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**BEFORE THE ARIZONA MEDICAL BOARD**

In the Matter of  
**MICHAEL BISCOE, M.D.**  
Holder of License No. **20915**  
For the Practice of Allopathic Medicine  
In the State of Arizona.

Board Case No. MD-05-0622A

**FINDINGS OF FACT,  
CONCLUSIONS OF LAW AND ORDER**

(Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 8, 2007. Michael Biscoe, M.D., ("Respondent") appeared before the Board without legal counsel 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. 20915 for the practice of allopathic medicine in the State of Arizona.
3. The Board initiated case number MD-05-0622A after being notified of a medical malpractice settlement involving Respondent's care and treatment of a two year-old female patient ("MC"). MC was brought to the Maryvale Hospital emergency department by the Phoenix Fire Department at 7:05 a.m. on December 13, 2000 with a history of witnessed possible four or five seizures and fever of 105 degrees. There was no sign of rash and MC's father described her as febrile, fussy and as having a decreased activity level. Respondent evaluated MC at 8:00 a.m. and noted her to be attentive for her age with good eye contact and not lethargic on physical examination.

1           4.       At 8:15 a.m. Respondent ordered a full septic workup and, according to his  
2 deposition in the malpractice case, contemplated a differential diagnosis of meningitis.  
3 Respondent gave this testimony despite his having documented a well examination. At 11:20  
4 a.m. Respondent performed a lumbar puncture to rule out meningitis. MC's cerebral spinal fluid,  
5 urinalysis, and chest x-ray were normal. MC's complete blood count showed a slight left shift and  
6 a white blood count of 4.2. Respondent drafted an order discharging MC.

7           5.       At 12:15 p.m., MC was still in the emergency department, when a nurse noted a  
8 rash and notified Respondent. In Respondent's deposition in the malpractice case he stated he  
9 noticed petechiae during the lumbar puncture. At 2:00 p.m. the nurses noted MC had a purple  
10 rash all over and, at 2:25 p.m., Respondent was in to see her. At 2:50 p.m. Respondent cancelled  
11 his discharge instructions and attempted to locate a pediatrician and admit MC to the hospital. At  
12 this time, MC was febrile, confused and tachycardic. Respondent changed his diagnosis to new  
13 onset purpuric rash, viral exanthema versus Henoch-Schonlein Purpura. Respondent did not list  
14 meningococemia as a possible diagnosis. At 3:30 p.m. Respondent ordered an intravenous hep-  
15 lock, but did not order fluids or antibiotics. Respondent's hep-lock order was not carried out.

16           6.       MC was transferred to Phoenix's Children's Hospital where, at 5:05 p.m., a  
17 pediatrician ordered an intramuscular dose of an antibiotic. MC was in fulminant shock requiring  
18 intubation when she arrived and this made it difficult to obtain an intravenous line. MC died of  
19 complications related to poor perfusion of the body during the period of shock due to  
20 meningococemia.

21           7.       When Respondent was hired at Maryvale as a board-certified internal medicine  
22 doctor he had three years of experience working in another hospital where he saw very few  
23 children and he had never seen a really sick infant or young child and had never done a lumbar  
24 puncture on a pediatric age patient. When he treated MC Respondent had never seen  
25 meningococemia in either a pediatric or adult patient. Respondent admitted to not recognizing

1 the rash, but noted he tried to admit her to the hospital and got her on a waiting list at Phoenix  
2 Children's. Respondent called two pediatricians and there was a pediatric service on call, but he  
3 could not get anyone from that service. Respondent did eventually speak with a pediatrician and  
4 claims he was never advised to start an antibiotic. Respondent did not recall whether he actually  
5 asked the pediatrician whether he should give an antibiotic, but if he had been told to do so, he  
6 would have. Respondent's training taught him not to administer an antibiotic to a patient without  
7 knowing the organism and he thought the rash was more than likely viral.

8 8. The lumbar puncture coming back negative gave Respondent a false sense of  
9 security and he was not even thinking about meningitis, meningococemia, Neisseria  
10 meningitidis. Respondent had never seen a rash like MC's rash and he even took a picture of it  
11 that he feels is somewhat incriminating because, looking back at it now, it was a fairly classic  
12 meningococemia rash, but MC was sitting up without assistance, holding a bottle of Pedialyte  
13 and looked great. Respondent no longer works in an emergency department and is a primary  
14 care physician specializing in internal medicine.

15 9. All of Respondent's care for MC in the emergency department was captured on  
16 one page of the hospital record – the physical examination, labs, and x-rays. In Respondent's  
17 records a diagonal slash indicates a negative finding. Respondent documented MC was not  
18 lethargic and under "neck" he noted there was no meningism, Brudzinski or Kernigs. Under "rash"  
19 in the record is a "star" mark that says "new onset rash approximately 11:00 developed over next  
20 three hours to frankly generalized rash." At 2:00 Respondent noted reexamining MC, that she  
21 was afebrile and "generally improved" and noted a "[p]ositive rash . . . . Generalized. Macular,  
22 questionable non-pruritic. Negative speech disturbance." Respondent also documented he  
23 discussed MC with the pediatrician on call and that he counseled the family with lab results, his  
24 diagnosis and the need for follow-up. In the medical record MC's temperature was recorded at  
25 2:35 and 4:10 as 101.8 and 101.4, but there is no temperature reading that was afebrile. At

1 3:00 p.m. Respondent noted the rash was tender. Although MC was in the emergency  
2 department from 7:05 a.m. to almost 5:00 p.m. Respondent's total record of his care of MC is one  
3 page. Respondent claimed to have relied on the nurse a lot for vital signs, general condition,  
4 urine output, and any change in the rash and that he went into MC's room on at least two  
5 occasions. There are no urine outputs noted in MC's chart.

6 10. MC arrived at the emergency department with a temperature of 105 degrees and  
7 remained there over a period of nine hours, but no IV was started and she was not getting any  
8 fluids except what she was able to take orally. Respondent relied on the nurses who were relying  
9 on the parents reporting wet diapers. At 2:00 Respondent noted MC improved and was afebrile,  
10 but the order sheet at 2:35 shows her temperature at 101.8 and has entries crossed out that  
11 appear to be the orders sending MC home. At this same time the nurse noted MC had "increased  
12 rash all over. Purple in appearance. Review chart for disposition. [Respondent] in to see patient.  
13 [at 2:35]."

14 11. When MC arrived at Maryvale her fever was 105 degrees, her pulse was 156, and  
15 there were four or five possible seizures reported. Respondent ordered a septic workup at 8:15  
16 and got consent for and ordered a lumbar puncture at 9:00 that he did at 11:20. Respondent  
17 maintained he was considering a meningitis diagnosis, yet he delayed the lumbar puncture for at  
18 least two hours from when he received consent. According to Respondent the delay was caused  
19 by the chaotic nature of the emergency department and MC's chart may have sat in the chart  
20 rack for a couple of hours before being picked up and it was difficult to find a nurse to do a lumbar  
21 puncture. Respondent could not say specifically why it took so long, but he was not surprised that  
22 it did.

23 12. Respondent noticed a rash when he was doing the lumbar puncture at 11:20, the  
24 rash was also noted at 12:00 and Respondent saw MC at 2:25, but he made no entries into the  
25 record. At 2:50 when Respondent cancelled the discharge instructions MC was still febrile,

1 confused and tachycardic, but he did not start an IV. Respondent changed his diagnosis to new  
2 onset purpuric rash: viral exanthema versus Henoch-Schonlein Purpura. Respondent spoke with  
3 a pediatrician about the rash at approximately 3:00, but still did not start an IV or measure urinary  
4 output. At 3:30 Respondent ordered IV fluids, but the nurses were unable to get an IV in.  
5 Respondent still had not ordered antibiotics. At 4:30 the pediatrician arrived and ordered  
6 Rocephin IM. MC was transferred at 5:05 in shock, there was difficulty in obtaining an IV line and  
7 she died of complications of poor perfusion during shock caused by meningococemia.

8       13. Respondent maintained MC looked good, was making urine, her skin was moist  
9 and they were not even doing blood pressures and that he kept MC, even though she looked  
10 good, in the emergency department for ten hours because of the rash he had never seen before  
11 and because she was still spiking fevers. Respondent was not really aware of meningococemia  
12 with a clean lumbar puncture without meningitis. Meningococemia carries a very rapid, fulminate  
13 course and the treatment, the only chance of improvement, requires IV fluids and support be  
14 initiated and antibiotics started vigorously the minute it is suspected. Fever and purpura in a child  
15 or adult should be presumed to be meningococemia unless proved otherwise. The lumbar  
16 puncture was negative because MC did not have meningitis at the time of the puncture – the  
17 septicemia of meningococcus had not invaded her nervous system at that point. The success rate  
18 in treating patients with meningococemia is twenty to thirty percent. Fulminant meningococemia  
19 is a rare infection.

20       14. The standard of care requires a physician to frequently re-evaluate a patient who  
21 presents with fever and develops a rash and remains for an extended period of time in the  
22 emergency department.

23       15. Respondent deviated from the standard of care because he did not frequently re-  
24 evaluate MC during her extended stay in the emergency department.

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**ORDER**

Based upon the foregoing Findings of Fact and Conclusions of Law,  
IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for failure to recognize and treat meningococemia in a timely manner, failure to repeat physical examinations during the time the patient was in the emergency department and for inadequate medical records.

**RIGHT TO PETITION FOR REHEARING OR REVIEW**

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

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

DATED this 13<sup>th</sup> day of April 2007.



THE ARIZONA MEDICAL BOARD

By   
TIMOTHY C. MILLER, J.D.  
Executive Director

ORIGINAL of the foregoing filed this 13<sup>th</sup> day of April, 2007 with:

Arizona Medical Board  
9545 East Doubletree Ranch Road  
Scottsdale, Arizona 85258

1 Executed copy of the foregoing  
mailed by U.S. Mail this  
2 13<sup>th</sup> day of April, 2007, to:

3 Michael Biscoe, M.D.  
Address of Record  
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