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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of
JAMIE McREYNOLDS, M.D.
Holder of License No. **15120**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-04-0850A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER**
(Letter of Reprimand and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on August 10, 2006. Jamie McReynolds, M.D., ("Respondent") appeared before the Board for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
2. Respondent is the holder of License No. 15120 for the practice of allopathic medicine in the State of Arizona.
3. The Board initiated case number MD-04-0850A after receiving notification of a malpractice settlement regarding Respondent's care and treatment of a forty-nine year-old male patient ("JC"). JC presented to Respondent on October 2, 1998 and reported that two and one-half months prior he had an episode of left arm numbness and right eye visual disturbance. Respondent's examination revealed a blood pressure of 180/110 and she assessed Hypertension and possible TIA. Respondent ordered CBC, SMAC and cholesterol labs (which were normal) and a Doppler US of carotids. Respondent refilled JC's Zestril. In her initial response to the

1 Board Respondent stated JC never followed through on obtaining the Doppler studies of the
2 carotids.

3 4. JC was next seen on February 24, 1999 by a nurse practitioner at Respondent's
4 office. JC complained of numbness at the finger tips, left leg and right eye visual changes with
5 slurred speech. JC reported he had fallen and, while catching himself, hurt his left thumb. The
6 examination showed a blood pressure of 170/100, 5+ strength and 2+ reflexes with a steady gait
7 and otherwise negative neurological examination. JC's left thumb was tender, painful, swollen
8 and red. The nurse practitioner assessed left sided weakness, right blurred vision and left thumb
9 pain and ordered Carotid Dopplers and a left thumb x-ray. JC was instructed to follow-up after the
10 Doppler examination. The nurse practitioner did not communicate this visit with any doctors in the
11 office.

12 5. A March 4, 1999 Carotid US Preliminary report received at Respondent's office by
13 facsimile notes "99+%" stenosis of right internal carotid artery. The report is not signed by a
14 practitioner in Respondent's office. During the malpractice suit Respondent admitted the facsimile
15 came to her and she wrote "Needs vascular surgeon ?Cintora on plan," but the facsimile was not
16 with JC's chart so she asked for the chart without communicating the high degree of acuity
17 attendant to the situation because she had confidence in her office getting the chart to her in a
18 timely fashion. During the malpractice case Respondent also stated she did not know what
19 happened to the chart between March 4, 1999 and the time she asked her staff to get the chart.
20 There are two copies of the carotid report in JC's file. The first is not signed by anyone in
21 Respondent's office and the second copy has a stamp "[r]eceived March 09,1999" with
22 Respondent's initials and "x-ray" on it. This entry was not dated, but in her deposition,
23 Respondent stated she wrote this on March 15, 1999 after JC suffered a stroke. A March 15,
24 1999 telephone call from JC's co-worker noted JC was still waiting to hear from Respondent's
25 office about the results of his testing, was unable to dress himself, and was not eating well.

1 Respondent wrote in the chart "LM on home VM – to call Tues – [nurse practitioner] should
2 explain to him. Too complex for MA."

3 6. Over the course of the next week the results were not communicated to JC and
4 when Respondent received the phone message on March 15, 1999 she called his home number
5 and left a message for JC to call the office and talk to the nurse practitioner because Respondent
6 would be out of the office. The nurse practitioner indicated all tests were ordered through the
7 physician and she could not order them without first going through the physician, but she signed
8 the February 24, 1999 prescription for the carotid Doppler. JC presented to the emergency room
9 on March 15, 1999 because he again had left-sided weakness and numbness and blurred vision
10 in his right eye, but instead of the symptoms resolving as they had previously, the symptoms
11 lasted for more than twenty-four hours. A CT scan of JC's head showed "hypoattenuating lesions
12 1.5-2cm in the frontal lobe and 2.5 cm at the parietal lobe consistent with acute infarcts in the
13 MCA distribution." JC was put on Heparin and admitted to telemetry after approval from the
14 physician covering for Respondent. JC was diagnosed with cerebral vascular accident with right
15 anterior parietal and posterior parietal infarct and hypertension. Respondent followed JC during
16 his hospital stay. JC suffered significant permanent injury and later became significantly disabled.
17 JC subsequently died from pneumonia in April 2001.

18 7. Respondent is currently employed in an administrative position as a physician at a
19 company. During February and March 1999 she was employed in a clinic with two other family
20 physicians and a nurse practitioner. All three physicians were in charge of supervising the nurse
21 practitioner's care. A nurse practitioner was hired as opposed to a physician assistant because
22 the goal was to hire someone whose scope of practice and license allowed her to function more
23 independently and without as much oversight as a physician assistant would require. According
24 to Respondent, at the time the incident with JC occurred the nurse practitioner had been with the
25 clinic for approximately two years and Respondent and one of her associates had concerns about

1 patients with chronic disease modalities being managed solely by the nurse practitioner and
2 checks and balances to make sure a physician saw the patient every certain number of visits or
3 as clinically appropriate were not in place.

4 8. Respondent saw JC in October of 1998 and did not see him in February 1999.
5 Respondent spoke to the nurse practitioner on February 24th when the Doppler was ordered and
6 did not see JC in conjunction with nurse practitioner on this date. Respondent noted the nurse
7 practitioner would come and find a physician only in circumstances where she felt she had a
8 challenge she could not handle and, at that point, it had evolved to where the nurse practitioner
9 was practicing independently. Respondent testified results of the Doppler were first reported by
10 facsimile after the close of business on March 4, 1999 and she did not review the report on that
11 day. Respondent was not certain as to the exact date the report came to her attention because of
12 the system that existed in the clinic. The Board asked if Respondent saw the facsimile report prior
13 to the hard copy report arriving at the office. Respondent believed she did. Respondent testified
14 the facsimile copy of the report had a handwritten note from the radiologist where the test was
15 performed noting an abnormal "99+%" stenosis of the right internal carotid artery. The Board
16 asked if in Respondent's practice this finding was significant. Respondent stated it absolutely
17 was.

18 9. The Board asked Respondent the significance of a 99% occlusion. Respondent
19 testified that JC had an impending event, unless there is an undue amount of collateral circulation
20 – the more euphemistic term "a ticking time bomb" applied. The Board asked Respondent what
21 action she took between March 4, 1999 when the report arrived at her office and March 9, 1999
22 when the hard copy arrived. Respondent was not certain that on March 9, 1999 the report
23 actually appeared in front of her and one of the problems of the clinic was an on-going struggle
24 with the medical records staff finding the hard copy charts in order to attach results that came in
25 and she found the system somewhat chaotic and difficult. Respondent stated the procedure in

1 place had a non-clinical person attaching results to the hard chart as they came in and they were
2 to place the chart in the physician's inbox and the physician was to look at them daily.
3 Respondent stated clinical staff was to note anything that said "abnormal" and were to flag the
4 abnormal results to be seen by the physician on the same day. Respondent believed with JC's
5 results, because of the circumstances, staff had difficulty finding the chart and the test results
6 "floated."

7 10. The Board directed Respondent to the Preliminary Patient Report that says
8 "Carotid US prelim" and noted on the bottom there was a handwritten note "needs vascular
9 surgeon." The Board confirmed that sometime between March 4, 1999 and March 9, 1999
10 Respondent saw the report and this is the action she took. Respondent testified the process
11 when she made the note on the report would have been for staff to find the chart and find JC's
12 phone number. Respondent suspects at that time she did not remember who JC was as she had
13 only met him once five months earlier. The Board confirmed there was a time when Respondent
14 saw the facsimile, was aware of the 99% occlusion of the carotid artery, and wrote the note about
15 JC needing a vascular surgeon. The Board asked what urgent, critical, emergent type of action
16 Respondent took when JC was about to have a stroke – no matter what time of day the report
17 arrived and no matter whether she had the chart – what did she do proactively to try to prevent
18 JC's stroke. Respondent testified obviously nothing happened and it was indeed her fault and the
19 system's fault. Respondent did not know and cannot state with certainty on what date her note
20 was written and it should have been initialed and dated, but she believes it was not because she
21 had anticipated it was going to be attached to JC's chart and brought to her that same day to be
22 taken care of. Respondent could not account for the time of where the report went after it left her
23 hands with the note on it to put it with the chart. Respondent had suspicions that it went back to
24 the nurse practitioner's desk, but she did not know.

25

1 11. The Board asked the standard of care when a physician sees a 99% occlusion of
2 the carotid artery. Respondent testified the standard of care was: to contact the patient
3 immediately and facilitate the patient receiving emergent care through the appropriate specialty
4 venue and/or through a hospital. The Board directed Respondent to the typewritten Carotid
5 Doppler Report that is stamped "received" by her practice on March 9, 1999, specifically the
6 handwritten note "x-ray." Respondent confirmed she wrote this note, but could not state with
7 certainty she saw the report on the 9th. Respondent testified she believes this particular paper
8 was seen long after JC's stroke. Respondent noted whenever she signed and wrote "x-ray" the
9 system was designed so that when the results came in the staff would know by that note under
10 which tab to place the result. The Board confirmed Respondent's "x-ray" note was not an order
11 for an x-ray and the report was just to be filed under the "x-ray" tab in JC's chart. The Board
12 asked if this was the proper action for Respondent on a report of a 99% occlusion of a carotid
13 artery. Respondent testified this report came in after the stroke had already occurred and JC was
14 out of the hospital – this particular page did not come to her attention before the stroke.

15 12. The Board directed Respondent to the phone message in JC's medical record
16 from his co-worker, specifically, the note on the bottom "LM." Respondent testified she wrote this
17 note and it meant a message was left on JC's home voice mail. The Board confirmed the
18 message was someone would call JC on Tuesday and the nurse practitioner would explain the
19 results to him. The Board noted this message informed Respondent JC could not dress himself
20 and this is a change in his condition even if Respondent did not know the results of the Dopplar,
21 yet she told him to come in on Tuesday. The Board asked if this was appropriate. Respondent
22 testified she did not intend to have him come in on Tuesday because she would not have been in
23 the office, she intended to make contact and make sure he was in the proper arena of care. The
24 Board asked what was the proper arena of care for JC – someone who has a change in
25 neurological status. Respondent testified it was the emergency room. Respondent agreed the

1 proper arena of care was not leaving a voice message that someone will call him on Tuesday.
2 The Board noted the proper action was to hunt and seek JC. Respondent testified she did when
3 she saw the message from JC's co-worker at approximately 5:30 p.m. and she called JC's home
4 number and left a message and then tried to call his work number, but the office was closed.
5 Respondent testified leaving a message on the home voice mail for JC to call her as soon as he
6 got the message was the only avenue she had in a particular short period of time. Respondent
7 noted by this time JC was already in the emergency room.

8 13. The Board clarified with Respondent that her position was that, prior to the time JC
9 had a full-blown stroke, she never saw either a facsimile copy of the report or a hard copy of the
10 report of the 99% occlusion. Respondent's recollection was that she was not made aware of the
11 critical nature of things until the second message from the co-worker. The Board asked
12 Respondent whether it was her testimony that she had no duty to supervise the nurse practitioner
13 in the care of patients previously seen by Respondent. Respondent testified the system in the
14 office was not set up for that to happen. The Board asked what type of supervision the nurse
15 practitioner had with regard to the care of JC – Respondent's patient. Respondent noted if the
16 nurse practitioner encountered problems she would come and discuss them with a physician and
17 the office was instructed the nurse practitioner was not to be the exclusive provider and was to be
18 used for overflow and overbooking and acute care. Respondent testified she and others raised
19 concerns about the system and were reminded they were not her employer. The Board asked if
20 Respondent's testimony was that she worked in this practice for three years under a system
21 where staff would not inform her of urgent messages. Respondent testified if a patient called in
22 with an urgent situation and she was booked the patient was offered an appointment with the
23 nurse practitioner.

24 14. The Board asked what steps Respondent took to change the system within the
25 office. Respondent testified there were many meetings, but the clinic was owned by a hospital

1 corporation and, although the idea was to set up systems that allowed for quality, things were
2 driven by the corporation's agreement with the federal government. The Board directed
3 Respondent back to her note on JC's Dopplar report about contacting a particular vascular
4 surgeon to see if he was on JC's insurance plan and asked what happened with that note – did
5 she find out if he was on the plan and did she call him. Respondent testified this was where she
6 fell down and lost control of the case and she takes responsibility for handing the report to
7 someone and telling them to find out about the vascular surgeon and bring her JC's chart. The
8 Board asked if Respondent followed through. Respondent testified she did not because it was a
9 busy day and she forgot about it.

10 15. The Board asked whether Respondent was JC's primary care physician ("PCP").
11 Respondent testified not in the sense that she thinks of a PCP – JC had engaged the care of her
12 office in October, but they had not yet developed a doctor-patient relationship. Respondent
13 admitted by definition she had developed such a relationship on that first visit. The Board noted
14 the ultrasound report noted her as the referring physician. Respondent testified she became the
15 physician of record because she saw JC when he came to the office in October. The Board noted
16 it appeared JC had been stuttering along for days to weeks prior to the stroke on the 15th and
17 asked Respondent to comment on why she was concerned about JC's insurance and did not just
18 get him into the hospital. Respondent noted the point was well made and her intention, while it
19 may not be clear, was actually to facilitate that and jump start things by getting a vascular
20 surgeon to whom JC would be referred emergently. The Board asked if this was Respondent's
21 usual pattern for a patient with a critical issue – to call a consultant rather than sending the patient
22 to the emergency room. Respondent testified it was not.

23 16. The Board confirmed Respondent's testimony was that she saw the March 4, 1999
24 Dopplar report and the March 15, 1999 phone message at the same time on the 15th and asked
25 staff to find out if a vascular surgeon was on his plan, but then just went back to routine office

1 work. The Board asked Respondent to explain why, with both the report and the phone message
2 about JC's status she did not drop everything and find her patient through any possible means.
3 Respondent noted the Board was absolutely correct and she did not believe JC received the
4 absolute standard of care and she acknowledges that and is appalled at what happened.
5 Respondent testified it should have never gotten to March 15 and should have been taken care of
6 on February 24. The Board asked why she would take the time on the 15th, knowing what she
7 knew at that point, to even bother to find a vascular surgeon on JC's insurance and not just spend
8 time on finding JC and getting him to the emergency room. Respondent testified it all happened in
9 a short period of time.

10 17. The Board noted on JC's first visit when he saw Respondent, his subjective history
11 was "two and a half months ago had episodes of left arm numbness and right eye visual
12 disturbance" and asked Respondent the standard of care for a family practitioner who sees a
13 patient with episodes of left arm numbness and right eye visual disturbance. Respondent testified
14 the standard of care required an immediate work-up. The Board noted on that day Respondent
15 simply refilled JC's medications and he returned to work. Respondent did not feel the immediate
16 workup needed to be done on that day. The Board asked how a physician evaluates a trans
17 ischemic attack ("TIA"). Respondent testified it is evaluated by insuring the circulation through the
18 carotid arteries is intact and this is done by looking for other sources of a TIA, such as embolic
19 phenomenon and reason for the phenomenon. The Board asked the natural course for a patient
20 who has several TIAs. Respondent testified the natural course is a stroke.

21 18. Respondent noted there was a complex sequence of events around JC's care
22 accompanied by a completely inadequate office system that contributed to the initial sentinel
23 event. Respondent recognized as JC's physician she bore ultimate responsibility for insuring all
24 diagnostic testing was promptly and timely assessed and responded to. Respondent noted it was
25 not an excuse to say the system was poor and the reason she went into administrative medicine

1 was her desire to focus on quality of care and issues facing physicians and the primary issue in
2 JC's case was the actions of a nurse practitioner in a system where those actions were not
3 adequately supervised.

4 19. The standard of care required Respondent to urgently notify a patient of abnormal
5 test results indicating a 99% stenosis of the carotid artery and urgently respond to a phone
6 message that the patient had difficulty dressing himself by urgently referring the patient to a
7 vascular surgeon or admitting the patient to the hospital.

8 20. Respondent deviated from the standard of care because she did not urgently notify
9 the patient of the abnormal tests results and did not urgently respond to the phone message
10 either by urgently referring him to a vascular surgeon or to the hospital.

11 21. JC had a severe cerebral vascular accident resulting in a stroke.

12 22. The Board noted in aggravation a previous advisory letter issued to Respondent
13 for failure to report findings promptly to a patient and failure to maintain adequate records.

14 **CONCLUSIONS OF LAW**

15 1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof
16 and over Respondent.

17 2. The Board has received substantial evidence supporting the Findings of Fact
18 described above and said findings constitute unprofessional conduct or other grounds for the
19 Board to take disciplinary action.

20 3. The conduct and circumstances described above constitutes unprofessional
21 conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice which is or might be
22 harmful or dangerous to the health of the patient or the public").

23 **ORDER**

24 Based upon the foregoing Findings of Fact and Conclusions of Law,

25 IT IS HEREBY ORDERED:

1 petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35)
2 days after it is mailed to Respondent.

3 Respondent is further notified that the filing of a motion for rehearing or review is required
4 to preserve any rights of appeal to the Superior Court.

5 DATED this 12th day of October, 2006.



6 THE ARIZONA MEDICAL BOARD

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8
9 By Timothy C. Miller
10 TIMOTHY C. MILLER, J.D.
Executive Director

11 ORIGINAL of the foregoing filed this
12 13th day of October, 2006 with:

13 Arizona Medical Board
14 9545 East Doubletree Ranch Road
15 Scottsdale, Arizona 85258

16 Executed copy of the foregoing
17 mailed by U.S. Certified Mail this
18 13th day of October, 2006, to:

19 Jamie McReynolds, M.D.
20 Address of Record

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25 Jim Miller