North Carolina Medical Board

Christine M. Khandelwal, DO, MHPE: President | Devdutta G. Sangvai, MD, MBA: President-Elect | Anuradha Rao-Patel, MD: Secretary/Treasurer

July 24, 2024

Randall Wayne Jennings, M.D.
Advanced Orthopedics and Sports Medicine Center
1106 Port Arthur Terrace
Leesville, LA 71446

Dear Dr. Jennings:

The North Carolina Medical Board ("Board") has concluded its investigation regarding your care of Patient A. It is the Board's decision not to commence formal proceedings against your license. However, the Board voted to issue you this public letter of concern. The Board does not consider a public letter of concern to be a disciplinary action or a limitation or restriction on your license.

On March 17, 2020, you performed a right knee replacement on a 67-year-old female ("Patient A"). Patient A's bone was very soft, and while placing the cutting guide you inadvertently perforated the back protective layer (posterior cortex) of the thigh bone (femur). You recognized the abnormal position of the guide and repositioned it; however, you did not recognize that the drill had perforated the posterior cortex of the femur. The remainder of the procedure appeared unremarkable.

While in the post-anesthesia care unit there were no recorded findings suggestive of vascular injury with Patient A's pedal pulses only slightly diminished (2+). Patient A was moved to an in-patient room, and around 4:30 p.m., you were contacted by a nurse concerning Patient A's condition. The nursing notes indicate that you were informed that Patient A was experiencing pain in the right ankle area and that her foot was dusky and cold, but there were detectable pulses in her right foot, although they were weak. You did not return to evaluate Patient A at this time.

Throughout the night, Patient A began to experience right leg numbness and extreme pain in her right lower extremity and continued to have weak pulses in her right foot. The next morning Patient A's right foot was pale with no detectable pulse. You were informed of Patient A's deteriorating condition and returned to evaluate Patient A. An ultrasound revealed a blockage of the mid-right superficial femoral artery, which delivers blood to the lower leg. Patient A was transferred to the closest facility with vascular service and a procedure to restore blood flow (revascularization) to the mid-right superficial femoral artery was performed. However, the revascularization was unsuccessful and Patient A's right leg was ultimately amputated above the knee.

The Board had your care of Patient A reviewed by an independent medical expert. The reviewing expert believes that your postoperative care of Patient A may have fallen below the standard of care in North Carolina. Specifically, the reviewing expert stated that your knowledge of the abnormal position of the guide combined with the information relayed during the 4:30 p.m. call from the nurse, should have triggered concern about the vascular status of Patient A's right limb. The reviewing expert noted that Patient A had persistent differences in pulse strength, temperature, and capillary refill time in her right and left foot, several hours after the surgery and opined this was not normal and should not have been disregarded simply based on the presence of pedal pulses in the right foot. The expert reviewer also criticized your failure to investigate Patient A's progressive, inadequate blood flow as a medical emergency, which could have led to prompt treatment and potentially avoided the loss of Patient A's lower leg.

The Board is concerned that your care of Patient A may have failed to conform to the standards of acceptable and prevailing medical practice in North Carolina. The Board urges you to take steps to ensure the conduct giving rise to the Board's concerns does not happen again. Otherwise, the Board may take additional action against your license to practice medicine. If that happens, this letter may be reviewed in determining the appropriate action.

The Board acknowledges that you have maintained that the nurse's notes are not an accurate reflection of the information that was shared with you during the conversation with the nurse. You have specifically indicated that the on-call orthopedist was never notified of Patient A's condition and that you were only called twice—once at about 4:30 p.m. on the day of surgery and once at about 6:30 a.m. The Board also notes that you have indicated that you have made changes to your practice to avoid the potential for a similar occurrence in the future.

This letter is a public record within the meaning of Chapter 132 of the North Carolina General Statutes and is subject to public inspection and dissemination as required by that law. It will be reported to the Federation of State Medical Boards.

Sincerely,

Christine Khandelwal, DO

Christine M. Khandelwal, D.O., MHPE
President

CMK/DTB/jhg

Consent and Waiver

I, Randall Wayne Jennings, M.D., would like to resolve this matter without the need for more formal proceedings and consent to the Board's issuance of this public letter of concern in resolution of the above matter. I hereby waive any requirement under any law or rule that this public letter of concern be served on me.

Consented to this the 24th day of July, 2024.

Randall Wayne Jennings, M.D.

State of Louisiana

County of Vernon

I, Alvin C. Dowden, III, do hereby certify that Randall Wayne Jennings, M.D. personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal this the 24th day of July, 2024.

Notary Public

OFFICIAL SEAL
ALVIN C. DOWDEN III
NOTARY ID # 149273
STATE OF LOUISIANA
PARISH OF VERNON
My Commission is for Life.

(Official Seal)

My Commission Expires: With Life.