[redacted]

[redacted]

[redacted]

~~District of Columbia Health Professional~~
Licensing Administration
Board of Medicine
899 North Capitol Street, NE.
2nd Floor
Washington, D.C. 20002

Re: Response to Board Request Dated May 26, 2011

Dear [redacted]

This letter comes in response to your letter to me dated May 26, 2011. Your letter indicated that the District of Columbia Board of Medicine had completed a review of a malpractice suit filed against [redacted] and other defendants, including myself. Your letter advised that the Board's legal and medical review of the case did not warrant initiation of formal disciplinary action.

The Board did conclude, however, that corrective action is appropriate, and you instructed me to submit a Corrective Action Plan (CAP), discussing the following:

(A) A statement of [my] perspective on the case;
(B) Identification of the deficiency or the root cause that led to the matter at issue; and
(C) Efforts undertaken to improve or correct the problem, including any additional training or changes you may have made to your practice protocols to minimize the chance of future occurrences.

As for my perspective on the case, I was initially surprised to learn that the subject patient had died as the result of bowel ischemia, bowel obstruction, or anything to suggest the need for emergency surgery, per my review of the patient's abdominal CT scan. Subsequently, I conducted medical literature search, which revealed that there is an increasing incidence of small bowel volvulus and ischemic bowel (with or without an identifiable volvulus), in patients who

[redacted]

have undergone gastric bypass procedures. Further, I am cognizant that these patients require a consult by a surgeon, and sometimes also require a laparoscopy to exclude an internal hernia and/or volvulus at the time of presentation. While I regularly attend CME courses, as a [redacted] ~~I generally attend lectures focusing on body imaging.~~

As for medically substantive or procedural deficiencies leading to the matter at issue, in my judgment there were several, warranting corrective measures discussed herein below. In my estimation, the *root cause* that lead to the patient's demise was a lack of communication between the emergency room physicians and the attending radiologist (myself).

I have since instituted protocols at [redacted] Hospital designed to help identify these and other high risk patients. I have also successfully improved the communications between referring physicians and the hospital emergency room physicians, as well as the communications between the hospital's emergency room physicians and attending radiologists. The aforementioned changes include, but are not limited to:

(A) Installation of a new PACS system to review all images. The department is now essentially filmless. All images are reviewed on a computer and dictated more efficiently and accurately. Additionally, any previous images for that patient that were archived, are then automatically presented on the screen with the previous report when any subsequent images are reviewed;

(B) Target training of medical personnel. All of the radiologists, emergency department physicians, and most of the hospital's general surgeons at [redacted] Hospital have been made aware of the increasing incidence of small bowel volvulus and ischemic bowel in this particular patient population; further, hospital staff have discussed and agreed upon how these patients should be managed; and

(C) Supplemental verbal protocols instituted. Staff have agreed that in presenting cases such as the one involving the subject patient, verbal contact between the referring physician and the radiologist is made and *documented in the report.* A surgical consultation will henceforth be recommended *regardless* of the CT findings.

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Since institution of the above corrective measures, two more patients have presented to our emergency department and have been accurately diagnosed with a small bowel volvulus by subtle CT findings. The experience regarding the subject patient has further heightened my diligence in imaging review of patients who have a history of gastric bypass surgery, in part because they present so differently than typical patients presenting with differentially suspected small bowel obstruction. I, as well as the other radiologists collectively at [redacted] Hospital, have learned a great deal from this experience. I have three (3) cases now in my collection. I plan to continue to collect cases and hope to eventually have enough to give a CME meeting at [redacted] Hospital on this very topic.

Thank you for your consideration of the enclosed. If you have additional questions or concerns, kindly advise.

Sincerely,

[redacted]

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