

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2024-034

In the Matter of

Janice Michelle P. Trull, D.O.

CONSENT ORDER

Pursuant to G.L. c. 30A, § 10, Janice Michelle P. Trull, D.O. (Respondent) and the Board of Registration in Medicine (Board) (hereinafter referred to jointly as the "Parties") agree that the Board may issue this Consent Order to resolve the above-captioned adjudicatory proceeding.

The Parties further agree that this Consent Order will have all the force and effect of a Final Decision within the meaning of 801 CMR 1.01(11)(d). The Respondent admits to the findings of fact specified below and agrees that the Board may make the conclusion of law and impose the sanction set forth below in resolution of investigative Docket No. 22-004.

Findings of Fact

1. The Respondent graduated from the Philadelphia College of Osteopathic Medicine in 2005 and is certified by the American Board of Family Medicine. She has been licensed to practice medicine in Massachusetts under certificate number 236883 since July 2008. She works at Family Medicine Associates of South Attleboro.

2. In G.L. c. 4, § 7(26)(c) 2015, Patient A was a G.L. c. 4, § 7(26)(c) man with a medical history of

G.L. c. 4, § 7(26)(c)

  Patient A also had a medical history that included G.L. c. 4, § 7(26)(c)

G.L. c. 4, § 7(26)(c). Patient A was being treated with G.L. c. 4, § 7(26)(c) medications, including the G.L. c. 4, § 7(26)(c) - G.L. c. 4, § 7(26)(c).

3. On G.L. c. 4, § 7(26)(c) 2015, Patient A went to G.L. c. 4, § 7(26)(c) Hospital G.L. c. 4, § 7(26)(c) Emergency Department (ED) complaining of G.L. c. 4, § 7(26)(c). He underwent a G.L. c. 4, § 7(26)(c) that day and the G.L. c. 4, § 7(26)(c) G.L. c. 4, § 7(26)(c). Patient A was administered G.L. c. 4, § 7(26)(c) and was discharged home with reduced pain and instructed to use G.L. c. 4, § 7(26)(c) as prescribed.

4. On G.L. c. 4, § 7(26)(c), 2015, Patient A returned to the G.L. c. 4, § 7(26)(c) ED reporting that the medications did not resolve his G.L. c. 4, § 7(26)(c). The G.L. c. 4, § 7(26)(c) ED attending physician prescribed G.L. c. 4, § 7(26)(c), which provided Patient A pain relief, and G.L. c. 4, § 7(26)(c). The ED physician also encouraged Patient A to follow up with an G.L. c. 4, § 7(26)(c) specialist and advise his primary care physician (PCP) what was going on.

5. On G.L. c. 4, § 7(26)(c) 2015, Patient A went to his PCP's office. His usual PCP was unavailable and, instead, he was seen by the Respondent. Patient A reported the ED provider's recommendation for an G.L. c. 4, § 7(26)(c) referral, and reported he had a G.L. c. 4, § 7(26)(c). The Respondent recommended he continue on the G.L. c. 4, § 7(26)(c) and referred him to an G.L. c. 4, § 7(26)(c) specialist for further evaluation.

6. On G.L. c. 4, § 7(26)(c) 2015, Patient A visited an G.L. c. 4, § 7(26)(c) specialist who evaluated him, performed a G.L. c. 4, § 7(26)(c). At the time of this visit, Patient A's G.L. c. 4, § 7(26)(c). The G.L. c. 4, § 7(26)(c) specialist noted Patient A was experiencing significant pain, G.L. c. 4, § 7(26)(c).

G.L. c. 4, § 7(26)(c). The results of the G.L. c. 4, § 7(26)(c) were not consistent with G.L. c. 4, § 7(26)(c) as the cause of Patient A's G.L. c. 4, § 7(26)(c) pain. The G.L. c. 4, § 7(26)(c) specialist urged Patient A and G.L. c. 4, § 7(26)(c) to discuss getting a G.L. c. 4, § 7(26)(c) evaluation with his PCP within one week. Despite Patient A's request, the G.L. c. 4, § 7(26)(c) specialist declined to prescribe more G.L. c. 4, § 7(26)(c) to ease Patient A's pain because she wanted a G.L. c. 4, § 7(26)(c) to evaluate his G.L. c. 4, § 7(26)(c) pain. The encounter notes were faxed to the Respondent's office on or around G.L. c. 4, § 7(26)(c) 2015. The G.L. c. 4, § 7(26)(c) provider did not recommend Patient A report to the Emergency Department for an urgent work up.

7. On G.L. c. 4, § 7(26)(c), 2015, Patient A went back to the Respondent complaining of G.L. c. 4, § 7(26)(c) since the previous weekend. Patient A's G.L. c. 4, § 7(26)(c) at the time of this encounter was G.L. c. 4, § 7(26)(c). Patient A relayed the G.L. c. 4, § 7(26)(c) specialist's findings that his G.L. c. 4, § 7(26)(c) were not due to G.L. c. 4, § 7(26)(c) and most likely G.L. c. 4, § 7(26)(c) in nature and he should see a G.L. c. 4, § 7(26)(c).

8. At the G.L. c. 4, § 7(26)(c) 2015 visit, the Respondent diagnosed Patient A with G.L. c. 4, § 7(26)(c). The Respondent encouraged Patient A's G.L. c. 4, § 7(26)(c) to make an appointment with a G.L. c. 4, § 7(26)(c), noting the appointment should be at the provider's discretion. Patient A was also instructed to follow up with the Respondent on G.L. c. 4, § 7(26)(c) 2015.

9. G.L. c. 4, § 7(26)(c)

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10. Given the report by Patient A, his previous 2 recent presentations to the Emergency Department and discharge as well as her own examination, the Respondent did not

resend Patient A to the ED for an urgent work up or schedule an urge appointment for Patient A to see a [G.L. c. 4, § 7(26)(c)]

11. The Respondent was not privy to the [G.L. c. 4, § 7(26)(c)] written recommendation until after Patient A was admitted to [G.L. c. 4, § 7(26)(c)] Hospital. Per patient report, during the [G.L. c. 4, § 7(26)(c)] 2015 office visit, Patient A indicated there was a discrepancy between the [G.L. c. 4, § 7(26)(c)] and the [G.L. c. 4, § 7(26)(c)] specialist's interpretations of the [G.L. c. 4, § 7(26)(c)] 2015 [G.L. c. 4, § 7(26)(c)].

12. On [G.L. c. 4, § 7(26)(c)] 2015, at approximately [G.L. c. 4, § 7(26)(c)] (after business hours) Patient A contacted the Respondent through the Patient Portal to tell her he was unable to make an appointment with a [G.L. c. 4, § 7(26)(c)] until [G.L. c. 4, § 7(26)(c)] 2015. Patient A asked if the Respondent could get him in to see a [G.L. c. 4, § 7(26)(c)] sooner, as he could not deal with the pain for another three weeks.

13. The Respondent did not have an opportunity to review patient portal communications until the afternoon of [G.L. c. 4, § 7(26)(c)] 2015. The Respondent did not facilitate an earlier appointment with a [G.L. c. 4, § 7(26)(c)] or direct her staff to do so. The Respondent responded on [G.L. c. 4, § 7(26)(c)] 2015 at [G.L. c. 4, § 7(26)(c)] through the patient portal, by asking how the pain medication she had prescribed was working.

14. On [G.L. c. 4, § 7(26)(c)] 2015, at about [G.L. c. 4, § 7(26)(c)] Patient A went to [G.L. c. 4, § 7(26)(c)] Hospital's Emergency Department and reported he had been experiencing a [G.L. c. 4, § 7(26)(c)] [G.L. c. 4, § 7(26)(c)] [G.L. c. 4, § 7(26)(c)], [G.L. c. 4, § 7(26)(c)]. Patient A was administered [G.L. c. 4, § 7(26)(c)] medications for pain.

15. About one hour after he arrived at [G.L. c. 4, § 7(26)(c)] Hospital, Patient A's [G.L. c. 4, § 7(26)(c)] noticed an acute change in his [G.L. c. 4, § 7(26)(c)]. A [G.L. c. 4, § 7(26)(c)] was ordered and revealed an [G.L. c. 4, § 7(26)(c)]

[REDACTED]

16. Patient A was transferred to G.L. c. 4, § 7(26)(c) Hospital via G.L. c. 4, § 7(26)(c) the same evening and died in the hospital on G.L. c. 4, § 7(26)(c) 2017.

17. The Respondent's treatment of Patient A was negligent in the following respects:

- a. She did not act with enough urgency in facilitating an appointment with a G.L. c. 4, § 7(26)(c) for Patient A given his G.L. c. 4, § 7(26)(c) despite his numerous pain medications, two previous emergency room visits, the G.L. c. 4, § 7(26)(c) specialist recommendation that he see a G.L. c. 4, § 7(26)(c), and Patient A's request for assistance in expediting a G.L. c. 4, § 7(26)(c) appointment;
- b. She did not document counseling Patient A to return to the clinic or the Emergency Department if his symptoms persisted or worsened;
- c. Upon diagnosing Patient A with G.L. c. 4, § 7(26)(c), she did not facilitate a hospital admission for Patient A and consultation with a G.L. c. 4, § 7(26)(c) to address her diagnosis;
- d. She did not adequately consider other etiologies of Patient A's G.L. c. 4, § 7(26)(c) beyond G.L. c. 4, § 7(26)(c) despite Patient A's medical history, previous G.L. c. 4, § 7(26)(c), and being over G.L. c. 4, § 7(26)(c);
- e. She did not consult the G.L. c. 4, § 7(26)(c) who read Patient A's G.L. c. 4, § 7(26)(c) 2015 G.L. c. 4, § 7(26)(c) and had a different interpretation than that of the G.L. c. 4, § 7(26)(c) specialist.

18. As a result of the above, Patient A was not sent for emergent care and subsequently suffered injuries that resulted in his death.

### Conclusion of Law

A. The Respondent has violated G.L. c. 112, § 5, eighth par. (c) and 243 CMR 1.03(5)(a)3 by engaging in conduct that places into question the Respondent's competence to practice medicine including practicing medicine with negligence on repeated occasions.

B. The Respondent has violated 243 CMR 1.03(5)(a)17 by committing malpractice within the meaning of M.G.L. c. 112, § 61.

### Sanction and Order

The Respondent's license is hereby REPRIMANDED.

### Execution of this Consent Order

Complaint Counsel and the Respondent agree that the approval of this Consent Order is left to the discretion of the Board. The signature of Complaint Counsel, the Respondent, and the Respondent's counsel are expressly conditioned on the Board accepting this Consent Order. If the Board rejects this Consent Order in whole or in part, then the entire document shall be null and void; thereafter, neither of the parties nor anyone else may rely on these stipulations in this proceeding.


As to any matter in this Consent Order left to the discretion of the Board, neither the Respondent, nor anyone acting on her behalf, has received any promises or representations regarding the same.

The Respondent waives any right of appeal that she may have resulting from the Board's acceptance of this Consent Order.


The Respondent shall provide a complete copy of this Consent Order with all exhibits and attachments within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: any in- or out-of-state hospital, nursing home,

clinic, other licensed facility, or municipal, state, or federal facility at which the Respondent practices medicine; any in- or out-of-state health maintenance organization with whom the Respondent has privileges or any other kind of association; any state agency, in- or out-of-state, with which the Respondent has a provider contract; any in- or out-of-state medical employer, whether or not the Respondent practices medicine there; the state licensing boards of all states in which the Respondent has any kind of license to practice medicine; the Drug Enforcement Administration Boston Diversion Group; and the Massachusetts Department of Public Health Drug Control Program. The Respondent shall also provide this notification to any such designated entities with which the Respondent becomes associated in the year following the date of imposition of this reprimand. The Respondent is further directed to certify to the Board within ten (10) days that the Respondent has complied with this directive.

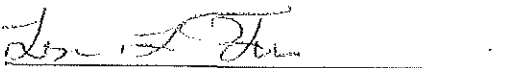
The Board expressly reserves the authority to independently notify, at any time, any of the entities designated above, or any other affected entity, of any action it has taken.

  
Janice Michelle P. Trull, D.O.  
Licensee

6/7/24  
Date

  
Daniel J. Bioniconi, Esq.  
Attorney for the Licensee

6/12/24  
Date

  
Lisa Fuccione, Esq.  
Director of Enforcement

6/25/24  
Date

So ORDERED by the Board of Registration in Medicine this 27th day of June,  
2024.

A handwritten signature in black ink, appearing to read 'Frank O. Donnell', written over a horizontal line.

Frank O Donnell,  
Acting Board Chair