BEFORE THE COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

STATE OF GEORGIA

Composite State Board
of Medical Examiners

SEP 0 3 2004

DOCKET NUMBER

IN THE MATTER OF: *

TYRONE MALLOY, M.D. *
License No. 23086, * **DOCKET NO.** 20050230
*
Respondent. *

PUBLIC CONSENT ORDER

By agreement of the Composite State Board of Medical Examiners ("Board") and Tyrone Malloy, M.D. ("Respondent"), the following disposition of this matter is entered into pursuant to the provisions of O.C.G.A. § 50-13-13 (a) (4), as amended.

FINDINGS OF FACT

1.

The Respondent is licensed to practice as a physician in the State of Georgia and was licensed at all times relevant to the matters stated herein.

2.

On or about June 3, 1999, patient L.S. presented to Dekalb Medical Center for induction of labor under the care of Consolidated OB/GYN Specialty group. Patient L.S. presented for induction with risk factors including obesity, Group B Strep, and diabetes. The medical records indicate that active labor began at approximately 4 p.m. on June 5, 1999 and indicate that at approximately 9:00 p.m., the fetal heart rate tracings were showing variable decelerations and that Patient L.S. had a temperature of approximately 102 degrees. The medical records also show that on June 5, 1999, the on call physician for Consolidated, Dr. Hadley, was involved in handling a serious procedure and requested that his partner, Respondent, who was performing a C-section on another patient, evaluate patient L.S.

3.

Medical records indicate that at approximately 9:40 p.m. on June 5, 1999, Respondent was made aware of patient L.S.'s elevated temperature and of the late decelerations in the fetal heart rate. The medical records further show that the fetal heart rate continued to show variable decelerations; however, nurses' entries at approximately 9:20 p.m. and 10:20 p.m. state that the decelerations had improved. At approximately 10:40 p.m., Dr. Hadley again asked Respondent to evaluate patient L.S. At approximately 10:50 p.m. on June 5, 1999, Respondent evaluated patient L.S. and she was 8 cm dilated. Respondent requested preparation for a C-section to be performed by Dr. Hadley in the event that Dr. Hadley determined that a c-section was indicated. Respondent did not communicate directly with Dr. Hadley about the possible need for a C-section and left the hospital after his evaluation of patient L.S. The medical records indicate that Dr. Hadley did not begin the C-section until approximately 2:34 a.m. on June 6, 1999, at which time he delivered a baby with thick meconium who died shortly after delivery.

4.

A Board appointed peer reviewer evaluated the treatment of patient L.S. and concluded that the treatment of patient L.S. departed from and failed to conform to the minimum standard of acceptable and prevailing medical practice in the following ways:

1. In light of the obvious elevated temperature in a high risk patient, Respondent acted below the minimum standard of care in not ordering a STAT C-section. Once Respondent became aware of the elevated temperature in the high risk patient, he should have ordered and conducted a STAT C-section.

2. The fetal monitoring tracings showed that fetal distress was present on June 5, 1999 from approximately 9:10 p.m. Having evaluated the patient and the tracings at

approximately 9:40 p.m. on June 5 1999, Respondent should have recognized the distress and managed the patient on an emergency basis. Furthermore, in light of the emergency status of the case, it was below the minimum standard of care for Respondent to leave the hospital and the patient without directly communicating with Dr. Hadley about the condition of the patient.

5.

The Respondent admits the above findings of fact and waives any further findings of fact with respect to the above-styled matter. The Respondent, however, has prepared a written statement attached hereto as Exhibit A in explanation and mitigation of the matters stated herein and for the Board's consideration prior to its review of this Consent Order.

CONCLUSIONS OF LAW

The Respondent's conduct constitutes sufficient grounds for the imposition of discipline upon his license to practice as a physician in the State of Georgia pursuant to O.C.G.A. Chs. 1 and 34 T. 43, as amended. The Respondent hereby waives any further conclusions of law with respect to the above-styled matter.

ORDER

The Composite State Board of Medical Examiners, having considered all the facts and circumstances of this case, hereby orders, and Respondent hereby agrees, that the following sanctions shall be imposed upon the Respondent's license to practice as a physician in the State of Georgia.

1.

Respondent shall obtain twenty (20) hours of continuing medical education ("CME") in the area of gynecology in addition to the CME required of all Georgia physicians. Respondent shall complete said additional twenty hours within two years from the docketing of this order. Prior to obtaining the CME, Respondent shall submit the title of the course(s) he plans to attend

and information concerning the course(s) to the Board. Within two years from the docketing of this consent order, Respondent shall submit proof of completion of said additional twenty hours to the Board.

2.

Respondent shall submit to the Board a fine of five thousand dollars ($5000.00), to be paid in full by cashier's check or money order made payable to the Board within 30 days of the effective date of this Consent Order. Failure to pay the entire amount by the 30th day shall be considered a violation of this Order and shall result in further sanctioning of Respondent's license, including revocation, upon substantiation thereof.

3.

This Consent Order and dissemination thereof shall be considered a PUBLIC REPRIMAND of Respondent by the Board.

4.

Respondent also understands that pursuant to O.C.G.A. Title 43, Chapter 34A, the contents of this order shall be placed on Respondent Physician Profile. Furthermore, by executing this Consent Order, Respondent hereby agrees to permit the Board to update the Physician's Profile reflecting this Consent Order.

5.

The Respondent acknowledges that Respondent has read this Consent Order and understands its contents. Respondent understands that the Respondent has the right to a hearing in this matter and freely, knowingly and voluntarily waives that right by entering into this Consent Order. Respondent understands and agrees that a representative of the Department of Law may be present during the Board's consideration of this Consent Order and that the Board shall have the authority to review the investigative file and all relevant

evidence in considering this Consent Order. Respondent further understands that this Consent Order will not become effective until approved and docketed by the Composite State Board of Medical Examiners. **Respondent understands that this Consent Order, once approved and docketed, shall constitute a public record, evidencing disciplinary action by the Board.** However, if this Consent Order is not approved, it shall not constitute an admission against interest in this proceeding, or prejudice the right of the Board to adjudicate this matter. Respondent hereby consents to the terms and sanctions contained herein.

Approved, this 26 day of August, 2004.

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

(BOARD SEAL)

BY: [signature]
ROLAND S. SUMMERS, M.D.
President

ATTEST: [signature]
LASHARN HUGHES
Executive Director
Composite State Board of Medical Examiners

CONSENTED TO: [signature]
TYRONE MALLOY, M.D.
Respondent

Sworn to and Subscribed
before me this 26th day
Of August, 2004.

[signature]
NOTARY PUBLIC
My commission expires:

My Commission Expires
January 8, 2006

EXHIBIT A

My name is Tyrone Malloy, M.D., and I am an obstetrician with a physician group called Consolidated OB/Gyn. This Patient who is the subject of the Consent Order was a 28 year-old obstetrical patient, and this was her first pregnancy.

On June 5, 1999, I was providing services at DeKalb Medical Center. My partner, Phillip Hadley, M.D., was my practice group's on-call physician at DeKalb Medical Center. On that date, while I was performing a C-section on another patient, I received a call from Dr. Hadley asking me to evaluate a patient because he could not do so. I understood that he was handling a serious procedure at the time, though I can't specifically recall what that was. Although I don't recall, custom and practice would indicate that Dr. Hadley gave me some information about the Patient's condition. In any event, a nurse brought me the strip while I was in the operating room and gave me an update on the Patient's condition.

Based on the information the nurse relayed to me, my personal review of the fetal monitoring tracing, and based upon the medical records from approximately 2140 hours on June 5th, I concluded there was no indication of fetal or maternal compromise with this Patient or her unborn child. I wrote a note stating my belief that Dr. Hadley might want to perform a C-section on the Patient for failure to progress. I requested preparation for a C-section to be performed by Dr. Hadley if and only if Dr. Hadley felt the indication for C-section, secondary to cephalic-pelvic disproportion.

Contrary to what was argued in the subsequent lawsuit, at no time did I order a C-section to take place. I would not have done so because a C-section was not indicated at the time and, because of that, it was completely Dr. Hadley's call as to whether a C-section would take place for failure to progress. Had I believed the child's well-being was in danger, I would have then taken steps necessary to ensure that the child was delivered. Based on the information I had at hand and from the nurse, I had no reason to believe that the fetus was anything but healthy. I continued to perform the C-section of the patient I was then caring for in the operating room.

Later that night, I believed, I received at least one more update on the Patient's condition. I do not specifically recall it, but I am certain that every indication pointed to fetal well-being. If not, I would have delivered this child. Because I was reasonably certain that the fetus was well, I left the hospital, knowing that the Patient was still in the care of my partner, Dr. Hadley. I relied on the nurses and chart entries as means of communication with Dr. Hadley regarding the Patient.

At some point, I learned that the Patient lost her child. I do not know what caused the death, but I am confident I provided appropriate medical care and treatment to her. In the context of the lawsuit the Patient filed against me and my partner, I had an opportunity to review the care Dr. Hadley rendered. I believe that, given the information the nurses relayed to him, he provided appropriate care to the Patient as well.

Dr. Hadley and I found ourselves in a unique situation that night, trying to juggle patients' cases and priorities appropriately. This case also is unique because some of the nurses' notes in the case were apparently "late" entries, added to the chart by the nurses after the incident occurred. I relied in good faith on the nurses as part of a team, and I am disappointed in the late entries. I also wish to point out that as part of defending the Patient's lawsuit, three different experts reviewed the Patient's medical records, and each of these experts supported the care that I and Dr. Hadley provided to her in this case.

I no longer intend to practice obstetrics because of the increasing medical malpractice premiums involved. This decision is completely voluntary and is not a condition, requirement or result of the Consent Order. My practice is now focused on gynecological care.