BEFORE THE BOARD OF MEDICAL EXAMINERS

IN THE STATE OF ARIZONA

In the Matter of **WILLIAM G. ODETTE, M.D.** Holder of License No. **17234** For the Practice of Medicine In the State of Arizona.	Board Case No. MD-01-0465 **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

This matter was considered by the Arizona Board of Medical Examiners ("Board") at its public meeting on February 7, 2002. William G. Odette, M.D., "Respondent") appeared before the Board with legal counsel, Neil Alden, for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(I). After due consideration of the facts and law applicable to this matter, the Board voted to issue the following findings of fact, conclusions of law and order.

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. 17234 for the practice of medicine in the State of Arizona.

3. The Board initiated case number MD-01-0465 after receiving a report from the Department of Health Services ("DHS") concerning Respondent's care and treatment of a 43 year-old male patient ("Patient") at Summit Hospital of Southeast Arizona. The DHS report named additional physicians. The Board conducted an investigation of those physicians and subsequently dismissed those cases.

4. Patient was transferred into Respondent's care on January 17, 2001 for total parenteral nutrition and "gut rehabilitation". DHS reported that Respondent

misidentified a peritoneal dialysis catheter as a jejunostomy tube and the nursing staff then set Patient up for 2 tube feedings through the catheter into the peritoneal cavity. Patient later expired due to acute peritonitis. When the investigator presented the case to the Review Committee at the formal interview, she noted that Respondent has been forthright throughout the investigative process in accepting responsibility for his error and the subsequent results.

5. Respondent testified that Patient had previously been on peritoneal dialysis and was blind and encephalopathic at the time he was transferred to Respondent's care. Respondent noted that Patient also had a relative contraindication to peritoneal dialysis, which is why the feeding tubes were placed in him. According to Respondent, the peritoneal dialysis catheter was left in place while Patient received hemodialysis. Respondent testified that he had never looked at a peritoneal dialysis catheter before. Respondent noted that when peritoneal dialysis is being done in the hospital the rooms are closed and have signs stating "do not enter, peritoneal dialysis in process."

6. Respondent noted that the catheter itself has no warning on it that it is to be used for peritoneal dialysis only. According to Respondent the catheter is a Silastic catheter, which he now knows has a robin's egg blue top – the only identifier that tells you it is a peritoneal dialysis catheter.

7. Respondent testified that when he examined Patient there was a catheter in place that was taped up and he could not see the stopper on the end of it. Respondent stated that he later found out that peritoneal dialysis catheters have Luer locks rather than plugs like jejunostomy feeding tubes. Respondent testified Patient had two tubes – a surgically placed gastrostomy feeding tube and a surgically placed Silastic catheter that he misidentified as a jejunostomy tube - and the nurses administered two feedings

through that tube after they expended much effort to find a connector that actually fit the tube.

8. Respondent was asked whether he had Patient's chart discharging Patient from one institution and admitting him to the other that would identify that Patient had a peritoneal dialysis catheter. Respondent indicated that he did not recall if he was told, or if it was his understanding, that Patient had a gastrostomy feeding tube and Respondent was under the impression that Patient had a jejunostomy feeding tube. To the best of Respondent's recollection he did not have medical records or a discharge summary in front of him that said Patient had a peritoneal dialysis catheter.

9. According to the records, the nurses contacted Respondent one or two times after beginning the feedings to report that Patient was experiencing pain. The nurses asked to have radiographic studies or some other evaluation or maybe even a transfer because they were worried about what was going on. The records indicate that Respondent declined the nurses' suggestion. Respondent testified that in response to the nurses' calls he stated that it was common for a patient to be in some distress because of the paretic stomach and that he had examined the tube, it was in place and it was not going to go anywhere and x-rays would not add anything. Respondent stated that he ordered the tube feedings to stop to allow time to pass for things to calm down and then to restart the feeding at a lower level. Respondent testified that he did so because he thought the tube was in the jejunum and was fully functional.

10. Respondent indicated he evaluated Patient the following morning. Patient was hypotensive, on dopamine and was transferred out to the intensive care unit. Respondent testified that after he had spoken to the nurses in the early evening he was off duty and his responsibility for Patient ended. Respondent indicated that the facility was a long-term acute care facility where they are quite capable of running IV antibiotics,

hemodialysis, ventilators, dopamine, IV fluids and of running stable intensive care unit cases.

11. Respondent testified that he had altered his practice in response to this case in that when accepting care of a patient he talks to the physician who is involved in the case to get a more full picture and he does not make assumptions about what the patient has or how the patient is being treated from elsewhere.

12. The records indicate that when the nurses initially went to do the feeding, they had trouble attaching the tube and could not find a connector. Respondent was asked if he was contacted or notified in any way of the difficulty the nurses' experienced. Respondent indicated he was not contacted or notified.

13. Respondent missed the opportunity to correct his grievous error when the nurses informed him that Patient was not doing well.

14. Respondent's conduct fell below the standard of care.

CONCLUSIONS OF LAW

1. The Board of Medical Examiners of the State of Arizona possesses jurisdiction over the subject matter hereof and over Respondent.

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

3. The conduct and circumstances above in paragraphs 2, 7, 9, 13 and 14 constitute unprofessional conduct pursuant to A.R.S. § § 32-1401 (25)(q) "[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public;" and 32-1401(25)(ll) "[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient."

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for misidentifying the peritoneal dialysis catheter as a jejunostomy tube that resulted in significant patient complications and subsequent death.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing or review must be filed with the Board's Executive Director within thirty days after service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a rehearing or review. Service of this order is effective five days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five 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 2nd day of May, 2002.

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

By Claudia Foutz
CLAUDIA FOUTZ
Executive Director

ORIGINAL of the foregoing filed this
3RD day of MAY, 2002 with:

The Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Certified Mail this
3RD day of JULY, 2002, to:

Neil C. Alden, Esq.
Sanders & Parks, PC
3030 N. Third St., Suite 1300
Phoenix, AZ 85012-3099

Executed copy of the foregoing
mailed by U.S. Mail this
3RD day of JULY, 2002, to:

William G. Odette, M.D.
6039 E. Grant Road
Tucson, AZ 85712-2317

Copy of the foregoing hand-delivered this
3RD day of JULY, 2002, to:

Christine Cassetta
Assistant Attorney General
Sandra Waitt, Management Analyst
Lynda Mottram, Compliance Officer
Investigations (Investigation File)
Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258