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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of
JAMES M. HURLEY, M.D.
Holder of License No. **3191**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-06-0236A

**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 October 11, 2006. James M. Hurley, M.D., ("Respondent") appeared before the Board with legal counsel Thomas G. Baker 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. 3191 for the practice of allopathic medicine in the State of Arizona.
3. The Board initiated case number MD-06-0236A after receiving a complaint regarding Respondent's care and treatment of a seventy-three year-old female patient ("EG") alleging Respondent failed to diagnose and treat small bowel obstruction resulting in EG's death. EG presented to the urgent care clinic where Respondent was employed complaining of severe lower abdominal pain. EG had a past history of diverticulitis and irregular menstrual spotting, hypertension, high cholesterol, and was on aspirin therapy. EG reported she had nausea along with her pain, but had no fever, chills, back pain, frequency, urgency, dysuria, or vomiting. Respondent's examination was localized to the abdomen, where he found tenderness, but no

1 rebound. Respondent did not perform any other part of the physical examination and did not
2 obtain lab work or imaging studies. Respondent diagnosed diverticulitis, prescribed Cipro, and
3 instructed EG to use Metamucil. EG collapsed and arrested three days after her visit to the urgent
4 care and could not be revived by paramedics. EG's autopsy concluded her death started from
5 her having internal abdominal adhesions that caused a volvulus and resulted in a small bowel
6 obstruction and then an infarction of the small bowel.

7 4. Respondent testified EG came into urgent care about two hours after the on-set of
8 pain and was examined by a triage nurse who did not immediately put her in the holding area
9 reserved for acutely ill patients. Respondent was working in another part of the building and
10 came over to help out in urgent care because they were running five hours behind. Respondent
11 saw EG approximately two and one-half hours after she was initially worked up. According to
12 Respondent the facility does not have the ability to perform "stat" labs or CT scans, but does have
13 X-ray. Respondent stated any time he has a patient he believes is acutely ill the patient is
14 automatically transferred and his examination of EG did not reveal she was acutely ill.
15 Respondent testified EG was not in pain, or her pain was not evident, and her examination was
16 completely benign other than a slightly elevated blood pressure - not unusual in people coming
17 into urgent care.

18 5. Respondent testified he found nothing in the examination indicating a bowel
19 obstruction with normal bowel sounds, with slight tenderness in the lower right quadrant.
20 Respondent stated EG reported having a normal bowel movement that morning and had normal
21 bowel sounds when he saw her and, with her past history of diverticulitis, he felt that was the
22 most likely result of the examination. Respondent testified he told EG and her husband if she had
23 any problem to please either go to the emergency room or return to urgent care. Respondent
24 was shocked and dismayed when he found out EG had subsequently died.

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1 6. During his forty years of practice Respondent was on-site and working in an
2 emergency room on approximately ten occasions. Respondent testified the classical or textbook
3 presentation of someone with diverticulitis involves localized pain very similar to appendicitis,
4 sometimes involving cramping pain or diarrhea and, if the patient is oozing or perforating, then
5 there will usually be an ileus and generalized abdominal pain, but generally the pain is pretty
6 much localized. The Board asked if Respondent uses any other studies to help substantiate a
7 diagnosis of diverticulitis. Respondent testified it depends on whether the patient had a history of
8 diverticulitis and, if they do, he usually does not do additional studies. If they do not, he will
9 usually either do a sigmoidoscopy, colonoscopy, or, depending on where the area is, barium
10 enema with air contrast. The Board asked if Respondent usually does any routine lab studies to
11 evaluate how sick the patient is, or the level of their white count, and, if so, would he use those
12 findings to determine if the patient should be hospitalized, could be treated as an outpatient, or
13 needed a surgical consult. Respondent testified he would, to a degree, and in the acute phase,
14 generally in people who have a past history of diverticulitis and relatively benign findings, the
15 blood count would probably not show that much. But, if they had definite findings, he would order
16 a blood count and, if the lab was available, would send the patient right away.

17 7. The criteria Respondent uses to decide whether to hospitalize a patient with
18 diverticulitis are fever, ongoing pain, bloody diarrhea, and persistent rebound tenderness. The
19 Board asked whether Respondent would use a white count and elevation to help him determine
20 whether or not to hospitalize the patient. Respondent testified he would and, in EG's case, he did
21 not feel it was warranted because she had a relatively benign abdomen. The Board asked if
22 Respondent had any reason to doubt EG's credibility – her ability to relate an accurate history.
23 Respondent testified he did not and only questioned the degree of pain because both EG and her
24 husband said she was having a lot of pain, but she was not having pain when he saw her, at least
25 it was not very evident, so he did not know quantitatively how much pain she was having. This

1 contradicted Respondent's record where he wrote EG classed her pain as "9 to 10" on a scale of
2 10 and he noted it to be "severe, severe," lower abdominal pain and also described it as "colicky"
3 and "sharp." Respondent testified EG was having pain when she came in, but it was not as
4 apparent when he saw her two hours later.

5 8. The Board directed Respondent to his response filed with the Board, specifically
6 where he elaborated on his urgent care record and twice mentioned EG had no rebound
7 tenderness. The Board asked how much Respondent was led to conclude EG had diverticulitis
8 by the history EG recorded that she had a prior attack of diverticulitis. Respondent testified he
9 could not otherwise explain why EG was having abdominal pain and could not find anything on
10 examination that would make him think of bowel obstruction, acute gastroenteritis, or any other
11 source of abdominal pain and, looking back through her history and seeing she had a history of
12 diverticulitis, he presumed that was the cause of her abdominal pain. The Board noted
13 Respondent had a patient with severe pain and a paucity of physical findings and asked whether
14 that alone would cause him to think about anything specific as far as a diagnosis. Respondent
15 testified it would cause him to think about bowel obstruction since volvulus, in his experience, is a
16 very rare occurrence. Respondent stated the nature of volvulus where the pain comes on when
17 the bowel twists and then goes away if the bowel untwists would certainly lead to that
18 assumption, but he had nothing else to go on except his examination and the way EG was at that
19 particular time.

20 9. Respondent agreed with the Board that medical students and family practice
21 residents are taught that pain out of proportion to the physical findings is mesenteric infarction
22 until proven otherwise and this is exactly what EG presented with. Respondent testified this
23 thought and this differential never entered his mind as a consideration for EG. The Board
24 confirmed because the facility was an urgent care facility lab work would be delayed, but
25 Respondent could have done a KUB and upright X-ray and asked why he chose not to.

1 Respondent testified he did not because with the benign findings he did not see the need. A lot
2 of information could have been gathered from abdominal films in addition to reinforcing a
3 preliminary diagnosis of diverticulitis. The Board confirmed Respondent was aware that in cases
4 of mesenteric infarction the white blood count goes up quite high and it is an immediate effect.
5 The Board asked if Respondent was ever taught, or whether it was policy, when any adult comes
6 to urgent care or an emergency room with acute abdominal pain that a serum amylase should be
7 ordered. Respondent testified with upper abdominal pain he would have ordered a serum
8 amylase, but EG had no back pain, no upper abdominal pain, and her pain was isolated to the
9 lower abdomen. The amylase is elevated in episodes of mesenteric infarction.

10 10. The standard of care in treating an adult with acute abdominal pain required a
11 more thorough history and physical examination, a complete blood count, urinalysis and amylase,
12 and a flat plate X-ray and upright X-ray of the abdomen.

13 11. Respondent deviated from the standard of care by failing to perform an adequate
14 examination and failing to order the appropriate labs and X-rays.

15 12. Respondent's failure led to EG's lost opportunity to have the infarction treated and
16 her ultimate demise.

17 CONCLUSIONS OF LAW

18 1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof
19 and over Respondent.

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

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

1 ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence
2 resulting in harm to or the death of the patient").

3 **ORDER**

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

5 IT IS HEREBY ORDERED:

6 1. Respondent is issued a Letter of Reprimand for failure to evaluate and appropriately
7 diagnose a patient with acute abdominal pain.

8 2. Respondent is placed on probation for one year with the following terms and
9 conditions:

10 a. Respondent shall obtain 12-15 hours of Board Staff pre-approved Category I
11 Continuing Medical Education ("CME") encompassing the differential diagnosis and management
12 of the acute abdomen in both adults and children. The probation will terminate when Respondent
13 supplies proof of course completion satisfactory to Board Staff.

14 3. Respondent shall obey all federal, state, and local laws and all rules governing the
15 practice of medicine in Arizona.

16 4. In the event Respondent should leave Arizona to reside or practice outside the
17 State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall
18 notify the Executive Director in writing within ten days of departure and return or the dates of non-
19 practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during
20 which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent
21 residence or practice outside Arizona or of non-practice within Arizona, will not apply to the
22 reduction of the probationary period.

23 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

24 Respondent is hereby notified that he has the right to petition for a rehearing or review.
25 The petition for rehearing or review must be filed with the Board's Executive Director within thirty

1 (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review
2 must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103.
3 Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a
4 petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35)
5 days after it is mailed to Respondent.

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

8 DATED this 7th day of December 2006.



THE ARIZONA MEDICAL BOARD

By *Timothy C. Miller*
TIMOTHY C. MILLER, J.D.
Executive Director

14 ORIGINAL of the foregoing filed this
15 8th day of December, 2006 with:

16 Arizona Medical Board
17 9545 East Doubletree Ranch Road
18 Scottsdale, Arizona 85258

19 Executed copy of the foregoing
20 mailed by U.S. Certified Mail this
21 8th day of December, 2006, to:

22 Thomas G. Bakker
23 Olson, Jantsch & Bakker, PA
24 7243 N. 16th St.
25 Phoenix, Arizona 85020-7250

James M. Hurley, M.D.
Address of Record

J M Hurley