ATTACHMENT A

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine
Docket No. RM,,20-0217

In the Matter of

EDWARD J. WILLIAMS, M.D.

JOINT STIPULATION

Edward J. Williams, M.D. (the "Respondent"), the Respondent's attorney, and Complaint Counsel (hereinafter referred to jointly as the "Parties") agree that this Joint Stipulation shall be filed with the Administrative Magistrate for the Division of Administrative Law Appeals ("DALA") as a resolution of questions of material fact and law as set forth by the Statements of Allegations in the above matter. The Respondent admits to the Findings of Fact described below and agrees that the Administrative Magistrate and the Board of Registration in Medicine (the "Board") may make the Conclusions of Law as set forth below.

FINDINGS OF FACT

BACKGROUND

L The Respondent was born on January 6, 1967, He is a 1993 graduate of the Georgetown University School of Medicine. The Respondent is certified by the American Board of Medical

Specialties in Emergency Medicine. His practice specialty is Emergency Medicine. He was licensed to practice medicine in Massachusetts on June 26, 1996 under certificate number 150636.

2, The Respondent has held a license to practice medicine in New Hampshire and West Virginia. His license to practice in West Virginia has lapsed.

STIPULATED FACTS

1. On February 27, 2014, the New Hampshire Board of Medicine ("New Hampshire Board") received a copy of a Complaint ("Complaint") filed in Strafford County Superior Court against the Respondent and a physician's assistant ("PA") on the Wentworth-Douglas Hospital Emergency Department. The Complaint alleged that the Respondent and the PA were negligent in the treatment of Patient A and that their negligence resulted in patient harm. The civil proceeding that led to the New Hampshire Board's investigation was fully tried over approximately four days before Judge Stephen Hourak and a jury in the Stratford County Superior Court and resulted in a jury verdict in favor of the Respondent. Nonetheless, the New Hampshire Board conducted its own hearing, which lasted several hours, and then reprimanded the Respondent.

2. On December 8, 2017 the New Hampshire Board found that the Respondent displayed medical practice that is incompatible with the basic knowledge and competence expected of persons licensed to practice medicine when he failed to recognize that the abnormal lab results for Patient A indicated something more serious than what was diagnosed. The Respondent's treatment of Patient A fell below the standard of care and was negligent. The New Hampshire Board issued a Reprimand. A copy of the New Hampshire Medical Board's Final

Decision and Order is attached hereto as Attachment A and is incorporated herein by reference,

3. The Respondent appealed the Final Decision and Order by the New Hampshire Board. On March 8, 2019, the New Hampshire Supreme Judicial Court upheld the New Hampshire Board's Final decision and Ordere A copy of The State of New Hampshire Supreme Court ruling for Case No. 2018-0138 is attached hereto as Attachment B and is incorporated herein by reference.

4.The New Hampshire Medical Board's Final Decision and Order set forth the following facts:

a. On February 23, 201 1, Patient A presented to the Wentworth-Douglass Emergency Room after being ill for five days with fever, chills, vomiting, diarrhea, and upper abdominal pains. Patient A was first evaluated by the Physician's Assistant ("PA"), who was under the supervision of the Respondent. The PA ordered lab tests for Patient A and then conferred with the Respondent on Patient A's symptoms and lab results.

b. The lab results revealed that Patient A had a low White Blood Cell Count ("WBC") and multiple organ dysfunction,

c. 'The Respondent suggested ordering influenza and hepatitis tests. The results of which came back negative.

d. The Respondent and the PA did not order imaging or any further studies. Patient A was treated for gastroenteritis and diagnosed with a viral syndrome. Patient A

was discharged by the PA with prescriptions for a cough suppressant and antinausea medication.

e. Patient A returned to the Emergency Department the following evening and was diagnosed with bilateral pneumonia, acute respiratory distress syndrome, pleural effusions, pneumothoraxes which required surgical intervention, and a seven week hospitalization.

CONCLUSIONS OF LAW

A. The Respondent has violated 243 CMR I 03(5)(a)12 in that he has been disciplined in another jurisdiction in any way by the proper licensing authority for reasons substantially the same as those set forth in G.L. cr 112, 5 or 243 CMR 1.03(5)—specifica11y::

1 . Pursuant to 243 CMR 1.03(5)(a)3, the Board may discipline a physician upon proof satisfactory to a majority of the Board, that said physician's conduct placed into question the physicians competence to practice medicine, including but not limited to gross misconduct in the practice of medicine, or practicing medicine fraudulently, or beyond its authorized scope, or with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions,

SANCTION AND ORDER

The Parties expressly acknowledge that the Board may impose sanctions against the Respondent based upon the above Findings of Fact and Conclusions of Law. The Parties hereby jointly agree to recommend to the Board that it impose the sanction set forth below. The Parties

understand that the recommended sanction is not binding on the Board, and that the Board may wish to impose a different sanction on the Respondent,

At the time the Board considers this Stipulation, it will infom the Parties of its inclination as to sanction. If the Board's sanction is different from the one recommended by the Parties, the Respondent will be given an opportunity to either accept or reject the proposed sanction. If the Respondent rejects the proposed sanction, then the matter will continue through the adjudicatory process pursuant to Mass. Gen, Laws c. 30A and 801 CMR I .00 et seq.

The Respondent's license to practice medicine in the Commonwealth of Massachusetts is hereby reprimanded. These sanctions are imposed for each violation of law listed in the Conclusions of Law section, above, and not a combination of any or all of them.

EXECUTION OF THIS STIPULATION

The Parties agree that the approval of this Stipulation is left to the discretion of the Administrative Magistrate and the Board. As to any matter this Stipulation leaves to the discretion of the Administrative Magistrate or the Board, neither the Respondent, nor anyone else acting on his behalf, has received any promises or representations regarding the same.

The signatures of the Parties are expressly conditioned on the Administrative Magistrate and the Board accepting this Stipulation.

If the Administrative Magistrate rejects any provision contained in this Stipulation, the entire document shall be deemed null and void and the matter will be scheduled for a hearing pursuant to Mass. Gen. Laws c. 30A and 801 CMR 1.00 et seq.

John Cassidy
Attorney for Respondent

9/25/20
Date

9/29/20

provision in this Stipulation or modifies the Sanction and said modification is rejected by the Respondent, the entire document shall be null and void and the matter will be recommitted to DALA for appropriate proceedings and an eventual hearing pursuant to Mass. Gen. Laws c. 30A and 801 CMR I .00 et seq.

Neither the Parties nor anyone else may rely on the Stipulation in either the proceedings or hearing referenced in the preceding paragraph or in any appeal therefrom,

Edward J. Williams,
M.D.
Respondent

9/24/2020
Date

Katelyn Giliberti
Complaint Counsel

atelyn Giliberti Date

Attachment A

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
STATE OF NEW HAMPSHIRE
DIVISION OF HEALTH PROFESSIONS
Board of Medicine
121 South Fruit Street, Suite 301
Concord, N.H. 03301-2412
Telephone 603-271-1203 · Fax 603-271-6702

PETER DANLES
Executive Director

JOSEPH G. SHOEMAKER
Division Director

December 21, 2017

BARBARA A PISELLI INTERIM EXEC DIR
MASSACHUSETTS BOARD
OF REGISTRATION IN MEDICINE
200 HARVARD MILL SQ STE 330
WAKEFIELD MA 01880-3238

Re: Edward J. Williams, III, M.D.
DOB: 1/6/1967

Dear Ms. Piselli:

The New Hampshire Board of Medicine has recently taken Board action against the above referenced physician. Based on our records, there is reason to believe that this physician also holds a license or has held a license in your state. For this reason, we are providing a copy of this Board action for your records.

Please feel free to contact us for any additional information that may be necessary.

Sincerely,

Penny Taylor

Penny Taylor
Administrator

Encl.

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 Picksman & 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

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.

Attachment B

THE STATE OF NEW HAMPSHIRE

SUPREME COURT

In Case No. 2018-0138, Appeal of Kasey L. Dillon, P.A. & a., the court on March 8, 2019, issued the following order:

Having considered the briefs and oral arguments of the parties, the court concludes that a formal written opinion is unnecessary in this case. Petitioners Kasey L. Dillon, P.A., and Edward J. Williams, M.D., appeal a decision of the New Hampshire Board of Medicine (board). In its decision, the board concluded that the petitioners' treatment of a certain patient, K.H., on February 23, 2011, fell below the standards established by RSA 328-D:6, IV (2017) and RSA 329:17, VI (2017), respectively, and thus subjected the petitioners to formal discipline. The petitioners argue that: (1) the board's order is unjust and unreasonable in light of the favorable jury verdict the petitioners received in the civil case that spurred the board's investigation; (2) the board erred by failing to disqualify hearing counsel's expert witness, Colin O'Brien, M.D.; and (3) the board's order and certain factual findings therein are unjust and unreasonable because they are not supported by sufficient evidence. We affirm.

The following facts were found by the board or are otherwise derived from the record. The petitioners are, respectively, a physician assistant and a physician. They were both working in the Emergency Department of Wentworth-Douglass Hospital the evening of February 23, 2011. K.H. presented to Wentworth-Douglass's emergency room that night after being ill for five days with a fever, chills, vomiting, diarrhea, upper abdominal pains, and a cough. Dillon conducted a physical examination of K.H. After the physical examination, Dillon ordered certain testing, including a complete blood count (CBC). After Dillon conferred with Williams, influenza and hepatitis tests were also ordered. No chest x-ray was ordered or conducted. The CBC disclosed certain abnormal results, including a low white blood cell count and 36% bands. However, Dillon did not record these abnormalities on K.H.'s emergency room physician report.

Dillon ordered treatment for K.H., which included two liters of intravenous normal saline and Zofran, an anti-nausea medication. The petitioners ultimately diagnosed K.H. with a gastrointestinal virus. Dillon discharged K.H. with prescriptions for Tussionex, a cough suppressant, as well as more Zofran, and instructed her to follow up with her primary care physician. The following day, K.H. returned to Wentworth-Douglass and was diagnosed with pneumonia, impending respiratory failure, acute respiratory

distress syndrome, and sepsis. Her condition required surgical intervention and a seven-week hospitalization.

In 2014, the board received a copy of a civil complaint filed in Strafford County Superior Court. See RSA 329:17, II (2017). The complaint alleged that the petitioners were grossly negligent in their treatment of K.H. The board then commenced an investigation of the allegations in the complaint. The civil proceeding that led to the board's investigation culminated in a jury verdict for the petitioners. However, based on information gathered during the board's investigation, including letters received from the petitioners, the board proceeded with the instant disciplinary action. At the hearing, the board heard testimony and received various exhibits into evidence. The board ultimately concluded that Dillon's treatment of K.H. fell below the standards set by RSA 328-D:6, IV, and that Williams' treatment of K.H. fell below the standards of RSA 329:17, VI. See RSA 328-D:6, IV (authorizing board to discipline licensed physician assistant upon finding, after hearing, that licensee "[h]as 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"); RSA 329:17, VI(c) (authorizing board to discipline licensed physician upon finding, after hearing, that licensee "[h]as 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"). The board also concluded that formally reprimanding the petitioners was the appropriate measure of discipline to impose. See RSA 328-D:7 (2017); RSA 329:17, VII (2017). This appeal followed.

RSA chapter 541 governs our review of the board's decision. RSA 328-D:8 (2017); RSA 329:17, VIII (2017); see Appeal of Rowan, 142 N.H. 67, 70 (1997). We will not set aside the board's order except for errors of law, unless we are satisfied, by a clear preponderance of the evidence, that it is unjust or unreasonable. Appeal of Dell, 140 N.H. 484, 487-88 (1995); RSA 541:13 (2007). The petitioners, as the parties seeking to set aside the board's order, have the burden of proof. RSA 541:13. The board's findings of fact are presumed prima facie lawful and reasonable. Id.; Dell, 140 N.H. at 497. In reviewing the board's findings, our task is not to determine whether we would have found differently than did the board, or to reweigh the evidence, but rather to determine whether the findings are supported by competent evidence in the record. Dell, 140 N.H. at 498. However, we review the board's rulings on issues of law de novo. See In the Matter of Bloomfield, 166 N.H. 475, 478 (2014).

We first address the petitioners' argument concerning the effect of the civil malpractice case on the board's proceeding. The petitioners argue that, in light of the favorable jury verdict they received in the civil case that gave rise to the board's investigation, the board's order to the contrary is unjust and

unreasonable. However, they never presented this argument to the board, in their motion for reconsideration or otherwise. Accordingly, it is not preserved for our review. See RSA 541:4 (2007) (providing that "no ground not set forth [in a motion for rehearing] shall be urged, relied on, or given any consideration by the court"); Appeal of Northern New England Tele. Operations, LLC, 165 N.H. 267, 272 (2013); Appeal of Walsh, 156 N.H. 347, 352 (2007); Appeal of Coffey, 144 N.H. 531, 533 (1999) ("Issues not raised in the motion for rehearing cannot be raised on appeal."). Even if we were to conclude otherwise, the petitioners have not adequately developed their argument. See Lennartz v. Oak Point Assocs., P.A., 167 N.H. 459, 464 (2015) (explaining that judicial review is not warranted for complaints regarding adverse rulings without developed legal argument). For these reasons, we decline to consider the petitioners' argument.

We turn next to the petitioners' arguments concerning hearing counsel's expert witness, O'Brien. The petitioners contend that the board violated their due process rights under the State Constitution by failing to disqualify O'Brien. See N.H. CONST. pt. I, art. 15. They do not argue that their due process rights under the Federal Constitution were violated.

At the time of the petitioners' hearing, O'Brien was a member of the Medical Review Subcommittee (MRSC), a subcommittee composed of persons who are nominated by the board and appointed by the governor and council. See RSA 329:17, V-a (2017) (amended 2018); N.H. Admin. R., Med 102.08. The MRSC investigates possible misconduct by licensees. See RSA 329:18, I (2017). The petitioners argue that O'Brien, in light of his status as an MRSC member sharing a common purpose with the board, "had an undue influence with the Board or, at a minimum, the appearance thereof." They argue further that O'Brien's statutory duty to protect the public raises "the appearance of bias on the part of . . . O'Brien in favor of [the patient], as a member of the public, and against the petitioners." See RSA 329:1-aa (2017) ("The primary responsibility and obligation of the board of medicine is to protect the public."); RSA 329:18, I (authorizing the board to investigate possible misconduct through the MRSC). They also note that the initial investigation of the petitioners by the MRSC was performed by a former member of the subcommittee, which "raised the prospect" that O'Brien's testimony was biased in favor of his former colleague. They argue that O'Brien's "lack of impartiality, or appearance thereof, . . . hindered the ability of the petitioners to receive a fair hearing," and that this hindrance "became self-evident during the hearing when the Board critically cross-examined the petitioners and their expert witness . . . while at the same time all but accepted . . . O'Brien's opinions from the outset."

With respect to the petitioners' due process claim, we have said that, when a single individual commingles investigative, accusative, and adjudicative functions, the mere appearance of prejudice may be sufficient to violate due

process. Appeal of Mullen, 169 N.H. 392, 399 (2016). We have also recognized, however, that the legislature does not offend due process merely by assigning investigative and adjudicative functions to the same administrative body. Appeal of Trotzer, 143 N.H. 64, 68 (1998). Where investigative, accusative, and adjudicative functions are commingled within a single administrative agency, rather than within a single individual, a party alleging a due process violation must show actual bias in order to prevail. See id.

In Trotzer, a psychologist was disciplined by the New Hampshire Board of Examiners of Psychology and Mental Health Practice (psychology board). Id. at 65. He argued on appeal that his due process rights were violated when a member of the psychology board who was recused from participating in the disciplinary proceeding nevertheless "s[a]t at the prosecution table and assist[ed] in the proceedings." Id. at 69. We concluded that the recused board member's "conduct did not commingle investigative, accusative, and adjudicative functions within the same individual." Id. We explained:

> Even assuming [the psychology board member] had an investigative and accusative role with respect to the allegations . . . there is no evidence to suggest, nor does [the psychologist] allege, that she had an adjudicative role. To the contrary, [the psychology board member] appropriately refrained from participating in the actions of the board and neither voted nor deliberated in any matter as a board member concerning [the psychologist's] disciplinary proceeding.

Id. Thus, the combination of investigative and accusative functions alone was not sufficient to render the proceeding unconstitutional. Id. at 69-70.

Here, O'Brien did not commingle investigative, accusative, and adjudicative functions. Even assuming he had an investigative and accusative role, there is no evidence to suggest that he had an adjudicative role. There is no evidence that he deliberated or voted with the board in reaching its ultimate disposition as to whether the petitioners' conduct came within RSA 328-D:6 and/or RSA 329:17, VI. See id. at 69; see also Mullen, 169 N.H. at 399-400 (concluding that agency commissioner did not have adjudicative function despite ability to order a de novo adjudicatory hearing in certain circumstances; commissioner "does not make the determination regarding whether the department has proven" its case). Thus, to prevail in their due process claim, the petitioners must demonstrate actual bias. Trotzer, 143 N.H. at 68; see also Mullen, 169 N.H. at 399; Appeal of Office of Consumer Advocate, 134 N.H. 651, 660 (1991); Appeal of Beyer, 122 N.H. 934, 940 (1982).

The petitioners have not demonstrated actual bias. The mere fact that O'Brien is a member of the MRSC does not establish actual bias. See Trotzer,

143 N.H. at 68 (stating that "it is permissible for one assistant attorney general to represent the board in its quasi-judicial capacity and another assistant attorney general to prosecute the case before the board, provided no actual bias exists" (quotation and brackets omitted)); Appeal of Maddox a/k/a Cookish, 133 N.H. 180, 182 (1990) (concluding no actual bias shown where adjudicator was employee of agency that plaintiff had brought action for damages against). Further, the petitioners' arguments that O'Brien's statutory duties or his professional relationships raised an appearance of bias are per se insufficient to meet their burden of showing actual bias. See Mullen, 169 N.H. at 399 (differentiating apparent bias from actual bias). As to their claim that the effect of O'Brien's bias on the proceeding became "self-evident" when members of the board critically cross-examined the petitioners and their expert but not O'Brien, we have reviewed the transcript of the hearing and cannot say that the board's questions demonstrate the existence of actual bias. The questions posed by the board members primarily sought to assist the board in conducting the proceeding. See Trotzer, 143 N.H. at 68. We thus find no due process violation.

In addition to their due process argument, the petitioners contend that allowing O'Brien to testify violated RSA 329:18, II. See RSA 329:18, II (2017) (authorizing the board to "retain expert witnesses . . . to assist with any investigation or adjudicatory proceeding," but providing that members of the board "are not eligible for retainment"). They point out that O'Brien, as a member of the MRSC, was "affiliat[ed]" with the board, and argue that "the Board and the MRSC are indistinguishable for the purposes of the statutory prohibition on expert witness retention" because "[t]he Board and the MRSC work with the same purpose and have the same duties, responsibilities and privileges."

Even assuming, without deciding, that RSA 329:18, II prevents board members from testifying at adjudicatory proceedings before the board, as opposed to merely preventing them from being compensated or "retained" as expert witnesses for such testimony, nothing in the record suggests that O'Brien is a member of the board. See RSA 329:2 (2017) ("There shall be a board of medicine consisting of 11 members . . . ."); RSA 329:4, I (2017) ("The commissioner or the medical director of the department of health and human services shall serve as a voting member of the board . . . ."); RSA 329:4, II (2017) ("The remaining 10 members of the board shall be appointed . . . by the governor with the advice and consent of the council."); N.H. Admin. R., Med 103.01 ("The board consists of 11 members who are appointed by the governor . . . ."). Thus, the statute does not apply to him. See Appeal of FairPoint Logistics, Inc., 171 N.H. ___, ___ (decided Sept. 28, 2018) (slip op. at 6) ("[W]e will not add language to a statute that the legislature did not see fit to include."). We do not agree with the petitioners that any shared purpose or similarity in duties or powers transmutes MRSC members into board members for purposes of RSA 329:18, II. See id.

We turn now to the petitioners' arguments concerning the sufficiency of the evidence before the board. They argue that the board's ultimate conclusions that the petitioners' conduct fell below the standards of RSA 328-D:6, IV and RSA 329:17, VI, respectively, are not supported by sufficient evidence. In essence, they argue that their testimony at the hearing, as well as the testimony of their expert and the evidence they submitted to the board, established that their treatment of K.H. was appropriate, notwithstanding O'Brien's testimony to the contrary.

RSA 328-D:6, IV provides that "[t]he board, after hearing, may take action against [a physician assistant] licensed under this chapter upon finding that the licensee . . . [h]as engaged in dishonest or unprofessional conduct or has been grossly or repeatedly negligent in practicing his or her profession . . . ." The board found that Dillon's conduct came within this statute. RSA 329:17, VI(c) provides that "[t]he board, after hearing, may take disciplinary action against [a licensed physician] upon finding that the [physician] [h]as 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." The board found that Williams' conduct fell within this statute.[1] This is a close case, however, having reviewed the record, we find that the petitioners have failed to demonstrate that there was no competent evidence from which the board could conclude that Dillon's conduct was, at a minimum, unprofessional, and that Williams' conduct was incompatible with at least an aspect of the medical competence expected of licensed physicians. See RSA 328-D:6, IV; RSA 329:17, VI(c). Where, as here, the board was faced with conflicting testimony from medical experts, it could resolve such conflicts by using its own expertise and technical judgment. See Dell, 140 N.H. at 496; Appeal of Gamas, 138 N.H. 487, 490-91 (1994).

The petitioners further argue that certain of the board's factual findings are not supported by sufficient evidence. Specifically, they argue that the board's conclusion that Dillon failed to appreciate abnormalities in K.H.'s CBC lab results is not supported by sufficient evidence, and that the board's conclusion that Williams did not personally examine K.H. is not supported by

[1] In its order, the board stated that "[u]nder RSA 329:17 VI [it] may take disciplinary action against [a licensed physician] if it determines that a licensed physician . . . 'has displayed a pattern of behavior which is incompatible with the basic knowledge and competence expected of persons licensed to practice medicine . . .'." However, RSA 329:17, VI(c) was amended in 2009, two years prior to the petitioners' treatment of K.H. Laws 2009, 206:14. This amendment removed the requirement that the physician have displayed a "pattern of behavior," and replaced it with a requirement that the physician have 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." Id. (emphasis added). Although the board seems to have misidentified the pertinent statutory language, its ultimate conclusion was that Williams "has displayed medical practice which is incompatible with the basic knowledge and competence of a person licensed to practice medicine." Thus, its ultimate conclusion tracks the correct statutory language.

sufficient evidence. With regard to the challenged finding as to Williams, it is unclear if the board actually concluded that Williams did not examine K.H. In its order, the board states that "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." The board also states that Williams' "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." Even assuming these statements amount to a finding that Williams did not examine K.H., we conclude that the petitioners have failed to meet their burden of showing that there was no competent evidence from which the board could properly make this finding. See Dell, 140 N.H. at 497-98. Specifically, in a letter submitted to a board investigator, Williams stated that his "only involvement" in K.H.'s treatment was discussing said treatment with Dillon.

With regard to the board's finding that Dillon failed to appreciate abnormalities in K.H.'s lab results, here too we conclude that the petitioners have not shown that there was no competent evidence from which the board could properly make this finding. See id. In a letter sent to a board investigator, Dillon stated that K.H.'s "CBC was normal." Counsel for the petitioners represented to the board, as well as to this court, that this statement was included in Dillon's letter due to counsel's own error, and asks that we not attribute his error to Dillon. Such errors are, of course, regrettable. Nonetheless, even assuming without deciding that the board should have accepted counsel's representations and disregarded the mistaken statement in Dillon's letter, other evidence in the record provides support for the board's conclusion that Dillon failed to appreciate abnormalities in K.H.'s lab results. Specifically, in a deposition that was submitted to the board, Dillon stated that K.H.'s CBC values "were not clinically significant."

For the reasons discussed above, we affirm the board's order.

Affirmed.

LYNN, C.J., and HICKS, BASSETT, HANTZ MARCONI, and DONOVAN, JJ., concurred.

Eileen Fox,
Clerk