STATE OF RHODE ISLAND
DEPARTMENT OF HEALTH
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

IN THE MATTER OF:
JOSEPH P. TURNER, D.O. License Number DO0058
Controlled Substances Registration Number CDO0058

CONSENT ORDER

Joseph P. Turner, D.O. (hereinafter "Respondent") is licensed as a physician in Rhode Island and is licensed to prescribed controlled substances under RIGL 21-28, having both a state Controlled Substances Registration and a Federal Drug Enforcement Administration Registration to prescribe controlled substances. The Board of Medical Licensure and Discipline (hereinafter the "Board") through its investigating committee voted to find Respondent had committed unprofessional conduct and made the following:

FINDINGS OF FACT

1. Respondent is a licensed physician in the State of Rhode Island and was issued his license on May 14, 2003. Respondent's office is located at 3462 South County Trail, East Greenwich, Rhode Island, and his primary specialty is internal medicine, in which he is board certified. He has privileges at Rhode Island, South County and Saint Joseph's Hospitals.

2. 56 year old male patient on March 16, 2009, had undergone an elective laparoscopic cholecystectomy (gallbladder removal), and on March 23, at 6:25 p.m., patient went to the emergency department of Our Lady of Fatima Hospital complaining of severe lower abdominal pain at "ten on a scale of ten". The patient was seen and cared for by a Nurse Practitioner. The Nurse Practitioner prescribed two doses of intravenous Dilaudid (which reduced the patient's pain) and Zofran. X-rays showed no free

intraperitoneal air, and "mild distention of central bowel loops suspicious for small bowel with air fluid levels[.]" The Nurse Practitioner's notes indicated that the "findings may represent ileus, enteritis, or small bowel obstruction. ***Advise follow up."

3. The Nurse Practitioner spoke by telephone on March 23 with patient's cholecystectomy surgeon, who felt the laboratory work was not alarming and the patient had no free air; so the surgeon advised that no CT scan should be done, and that patient should be discharged and then follow up with surgeon within 48 hours. The Nurse Practitioner agreed to discharge patient because he had no acute hemorrhage or free air that would indicate a perforation and no signs of peritonitis (guarding or rebound). The Respondent reviewed the foregoing, confirmed by physical exam there was no guarding or tenderness and was assured the patient would follow up with his surgeon the next day.

4. Patient was discharged at 9:37 p.m., with a prescription for Oxycodone and Phenergan. The following day, March 24, the surgeon was in the hospital and personally reviewed the emergency department record and x-ray film from the night before and was satisfied the patient could keep his scheduled follow up for later in the week. On March 25th the surgeon was contacted by the patient's wife and advised the patient was not doing well; the patient was constipated. The surgeon advised the patient to discontinue the narcotic medication in favor of over-the-counter analgesics Tylenol or Advil and confirmed he would see the patient on March 26th. The patient arrived by rescue at another hospital at 3:24 a.m., on March 26, where patient died about one hour after admission.

5. The Medical Examiner's report found that the cause of the patient's death was "[p]ostoperative peritonitis following laparoscopic cholecystectomy of treatment of cholelithiasis with chronic cholecystitis". No source for the peritonitis (inflammation of

the membrane that lines cavity of the abdomen) could be identified by the Medical Examiner.

6. The Board's expert case reviewer found that both the surgeon and the Respondent as emergency department attending physician overlooked important clinical findings in light of patient's recent cholecystectomy. The severity of pain, which is extraordinary after such surgery, and the need for two doses of Dilaudid, was unexpected without a thorough search for the etiology of the patient's pain. Further evaluation was warranted by the blood test that showed a 94 percent polys and one band (a large left shift) and by significant dehydration per urine glucose test. The expert opined that the surgeon and Respondent should have ordered an abdominal CT scan (in addition to the x-ray that had been ordered), done more vigorous treatment, and admitted the patient to the hospital. The expert opined that they should have considered diagnoses of partial small bowel obstruction, due to the description of the patient's flat plate; however, they considered bleeding or overt perforation as the only two causes of the patient's distress. The reported cause of death, peritonitis, could have been caused by either micro perforation or transmural migration of bacteria, in the opinion of the Board's expert. He felt the patient had too many alarming findings to have been discharged on March 23.

7. Respondent is in violation of Rhode Island General Laws § 5-37-5.1 (28) for malpractice on a particular occasion.

Based on the foregoing, the parties agree as follows:

1. Respondent admits to the jurisdiction of the Board;

2. Respondent has reviewed this Consent Order and understands that it is subject to final approval of the Board; and this Consent Order is not binding on Respondent until final ratification by the Board;

3. If ratified by the Board, Respondent hereby acknowledges and waives:

a. The right to appear personally or by counsel or both before the Board;

b. The right to produce witnesses and evidence on his behalf at a hearing;

c. The right to cross examine witnesses;

d. The right to have subpoenas issued by the Board;

e. The right to further procedural steps except for those specifically contained herein;

f. Any and all rights of appeal of this Consent Order;

g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review.

4. Respondent shall remit a fee of $500 to the Rhode Island Department of Health, payable to the State of Rhode Island, for costs associated with investigation of the complaint upon which this Consent Order is based.

5. Respondent agrees to this Reprimand by the Board based on the above findings.

6. Respondent will remain on probation for five years following ratification of this order by the Board.

7. In the event that any conditions of this Consent Order are violated after it is signed and accepted, the Director of the Department of Health shall have the discretion to impose further disciplinary action, including summarily suspending the Respondent's license to practice medicine in the State of Rhode Island. If the Director suspends such license,

Respondent shall be given notice and shall have the right to request an administrative hearing within twenty (20) days of the suspension. The Director of the Department of Health shall also have the discretion to request an administrative hearing after notice to Respondent of any violation of this Consent Order. The Administrative Hearing Officer may suspend Respondent's license for the remainder of Respondent's probationary period if the alleged violation is proven by a preponderance of evidence.

Signed this 28th day of November, 2012.

Joseph P. Turner, ~~M.D.~~ D.O.

Ratified by the Board of Medical Licensure and Disciplien on the 12th day of ~~November~~, December, 2012.

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