State of Rhode Island
Department of Health
Board of Medical Licensure and Discipline

IN THE MATTER OF:
Nocif Joseph Espat, MD
License No.: MD 12407
Case Nos.: 190450, 190641, and 191457

CONSENT ORDER

Nocif Joseph Espat, MD ("Respondent") is licensed as a physician in Rhode Island. The Rhode Island Board of Medical Licensure and Discipline ("Board") makes the following

FINDINGS OF FACT

1. Respondent has been a licensed physician in the State of Rhode Island since June 13, 2007.
2. Respondent graduated from the University of Florida School of Medicine. Respondent's specialty is surgical oncology. Respondent is board certified by the American Board of Surgery.
3. The Board received complaint C190450 from an individual ("Complainant") who asked to remain anonymous. Complainant voiced concern that, in Complainant's view, Respondent's actions had created a contentious environment at Roger Williams Medical Center ("RWMC"), where Respondent is chair of surgery.
4. The Investigative Committee approved questions to and obtained statements from several physicians ("Physicians A-H") (aliases) who were witnesses to Respondent's behavior and could offer an opinion Respondent's conduct.
5. The Investigative Committee issued a subpoena to Physician I (alias), who is the Chief of Medicine at RWMC.

6. Complainant and Physicians A-I provided comments of a pattern of behavior including impact on patient care.

7. The Investigative Committee also received 30 letters from various RWMC representatives, including physicians, nurses, and administrative staff, who provided comments supportive of Respondent's clinical care, judgement, and demeanor, but the Investigative Committee concluded that, on balance, Respondent violated R.I. Gen. Laws § 5-37-5.1.

8. Complaint 191457, which relates to Respondent's care of Patient A (alias), was referred to the Board from the Rhode Island Department of Health ("RIDOH") Center for Health Facilities Regulation.

9. Respondent was the attending physician for Patient A.

10. Patient A was an 83-year-old male who Respondent treated with a surgical procedure for a perforated duodenal ulcer and sepsis on April 28, 2019. Patient A was transferred to the geri-psych floor at RWMC on May 13, 2019. Patient A was cleared for transfer based on Respondent's representation that Patient A was stable for the transfer. Patient A died a few hours after transfer to the geri-psych floor.

11. Respondent appeared before the Investigative Committee on November 27, 2019 and explained that, in his opinion, Patient A no longer needed to be on a surgical floor and was stable for transfer to the geri-pysch ward. Respondent also stated that, because other patients had been transferred ahead of Patient A, he contacted the geri-psych service late in the afternoon of May 13, 2019 to ask that his patient take priority.

12. The Investigative Committee issued a subpoena to the attending psychiatrist of the geri-psych ward, Physician J (alias), who explained to the Investigative Committee that she had seen Patient A pre-transfer on the day in question and was evaluating Patient A for appropriateness of

transfer. Physician J stated that she was contacted in the early evening of May 13, 2019 by the nurse care manager who did not think Patient A was medically stable and recommended the transfer of Patient A be postponed until the next morning so that their medical consultant could evaluate Patient A and provide medical clearance.

13. Physician J was then contacted by Respondent who stated that he was "clearing the patient" and "I take full responsibility." After several phone calls, Physician J agreed to allow Patient A to be transferred to the geri-psych floor.

14. The Investigative Committee reviewed the medical record and saw an evaluation from Respondent on May 13, 2019 that was authored by a physician assistant student and another physician. It was also evident from the medical record that Patient A's hemoglobin (6.9) was decreasing gradually over time, with no clear documented explanation therefor. Notably, the medical record for May 13, 2019 includes an addendum signed by Respondent on May 14, 2019 at 3:03PM, after Patient A had expired.

15. In his written response to the Board, Respondent stated

> *"I am surprised that there would be a clinical complaint against me in my treatment of [Patient A], particularly if the complaint was predicated on an assertion of a misdiagnosis. Over the course of more than two weeks of care, I was able to take a critically ill, septic patient in his eighth decade, a patient with a perforated viscus, through a major operation. [Patient A] recovered to the point where his wound was healed and his staples were removed. I managed his hepatic encephalopathy secondary to post sepsis hepatic failure as would be the norm in my field of hepatobiliary surgery and hepatobiliary oncology. [Patient A] was evaluated and accepted to an outside nursing facility several days prior to his being transferred to the geriatric psychiatry unit. [Patient A] was not transferred to the outside facility on May 10, 2019 because he required a one on one sitter for delirium/dementia/behavioral issues. He was evaluated by the geriatric psychiatrist, deemed acceptable for transfer to the geripsychiatry unit. [Patient A] was given one unit (1) of blood on May 13, 2019 not because of acute blood loss anemia but rather from a slowly drifting down anemia*

most likely associated with ongoing laboratory draws. There was no evidence of hemodynamic instability for several days prior to transfer."

16. The Investigative Committee concluded that Respondent's care of Patient A failed to meet the minimum standard of care and that Respondent, therefore, had violated R.I. Gen. Laws § 5-37-5.1(19), which defines "unprofessional conduct" as including, "*[i]ncompetent, negligent, or willful misconduct in the practice of medicine, which includes the rendering of medically unnecessary services, and any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice in his or her area of expertise as is determined by the board.*"

17. The Board received complaint 190641 from an individual who requested to be anonymous ("Complainant #2"). The complaint related to Respondent's care of Patient B (alias).

18. Patient B was a 70-year-old male with esophageal cancer who was treated by Respondent.

19. Respondent was the attending physician for Patient B.

20. Patient B was admitted to RWMC on March 25, 2019. He was discharged on April 29, 2019 at 1:00PM, but was readmitted several hours later with a fever and elevated white blood count and a chest x-ray showing evidence of aspiration pneumonia.

21. Complainant #2 stated that Respondent was told Patient B had a fever prior to discharge, yet discharged Patient B anyway, without conducting a new evaluation, despite the new fever. Complainant #2 stated that the nurse for Patient B contacted the appropriate resident physician who reportedly spoke with Respondent, who, in turn, authorized Patient B to be administered Tylenol and discharged to a skilled nursing facility. Complainant #2 also stated that Patient B was sent back to the hospital four hours later, completely unstable, and that Respondent refused to admit Patient B back on his service. It is reported that Patient B was subsequently diagnosed with pneumonia, transferred to the ICU, and subsequently transferred to a tertiary care facility where

he expired.

22. The Investigative Committee reviewed the medical records for Patient B and noted on the emergency department discharge note that he returned from the skilled nursing facility and, in the family's opinion, was unchanged from discharge. His physical exam by the emergency department attending describes a patient in moderate acute distress, with diffuse rhonchi, and tachypneic, with a respiratory rate of 40. Patient B was tachycardic with a heart rate of 120. His temperature was 99.3, and his pulse oximetry read 94%. Other relevant labs included an elevated sodium of 150 (normal 135-145) and a low potassium of 3.2 (normal 3.5-4.9). Patient B had an elevated white blood count of 12.5K and 86% neutrophils. A chest x-ray done at that time revealed interval increase in right basilar airspace disease, which could represent aspiration pneumonia or atelectasis. Patient B was started on Zosyn and vancomycin (antibiotics), as well as IV fluids to address his hypernatremic dehydration. Admission was planned, as well.

23. The Emergency Department physician documented that Respondent declined to admit Patient B, even though Patient B had been discharged from Respondent's service less than six hours earlier.

24. Review of the nursing notes for April 29, 2019 at 1:39PM reveals that Patient B had an axillary temperature of 101.5. A Tylenol suppository was ordered, and Patient B's subsequent temperature reading was 99.3. There is a note that Patient B was to be discharged. A nurse's note from earlier in the day reveals that Patient B had episodes of delirium.

25. Review of the physician progress note from April 29, 2019, prior to discharge, reveals that, on physical exam, Patient B was anxious appearing and had "*labored breathing, rhonchorous lungs bilaterally with end expiratory wheeze, with green brown secretions.*" There is no documentation that Patient B was examined again prior to discharge and there is no documented

exam after nurses called Respondent about the new fever.

26. In his written response to the Board, Respondent stated that Patient B was an incredibly complex case and that he and his team managed Patient B through sepsis, arrhythmia, renal failure, pneumonia and esophageal leak. Respondent's discharge of Patient B was a decision made after caring for the patient for several weeks. Specifically, Patient B had a normal white blood cell count, good oxygen saturization, and routine normal exam on morning rounds on the day of discharge and, therefore, Respondent decided that it was in Patient B's best interest to progress to a facility where he could begin a restorative rehabilitation process. For several weeks, Patient B had been bed-bound and only out to a chair. Respondent was not made aware of Patient B's afternoon tachycardia. However, Respondent reported that he would have made the same decision regarding discharge due to the number of times Patient B had gone in and out of hemodynamically stable atrial arrhythmias.

27. The Investigative Committee concluded that Patient B should have been re-examined prior to discharge to evaluate the new fever and its etiology. The Investigative Committee concluded that Respondent failed to meet the minimum standard of care and that, therefore, Respondent had violated R.I. Gen. Laws § 5-37- 5.1(19).

Based on the foregoing, the parties agree as follows:

1. Respondent admits to and agrees to remain under the jurisdiction of the Board.

2. Respondent has agreed to this Consent Order and understands that it is subject to final approval of the Board and is not binding on Respondent until final ratification by the Board. This Consent Order is neither an admission of liability by Respondent nor a concession by the Board that its claims are not well founded.

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; and

h. Any objection to the fact that this Consent Order will be reported to the National Practitioner Data Bank and Federation of State Medical Boards and posted to the RIDOH public website.

4. Respondent agrees to pay, within 5 days of the ratification of this Consent Order, an administrative fee of $2750.24 for costs associated with investigating the above-referenced complaint. Such payment shall be made by certified check, made payable to "**Rhode Island General Treasurer**," and sent to Rhode Island Department of Health, 3 Capitol Hill, Room 205, Providence, RI 02908, Attn: Lauren Lasso. Respondent will send notice of compliance with this condition to DOH.PRCompliance@health.ri.gov within 30 days of submitting the above-referenced payment.

5. Respondent agrees to this reprimand.

6. Respondent, at his own expense, shall successfully complete eight hours of Board approved CME in subjects germane to discharge planning and evaluation of patients prior to discharge.

7. If Respondent violates any term of this Consent Order after it is signed and accepted, the Director of RIDOH ("Director") shall have the discretion to impose further disciplinary action,

including immediate suspension of Respondent's medical license in accordance with R.I. Gen. Laws § 5-37-8. If the Director imposes further disciplinary action, Respondent shall be given notice and shall have the right to request an administrative hearing within 20 days of the suspension and/or further discipline. The Director shall also have the discretion to request an administrative hearing after notice to Respondent of a violation of any term of this Consent Order. The Administrative Hearing Officer may suspend Respondent's license, or impose further discipline, for the remainder of Respondent's licensing period if the alleged violation is proven by a preponderance of evidence.

Signed this 24 day of March 2020.

Nocif J. Espat, MD

Ratified by the Board of Medical Licensure and Discipline on the 8th day of April, 2020.

Nicole Alexander-Scott, MD, MPH
Director
Rhode Island Department of Health
3 Capitol Hill, Room 401
Providence, RI 02908

JV McDonald MD MPH
Acting Director