

1 .BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

Case No. MD-16-1495A

3 **MOHAMED H. EL-GASIM, M.D.**

**FINDINGS OF FACT, CONCLUSIONS
OF LAW AND ORDER FOR LETTER
OF REPRIMAND**

4 Holder of License No. 36344
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on
8 February 13, 2018. Mohamed H. El-Gasim, M.D. ("Respondent"), appeared with legal
9 counsel, Stephen Yost, Esq., before the Board for a Formal Interview pursuant to the
10 authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings
11 of Fact, Conclusions of Law and Order after due consideration of the facts and law
12 applicable to this matter.

13 **FINDINGS OF FACT**

14 1. The Board is the duly constituted authority for the regulation and control of
15 the practice of allopathic medicine in the State of Arizona.

16 2. Respondent is the holder of license number 36344 for the practice of
17 allopathic medicine in the State of Arizona.

18 3. The Board initiated case number MD-16-1495A after receiving notification of
19 a malpractice settlement regarding Respondent's care and treatment of a 2 month-old
20 male patient ("NH") alleging failure to send the patient to the ER given a temperature of
21 101.7, which led to a delay in diagnosis, infection and death.

22 4. NH presented to Respondent's office with complaints of fever at 101.7,
23 increased respiratory rate and fussiness. Respondent examined the patient, including
24 ordering a urine sample and complete blood count as well as obtaining a chest x-ray he
25 interpreted as pneumonia. Respondent concluded that NH had a viral infection and started
Azithromycin and prednisone. NH's parents presented to a different provider at the clinic

1 later that same evening, who evaluated and sent NH home with instructions to follow up
2 with NH's primary care provider. The x-ray was subsequently reported as showing no
3 active disease. NH was seen five days later by the primary care provider and diagnosed
4 with shock. NH was transported to an emergency room and expired two days later.

5 5. The standard of care prohibits the discharging of an 8 week-old with a
6 documented fever. Respondent deviated from the standard of care by discharging NH
7 with a documented fever.

8 6. The standard of care for an 8 week-old presenting with fever requires a
9 physician to consider sepsis as a differential diagnosis. Respondent deviated from the
10 standard of care by failing to consider sepsis as a differential diagnosis.

11 7. The standard of care prohibits the use of both antibiotics and steroids in the
12 face of infection as the steroids will "mask" any inflammatory or bacterial infection.
13 Respondent deviated from the standard of care by starting NH on both antibiotics and
14 steroids.

15 8. The standard of care requires referral to the hospital of an 8 week-old with
16 suspected pneumonia. Respondent deviated from the standard of care by failing to refer
17 NH to the hospital.

18 9. The standard of care requires a physician to see the patient upon return to
19 the clinic with continued concerns that the infant was not well. Respondent deviated from
20 the standard of care by failing to see NH when he was brought back to the clinic with
21 continued concerns that he was not well.

22 10. There was actual harm identified in that the patient expired from septic
23 shock. MRSA and pseudomonas were identified from the urine sample ordered by
24 Respondent at the clinic. The antibiotic prescribed by Respondent would not have treated
25 these bacteria.

