BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
WILLIAM SHANE TRYTHALL, M.D.	)	**Case No. 8002015012428**
Physician's and Surgeon's Certificate No. A84413	)	**OAH No. 2016080237**
Respondent	)	

DECISION

The attached Proposed Decision is hereby amended pursuant to Government Code section 11517(c)(2)(c) to correct technical or minor changes that do not affect the factual or legal basis of the Proposed Decision. The Proposed Decision is amended as follows:

Page 1, Case No.: The case number is corrected to "8002015012428."

The attached Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 14, 2017.

IT IS SO ORDERED June 14, 2017.

MEDICAL BOARD OF CALIFORNIA

By: Michelle Anne Bholat MD

Michelle Bholat, M.D.
Chair, Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: WILLIAM SHANE TRYTHALL, M.D. Sacramento, California Physician's and Surgeon's Certificate No. A 84413 Respondent.	MB No. 800-2015-102428 OAH No. 2016080237

PROPOSED DECISION

This matter was heard before Administrative Law Judge Erin R. Koch-Goodman, Office of Administrative Hearings (OAH), State of California, on March 27 and 28, 2017, and April 3, 2017, in Sacramento, California.

Desmond L. Philson, Deputy Attorney General, appeared on behalf of Kimberly Kirchmeyer (complainant), Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

John L. Fleer, Attorney at Law, appeared on behalf of William Shane Trythall, M.D. (respondent), who was present at hearing.

Evidence was heard, the record was closed, and the matter was submitted for decision on April 3, 2017.

FACTUAL FINDINGS

1. On August 22, 2003, the Board issued respondent Physician's and Surgeon's Certificate (license) No. A 84413. Respondent's license is in full force and effect until May 31, 2017, unless renewed or revoked.

2. On June 17, 2016, complainant, in her official capacity, made and served the instant Accusation, seeking discipline against respondent's license. Specifically, complainant alleges that respondent committed repeated acts of negligence during his

treatment of Patient CJ, by failing to identify and treat SIRS, conduct a rectal examination, and order a computerized tomography (CT) scan. On July 14, 2016, respondent timely filed a Notice of Defense.

Background

3. On January 24, 2014, Patient CJ had a colonoscopy, with several samples taken for biopsy. On February 18, 2014, Patient CJ was diagnosed with colon cancer. On February 22, 2014, Patient CJ was scheduled for imaging of his colon. However, Patient CJ awoke in pain and his wife took him to the Emergency Department (ED) at Kaiser Permanente South Sacramento.

4. Respondent is an ED doctor. He is employed by Kaiser Permanente South Sacramento. On February 22, 2014, respondent was supervising Carrieann Drenten, M.D., a third-year resident, and Dr. Drenten and respondent treated Patient CJ.

Emergency Department Visit

5. Patient CJ arrived at the ED at 8:48 a.m. and was admitted at 8:52 a.m. At 9:00 a.m., Dr. Drenten saw Patient CJ. Dr. Drenten took a history and physical. Dr. Drenten charted a Progress Note at 9:11 a.m. indicating: "[Patient CJ] is a 64 Y [ear old] male who presents to the Emergency Department from home complaining of abdominal pain and n/v [nausea/vomiting]. Past medical history significant for recent diagnosis of colon cancer. Patient has pain at night, took 2 Norco (that he had been prescribed for a prior condition), and this AM woke up with abdominal pain, nausea, and vomiting. Had similar pain yesterday after taking 1 norco, but it was less severe and had no emesis. Has not had a BM [bowel movement] in 3 days (no urge to defecate), but still passing gas." Dr. Drenten identified the following differential diagnosis: "Most concerned for possible obstruction given recent diagnosis of colon cancer and decreased number of BMs. Also considered gastritis, pancreatitis, hepatitis, cholecystitis, and irritation from norco. Patient's abdomen is non-surgical[1] at this time." Dr. Drenten ordered an "IV, IV rehydration, IV anti-emetics (anti-nausea), famotidine (antacid); labs; EKG [electrocardiogram]; CXR [chest x-ray]; abdominal series XR [x-ray]."

6. At 9:09 a.m., Patient CJ had an EKG, with normal findings. At 9:15 a.m., Patient CJ provided a urine sample and had his blood drawn for testing. Dr. Drenten ordered the following labs: CBC, plus differential, Chem-7, AST serum, ALT serum, Bilirubin total serum, Alkaline Phosphatase, and Lipase. A CBC is a complete blood count, with differential, including red blood cell count and white blood cell count. A Chem-7 tests levels of creatinine, blood urea nitrogen, carbon dioxide, chloride, glucose, sodium and potassium

[1] A non-surgical abdomen is found when the patient shows no signs of guarding (tensing of the abdominal wall muscles to guard inflamed organs), no rebounding (initial pressure does not cause pain, but when the examining hand is released, pain is felt), and no rigidity (board-like stiffness), upon palpation of the abdomen.

in the blood. Aspartate aminotransferase (AST) and alanine aminotransferase (ALT) are enzymes in red blood cells; high levels of AST and/or ALT suggest liver damage/disease, including hepatitis. Bilirubin total and alkaline phosphatase both test for liver function. Lipase testing helps diagnose or monitor pancreatitis, peritonitis, strangulated or infarcted bowel.

7. At 9:50 a.m., Dr. Drenten noted: "nausea improved with medication, patient continues to have abdominal pain. Labs concerning for elevated lipase to 452 (no priors for comparison). Will order US [ultrasound] of the abdomen to evaluate for possible gallstones."

8. At 10:26 a.m., Patient CJ had a PA [posterior to anterior] and lateral chest x-rays. Tan M. Nguyen, M.D., radiologist, read the x-rays and wrote a report, with findings indicating: "The heart size is within limits of normal. Mediastinal and hilar structures are not enlarged. Atherosclerosis is not present. Lungs are clear. No evidence of pleural effusion or pneumothorax or acute cardiac decompensation is seen. Osseous structures are intact." Final impression: "No active cardiopulmonary process." At 10:27 a.m., Patient CJ had an acute abdominal series x-rays. Dr. Nguyen read the x-rays and wrote a report, with findings indicating: "The chest radiograph shows no focal airspace. Cardiac size is within limits of normal. Upright and supine views of the abdomen show nonobstructed bowel gas pattern. Mild to moderate fecal load is seen in the colon most compatible with constipation, clinical correlation is advised. No free air underneath hemidiaphragm is seen. No abnormal calcifications are seen in the abdomen. Multiple phleboliths are noted within the pelvis. The osseous structures show bilateral hip degenerative osteoarthritis." Final impression: "No mechanical bowel obstruction. Findings most compatible with constipation, clinical correlation is advised. No active cardiopulmonary process."

9. At 10:48 a.m., Patient CJ had a right upper quadrant ultrasound. Dr. Nguyen read the ultrasound and wrote a report, noting the following findings: "The pancreas head and body are normal. The tail is obscured by overlying bowel gas. The liver parenchyma shows mild diffuse increased echogenicity without intrahepatic or extrahepatic biliary duct dilation. In the left lobe, 6.5 x 5.3 x 6.8 cm echogenic focus is noted compatible with a known cavernous hemangioma on prior abdominal CT. Adjacent to it is in small lobulated 1.7 x 1.1 x 2.2 cm cyst, also stable. The common bile duct is 4.0 mm. The main portal vein is patent with normal flow direction. The gallbladder shows no intraluminal shadowing echogenic foci, wall thickening, or pericholecystic fluid collection or sonographic Murphy's signs. Minimal sludge is seen. Survey imaging of the right kidney shows mild dilatation of the central renal pelvis, similar in appearance to [the prior] CT, therefore mild chronic hydronephrosis cannot be excluded. No nephrolithiasis is seen. No ascites is seen." Final impressions: "Echogenic liver with known large left lobe hemangioma. Minimal sludge in the gallbladder without wall thickening or dilated ducts. Findings suggestive of chronic mild right hydronephrosis without nephrolithiasis, probably stable since the CT [on] December 19, 2013."

10. Dr. Drenten reviewed the labs and radiographs for Patient CJ and charted the following notable findings: "CBC: mild leukocytosis at 15.8; normal Hg; and normal plt [platelet]. BMP[basic metabolic panel]: no electrolyte abnormalities; normal creatinine. LFTs [liver function tests]: normal. Lipase: elevated at 452. Udip [Urine Dipstick]: negative for blood; negative for infection. CXR [chest x-ray]: no focal consolidation; no pleural effusions; no pneumothorax; no fractures. Abdominal XR [abdominal x-ray]: large stool burden, non-obstructive gas pattern. Abd US [abdominal ultrasound]: no gallstones; hemangioma in liver as seen before; hydronephrosis in right kidney as seen before. No free fluid; normal pancreas.

11. At 10:54 a.m., respondent examined Patient CJ, and ordered an enema (300 ml warm water, 200 ml magnesium citrate, and 100 ml glycerin). At 11:26 a.m., Registered Nurse (RN) Hamerling Santos, administered half of the enema, charting: "pt unable to hold; on BSC [bedside commode]." At 11:56 a.m., RN Santos charted: "Small BM noted. Pt declined further enema. MD aware. Awaiting dispo[sition]."

12. At 11:55 a.m., Dr. Drenten ordered Patient CJ be discharged. At 12:00 p.m., Dr. Drenten charted: "pain improved mildly; unable to have BM (only tolerated ½ of enema); nausea resolved. Comfortable going home to stimulate bowels there. Final Impression: Constipation, Abdominal pain, [and] nausea with vomiting. Disposition: Patient stable and improved at time of disposition." At 12:13 p.m., RN Tina Nixon charted: "Discussed discharge instructions with patient. Patient agreed to and verbalized understanding of discharge instructions. Patient given copy. Handout on constipation attached to discharge paperwork. Patient aware. All questions answered by MD and RN, No concerns at this time. Not in any distress at time of discharge. Patient P/W/D [pain free walking distance]. Patient instructed the ED is always available to return for further evaluation if condition changes or worsens. Patient taken to discharge area for check out. Patient ambulated with steady gate."

13. In the discharge area, Patient CJ sat down, expressed greater abdominal pain, and asked to speak to the doctor. Respondent came to the discharge area and spoke to Patient CJ and his wife. Respondent offered to take Patient CJ back into the ED, administer another enema, provide oral medication for constipation, and be monitored in the observation area. Patient CJ refused another enema, but accepted an oral dose of medication for constipation, and then left the ED. Patient CJ was discharged from the ED at 12:56 pm.

14. On February 27, 2014, respondent late charted the following note:

> I have seen and examined patient, I agree with resident note and plan, I have confirmed key aspects of the history and physical examination and have helped to formulate a plan of care for this patient in the emergency department. Please note that this patient was seen and evaluated with the resident on 2/22/2014. I am co-signing this note on 2/27 with the knowledge that the patient passed away on 2/23. The patient presented to the ED

on the morning of 2/22 with abdominal pain and some vomiting. He had recently been diagnosed with rectal cancer. He reported to me that he had not had a bowel movement in 4-5 days but was still passing gas. He had taking norco recently. He was slightly tachycardic (102) upon arrival but maintained a normal blood pressure and was afebrile. On exam, he was well appearing. His abdomen was soft with mild diffuse ttp [thrombotic thrombocytopenic purpura tender to palpation], maximally ttp in the epigastric region with no rebound and no guarding. Initially it was felt that he could have a bowel obstruction versus constipation. An ECG [electrocardiogram] was obtained which showed a NSR [normal sinus rhythm] with a HR [heartrate] of 79. He had some j-point elevation inV1 and V2 (the morphology was not concerning for an ST segment elevation MI) and he had no ST depression. No significant change from prior ECG. He denied any chest pain or SOB [shortness of breath]. The CXR [chest x-ray] showed no acute cardiopulmonary process. The abdominal series showed no free air and no evidence of obstruction. He did have findings on the abdominal series suggestive of constipation. His CBC demonstrated a WBC [white blood count] count of 15.8 with 79% polys and no bands [Polys are the most numerous of our white blood cells, and are the first line of defense against infection. Bands are immature polys.] His lipase was also slightly elevated at 452. He was not acidotic. Given the leukocytosis and epigastric ttp on exam we obtained a RUQ [right upper quadrant] US [ultrasound] to evaluate for cholecystitis. The ultrasound showed an echogenic liver with a known large left lobe hemangioma, minimal gallbladder sludge with no radiographic evidence of acute cholecystitis and no dilated ducts. He had chronic right hydronephrosis that appeared stable from a prior CT scan. His abdominal exam remained benign and he was given an enema with warm water, magnesium citrate and glycerin. He had a small bowel movement but did not feel much better. I repeated an abdominal exam which remained soft with mild diffuse ttp, he had no rebound and no guarding and his vital signs were normal. At that point we talked about trying some medication orally for constipation and the patient was discharged home with a prescription for lactulose. As the patient was waiting in the discharge area I was asked by the nurse to go and talk to the patient and his wife because he was not feeling much better. I went and spoke to both of them. I offered to move the patient back to a room to try another enema and to give him some medication orally for constipation. We also discussed the

observation area (CDA) for the patient. The wife agreed but the patient reported he did not want to have another enema. As his wife tried to convince him to stay he got upset with her and stated he did not want another enema and that he wanted to go home. He did agree to taking the first dose of lactulose in the ED which he received and then the patient and his wife left the ED.

Medical Evidence

BOARD EXPERT – MARC COHEN, M.D., EMERGENCY MEDICINE

15. Dr. Cohen completed his Bachelor of Arts in biology and the history of arts at Johns Hopkins University, Baltimore, Maryland, in 1995, before completing his medical degree at Stanford University, Palo Alto, California, in 1999. Dr. Cohen then completed a three-year residency in emergency medicine at Harbor-University of California, Los Angeles Medical Center Hospital. In 2001, he became licensed to practice medicine in California. He is Board Certified by the American Board of Emergency Medicine. Since 2002, Dr. Cohen has been an Attending Physician in the Department of Emergency Medicine for the California Hospital Medical Center (Los Angeles), Centinela Freeman Medical Center (Marina Del Ray), Providence Little Company of Mary Hospital (Torrence), and currently, St. Joseph Mission Hospital (Mission Viejo). He has been a Board Expert Medical Examiner since 2008. He has reviewed numerous cases for the Board, but this is the first time he has been called to testify on behalf of the Board.

16. On March 17, 2016, the Board retained Dr. Cohen to conduct a review of documents and provide an opinion on whether respondent acted within the medical standard of care when he treated Patient CJ. The Board provided Dr. Cohen with the following documents for his review: Investigative Report; Consumer Complaint form and signed medical releases; Death Certificate for Patient CJ; respondent's summary of care, dated January 24, 2015, and his curriculum vitae; a transcript of respondent's interview with the Board on March 9, 2016; and two compact discs with Patient CJ's medical records and a recording of respondent's March 9, 2016 interview with the Board; Dr. Drenten's summaries of care, dated July 7 and 8, 2015, and her curriculum vitae; a transcript of Dr. Drenten's interview with the Board on March 9, 2016; and a compact disc with a recording of Dr. Drenten's March 9, 2016 interview with the Board. Dr. Cohen wrote two reports, both dated March 21, 2016: one report regarding respondent's care of Patient CJ and one report regarding Dr. Drenten's care of Patient CJ. Dr. Cohen evaluated both doctors in four areas: (1) identify and treat Systemic Inflammatory Response Syndrome (SIRS)/sepsis; (2) perform a rectal exam; (3) choice of imaging modality to evaluate for bowel obstruction; and (4) discharge of Patient CJ. Dr. Cohen testified at hearing, consistent with his reports.

17. For Dr. Drenten, Dr. Cohen found two simple departures from the standard of care: failure to identify and treat SIRS/sepsis and perform a rectal examination. Dr. Cohen

based his opinions about Dr. Drenten's care of Patient CJ on her resident status and the relationship between a resident and attending physician. He explained:

> In most academic medicine models, resident physicians are granted clinical privileges under an attending physician's supervision. Although residents see, treat, and disposition (sic) patients, it is under the authority of that attending physician. Residents will often interview and examine before discussing care plans with a supervising attending. This ensures that an experienced, board certified physician is involved in the patient's treatment and also allows for education to the resident. It should be noted that when an attending physician cosigns a resident chart, they are accepting responsibility for the contents of the chart and overall patient care.
>
> The resident-attending dynamic appears to be present and standard in this instance. In her response letter, Dr. Drenten states that all care was discussed with her attending physician who independently evaluated the patient during the encounter. She states that the patient was reexamined by her attending when he was not feeling better. Dr. Trythall wrote in his note found on page 152 of the medical record: STAFF NOTE: I have seen and examined patient, I agree with resident note and plan, I have confirmed key aspects of the history and physical examination and have helped to formulate a plan of care for this patient in the emergency department.

Because of the resident-attending relationship, Dr. Cohen excused Dr. Drenten from any deviations of the standard of care and assigned all responsibility to respondent.

18. For respondent, Dr. Cohen found three simple departures from the standard of care, including failure to identify and treat SIRS/sepsis, perform a rectal examination, and his selection of plain radiographs instead of a CT to evaluate for bowel obstruction. First, Dr. Cohen found respondent failed to recognize and treat patient CJ's SIRS/sepsis: a simple departure from the standard of care. "SIRS is defined as two or more of the following symptoms: Fever of more than 100.4 degrees or less than 96.8 degrees; heartrate of more than 90 beats per minute; respiratory rate of more than 20 breaths per minute or arterial carbon dioxide tension of less than 32mm Hg; and/or abnormal white blood cell count greater than 12,000 uL or less than 4,000 uL or greater than ten percent immature band forms. Sepsis is defined as SIRS with confirmed or suspected infection. When Patient CJ presented to the ED, his heartrate was above 90. Lab testing revealed a white blood count of 15,800 uL. By definition, Patient CJ had SIRS." Dr. Cohen found no mention of SIRS in Patient CJ's medical chart.

19. Second, Dr. Cohen found respondent failed to perform a rectal examination on Patient CJ: a simple departure from the standard of care. In his Board interview, respondent admitted not completing a rectal examination, noting his practice is to do rectal examinations only if there is a history of gastrointestinal bleeding. However, Dr. Cohen opined: "[a] brief chart review would have revealed multiple references to an abnormal prostate mass and recently discovered rectal mass," which "was within reach of digital palpation." Because "[t]he patient was recently diagnosed with cancer and was known to have a rectal mass . . . , [a] rectal exam should have been done to assess the mass and its potential for causing obstruction."

20. Third, Dr. Cohen found respondent failed to order a CT scan to evaluate Patient CJ for a small bowel obstruction: a simple departure from the standard of care. Dr. Cohen opined:

> Although plain abdominal films have a reasonable sensitivity for the detection of high-grade small bowel obstruction, they are less useful in diagnosing low-grade/partial obstruction or ileus. Plain films can be equivocal in 20 to 30 percent of patients with true obstruction and are "normal, nonspecific, or misleading" in an additional 10 to 20 percent of patients (UpToDate). According to a 2013 study, "X-ray was determined to be the least useful imaging modality for the diagnosis of SBO [small bowel obstruction] (Taylor)."] CT is a more sensitive and specific test to evaluate for obstruction. One study suggest[s] CT sensitivity and specificity as high as 93 and 100% respectively, while plain radiographs were only 75% sensitive and 50% specific (Suri). Such data is consistent with other studies, thus obtaining a CT is standard when there is a clinical concern for even a low grade obstruction.

21. Fourth, Dr. Cohen found no failure by respondent when he discharged Patient CJ from the ED, noting that the "[s]tandard of care in emergency medicine discharges is to ensure patient safety through the exclusion of acute pathology and emergency medical conditions." Dr. Cohen opined: [t]he patient met criteria for SIRS and continued to have severe pain, and he should have been admitted to the hospital. . . . However, he [Patient CJ] was also capable of making informed decisions. The patient's choice to go home, as opposed to staying for observation, was not the correct one, but it was one he was entitled to make."

RESPONDENT'S EXPERT – ELLIOT NIPOMNICK, M.D., EMERGENCY MEDICINE

22. Dr. Nipomnick earned a Bachelor of Arts in biological sciences at Alpine College, Yellow Springs, Ohio, in 1972. He earned a Master of Arts in biological sciences at Stanford University, Palo Alto, California, in 1974, before completing his medical degree at the State University of New York, Stony Brook Health Sciences Center, in 1978. Dr. Nipomnick

then completed a one-year residency in internal medicine at Presbyterian Hospital Pacific Medical Center in San Francisco. Thereafter, Dr. Nipomnick shifted his practice to emergency medicine. Since 1979, Dr. Nipomnick has been an Emergency Physician at Sutter Coast Hospital (Crescent City), Pacific Presbyterian Medical Center (San Francisco), Children's Hospital Medical Center (San Francisco), Parkview Community Hospital (Riverside), Brookside Hospital (San Pablo), Natividad Medical Center (Salinas), St. Rose Hospital (Hayward), Mark Twain St. Joseph's Hospital (San Andreas), Kaiser Hospital (Hayward & San Francisco), Mercy San Juan Medical Center (Sacramento), and currently, Chinese Hospital (San Francisco). In addition, he has served as the Medical Director for Del Norte Ambulance and Del Norte Air Ambulance, North Coast EMS, Brookings Urgent Care, Sutter Coast Hospital, Brookside Hospital, Navidad Medical Center, St. Rose Hospital, Emergency Physicians Medical Group, and currently, at Chinese Hospital. In 1979, he became licensed to practice medicine in California. He is Board Certified by the American Board of Emergency Medicine. He has been a member of several medical quality assurance committees, providing opinions on doctors' conduct and care, including the Board, since 1996. He has testified as an expert for patients, doctors, and the Board.

23. Respondent retained Dr. Nipomnick, to conduct a review of documents and provide an opinion as to whether respondent acted within the medical standard of care when he treated Patient CJ. Respondent provided Dr. Nipomnick with the following documents for his review: Investigative Report; a transcript of respondent's interview with the Board on March 9, 2016; a transcript of Dr. Drenten's interview with the Board on March 9, 2016; a compact disc with Patient CJ's medical records; and Dr. Cohen's report, dated March 21, 2016. Dr. Nipomnick wrote a report, dated January 21, 2017. Dr. Nipomnick testified at hearing, consistent with his report.

24. In sum, Dr. Nipomnick found one minor deviation from the standard of care relative to respondent's treatment of Patient CJ: not performing a rectal examination. Otherwise, Dr. Nipomnick found respondent's treatment of Patient CJ to be within the standard of care for an ED physician. First, Dr. Nipomnick found respondent recognized and treated Patient CJ for SIRS/sepsis, and was not required to write SIRS/sepsis in the medical chart. "SIRS is a clinical syndrome that casts a broad net around signs that may help lead a physician to identify subtle infections and sepsis in patients presenting to the Emergency Department." Respondent "pursued avenues of possible infection sources by obtaining the CXR, acute abdominal series, urinalysis, and ultrasound . . . [and] used their [Dr. Drenten and respondent] clinical judgment to determine that there was (*sic*) no sources of infection and therefore no sepsis."

25. Second, Dr. Nipomnick found respondent failed to perform a rectal examination of Patient CJ: a minor deviation of the standard of care. Patient CJ "had a known rectal mass, constipation for three days, diffuse cramping abdominal pain, and mild tenderness to palpation. A distal bowel obstruction was within the differential diagnosis. [Therefore,] [a] distal rectal exam . . . should have been performed."

26. Third, Dr. Nipomnick found respondent's use of an acute abdominal series x-ray to be a reasonable first line screening imaging modality for a possible bowel obstruction. The abdominal series x-rays showed no bowel obstruction. "Had there been a hint of possible bowel obstruction or perforation on the radiographs, a CT scan could have . . . been ordered." Dr. Nipomnick opined: "[o]rdering an acute abdominal series is a screening tool for bowel obstruction, [and] is commonly performed by competent emergency physicians in the same or similar circumstances, and was not below the standard of care in this case.

27. Finally, Dr. Nipomnick found no failure by respondent in discharging Patient CJ from the ED. "The essence of emergency medical care is to evaluate the patient's signs and symptoms using a thorough history and physical exam, diagnostic testing, repeat exams, and shared decision making with the patient, and to decide on a course of treatment and disposition. That is exactly what Dr. Trythall and Dr. Drenten did with [Patient CJ]."

RESPONDENT

28. Respondent earned a Bachelor of Arts in Spanish at Brigham Young University, Provo, Utah in 1996. He earned a Master of Science in public health and epidemiology at the University of Michigan, Ann Arbor, Michigan, in 1998, before completing his medical degree at George Washington University, Washington, D.C., in 2002. Respondent then completed a three-year residency in emergency medicine at the University of California, Davis (UC Davis) Medical Center. Since 2005, respondent has been an ED Physician with Kaiser South Sacramento, where he remains to date. In 2003, respondent became licensed to practice medicine in California. He is also Board Certified by the American Board of Emergency Medicine.

29. Respondent does not dispute the facts as presented. Writing to the Board, on July 24, 2015, respondent stated: "[M]y care was completely appropriate based on the information available to me at the time I treated him [Patient CJ]. Given his history, physical examination, and diagnostic test results, my judgment was that his symptoms were due to constipation, and that the vomiting was a side effect of the Vicodin that he had taken earlier. He had no evidence of a surgical abdomen, and I did not believe he was septic or had a bowel obstruction." At hearing, respondent addressed each area of concern raised by Dr. Cohen. First, respondent was aware Patient CJ met the SIRS criteria, indicating in Patient CJ's chart: "[h]e was slightly tachycardic (102) upon arrival . . . [and] [h]is CBC demonstrated a WBC [white blood count] count of 15.8 with 79% polys and no bands." As a result, respondent, via Dr. Drenten, followed the SIRS protocol and looked for infection in Patient CJ. Dr. Drenten ordered labs to find any infectious processes; a urinalysis to evaluate kidney and liver function; an abdominal series x-rays to rule out peritonitis; and an ultrasound to rule out colitis and pancreatitis. No infection was found and respondent and Dr. Drenten determined Patient CJ did not have sepsis and noted as much in the patient file.

30. In general, respondent does not write SIRS in patient charts, nor does he require his residents to document the word SIRS in a patient chart either, because SIRS is not a diagnosis; sepsis is a diagnosis. According to respondent, the SIRS criteria were established to encourage early detection of infection and sepsis in ED patients, and thereby

decrease morbidity and mortality. If a patient meets the SIRS criteria, the protocol requires the doctor to look for signs of infection. In this case, respondent followed the SIRS protocols and ruled out sepsis.

31. Second, respondent did not perform a rectal examination on Patient CJ, finding the examination to be unnecessary. In general, respondent completes a rectal exam when he is worried about a gastrointestinal bleed, a rectal impaction, or when a patient complains of black, dark, or tarry stools, or bright red blood coming from the rectum. Patient CJ never complained of bleeding from the rectum or discolored stool. In addition, respondent was aware of Patient CJ's perirectal mass; Patient CJ reported passing gas; and respondent attributed Patient CJ's constipation to the Norco. Given the above, a rectal examination was unnecessary to diagnose or treat Patient CJ. Following imaging, there was no need to complete a rectal examination to diagnose or treat Patient CJ. The abdominal series x-rays were normal, showing no bowel obstruction and a large stool burden in the transverse colon, which is not reachable for distal disimpaction. Following the enema, there was no need to complete a rectal examination, because Patient CJ produced a small bowel movement. Finally, respondent has never been counseled to give rectal examinations for patients who present with constipation, nor has the requirement to perform rectal examinations ever come up in quality care meetings when reviewing patients presenting with constipation.

32. Third, respondent did not order a CT scan of Patient CJ. Respondent was taught, and medical textbooks instruct doctors to order an abdominal series of x-rays, as the first line screening modality, for diagnosing a bowel obstruction. In this case, the abdominal series x-rays showed no bowel obstruction and supported the clinical diagnosis of constipation; Patient CJ's abdomen was non-surgical; and there was no air in the abdomen. Given the above, there were no evidence an additional imaging modality was indicated. In addition, Patient CJ reported passing gas, and RN Santos charted a "small BM" following the enema; for respondent, both confirming signs a bowel obstruction was not present. Finally, respondent clearly remembers, Dr. Drenten never expressed a desire to order a CT scan of Patient CJ, and respondent would not have denied her request, but Dr. Drenten never discussed a CT scan with him.

33. Fourth, in the discharge area, Patient CJ reported being in pain again. Respondent came to speak with Patient CJ. Respondent offered Patient CJ: (1) return to the ED for another enema; (2) a bed in the observation area; and/or (3) oral laxative medication. Patient CJ accepted a dose of the oral laxative medication and then asked to go home. Respondent honored both requests.

DR. DRENTEN

34. Dr. Drenton earned a Bachelor of Science in molecular and cellular biology and Italian culture, in 2007, and her medical degree in 2011, at the University of Arizona, Tuscon. Respondent then completed a three-year residency in emergency medicine at the UC Davis Medical Center, with rotations at Kaiser South Sacramento ED. Since 2014, respondent has

been an emergency medicine physician with California Emergency Physicians, working at Sutter Hospital in Sacramento, where she remains to date. She has hospital privileges at Sutter and Mercy San Juan hospitals. In 2013, respondent became licensed to practice medicine in California, and in 2016, became Board Certified by the American Board of Emergency Medicine.

35. On February 22, 2014, Dr. Drenten was a third-year resident, working at Kaiser South Sacramento under the direction of an attending physician, respondent. On July 7 and 8, 2015, Dr. Drenten provided a written response to the Board, and on March 9, 2016, Dr. Drenten sat for an interview with the Board. Dr. Drenten did not testify at hearing, but her letters to the Board and the transcript of her Board interview were admitted into evidence.

36. Writing to the Board, Dr. Drenten stated:

> The patient had a diagnosis of rectal adenocarcinoma and had presented with abdominal pain and vomiting, mostly in the upper abdomen, and decreased bowel movements, however, was still passing gas. Our workup showed that the patient had a nonobstructive bowel gas pattern. Patient was given an enema in the ED that resulted in a small bowel movement. And initial plan was to discharge the patient to home. The patient later commented that he was not feeling better and was reevaluated by the attending physician, who offered having the patient return back to the ED patient room and consider admission to the observation unit for further evaluation and monitoring of his condition. The patient's wife wanted the patient to stay, however the patient declined these two options and stated that he wanted to go home.

37. During her interview with the Board, Dr. Drenten confirmed her status on February 22, 2014, as a third-year resident working under the direction of an attending physician, respondent, at Kaiser South Sacramento ED. Dr. Drenten recounted her resident-attending relationship with respondent, and the requirement to discuss each patient with respondent before taking any action. Dr. Drenten then walked through her chart note for Patient CJ, explaining his history, including no bowel movement for three days, but passing gas, and no abdominal guarding upon physical examination; lab results found nothing significant; abdominal series x-rays showed no obstruction and confirmed the constipation diagnosis; and an enema produced a small bowel movement, confirming the bowels were not obstructed. However, without the medical records, Dr. Drenten admitted she had no specific recollection of her care and treatment of Patient CJ.

38. Dr. Drenten acknowledged no rectal examination was completed on Patient CJ, noting she does not perform rectal examinations for complaints of constipation, but for complaints of blood in the stool. She also confirmed no CT scan was taken of Patient CJ either. When questioned, Dr. Drenten was unsure about whether she discussed a CT scan

with respondent (e.g., "I think I discussed a CT scan with my attending . . . ." "I believe I remember discussing should we get a CT scan . . . .").

Character Testimony – Trevor Cadogan, M.D.

39. Dr. Cadogan testified at hearing on behalf of respondent. He is the ED Assistant Chief at Kaiser South Sacramento. Dr. Cadogan met respondent during their residency at UC Davis Medical Center, spending frequent rotations together and consulting one another on a regular basis. Dr. Cadogan is also a friend to respondent outside of work. Dr. Cadogan described respondent as a competent and skilled ED doctor, who colleagues rely on, and who is receptive to the opinions of others. He is devoted to patient care. He is an "MPS [Member-Patient Survey] Champion;" he always scores high, personally, and then assists colleagues and staff to help raise their scores. His peers regard him highly. Personally, Dr. Cadogan finds respondent to be honest and trustworthy, and a man of good character.

Discussion

40. Considering four areas, Dr. Cohen found three simple departures from the standard of care, failure to note SIRS/sepsis in the patient chart, complete a rectal examination, and order a CT scan, and Dr. Nipomnick found one simple deviation, failure to complete a rectal examination. The experts agree on two areas: a rectal examination should have been performed, and failure to do so was a minor deviation or simple departure from the standard of care; and there was no departure from the standard of care in discharging Patient CJ.

41. Both Dr. Nipomnick and Dr. Cohen are experienced emergency medicine doctors, although Dr. Nipomnick has been practicing for 38 years and Dr. Cohen for only 15. In comparison, Dr. Nipomnick has extensive experience in medical quality assurance evaluations; while Dr. Cohen has only evaluated cases for the Board. Dr. Nipomnick has testified numerous times for doctors, patients, and the Board, while Dr. Cohen has never testified on behalf of a doctor and this matter marks his first testimony for the Board. At hearing, Dr. Nipomnick provided specific references to the medical records to support his opinions, but Dr. Cohen repeatedly testified he was unable to recall the medical records, because he had last reviewed them more than one year ago. As a result, Dr. Cohen's testimony was full of abstract concepts and void of case specific references and discussion. Ultimately, Dr. Nipomnick provided a more persuasive assessment of the facts at issue, providing ample references to the medical records and indispensable case specific explanations for his opinions.

42. First, Dr. Nipomnick found respondent was not required to write SIRS in the medical record, but was required to follow the SIRS protocol and look for infection. In this case, Dr. Nipomnick opined, respondent followed the SIRS protocols. A review of the medical records revealed: (1) notation of Patient CJ's elevated heart rate and leukocytosis, making him a qualifying SIRS patient; and (2) multiple tests ordered to rule out infection,

including labs and urinalysis, chest and abdominal x-rays, and an abdominal ultrasound, meeting the SIRS protocols. Dr. Nipomnick noted that most ED doctors do not write SIRS into patient charts, because it is not a diagnosis. Instead, the standard of care requires an ED doctor to determine whether a patient meets the SIRS criteria, which then triggers a search for infection. Respondent followed the SIRS protocol and acted within the standard of care.

43. Second, Dr. Nipomnick found respondent properly ordered abdominal series x-rays, as a first line imaging modality, and the results of the abdominal series x-rays did not require a CT scan to be ordered. Dr. Nipomnick referenced emergency medicine texts and online resources to support the proposition that abdominal series x-rays are the first line imaging modality in diagnosing a bowel obstruction. In this case, the radiologist read the abdominal series x-rays to show no bowel obstruction and to be consistent with the diagnosis of constipation. Without a hint of bowel obstruction on the abdominal series x-rays, a CT scan is not required under the standard of care.

44. Overall, Dr. Nipomnick found respondent's care of Patient CJ within the standard of care, with the exception of failing to conduct a rectal examination. Dr. Nipomnick opined: Patient CJ "had a known rectal mass, constipation for three days, diffuse cramping abdominal pain, and mild tenderness to palpation. A distal bowel obstruction was within the differential diagnosis. [Therefore,] [a] distal rectal exam . . . should have been performed." Dr. Nipomnick indicated that many ED doctors do not perform rectal examinations on patients who present with constipation, but that does not change the standard of care. The failure to perform a rectal examination during the physical of Patient CJ was a simple deviation from the standard of care.

45. Given the above, there is one simple departure from the standard of care, in regards to an examination many ED doctors do not routinely complete in patients with constipation, making respondent's conduct less than a knowing act of negligence, on one occasion. Respondent is capable of changing his practice, and teaching his residents to conduct rectal examinations in patients who present with constipation. Respondent is a competent and intelligent ED doctor. His judgment is not in question, nor is his thoroughness or his concern for patients. Given the above, no discipline is necessary or appropriate. Considering the Factual Findings as a whole, respondent is safe to practice medicine.

LEGAL CONCLUSIONS

Applicable Laws

1. Business and Professions Code, section 2234, requires the Board to "take action against any licensee who is charged with unprofessional conduct." "Unprofessional conduct includes, but is not limited to: repeated negligent acts." (Bus. & Prof. Code, § 2234, subd. (c).) "To be repeated, there must be two or more negligent acts or omissions.

An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts." (*Ibid.*)

Cause for Discipline

2. No cause exists for disciplinary action under Business and Professions Code section 2234, subdivision (c), by reason of the matters set forth in the Factual Findings as a whole. Complainant failed to prove, by clear and convincing evidence, respondent acted repeatedly negligent in his care and treatment of Patient CJ.

3. Considering the Factual Findings and Legal Conclusions as a whole, respondent's actions do not constitute cause for discipline. As such, the Accusation should be dismissed.

ORDER

The Accusation against William Shane Trythall, M.D., Physician's and Surgeon's Certificate No. A 84413, is DISMISSED.

DATED: April 28, 2017

DocuSigned by:
6D644509A8FF4C5...

ERIN R. KOCH-GOODMAN
Administrative Law Judge
Office of Administrative Hearings

KAMALA D. HARRIS
Attorney General of California
VLADIMIR SHALKEVICH
Acting Supervising Deputy Attorney General
DEMOND L. PHILSON
Deputy Attorney General
State Bar No. 220220
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 322-9674
Facsimile: (916) 327-2247
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **WILLIAM SHANE TRYTHALL, M.D.** 6600 Bruceville Road Sacramento, CA 95823 Physician's and Surgeon's Certificate No. A 84413 Respondent.	Case No. 800-2015-012428 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about August 22, 2003, the Medical Board issued Physician's and Surgeon's Certificate Number A 84413 to William Shane Trythall, M.D. ("Respondent"). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2017, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states, in pertinent part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"...

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"..."

CAUSE FOR DISCIPLINE

(Repeated Negligent Acts During Care of Patient CJ)

6. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), in that he committed multiple negligent acts during the care and treatment of Patient CJ The circumstances are as follows:

///

7. On January 24, 2014, patient CJ underwent a biopsy. On February 18, 2014, CJ was diagnosed with colon cancer after review of the biopsy. CJ was scheduled for further testing on February 22, 2014, to determine the extent of the disease.

8. On February 22, 2014, CJ awoke in extreme pain and went with his wife to the Emergency Department located at Kaiser Permanente Hospital - South Sacramento. While enroute to the hospital, CJ began vomiting. Once at the hospital, CJ's wife informed the staff of her husband's recent colon cancer diagnosis and that he had a one week history of constipation.

9. At approximately 9:00 a.m., a third year emergency medicine resident examined the patient. She noted that CJ suffered from abdominal pain, nausea, vomiting with constipation, and had a recent history of colon cancer. She noted that he had tachycardia of 102 beats per minute. Respondent, supervising the third year emergency medicine resident, examined the patient and cosigned CJ's medical chart, noting the resident's findings. Respondent noted that CJ's abdomen was soft and non-distended, that an x-ray series showed constipation without obstruction, and that CJ had initial lab work indicating a leukocytosis (white blood cell count) of 15.8 ("15,800/μL") and an elevated lipase of 452. An ultrasound was ordered of the gall bladder and showed no acute findings. A rectal exam was not performed, and a CT ("Computerized Tomography") scan was not ordered.

10. Respondent ordered fluids and an enema to relieve constipation. CJ had to stop the enema before completion due to extreme pain. Only a small amount of stool was released. Respondent spoke with CJ and his wife regarding dietary changes and over the counter laxatives. Respondent prepared CJ for discharge. While CJ was waiting for discharge, he experienced more pain. Respondent met with CJ and his wife, and they went home in the early afternoon.

11. Approximately six hours after discharge, CJ and his wife returned to the Emergency Department at Kaiser Permanente Hospital - South Sacramento. A new attending emergency room physician discovered a hard immobile mass in CJ's rectum during a rectal examination and a CT scan revealed a small bowel obstruction due to a tumor. At readmission, CJ's leukocytosis was 19.7 and CJ was diagnosed with SIRS ("Systemic Inflammatory Response Syndrome").

///

Although admitted that evening, CJ passed away on February 23, 2014, as a result of multiple organ failure, and sepsis with a history of adenocarcinoma.

12. Respondent's actions represented repeated negligent acts for the following reasons:

1. Failure to identify and treat SIRS despite CJ having a heart rate over 90 beats per minute and having an abnormal white blood cell count over 12,000/μL at the time of initial admission to the Emergency Department;

2. Failure to perform a rectal exam during the initial visit to the Emergency Department despite CJ having a history of colorectal cancer and a complaint of constipation;

3. Failure to use advanced radiographic studies such as computerized tomography in order to evaluate for possible obstruction during the initial visit to the Emergency Department.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 84413, issued to William Shane Trythall, M.D.;

2. Revoking, suspending or denying approval of William Shane Trythall, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering William Shane Trythall, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: June 17, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SA2016300756
32476255.doc