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BEFORE THE BOARD OF MEDICAL EXAMINERS

IN THE STATE OF ARIZONA

In the Matter of **MALCOLM WILKINSON, M.D.** Holder of License No. **21001** For the Practice of Medicine In the State of Arizona.	Board Case No. MD-01-0141 **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

On February 8, 2002, Malcolm Wilkinson, M.D., ("Respondent") appeared before a Review Committee ("Review Committee") of the Arizona Board of Medical Examiners ("Board") with legal counsel Richard Rea, for a formal interview pursuant to the authority vested in the Review Committee by A.R.S. § 32-1451(Q). The matter was referred to the Board for consideration at its public meeting on April 10, 2002. 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. 21001 for the practice of medicine in the State of Arizona.

3. The Board initiated case number MD-01-0141 after receiving notification of a medical malpractice settlement involving Respondent's care and treatment of a 72 year-old female patient ("Patient").

4. A urologist referred Patient to Respondent for evaluation of abdominal pain, change in bowel habits and pneumaturia of several months duration. Patient had also reported poor appetite and weight loss, but no fever, chills, or sweats. Patient also had

1 occasional episodes of left lower quadrant pain and recent pain with hemorrhoids.
2 Respondent took Patient's history and performed a physical examination. Respondent
3 assessed a persistent colovesical fistula likely due to sigmoid colon diverticulosis and
4 recommended surgical correction in the form of sigmoid colon resection and takedown of
5 the colovesical fistula.

6 5. In August, 1997 Respondent admitted Patient for bowel preparation and
7 surgery to correct the colovesical fistula. Respondent performed an exploratory
8 laparotomy, and sigmoid resection and external hemorroidectomy. A second surgeon
9 performed a takedown of the colovesical fistula.

10 6. Patient did well post-operatively until October, 1997 when she developed
11 signs and symptoms consistent with an intraabdominal abscess. A CT scan revealed a
12 left psoas abscess. Patient underwent CT guided abscess drainage of the suspected
13 lesion. The abscess was not completely drained and Respondent performed an open
14 drainage of the abscess. A follow-up CT scan showed some improvement. However,
15 Patient continued to have adverse symptoms and the abscess was not completely
16 resolved.

17 7. In January, 1998, Respondent performed an exploratory laparotomy with a
18 left colon colostomy and drainage of the pelvic retroperitoneal abscess. A March 26,
19 1998 CT scan of the abdomen showed a sinus tract, left lower abdomen, but no evidence
20 of abscess. On March 27, 1998, Respondent performed an incision and drainage of an
21 abdominal wall abscess in the left lower quadrant. Subsequently, there was
22 redevelopment of a chronic sinus tract that drained infectious material. Continued
23 antibiotic therapy caused the bacteria to become resistant and sensitive only to
24 vancomycin. Patient's condition continued to deteriorate, with weight loss, lack of
25 appetite and worsening back pain.

7. Patient transferred her care to other physicians. Consultations were obtained from physicians specializing in internal medicine, infectious disease and surgery. A Gastrografin enema showed findings of chronic fistula emanating from the rectal stump of the previous resection. Patient was taken to surgery and the rectal stump and fistula were resected, the colostomy was taken down and colon continuity was restored. Patient made a relatively uneventful recovery.

8. The Board's Medical Consultant ("Medical Consultant") stated that his criticism of Respondent's actions was that throughout the attempts to clear the intra-abdominal abscess Respondent relied only on CT scans to attempt to find the source. According to the Medical Consultant, a simple fistulogram or a Gastrografin enema of the retained stump at any time throughout the prolonged postoperative course would have provided appropriate information and shortened Patient's prolonged postoperative complications.

9. Respondent testified that throughout the whole period he was treating Patient his impression was that the primary problem was a recurrent, persistent abscess that was not necessarily related to a fistula from the rectal stump, but had been persistent from the beginning. Respondent stated that he had gotten Patient to a point of discussing the process of closing her colostomy and resolving the process. According to Respondent that type of operation does require performing an imaging study to look at the colon, at the rectal stump. However, he had not advised to go ahead with that because he felt there was still too much infection associated with the original abscess to safely consider proceeding.

10. Respondent was asked why he had not made a more aggressive attempt via some type of contrast study to delineate the fistula, which would have helped eradicate the infection either through bowel rest or surgery or other options. Respondent

testified that he had initially relied on CT scan to demonstrate the abscess and he continued to rely on the CT scan to show its resolution over time. Respondent also testified that looking back at the situation he did not believe that even having done such an examination and having it show that there may have been a fistula from the rectum that he necessarily would have altered the decisions and procedures he recommended doing.

11. Respondent was asked to look back and address at what point in time he believed additional evaluation should have been done considering that the CT evidence was telling him Patient should be getting better, but she was not. Respondent stated that in general he felt there was improvement in Patient's condition and he believed the CT scan was the best imaging modality to help him assess what he believed was a primary abscess. Respondent indicated that if he were to handle this case today he would perform a sinogram, fistula tract imaging study or Gastrografin enema. Respondent also testified that he generally obtains 100 hours or more a year of continuing medical education in a variety of surgical topics, including colorectal surgery.

12. 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 6, 7, 8, and 10 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

1 public;" and 32-1401(25)(ll) "[c]onduct that the board determines is gross negligence,
2 repeated negligence or negligence resulting in harm to or the death of a patient."

3 **ORDER**

4 Based upon the foregoing Findings of Fact and Conclusions of Law, IT IS
5 HEREBY ORDERED that Respondent is issued a Letter of Reprimand for failure to use
6 either a fistulogram or a Gastrografin enema to further attempt to delineate the source of
7 fistula from the colon.

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

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

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

18 DATED this 2nd day of May, 2002.

19

20 BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA
21
22
By Claudia Foutz
23 CLAUDIA FOUTZ
Executive Director
24

25 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 MAY, 2002, to:

Richard Rea
Goodwin Raup PC
3636 North Central Avenue
Suite 1200
Phoenix, Arizona 85012-1998

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

Malcolm Wilkinson, M.D.
300 South Willard Street
Suite 101
Cottonwood, Arizona 86326-4160

Copy of the foregoing hand-delivered this
3RD day of MAY, 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
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