony.)
49. To be thorough, a doctor could have performed an electrocardiogram to see if the pacemaker was operating correctly and rule this out as a cause of illness. (Angel testimony.)
50. Patient A’s temperature of 97.7 was slightly lower than normal. That could be significant because infection, or sepsis, can lower or raise temperature. (Angel testimony.)
51. Dr. Angel later admitted it was a “borderline normal temperature.” (Angel testimony.)
52. Dr. Angel reluctantly agreed that he has treated healthy patients with a temperature in the high 90’s, but he could not guess what percentage. (Angel testimony.)
53. In Dr. Angel’s opinion, 18 breathes per minute is considered high, although he later characterized it as “borderline normal respiration.” (Angel testimony.)
54. Twelve to 14 breathes a minute is considered normal. (Angel testimony.)
55. Rapid respiration, otherwise known as tachypnea, could be caused by an infection or sepsis. (Angel testimony.)
56. On cross-examination, Dr. Angel admitted that there is a physical examination component that should be considered with respect to respiration. Here, the examination showed Patient A had normal, nonlabored respiration. By that note, her breathing was not

- tachypneic. (Angel testimony.)
57. Patient A's temperature, respiration, blood pressure, pulse, pulse oximetry, pulmonary exam, and cardiac exam were not consistent with pneumonia or sepsis—or an infection generally. (Angel testimony.)
58. Even though Patient A did not have a fever when she came in, she reported she had one before. That was concerning because fever can be a symptom of sepsis. (Angel testimony.)
59. Diarrhea itself is not a sign of infection, but other symptoms of sepsis can cause diarrhea—it is a secondary phenomenon. (Angel testimony.)
60. Diarrhea is typically associated with a viral infection, not bacterial. (Angel testimony.)
61. The Respondent's diagnosis of Raynaud's was not a good initial thought or diagnosis. Many symptoms were inconsistent with Raynaud's like fever, diarrhea, rash, and painful feet. (Angel testimony.)
62. Moreover, Patient A had no history of Raynaud's and it is unusual to see for the first time in a middle-aged person. (Angel testimony.)
63. Yet, Dr. Angel agreed someone with Raynaud's has a rash in their extremities, like Patient A did here; he also agreed the colors of her rash were "possibly" the colors you would find on a patient with Raynaud's; lastly, he agreed Patient A's rash was described as "modeling," which is consistent with Secondary Raynaud's. (Angel testimony.)
64. Dr. Angel explained that all doctors should do a differential diagnosis. He could not tell if the Respondent did a differential diagnosis in this case. He only saw a diagnosis, but no elaboration. (Angel testimony.)
65. In a case like this, a doctor should rule out a life-threatening illness first. But the

- Respondent did not take everything into account and recognize there was potentially a life-threatening diagnosis to be made here—early sepsis.³ (Angel testimony.)
66. Dr. Angel was not aware that there were diagnostic screening tools used to evaluate someone's risk of developing sepsis. (Angel testimony.)
67. Dr. Angel conceded that one factor for sepsis is mental status, and Patient A was alert. (Angel testimony.)
68. Dr. Angel did not know if the symptoms in this case were a sign of "bacterial" infection. (Angel testimony.)
69. Given these symptoms and history, Dr. Angel would have referred the patient for lab tests, blood and urine cultures, and blood counts, and sent her to the ER for concerns of an infection. (Angel testimony.)
70. That is what the Respondent should have done. (Angel testimony.)
71. Sending the patient home instead was below the standard of care, even with the instructions that were given. (Angel testimony.)
72. It was also negligent. (Angel testimony.)
73. In sum, Dr. Angel opined that sending the patient home—as opposed to sending her to the ER or checking her blood culture or blood count himself—fell below the standard of care. He did not articulate any other conduct that fell below the standard of care. Nor did he opine whether the Respondent's negligence "caused" Patient A's death.

³ Some of her symptoms were signs of early sepsis. Signs of late sepsis are septic shock or collapse, low blood pressure, and mental status changes. One can go from early sepsis to late sepsis in a matter of hours. (Angel testimony.)

Other expert evidence offered by the Board⁴

74. The Board submitted two additional expert affidavits, both of which were prepared for the malpractice case. (Exhibits 11 and 12.)
75. One affidavit was authored by Dr. Robert Janett in January 2015 and the other by Dr. Reisman in February 2017. (Exhibits 11 and 12.)
76. Although the Board attempted to call Dr. Reisman as a witness, he did not complete his testimony. *See* footnote 1, *supra*.
77. Even though I place limited weight on this evidence, the substance of the affidavits is similar to Dr. Angel's opinion. Each doctor opined that the Respondent's conduct fell below the standard of care, caused Patient A's death, and constituted malpractice. (Exhibits 11 and 12.)
78. Because neither doctor was offering an opinion about whether the Respondent violated any statute or regulation, neither opined about whether he committed gross negligence or negligence on repeated occasions. (Exhibits 11 and 12.)
79. The doctors thought that because Patient A was particularly susceptible to infection, the Respondent should have ruled out an infection by conducting blood tests and referring her immediately to the ER. (Exhibits 11 and 12.)
80. Both doctors used almost identical language in noting that, although Patient A's vital signs were normal, that did not rule out the possibility of an infection. (Exhibits 11 and 12.)
81. Both doctors also used almost identical language in formulating their opinions on

⁴ I give each of these opinions limited weight since the experts did not testify and were not subject to cross-examination. I nevertheless summarize the basis and reasoning for their opinions.

causation. (Exhibits 11 and 12.)

Steven Van Dam, M.D.

82. Dr. Steven Van Dam testified as an expert for the Respondent.
83. Dr. Van Dam is board-certified in internal medicine. He is a full-time practicing internist and primary care physician. (Van Dam testimony.)
84. Dr. Van Dam reviewed various records. (Van Dam testimony.)
85. He understood that Patient A died of an infection, meningitis and pneumonia. (Van Dam testimony.)
86. Pneumonia is a bacterium. Dr. Van Dam presumed Patient A died of pneumococcal or streptococcal bacteria. Because there was no pneumococcal culture taken, Dr. Van Dam was hesitant to say anything more definitively. (Van Dam testimony.)
87. Pneumococcal bacteria usually infect the lungs, but they can also infect skin, spinal cord, brain and other soft tissues. (Van Dam testimony.)
88. When a patient has a pneumococcal bacterial infection in the lungs, symptoms are a productive cough, shortness of breath, hypoxemia (low oxygen level), fevers, chills, rapid breathing, and an abnormal lung exam. (Van Dam testimony.)
89. Patient A did not exhibit any of these symptoms. She had a normal pulmonary exam. (Van Dam testimony.)
90. Her ear nose and throat (“ENT”) exam was normal. It was reassuring that she did not have a sore throat—meaning she did not have a bacterial infection in her throat. (Van Dam testimony.)
91. Her respiration rate of 18 breaths per minute was not worrisome. According to the doctor, this was within normal limits. (Van Dam testimony.)

92. Dr. Van Dam was taught normal limits are between 10 and 20 breaths per minute; anything over 20 would be worrisome. Dr. Van Dam consulted medical literature before his testimony to confirm this. (Van Dam testimony.)
93. Patient A was not tachypneic. (Van Dam testimony.)
94. Patient A's temperature was normal. (Van Dam testimony.)
95. Patient A's pulse rate was normal, even taking into consideration that Patient A had a pacemaker. (Van Dam testimony.)
96. Dr. Van Dam characterized the idea that a pacemaker could have been controlling Patient A's pulse as "ridiculous." A pacemaker causes the heart to beat; it does not prevent the heart from beating. A pacemaker would not have slowed down Patient A's heartrate if she had an elevated pulse. (Van Dam testimony.)
97. He explained there are some specialized pacemakers that prevent the heart from beating too fast. But they do not cap the pulse at 76. And, in any event, Patient A did not have this special kind of pacemaker. (Van Dam testimony.)
98. The fact that Patient A had diarrhea was irrelevant. Infectious diarrhea is never bacterial. (Van Dam testimony.)
99. Nothing before the Respondent would have suggested that Patient A had pneumococcal bacteria in the lungs—or in the brain or spinal cord for that matter. (Van Dam testimony.)
100. With respect to sepsis, Dr. Van Dam explained there is no specific definable diagnosis of "early" sepsis; it is a term used loosely. (Van Dam testimony.)
101. Dr. Van Dam has a lot of experience treating and evaluating patients with sepsis. (Van Dam testimony.)
102. Based on his training and experience, septic patients do not appear the way Patient A

- appeared the day she went to the clinic. (Van Dam testimony.)
103. In fact, based on her presentation, Dr. Van Dam did not think she had a bacterial infection the day she came into the clinic. (Van Dam testimony.)
104. Someone could be fine one day and then be septic the next day. It is sometimes called a “super infection,” where someone has a viral infection, and because of that, they later become infected with bacteria. It happens sometimes with influenza, where a patient with influenza may die a few days later. When that happens, they did not die from influenza, but rather because they were later infected with bacteria. (Van Dam testimony.)
105. He could not say what was causing Patient A’s symptoms. Her presentation was bizarre. There was no syndrome that would cause a skin rash, pain for two weeks, and normal vital signs. (Van Dam testimony.)
106. There exist objective measures, or risk assessments, that look at the presence or absence of certain factors to calculate someone’s risk to develop a serious infection or sepsis. (Van Dam testimony.)
107. Given Patient A’s history, based on these objective measures, she would have presented with 0 or 1% risk of infection when the Respondent treated her. (Van Dam testimony.)
108. Patient A’s skin presentation was consistent with Raynaud’s. (Van Dam testimony.)
109. Raynaud’s is very common. (Van Dam testimony.)
110. Time is an important piece of information used to make diagnoses. The fact Patient A reported having those symptoms for a week was diagnostic and reassuring. The longer someone has had symptoms, the less serious their condition. (Van Dam testimony.)
111. He agreed the Respondent’s instructions to Patient A upon discharge were important and within the standard of care. (Van Dam testimony.)

112. With respect to Patient A's splenectomy, Dr. Van Dam explained that did not mean she automatically had an infection upon presentation. Rather, it just means "the bar is lower for thinking that someone may have a bacterial infection—but that doesn't mean every patient—as low as that bar is, not every patient with a splenectomy makes it over the bar." (Van Dam testimony.)⁵

Michael Jones, Esq.

113. Michael Jones testified on the Respondent's behalf. He is an attorney and Chief Legal Officer for Cape Cod Healthcare. (Jones testimony.)
114. Mr. Jones met the Respondent when he began working at Cape Cod Healthcare in 2004. (Jones testimony.)
115. During that time, the Respondent was also staff at Cape Cod Hospital. (Jones testimony.)
116. The Respondent left Cape Cod Healthcare around 2012 but returned in 2015. In all, the Respondent worked there for about 12 years. (Jones testimony.)
117. Attorney Jones worked with the Respondent professionally. He also referred patients to him over the years. (Jones testimony.)
118. Cape Cod Healthcare (and Cape Cod Hospital) would routinely conduct physician audits, using evaluative tools to compare performance relative to the quality of care the doctor is providing. (Jones testimony.)
119. In the Respondent's 12 years, there were never any concerns about his skills or

⁵ On cross and redirect, he clarified that someone who has had a splenectomy may still have a residual spleen: a piece of the original spleen which was not removed or a whole other spleen. Patient A's autopsy indicated she had a residual spleen. (Exhibit 1.) That fact made little difference in this case because the Respondent would not have known that, nor would it have changed Patient A's symptomology. However, this testimony reflected his attention to detail and scope of knowledge. (Van Dam testimony.)

competence. He was never subject to any monitoring or remediation. He was never disciplined by any entity. (Jones testimony.)

120. The Respondent enjoys a reputation as one of the more caring and compassionate physicians, someone who takes time with each patient talking about their medical conditions and personal life. (Jones testimony.)

Other expert evidence offered by the Respondent⁶

121. The Respondent also offered an additional expert report by Dr. Mark Friedman. (Exhibit 13.)
122. Dr. Friedman's analysis is substantially similar to Dr. Van Dam's. (Exhibit 13.)
123. Dr. Friedman did not believe Patient A had pneumonia when she saw the Respondent, since she exhibited no signs of it. Rather, she could have developed it after she left his office. (Exhibit 13.)
124. He was not convinced "that the autopsy demonstrated S pneumonia and that the lungs were the clear source of widespread infection and sepsis." The source of the strep infection itself was unclear. (Exhibit 13.)
125. Dr. Friedman parted ways with Dr. Van Dam, in that he did not believe Raynaud's was the likely diagnosis. Rather, he thought her symptoms were more consistent with a viral syndrome, which likely evolved to sepsis after Patient A left the Respondent's office. (Exhibit 13.)
126. He concluded that "it is common knowledge that many conditions such as viral

⁶ Like the affidavits put forth by the Board, I do not put much weight on this opinion because Dr. Friedman did not testify and was not subject to cross-examination. Additionally, his report was not made under the pains and penalties of perjury. Like the other documentary expert evidence, I summarize the basis and reasoning for his opinion.

conditions can present and progress over a period of a few days and their progression is unpredictable. It is not the standard of care to predict every event that could occur after a patient is seen.” (Exhibit 13.)

DISCUSSION

The Board puts forth three theories of misconduct: negligence on repeated occasions, gross negligence on a particular occasion, and malpractice.

The Board has the burden of proof by a preponderance of the evidence. *See BRM v. Pahuja*, RM-20-0258 (DALA Sep. 4, 2020), *adopted by* Board, Nov. 19, 2020. Whether the Respondent violated a statute or regulation turns first on whether he met the standard of care, which is “the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession,” *Brune v. Belinkoff*, 354 Mass. 102, 109 (1968), or the level of care and skill that physicians in the same specialty commonly possess. *See Palandijan v. Foster*, 446 Mass. 100, 104-05 (2006).

The Board may discipline a physician who commits negligence on repeated occasions. *See* G.L. c. 112, § 5, eighth par. (c); 243 Code Mass. Regs. § 1.03(5)(a)(3). “Negligence occurs when a physician ‘fail[s] to meet generally accepted standards of care within the medical community.’” *BRM v. Govindan*, RM-18-0161 (DALA Apr. 28, 2021, *adopted by* Board, Nov. 18, 2021), *quoting* *BRM v. Osei-Tutu*, RM-07-64 (DALA Jul. 8, 2008, *adopted by* Board, Feb. 25, 2009); *see also* Superior Court Model Jury Instructions (“general negligence” is failure “to use reasonable care under the circumstances. That failure might have occurred through action or inaction.”).

The Board may also discipline a physician who commits gross negligence on a single occasion. *See* G.L. c. 112, § 5, eighth par. (c); 243 Code Mass. Regs. § 1.03(5)(a)(3). Gross negligence is:

substantially and appreciably higher in magnitude than ordinary negligence. It is materially more want of care than constitutes simple inadvertence. It is an act or omission respecting legal duty of an aggravated character as distinguished from a mere failure to exercise ordinary care. It is very great negligence, or the absence of slight diligence, or the want of even scant care. It amounts to indifference to present legal duty and to utter forgetfulness of legal obligations so far as other persons may be affected. It is a heedless and palpable violation of legal duty respecting the rights of others. The element of culpability which characterizes all negligence is in gross negligence magnified to a high degree as compared with that present in ordinary negligence.

Altman v. Aronson, 231 Mass. 588, 591-592 (1919). “Persistence in a palpably negligent course of conduct over an appreciable period of time” can amount to gross negligence. *Parsons v. Amen*, 97 Mass. App. Ct. 96, 109 (2020).

Finally, the Board may discipline a physician who commits malpractice within the meaning of G.L. c. 112, § 61. *See* 243 Code Mass. Regs. § 1.03(5)(a)(17). “Malpractice has three elements: i) a doctor-patient relationship; ii) failure to conform to good medical practice; and iii) injury that was caused by the defendant physician.” *BRM v. Aweh*, 2019-040 (RM-19-0353) (Board Oct. 20, 2022), *citing Doherty v. Hellman*, 406 Mass. 330, 333 (1999). “Where a physician’s failure to conform to good medical practice causes injury, it constitutes malpractice even if the failure to conform to good medical practice is limited to a single act.” *Ibid*. “Malpractice is a stand-alone ground for discipline, separate and independent from gross negligence or negligence on repeated occasions.” *Ibid*.

1. The Board failed to prove Dr. Shackelford’s conduct fell below the standard of care

The threshold question is whether the Respondent’s conduct fell below the standard of care. If it did not, he did not violate any statute or regulation under any theory. While the results

of this case are truly tragic, I find that the Respondent's conduct did not fall below the standard of care.

Patient A's symptomology was unusual or, as Dr. Van Dam put it, "bizarre." She presented with signs of Raynaud's syndrome, but some symptoms were incompatible with that diagnosis. Her vitals were normal, which is inconsistent with an infection or sepsis; but she had other symptoms that are sometimes signs of infection. Given Patient A's presentation, it is no wonder so many experts disagreed on the proper course of conduct.

As noted, I place little weight on the reports and affidavits unsupported by live testimony. Both attorneys did an excellent job bringing out important points from the testifying witnesses (during direct and cross-examination). There are opinions in the written reports that were contradicted by certain testimony. But because the authors of these reports did not testify, I do not know how they would have explained or defended these contradictions if questioned by counsel.⁷ See *Commonwealth v. Funches*, 379 Mass. 283, 292 (1979), quoting *Davis v. Alaska*, 415 U.S. 208, 316 (1974) (cross-examination is "principal means by which the believability of a witness and the truth of his testimony are tested").

Instead, I rely mostly on the testimony of Dr. Angel and Dr. Van Dam. Both doctors are experienced and qualified to testify as experts. Both doctors were sincere in their beliefs and their opinions were within the realm of possibility. If nothing else, because the Board has the burden of proof, when competing experts offer equally plausible opinions "the preponderance of the evidence would favor neither party." See *BRM v. Peters*, RM-20-0299 (DALA Sept. 30, 2021) *adopted in part* by Board, Feb. 17, 2022; cf. *Commonwealth v. Berry*, 393 Mass. 793, 796

⁷ In any event, the documentary expert evidence provided by each party largely mirrors the opinion of each party's testifying expert.

(1985), citing *Commonwealth v. Carter*, 306 Mass. 141, 147 (1940) (“When the evidence tends equally to sustain either of two inconsistent propositions, neither of them can be said to have been established by legitimate proof.”).

However, although both experts were qualified, Dr. Van Dam was more knowledgeable and persuasive, as I shall explain. That makes his opinion more credible as to what occurred here. I accept his ultimate opinion on the appropriate standard of care in this case and disregard Dr. Angel’s. See *Robinson v. CRAB*, 20 Mass. App. Ct. 634, 639 (1985) (“The probative value of the expert testimony is for the fact-finding tribunal to decide, and where there is conflicting expert testimony, the fact finder may completely discount the testimony of one expert and rely exclusively on the other.”).

Dr. Angel looked at the case through hindsight, as opposed to looking at what data was in front of the Respondent at the time. All of Patient A’s vital signs were normal. Patient A’s pulmonary exam revealed no issues. Nothing in her presentation at the time would have suggested any problems with her lungs, let alone a bacterial infection—and certainly not sepsis. The most Dr. Angel could say is that some of Patient A’s vitals were “borderline” normal. But borderline normal is still normal. His testimony that “borderline” normal is somehow abnormal was not credible. What is the significance of delineating a normal range if data within that range is interpreted as problematic? Moreover, his skepticism about whether her pulse was actually normal, because she had a pacemaker, reflected a misunderstanding of how pacemakers work.

Dr. Angel’s opinion that the “borderline” data was concerning because Patient A had a splenectomy also misses the point. Per Dr. Van Dam, not having a spleen, in and of itself, does not cause infection. The fact that Patient A had a splenectomy did not matter in diagnosing whether she had an infection. It might have made her more prone to an infection, but on the day

the Respondent examiner her, she either had, or did not have, an infection. When the Respondent treated Patient A, no data supported a diagnosis of an infection—certainly not bacterial infection of the lungs or sepsis.

Dr. Angel's opinion is basically that if a patient is more susceptible to an infection, you should test and/or treat them for an infection even if the data does not indicate they have an infection. He did not present evidence that this the prevailing standard of care.

Dr. Van Dam was more knowledgeable. His explanation of which data is considered to be within normal limits made more sense. He reinforced his opinion by consulting with research before testifying. He understood and explained better how a pacemaker worked; he pointed out that a pacemaker would never prevent someone's heart from beating, and certainly not to 76 beats per minute. He was familiar with objective tests which measure someone's risk of developing an infection. Given Patient A's presentation, these objective tests indicated her risk to develop an infection when she went to urgent care would have been virtually zero.

Dr. Van Dam also paid attention to detail. For example, he noted that Patient A had a residual spleen. He also could not definitively say Patient A died of pneumococcal or streptococcal bacteria because there was no pneumococcal culture taken at her autopsy. Yet, his attention to detail did not distract from his opinion. He still explained that the presence of a residual spleen in this case made little difference to the ultimate question. And he agreed Patient A likely died of pneumococcal bacteria, notwithstanding the lack of testing. This attention to detail informs my assessment of his entire testimony. His overall presentation was more credible because of it.

His explanation that it is possible for a patient to be infection-free one day, and then have an infection the next day, is the most reasonable explanation of what occurred here.⁸ Patient A could have had a virus, for example, which amplified her susceptibility to develop an infection; but she may not have yet developed the infection when she went to urgent care. The Respondent could not foresee that would happen. Yet, he covered his bases by telling her that if her symptoms persisted or worsened, she should go to the ER.

To be sure, this is a close case. However, given the “battle of experts,” and my assessment of Dr. Van Dam as more credible, the Board has not met its burden to show the Respondent’s conduct fell below the standard of care.

2. The Board failed to prove their case as a matter of law.

Although I find the Respondent’s conduct did not fall below the standard of care, I nevertheless address whether, if it did, he violated any statute or regulations (should the Board disagree with my initial finding). As a matter of law, I find the Board did not prove the various elements necessary to support each theory.

A. Respondent did not commit Gross Negligence

Even the Board’s strongest presentation of the evidence does not support a finding of gross negligence. This was not a case where the Respondent exhibited deliberate inattention; nor did his conduct persist over a period of time. *See e.g. BRM v. David*, RM-18-0604 (DALA June 8, 2020), *adopted by Board*, Nov. 19, 2020, *citing Parsons v. Ameri*, 97 Mass. App. Ct. 96, 109 (2020). The Board cites one case that comes close to the fact pattern here: *BRM v. Williams*,

⁸ Dr. Angel agreed an infection can develop quickly, but somehow discounted the possibility that it developed after Patient A left urgent care—even though the timing made sense. *See BRM v. Govindan*, RB-18-0161 (DALA Apr. 28, 2021)(expert’s “explanation appears to assume negligence because of the occurrence of a bad outcome.”)

Case No. 2020-020 (Board April 8, 2021). Williams failed to properly diagnose a patient; the patient had bilateral pneumonia, but Williams failed to order tests to rule it out. There were also additional aggravating factors in *Williams* that are not present here: Williams did not physically exam the patient directly, but merely relied on conversations with his physician assistant; and some of the patient's symptoms were factors included in the Systemic Inflammatory Response Syndrome ("SIRS") scoring system, an objective measure of risk of infection.

In contrast, the Respondent personally examined the patient. None of her symptoms were factors in any objective assessment of risk for infection. His diagnosis, even if mistaken, was understandable given the "bizarre" presentation of symptoms.⁹

B. Respondent did not commit negligence on repeated occasions

I also disagree with the Board's theory that the Respondent's conduct could be considered negligence on repeated occasions. There is an open question as to whether "repeated occasions" can mean multiple acts within one visit or, rather, it refers to acts over multiple visits. I can find no definitive case on point. The *Williams* case is close, but it does not explain if Williams committed negligence on repeated occasions or gross negligence. Similar cases cited in *Williams* are vague. In *Matter of Naiver Imam, M.D.*, Board of Registration in Medicine, Adjudicatory Case No. 2021-009 (Consent Order, Mar. 11, 2021), the Board did not articulate the misconduct—it could have been gross negligence, negligence on repeated occasions, or malpractice. In *Matter of Robert M. Shalvoy, M.D.*, Board of Registration in Medicine, Adjudicatory Case No. 2009-035 (Consent Order, Nov. 18, 2009) and *Matter of David Chapin*,

⁹ It is also unclear if the Board disciplined Williams because he committed one act of gross negligence or negligence on repeated occasions for multiple acts during that patient's one visit. If it was one act of gross negligence, this case is distinguishable. If it is for repeated acts of negligence in one visit, I reject that as a basis for discipline as explained below.

M.D., Board of Registration in Medicine, Adjudicatory Case No. 04-53-XX (Consent Order, Nov. 7, 2004), the physicians were disciplined for committing malpractice, not negligence. In *Matter of John Clapp, M.D.*, Board of Registration in Medicine, Adjudicatory Case No. 06-014 (Consent Order, Apr. 12, 2006), the physician's conduct stretched over years.

The cases the Board cites are likewise unhelpful. In *Matter of Rothchild, M.D.*, Board of Registration in Medicine, Adjudicatory Case Nos. 2006-021 and 2008-002, the physician's conduct was characterized as "gross negligence," not multiple acts of simple negligence. In *Matter of Petit, M.D.*, Board of Registration in Medicine, Adjudicatory Case No. 00-35-XX (Consent Order, Nov. 21, 2000), the level of negligence is unstated. In *Matter of Osei-Tutu, M.D.*, Board of Registration in Medicine, Adjudicatory Case No. 2007-004 (Final Decision and Order, Feb. 25, 2009), the Respondent committed numerous acts of negligence spread out over various dates and patient visits.

Moreover, it does not appear this issue was directly considered by the Board in any of these cases or raised by the physicians—especially since many cases involve consent orders. Because the issue is squarely contested in this case and raised by the Respondent, it deserves a fuller airing than reliance on prior cases which gloss over it.

As a matter of statutory interpretation, I believe the Respondent has the better argument. The plain meaning of the term "repeated occasions" refers to acts over multiple events or episodes. Respondent draws an apt analogy from a case about federal sentencing. See *Wooden v. U.S.*, 595 U.S. ___, 142 S.Ct. 1063 (2022). The issue in *Wooden* was whether the defendant's ten burglaries committed on one night (when he broke into one storage facility and stole from ten storage units) were convictions "committed on occasions different from one another." The Court relied on a commonsense understanding, and dictionary definition, of the word "occasion."

Consider first how an ordinary person (a reporter; a police officer; yes, even a lawyer) might describe Wooden's ten burglaries—and how she would not. The observer might say: "On one occasion, Wooden burglarized ten units in a storage facility." By contrast, she would never say: "On ten occasions, Wooden burglarized a unit in the facility." Nor would she say anything like: "On one occasion, Wooden burglarized a storage unit; on a second occasion, he burglarized another unit; on a third occasion, he burglarized yet another; and so on." She would, using language in its normal way, group his entries into the storage units, even though not simultaneous, all together—as happening on a single occasion, rather than on ten "occasions different from one another." §924(e)(1).

That usage fits the ordinary meaning of "occasion." The word commonly refers to an event, occurrence, happening, or episode. See, e.g., American Heritage Dictionary 908 (1981); Webster's Third New International Dictionary 1560 (3d ed. 1986). And such an event, occurrence, happening, or episode—which is simply to say, such an occasion—may itself encompass multiple, temporally distinct activities. The occasion of a wedding, for example, often includes a ceremony, cocktail hour, dinner, and dancing. Those doings are proximate in time and place, and have a shared theme (celebrating the happy couple); their connections are, indeed, what makes them part of a single event. But they do not occur at the same moment: The newlyweds would surely take offense if a guest organized a conga line in the middle of their vows. That is because an occasion may—and the hypothesized one does—encompass a number of non-simultaneous activities; it need not be confined to a single one.

Wooden, at 1069-71.

The same logic applies here. It would be odd to say during a single examination of a patient that on one occasion, the Respondent was negligent; on a second occasion, he was negligent again; on a third occasion, he was yet again negligent. Rather, "occasion" commonly refers to the entirety of an event, even though multiple acts can occur within that occasion. At least one other state court has interpreted similar language this way:

The statutory definition of "negligence" for professional misconduct requires proof of negligence "on more than one occasion." N.Y. Educ. Law § 6530(3). The Court of Appeals has interpreted "occasion" to mean "an event of some duration, occurring at a particular time and place, and not simply ... a discrete act of negligence which can occur in an instant" [*Rho v. Ambach*, 74 N.Y.2d 318, 322 (1989)]. While several acts of negligence occurring during a single autopsy do not constitute professional misconduct (*Rho*), an act of negligence regarding a single patient repeated on a subsequent occasion, does constitute misconduct. *Orosco v.*

Sobol, 557 N.Y.S.2d 738 (3d Dept 1990).

In the Matter of John Carey, M.D., 2015 WL 399648 (N.Y. Bd. for Professional Med. Conduct), BPMC No. 15-006, January 12, 2015.

The Board argues that the repeated occasions of negligence occurred when the Respondent 1) sent Patient A home with her presentation and lack of a spleen 2) failed to consider she might be suffering from an infection 3) diagnosed her with Raynaud's Syndrome and 4) failed to perform a differential diagnosis that contributed to the incorrect diagnosis. *See* Petitioner's Closing Brief, pg. 14. But these were all part of a continuous stream of conduct within one event. *Cf. Commonwealth v. Howze*, 58 Mass. App .Ct. 147, 152 (2003) *overruled on other grounds by Commonwealth v. Kelly*, 470 Mass. 682, 700-701 (2015) (“[D]ue process forbids separating the conduct into discrete units for prosecution. All were part of a continuous stream of conduct occurring within a short time frame and governed by a single criminal design.”).

In a similar case, the Board characterized different missteps within one visit as a “single act of negligence.” *See Matter of Edinburgh*, Board of Registration in Medicine, Adjudicatory Case No. 89-3-TR (Dec. 18, 1991):

The Respondent's treatment of Patient B on the night of September 30, 1987, was based on an incomplete set of facts, either because he did not obtain necessary information or he ignored or did not hear information which was given to him. This included a history of elevated blood pressure, nausea, and vomiting in this pregnancy, headaches, and consideration of the possibility that Patient B's pain was epigastric. Had these matters been considered, the standard of care would have mandated that the Respondent conduct laboratory tests and admit Patient B. Such actions on that evening possibly would have led to a different fetal outcome.

The Board concluded that the “law will not support a sanction for a single act of negligence,” implying that all of the physician's errors were part of a single episode. Although *Edinburgh* did

not directly consider whether the physician's conduct was "negligent on repeated occasions," its ultimate holding comports with my interpretation.

In short, the phrase "on repeated occasions" cannot apply to the conduct in this case, when there is only one occasion to consider.

C. The Board failed to prove the Respondent's conduct caused Patient A's injury

Finally, even if the Respondent's conduct fell below the standard of care, the Board failed to prove his conduct caused Patient A's injury (*i.e.*, her death). "This causal link generally must be established by expert testimony that the injury was more probably than not a result of the physician's negligence." *Harlow v. Chin*, 405 Mass. 697, 702 (1989). Dr. Angel did not opine on causation, just standard of care. The only opinions on causation came from the expert affidavits to which, as noted, I give little weight.

For example, Dr. Janet believed Patient A's symptoms were consistent with an infection generally, and specifically pneumonia, at the time of the Respondent's evaluation (again, even though she had no signs of pneumonia). In any event, he explains that, more likely than not, "streptococcus bacteria had crossed the blood-brain barrier and were infecting Patient A's brain and surrounding tissue, leading to tissue necrosis. The blood stream infection had been present long enough to also cause abscesses to form in other organs, including the kidneys and heart." He then says he believes Patient A would have survived if she was sent to the hospital for empirical antibiotic therapy. Dr. Reisman's affidavit is virtually identical.

These opinions presume Patient A had an infection when she arrived at urgent care—which I doubt. Nevertheless, there was also no explanation about how immediately antibiotics would have helped. How serious were the abscesses in her other organs? At what point does an infection in the brain become irreversible? What is the survival rate for a splenectomy patient

who has an untreated infection? Without testimony and further exploration of these opinions, I do not credit them with respect to the issue of causation. Absent these opinions, there is no other evidence to support this element.

CONCLUSION

I recommend the Board find that the Respondent's actions did not fall below the standard of care and that he did not commit misconduct by violating any statute or regulation.

DIVISION OF ADMINISTRATIVE LAW APPEALS

Eric Tennen

Eric Tennen
Administrative Magistrate

JUN 06 2023