BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
Michael P. Estivo, D.O.	)	
	)	**KSBHA Docket No. 16-HA00062**
Kansas License No.:05-23235	)	**OAH Docket No. 16-HA0008**

FINAL ORDER ON REVIEW OF INITIAL ORDER

On April 13, 2018, the above-captioned matter came before the Kansas State Board of Healing Arts ("Board") for review of the Initial Order filed with the Board on December 28, 2017. Respondent, Dr. Estivo, appeared in person and through counsel, Mark Stafford. The Petitioner appears through Susan Gering, Litigation Counsel. Board members Dr. Leinwetter, Dr. Settich, Dr. Templeton and Dr. Webb recused themselves from participating in the Board deliberations and decision in this matter, as these members served on the Disciplinary Panel.

Pursuant to the authority granted to Board by the Kansas Healing Arts Act, K.S.A. 65-2801 *et seq.*, and in accordance with the provisions of the Kansas Administrative Procedure Act ("KAPA"), K.S.A. 77-501 *et seq.*, specifically K.S.A. 77-527, the Board enters this Final Order.

BACKGROUND AND PROCEDURAL POSTURE

A Petition for discipline was filed against Respondent's license on February 9, 2016. The Petition alleged Healing Arts Act violations related to a surgery Dr. Estivo performed in October 2012. The Office of Administrative Hearings ("OAH") was appointed to conduct a formal hearing and issue an Initial Order. At hearing, the Board alleged that Dr. Estivo engaged in gross negligence in his follow-up care following the surgery and that he failed to create an adequate patient record relating to that care. The initial order of the Administrative Law Judge ("ALJ") concluded that the Board failed to prove that Dr. Estivo's post-operative treatment was either grossly negligent or negligent in a manner that indicates that he is a danger to patients. However, the ALJ found that Dr. Estivo "failed to adhere to the standard of care in a manner which does not rise to the level professional incompetency on a single date." The ALJ suggested three potential remedies, ranging from a Board-ordered professional development plan to a letter of concern from the Board. Petitioner timely filed a Petition for Review of the ALJ's Initial Order, the matter was fully briefed by both parties, and the Board held a hearing on review of the Initial Order on April 13, 2018 at which the parties were given an additional opportunity to be heard on the matter.[1]

[1] In advance of the April 13, 2018 oral arguments, the Board was provided the entire agency record to facilitate a comprehensive understanding of the underlying matter, including the hearing transcript and all exhibits, briefs, and motions filed by the parties in advance of oral arguments. The entire agency record was considered by the Board in rendering its decision. In reviewing the Initial Order, the Board gave due regard to the Presiding Officer's opportunity to observe the witnesses and determine their credibility during the formal hearing.

FINDINGS OF FACT

Dr. Estivo is an orthopedic surgeon. He has performed spine surgeries for 27 years.

The patient to which the parties refer as "Patient" (hereinafter "Patient") has a medical history that includes multiple surgeries including a discectomy at L4-L5 and three prior left-ankle surgeries. The patient's history shows a back injury to the cervical and lumbar spine on June 3, 2011. She sought pain management care at the Headache and Pain Center/Doctors Hospital.

Mark Pinkerton, M.D., treated Patient for several months prior to referring her to Dr. Estivo for a surgical consult. The chief complaint was low back pain. A discogram was positive at L4- L5, and an MRI disclosed spondylolisthesis and a protruding disc at L4-L5. Dr. Pinkerton referred Patient to Dr. Estivo in September 2012.

Dr. Estivo recommended a 360 degree fusion surgery using an interbody cage, a buttress plate, allograph, and Aileron plate with screws.

Dr. Estivo elected the lateral approach to the disc space rather than a posterior approach, called a posterior lumbar interbody fusion. The lateral approach requires dissection of the psoas muscle, located in the loin that runs from the lumbar vertebral region to the lower part of the pelvis. The psoas muscle is involved in bringing the leg forward, or if sitting down, lifting the thigh. By using the lateral approach on the left side, only the left psoas muscle had to be separated, with the right side being uninvolved. Complications are thus more likely on the left side. After surgery, soreness when lifting the leg or walking is expected because of the trauma to the psoas muscle. Within the psoas muscle lies the lumbar plexus, which is a bundle of nerve roots that exit the spine above the L4-L5 region. The heavily built retractor used to maintain the opening of the psoas muscle can put pressure on the lumbar plexus. Dr. Estivo was aware that separating the psoas muscle potentially could injure the lumbar plexus, resulting in pain, weakness, numbness, or the inability to use muscle groups innervated by the lumbar plexus.

On October 9, 2012, Patient presented to Doctors Hospital for surgery performed by Dr. Estivo. Neither the operative report nor the Intraoperative Neurophysiology Report reflect spinal nerve irritation during the procedure. Dr. Estivo' s operative report documented concern that the lateral portion of the procedure lasted longer than usual as a result of the patient's size and osteoporosis. Specifically, he noted her legs might have numbness or weakness; the left leg was particularly at risk.

Following surgery, Dr. Estivo obtained x-rays. The radiologist's report states the intervertebral discs appear unremarkable and soft tissues were normal. Post-operative changes were noted in the report. Dr. Estivo testified that he understood that to mean the instrumentation he installed could be visualized on the x-ray image.

Nurse Hancock performed an assessment and recorded information on the neuro- signs flow sheet. On October 10, 2012 at 7:15 a.m. she assessed motor abilities of both legs, noting

both to be strong. However, fifteen (15) minutes later at 7:30 a.m. of that same day, Nurse Hancock documented that Patient did not have full movement of her left leg. Further in Nurse Hancock's documented nursing notes at 7:30 a.m., Patient was unable to wiggle her left leg.

A physical therapy assessment was conducted by physical therapist Brian Hellebusch at approximately 8:30 a.m. on October 10, 2012. Patient's documented range of motion for her left lower extremity was "Limited: unable to actively move LLE [left lower extremity]." Additionally, Mr. Hellebusch documented that Patient's LLE strength was 0/5, which Mr. Hellebusch testified meant she had no active contraction in any of the muscles of the left lower extremity. During his assessment, Mr. Hellebusch documented a neuro assessment for Patient that stated abnormal, decreased sensation and tingling in the left lower extremity.

Mr. Hellebusch's assessment and Nurse Hancock's documentation of Patient's left leg weakness occurred before Dr. Estivo was in to see Patient at 11:50 a.m. on October 10, 2012 for her discharge.

Dr. Estivo's discharge note for Patient states that he was aware that she was suffering from left leg weakness, documenting "[t]here was no progressive neurologic loss, however her left leg is very weak. She was told ... that nerve injury was a possibility to either leg, especially the left leg, Bowel and/or Bladder, which may be temporary or possibly even permanent based on the left-sided approach for the anterior diskectomy procedure."

Dr. Estivo testified that because the symptoms Patient reported were known complications for the procedure they were not alarming to him. He was aware that the patient was capable of moving her left leg, at least to some extent, but he also knew there was an injury to the nerves supplying the left leg. Dr. Estivo concluded that Patient's symptoms involving her left leg were caused by a stretch injury to the lumbar plexus. Dr. Estivo testified that he believed the symptoms to be transient.

At Dr. Estivo's first follow-up appointment with Patient, on October 19, 2012, he documented a musculoskeletal examination that stated:

> Lumbar spine: Normal to inspection. Normal to palpation without muscle spasms, tenderness or step-offs. Muscle strength: Right quadriceps femoris normal. Left quadriceps femoris with +1/5 strength. Light touch perception: on the left reveals hypoesthesia in a stocking distribution from the proximal 1/3 of the thigh on distally. Right upper extremity: normal inspection/palpation, ROM, muscle strength and tone, and stability. Left upper extremity: normal inspection/palpation, ROM, muscle strength and tone, and stability. Right lower extremity: normal inspection/palpation, ROM, muscle strength and tone, and stability.

Dr. Estivo later testified that, when he saw Patient on the first post-surgery follow-up visit on October 19, 2012, he did not expect the left leg symptoms to be resolved by that time.

At the October 26, 2012, appointment, Licensee documented a musculoskeletal examination that stated:

> Lumbar spine: Normal to inspection. Normal to palpation without muscle spasms, tenderness or step-offs. Right upper extremity: normal inspection/palpation, ROM, muscle strength and tone, and stability. Left upper extremity: normal inspection/palpation, ROM, muscle strength and tone, and stability.

At the October 26th appointment, Licensee did not document Patient's left leg weakness. Urinary retention symptoms are also not documented.

Dr. Estivo did not order an MRI or any other imaging study to assess the cause of her symptoms at any time during his post-discharge care of Patient.

At an October 26th pain management appointment with Dr. Pinkerton, Dr. Pinkerton documented that Patient reported no feeling in her left lower extremity.

At a December 21, 2012 pain management appointment with Dr. Garcia, Patient presented with a complaint of low back pain and discussed with him that she was having some loss of feeling in her leg and that it was numb.

At a March 13, 2013 pain management appointment with Dr. Garcia, Patient reported she had left leg paralysis and weakness; she was unable to move or cross her left leg over; was unable to bear weight on her leg; and was having urinary retention and inability to void since her October 9, 2012, surgery. Dr. Garcia documented that Patient was scheduled for a follow-up visit with her surgeon, Dr. Estivo, in April 2013.

Dr. Estivo resigned from the Headache & Pain Center and Doctors Hospital on April 8, 2013. He testified that the reason for leaving without notice was his belief that the owner, Dr. Garcia, was engaging in alleged unlawful conduct and he further alleged that Dr. Garcia had invited Dr. Estivo to participate. The agency record does not describe the type of alleged activities that Dr. Estivo alleged might be unlawful nor any evidence corroborating any such allegations.

Patient saw Dr. Garcia for the scheduled surgical follow-up visit at the Headache and Pain Center instead of Dr. Estivo on April 11, 2013. Dr. Garcia's plan was to consider obtaining "new imaging because of the lengthy recovery."

On August 1, 2013, Dr. Garcia ordered MRI imaging of Patient's spine based on her continued neurological deficits and left leg weakness. Based on the imaging results, Dr. Garcia recommended Patient obtain a second opinion from a surgeon after he reviewed her entire case and her left leg symptoms continued. Dr. Garcia referred Patient to Dr. Josue Gabriel, M.D.

On October 2, 2013, Dr Gabriel first saw Patient and documented a history of present illness that included the following:

> [Patient] is not able to ambulate due to paralysis of the left leg. She has also loss of and bladder function since a few days after surgery by [Dr. Estivo] in 2012 of L4- L5 360 fusion lateral approach at L4-L5, posterior fusion with pedicle screws at the LS level, as she was seen in ER and had bladder distention of 3 liters with permanent bladder loss after that.

Based on his examination and review of imaging, Dr. Gabriel diagnosed Patient, in part, with "status post L4-L5 360 fusion by [Dr. Estivo] in approximately 2012 with weakness of left lower extremity quadriceps and iliopsoas function 3 to 3-/5" and with bowel issues.

Dr. Gabriel documented a plan that Patient would be scheduled for "revision posterior hardware removal and fusion exploration and decompression laminectomy L4-5." He also documented that Patient appeared to have "irreversible paralysis of the, bladder, and left lower extremity."

On October 21, 2013, Dr. Gabriel performed a "posterior lumbosacral laminotomy discectomy fusion instrumentation lumbar 4/lumbar 5, fusion exploration lumbar 4/lumbar 5, allograft, autograft" procedure. Dr. Gabriel testified that intraoperatively his findings showed the pedicle screw was causing some of the pain going down Patient's leg, along with radiculopathy and stenosis, from scarring. By performing a neuroplasty, removing the pedicle screw that Dr. Estivo had placed on October 9, 2012, and taking the pressure off the nerve and the dura, Dr. Gabriel was able to relieve Patient's loss of sensation.

Postoperatively, Dr. Gabriel ordered Patient be neurologically monitored to determine whether her preoperative neurologic deficits became worse postoperatively. In the event Patient's deficits became worse postoperatively, Dr. Gabriel testified he would have attempted to determine why the deficits had become worse and would have ordered a MRI to determine the cause.

Civil litigation followed Dr. Estivo's resignation. The Headache & Pain Center filed a civil action in Johnson County, Kansas District Court to enforce a non-compete clause in the employment agreement. That litigation ended in January 2015 following a mediated agreement among the parties.

Mr. Phil Harness, CEO and corporate counsel for the Headache and Pain Center, initiated a peer review proceeding following a report made to Mr. Harness in late 2013 or early 2014 regarding Dr. Estivo's care of Patient. Mr. Harness testified that he could not recall who brought the care of this patient to his attention.

The medical executive committee, sitting as the risk management committee for Doctors Hospital, conducted a peer review and concluded [redacted] Based on this peer

review determination, Mr. Harness filed (as required by law) a complaint with the Board on behalf of Doctors Hospital regarding the care of Patient by Dr. Estivo.

The Board initiated the instant case by filing a disciplinary Petition on February 9, 2016. A formal hearing was conducted by an ALJ employed by the Kansas Office of Administrative Hearings.

At the formal hearing, the Board presented testimony of expert witness Douglas G. Burton, M.D. Dr. Burton is an orthopedic spine surgeon licensed to practice medicine and surgery in the State of Kansas. He has been licensed to practice medicine in Kansas since approximately 2000. Dr. Burton is board certified with the American Board of Orthopedic Surgery. Currently, Dr. Burton practices spine surgery at the University of Kansas Hospital, Department of Orthopedic Surgery where he spends 90% of his time per week actively practicing.

Dr. Burton, based on his education, experience, knowledge, and training opined to a reasonable degree of medical certainty that Dr. Estivo's care and treatment rendered to Patient failed to adhere to the standard of care to a degree of gross negligence. Specifically, Dr. Burton testified that his opinion is based on Dr. Estivo's immediate postoperative care of Patient, where he asserted that Licensee's "standards of indifference and reckless disregard really are evident." Dr. Burton specifically testified that postoperatively:

> This was the time when [Patient] needed care. We know that there's been a change in neurologic status. Time is of the essence. An imaging study has got to be done at that time. Any reasonably competent spine surgeon, when faced with a postoperative patient with a new neurologic deficit, is going to get an imaging study after any spine surgery, but particularly after a spine surgery where implants have been placed in proximity to the spinal canal, that is the first thing that you're going to do. After you've evaluated the patient and documented that there was a neurologic deficit.

He testified that, regardless of neurological monitoring during surgery, the immediate postoperative X-rays ordered by Licensee on October 9, 2012, were suspicious on whether a screw was in the spinal canal. X-rays do not give an axial view which is necessary to determine if there was a screw in Patient's spinal canal, hematoma in the canal or something else in Patient's canal. While the postoperative X-rays ordered by Licensee are rotated, Dr. Burton opined there was one screw where the distance between the plate and the screw was close, which puts the surgeon, Dr. Estivo, on notice that the screw might be a little medial.

Dr. Burton testified that postoperatively on October 10, 2012, Licensee failed to document any neurological exam of Patient. In Dr. Burton's experience, knowledge and training as a doctor in orthopedic surgery "[i]t's the surgeon's duty to evaluate the patient and identify that the neurologic exam is consistent or if there's been a change."

Additionally, Dr. Burton opined that based on reasonable degree of medical certainty that Dr. Estivo's care on October 19, and 26, 2012, failed to meet the standard of care to a level of gross negligence when he failed to perform postoperative evaluations that included an evaluation of Patient's left leg weakness and urinary retention.

Further on October 19, 2012, Dr. Estivo failed to document a complete motor exam. Dr. Estivo failed to document Patient's hip flexors, dorsiflexion or plantar flexion. Additionally, the only documentation regarding Patient's postoperative neurological deficits was that her quadricep function was not normal at + 1/5, and that Patient was experiencing urine retention, being treated at the Rehab hospital.

Dr. Burton testified, and the Board finds, that Patient had concerning neurological symptoms subsequent to her surgery with Dr. Estivo, and he failed to take steps to actively identify the reasons for the issues. Dr. Burton testified, and the Board finds, that the standard of care required him to investigate, evaluate and attempt to understand why the change had occurred.

The Board finds that, while there was an assumption by Dr. Estivo that there was a stretch injury; it was inappropriate to assume the cause of Patient's symptoms in this case without further investigation of the cause and additional documentation of his workup, diagnosis, and plan.

Dr. Burton testified, and the Board finds, that Licensee failed his duty to Patient when he did not order appropriate medical imaging regarding Patient's neurological deficits postoperatively during his post-discharge care of Patient based on the neurological deficits that occurred postoperatively.

Finally, Dr. Burton opined, and the Board finds, that Dr. Estivo's medical records failed to meet the standard of care due to inadequate documentation of neurological examinations at every post-operative visit and failure to document a plan for evaluating the neurological symptoms Patient exhibited after his surgery.

Dr. Estivo testified, and the Board finds, that Dr. Estivo concluded in good faith that Patient's post-operative neurological symptoms were caused by a stretch injury to the lumbar plexus and that the symptoms were transient. Dr. Estivo testified, and the Board finds, that he chose not to order further imaging for Patient because he made those assumptions regarding the cause and nature of her nerve symptoms. Dr. Estivo admitted that his record keeping in regard to this patient was sub-par.

The Board finds that the errors made by Dr. Estivo in this case as described herein were not made with a malicious, reckless, or wanton state of mind.

Although many of the ALJ's finding of fact were of marginal relevance to the issues that required resolution in this case, the Board adopts, as having some material connection to the case

and reasonable basis in the record, the ALJ's findings of fact on pages 1 through 19 of the Initial Order by reference here, except as described below.

The Board declines to adopt the following findings of fact on pages 1 through 19 of the Initial Order, finding them to be immaterial to the issues framed by the pleadings and/or identified in this Final Order, not unsupported by the agency record (including assumptions, arguments or advocative characterizations improperly included as factual findings, and internet medical research conducted by the ALJ outside of the hearing), and/or unnecessarily duplicative:

- Page 2: Paragraphs 12, 3, 7, and 8.
- Page 3: Paragraphs 12-16.
- Page 4: Paragraphs 19, 20, and 22, and all text under "THE FOUNDATION OF THE RECORD AT BAR" heading, including paragraphs 1 and 2 thereunder.
- Pages 5-19: Paragraphs 4, 13, 16, 18, 20, 25, 29, 31, 36, 39, 41, 42, 44, 45, 61, 63, 64, 73, 79-81, 83, 84, 92, 95, 95-99, 102-107, 110-115, 124, 125, 127, 132, 133, 135-137, 141-146, 154, 155, 158, 159, 163, 169, 173, 174, 182, 184, 185, 192-195, 200, 201, 204, 206, 207, 209-215, 218, 219, 223, 226-228, 230, and 231.

In regard to the parties' proposed facts described at paragraphs 9 and 10 on page 3 of the Initial Order and attached as Appendix A and B to the Initial Order:

- The Board adopts the following paragraphs of Appendix A by reference, as redacted by the ALJ: 1-29, 31-106, 108-143, and 145-149.
- The Board rejects the ALJ's redactions and adopts the following paragraphs of Appendix A by reference as proposed by Petitioner without the ALJ's redactions: 30, 107, and 144. The Board finds the entirety of these paragraphs to be supported by the record as a whole.
- The Board adopts the following paragraphs of Appendix B by reference, as redacted by the ALJ: 1-92, 94-128, 130-134.
- The Board declines to adopt the following paragraphs of Appendix B adopted by the ALJ, finding them to be unsupported by the record as a whole: 93 and 129.

CONCLUSIONS OF LAW AND POLICY

I. Statutory and regulatory standards.

Based on the allegations and defenses appropriately raised in the parties' pleadings, the statutory and regulatory standards most relevant to this case include the following.

K.S.A. 65-2836:

> A licensee's license may be revoked, suspended or limited, or the licensee may be publicly censured or placed under probationary conditions . . . upon a finding of the existence of any of the following grounds:
> . . .
> (b) The licensee has committed an act of unprofessional or dishonorable conduct or professional incompetency, except that the board may take appropriate disciplinary action or enter into a non-disciplinary resolution when a licensee has engaged in any conduct or professional practice on a single occasion that, if continued, would reasonably be expected to constitute an inability to practice the healing arts with reasonable skill and safety to patients or unprofessional conduct as defined in K.S.A. 65-2837, and amendments thereto. . . .
> . . .
> (k) The licensee has violated any lawful rule and regulation promulgated by the board or violated any lawful order or directive of the board previously entered by the board.

K.S.A. 65-2837:

> (a) "Professional incompetency" means: . . . (1) One or more instances involving failure to adhere to the applicable standard of care to a degree that constitutes gross negligence, as determined by the board.
> (b) "Unprofessional conduct" means:
> . . .
> (24) Repeated failure to practice healing arts with that level of care, skill and treatment that is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances. . . .
> (25) Failure to keep written medical records that accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results and test results.

K.A.R. 100-24-1:

> (b) Each patient record shall meet these requirements:
> . . .
> (5) contain pertinent and significant information concerning the patient's condition;
> (6) reflect what examinations, vital signs, and tests were obtained, performed, or ordered and the findings and results of each;

(7) indicate the initial diagnosis and the patient's initial reason for seeking the licensee's services;

. . .

(9) reflect the treatment performed or recommended;

(10) document the patient's progress during the course of treatment provided by the licensee; and

(11) include all patient records received from other health care providers, if those records formed the basis for a treatment decision by the licensee.

K.S.A 77-527 states, in most relevant part:

> (d) Subject to K.S.A. 77-621, and amendments thereto, in reviewing an initial order, the agency head or designee shall exercise all the decision-making power that the agency head or designee would have had to render a final order had the agency head or designee presided over the hearing, except to the extent that the issues subject to review are limited by a provision of law or by the agency head or designee upon notice to all parties. In reviewing findings of fact in initial orders by presiding officers, the agency head shall give due regard to the presiding officer's opportunity to observe the witnesses and to determine the credibility of witnesses. The agency head shall consider the agency record or such portions of it as have been designated by the parties.

K.S.A. 77-526(d) states, in most relevant part:

> Findings of fact shall be based exclusively upon the evidence of record in the adjudicative proceeding and on matters officially noticed in that proceeding.

K.S.A. 77-522(a) states, in most relevant part:

> Discovery shall be permitted to the extent allowed by the presiding officer or as agreed to by the parties. . . . The presiding officer may specify the times during which the parties may pursue discovery and respond to discovery requests. The presiding officer may issue . . . discovery orders . . . in accordance with the rules of civil procedure.

II. Case law.

The case law most relevant to this case include the following.

"Where substantial evidence is presented that supports a finding of a violation of the [Kansas Healing Arts Act], Board members are entitled and expected to rely on their own expertise and experience in making these decisions." *Hart v. Bd. of Healing Arts of State*, 27 Kan. App. 2d 213 (2000).

The Kansas State Board of Healing Arts "is the agency peculiarly qualified to predicate judgment on a scientific basis, and that judgment ought not be readily interfered with." *Kansas State Bd. of Healing Arts v. Foote*, 200 Kan. 447, 459 (1968).

Under Kansas law, gross negligence requires "something more than ordinary negligence, and yet it is something less than willful injury . . . the act must indicate a realization of the imminence of danger and a reckless disregard and complete indifference and unconcern for the probable consequences of the wrongful act. It might be said to include a willful, purposeful, intentional act, but not necessarily so; it is sufficient if it indicates a reckless disregard for the rights of others with a total indifference to the consequences, although a catastrophe might be the natural result." *MacDougall v. Walthall*, 174 Kan. 663, 667 (1953).

Admission of expert testimony lies within the sound discretion of the hearing officer or judge. *Kansas Gas & Elec. Co. v. State Corp. Comm'n of State of Kan.*, 14 Kan. App. 2d 527, 537 (1990); *Bereal v. Bajaj*, 52 Kan. App. 2d 574, 371 P.3d 349, 350 (2016), review denied (June 5, 2017); *Thompson v. KFB Ins. Co.*, 252 Kan. 1010, 1028 (1993). Similarly, Kansas law recognizes a broad range of discretion to allow judge's to enforce their discovery and case management orders, including deadlines. E.g., *Gilkes v. Rattay*, 240 P.3d 986 (Kan. App. 2010) (unpublished) (district court did not err in denying request for an extension of time and striking designation of expert testimony testimony). Generally, a judge's decision to allow or disallow expert testimony will not be overturned absent an abuse of discretion. *City of Wichita v. Eisenring*, 269 Kan. 767, 776, 7 P.3d 1248, 1255 (2000).

III. Conclusions.

The Board has reviewed the entire agency record and considered the briefs, oral arguments, and comments of the parties at the April 13, 2018 hearing. The Board gave due regard to the Presiding Officer's opportunity to observe the witnesses and determine their credibility during the formal hearing. The Board bases its conclusions, including all differences between this Final Order and the Initial Order identified by a comparison of the orders, on the facts, law, and policy described above and below.

The Board overrules the parties' objections regarding admission of expert testimony

Respondent objects to the ALJ's decision not to allow him an extension of time to designate an independent expert witness. Petitioner objects the ALJ's decision to deny Petitioner's motion in limine to exclude Dr. Estivo from providing expert testimony in his own defense in regard to his own care of Patient. Admission of expert testimony and enforcement of discovery orders lie within the broad discretion of the hearing officer or judge. See supra, e.g., *Kansas Gas*, 14 Kan. App. 2d at 537; K.S.A. 77-522(a). Neither of these procedural decisions fell outside the range of the discretion ordinarily exercised in Kansas courts and administrative bodies. The parties cite nothing in the record showing abuse of discretion in this regard. The Board declines to disturb these rulings.

Dr. Estivo violated K.S.A. 65-2836(b), (k), and K.S.A. 65-2837(b)(25) by failing to keep adequate medical records

Dr. Estivo committed acts of unprofessional conduct, pursuant to K.S.A. 65-2836(b) and K.S.A. 65-2837(b)(25), when he failed to keep written medical records that accurately describe the services rendered to Patient, including histories, pertinent findings, examination results and test results, and the above-referenced elements of K.A.R. 100-24-1. These documentation failures are described in the findings of fact above, and include inadequate documentation of neurological examinations at every post-operative visit and failure to document a plan for evaluating the neurological symptoms Patient exhibited after surgery. These failures also violate K.S.A. 65-2836(k) because they constitute a violation of K.A.R. 100-24-1, a lawful regulation promulgated by the board.

As described in the in the findings of fact above, licensee's post-surgical treatment records omitted pertinent and significant information concerning the patient's neurological condition, neurological examinations and the findings and results of such examinations. His records also failed to adequately reflect the treatment recommended because they failed to adequately reflect a plan for assessment and treatment of her post-surgical neurological symptoms. Further, his records fail to adequately reflect Patient's progress or lack thereof in regard to these symptoms during the course of treatment.

The Board disagrees with the ALJ's determination that this documentations failure occurred on only one occasion. The ALJ erred in his focus on the relative quality of the records of providers within a single practice group. The legal standard is not defined by the habits of care providers at a single practice. Further, the ALJ's constant comparison of Dr. Estivo's record keeping habits to those of other providers within his practice group reflects a misunderstanding of the distinctions in the respective treatment roles of the different providers involved in the care of Patient. Dr. Estivo was the Patient's treating surgeon as opposed to seeing her for pain management appointments. Moreover, even if every other treatment provider had failed in their duties to Patient (the Board makes no findings in regard to any providers other than Dr. Estivo), Dr. Estivo would still be bound by the objective requirements of Kansas law.

As described in the findings of fact, the Board agrees with Dr. Burton's conclusion that Dr. Estivo failed to adequately document his care of Patient at each of his post-surgical visits with this patient. In addition to the findings of fact, which the Board finds sufficient to support its conclusions, the board relied on its own expertise and experience in evaluating the medical record issues in this case. See *Hart v. Bd. of Healing Arts of State*, 27 Kan. App. 2d 213 (2000).

Dr. Estivo violated K.S.A. 65-2837(b)(24) by failing to meet the standard of care in his documentation and his failure to order diagnostic imaging

Dr. Estivo committed acts of unprofessional conduct, pursuant to K.S.A. 65-2836(b) and K.S.A. 65-2837(b)(24) by violating the standard of care in both his record keeping and his decision to not order an MRI or any other imaging study to assess the cause of Patient's symptoms at any time during his post-discharge care of Patient.

The Board agrees with the conclusion of Dr. Burton that – in addition to constituting the statutory and regulatory violations described above – Dr. Estivo's inadequate documentation of post-operative neurological examinations and failure to document a plan for evaluating the neurological symptoms Patient exhibited after his surgery violated the standard of care. This constitutes a failure to "practice healing arts with that level of care, skill and treatment that is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances" as referenced in K.S.A. 65-2837(b)(24). Failure to appropriately document care represents a danger to continuity of care and creates opportunity for dangerous situations if subsequent providers are not able to accurately and completely ascertain the care provided for a patient. Failure to adequately document care is contrary to continuity of care and patient safety.

The Board also finds that Dr. Estivo violated the standard of care by failing to order an MRI or any other imaging study to assess the cause of Patient's symptoms at any time during his post-discharge care of Patient. The Board bases this conclusion on the findings of fact, including but not limited to the medical records, in conjunction with the Board's own expertise and experience. This conclusion is bolstered by the testimony of Dr. Burton.

Again, the Board diverts from the findings of the ALJ in regard to violations of the standard of care. Again, the ALJ erred in his focus on the relative quality of care rendered by providers within a single practice group. The standard of care is not defined by a single practice group, and the ALJ's focus on other providers again reflects a misunderstanding of the distinctions in the respective treatment roles of the different providers involved in the care of Patient.

Although the Board does not adopt the reasoning[2] of the ALJ, the Board agrees with the ALJ's determination that the record does not contain sufficient evidence to demonstrate gross negligence by Dr. Estivo. Under Kansas law, gross negligence requires a wrongful act taken with a realization of the imminence of danger and a reckless disregard and complete indifference for the probable consequences of the act. *MacDougall v. Walthall*, 174 Kan. 663, 667, (1953). The Board finds that, although wrongful, Dr. Estivo's failure to take appropriate steps to assess Patient's neurological symptoms was not an omission committed with a realization of the imminence of danger and a reckless disregard and complete indifference to the consequences. The Board's finds Dr. Estivo's testimony in regard to his state of mind credible. At hearing, he articulated a credible good faith explanation of his thought process in regard to this mistake.

"Credibility" determinations and evidentiary inferences

[2] In particular, the ALJ erred in his evaluation of *Kansas State Bd. of Healing Arts v. Foote*, 200 Kan. 447 (1968). Although the ALJ's analysis of this case was not clearly articulated in the Initial Order, the Initial Order could be read to imply that Kansas law requires more than one incident, more than one patient, or actual injury to support a finding of gross negligence in the context of medical negligence. Kansas law contains no such requirement.

K.S.A. 77-527 directs that the agency "shall give due regard to the presiding officer's **opportunity to observe the witnesses** and to determine the credibility of witnesses." *Id.* (Emphasis added). This statute communicates the well-settled legal concept that, when attempting to ascertain the candor of testimony, real-time observation provides an opportunity to make assessments of the demeanor of a witness that cannot be adequately reflected in a transcript or described in a written order. The Board has given such due regard in this case.

However, much of the ALJ's discussion framed under the heading of "CREDIBILITY ANALYSIS" was unrelated to the ALJ's opportunity to observe the relevant witnesses' testimony. Much of the discussion under this heading was analysis of the weight of the evidence and factual inferences taken from the absence of evidence, which were inaccurately framed in the Initial Order as credibility determinations. Therefore, although the Board does not disturb the ALJ's ultimate credibility determinations in regard to Dr. Estivo and Dr. Garcia, it rejects most of the remainder of the determinations characterized as "credibility" determinations.

The Board finds that its disagreements with the "credibility" analysis of the ALJ would not have altered the conclusions expressed in this Final Order. The Board's conclusions did not depend on the witness credibility determinations of any witness except Dr. Estivo. This is because the resolution of the issues in this case did not depend on choosing between conflicting factual accounts of events or circumstances. The Board found that the issues in this case could be resolved by evaluating the undisputed care provided to Patient, the factual testimony of Dr. Estivo (which the Board found credible), and the medical records in light of the Board's own experience and expertise.

Much of the ALJ's discussion of the credibility of Mr. Harness is an analysis of inferences drawn based on the absence of evidence rather than a determination of Mr. Harness's credibility based on either the ALJ's opportunity to observe his testimony or evidence in the record. The Board defers to the ALJ's credibility inferences related to this witness only in regard to: the existence of a source of potential bias (litigation); and such potential bias reflected in his testimony that he could not recall who initially requested that he look into Dr. Estivo's treatment of Patient. The Board rejects the remainder of the ALJ's inferences relating to this witness as unsupported by the record and unrelated to the presiding officer's opportunity to observe the witness.

In the context of the ALJ's discussion of Mr. Harness, he also draws inferences based upon inferences relating to certain peer review documents. First, the ALJ infers – without reference to a positive basis in the record – that the Board received certain peer review documents. Then, based on this inference, the ALJ infers the strategic motivations of litigation counsel for choosing not to offer those documents as evidence. Finally, based on the inference regarding attorney strategy and motivations, the ALJ infers that these documents must have been harmful to the Board's case. This is an evidentiary bridge too far.

In addition to being without a valid evidentiary basis in the record pursuant to K.S.A. 77-526(d), the ALJ's analysis on this point was premised on a misunderstanding of Kansas peer review law and the policy that underlies it. *See* K.S.A. 65-4921; K.S.A. 65-4923; K.S.A. 65-

4924; K.S.A. 65-4925; and K.A.R. 28-52-4. These documents were privileged in the hands of Doctors Hospital, and the ALJ failed to consider that the Board's use of such documents in an administrative hearing as evidence is significantly limited by K.S.A. 65-4925(e). Further, the above cited statutes and regulation reflect a public policy that peer review documents should be rarely used as evidence, especially in cases where the relevant facts contained in those documents can be produced through other means, **such as the witness testimony of Mr. Harness given in closed session in this case**. Because the Board's rejection of this analysis did not affect the outcome of this case, the Board will not further belabor this point.

The Board rejects the ALJ's analysis of Dr. Burton as unsupported by the record. Although the ALJ framed his criticisms under the heading of "credibility" determinations, they are more accurately characterized as factual conclusions regarding the qualifications of the expert and whether his conclusions were consistent with the ALJ's own view of the medical records and medical issues. These are factual determinations on which the Board is free to make its own determinations pursuant to K.S.A. 77-527(d). The ALJ asserted that Dr. Burton applied a "super surgeon" standard. However, the record does not support this assertion. Dr. Burton clearly referenced the appropriate standard of care, opining that "any reasonably competent spine surgeon" would have obtained an imaging study when the patient presents with new neurological deficits. He also applied the appropriate standard to his testimony regarding the standard of care relating to adequate documentation of care. (Tr. p. 589, lines 6-13; p. 594, lines 19-25; p. 595, lines 1-2; p. 596, lines 1-18). Although the Board disagrees with Dr. Burton's conclusion in regard to gross negligence, the Board finds him to be a well-qualified expert who applied the correct standard of care.

The ALJ's negative factual inferences based on the Board's decision not to call certain witnesses is unsupported by the record or Kansas law. None of these witnesses were either employed by the Board or in the unique control of the Board. Therefore, the case law that Dr. Estivo cites is not applicable.

Finally, the Board rejects the credibility conclusions that appear to be based on the ALJ's speculative theory of a conspiracy by the "powers that be" in the medical device industry to blame surgeons like Dr. Estivo for poor surgical outcomes. There is absolutely nothing in the record that supports such a conspiracy. The Board disregards this theory and any inferences drawn from it.

Improper additions to the record by the ALJ

The ALJ, a lay hearing officer, inserted independent internet medical research into the Initial Order. He also inserted research relating to the FDA in connection to his theory regarding the motivations of the "powers that be" in the medical device industry, as well as internet research regarding where a certain non-witness was located. K.S.A. 77-526(d) states that "findings of fact shall be based exclusively upon the evidence of record in the adjudicative proceeding and on matters officially noticed in that proceeding." *Id.* In addition, such injections of outside evidence into the record conflicts with accepted standards of due process and judicial restraint. Neither party was provided notice or the opportunity to confront this independent

research. These insertions were improper and the Board disregards them and any inferences drawn from them.

Sanctions

The Board approaches every case according to the totality of circumstances and facts unique to the case. Based on the above findings, the Board concludes a wide range of sanctions could be justified in this case. The oft-cited 2008 Guidelines for The Imposition of Disciplinary Sanctions is a general and non-binding informational document that litigants and the Board often use as a reference in framing the sanctions discussion. However, the Board is bound only by Kansas law and due process. In this case, the Board departs downward from the sanctions suggested by the Guidelines.

In this case, the Board has found violations of the standard of care in two respects in addition to record keeping violations. The Guidelines would direct attention to row 1C, columns 3 through 6 and row 10B, columns 3 through 6. These columns and rows would suggest sanctions ranging from a combination of a fine and probation to revocation. However, under all the circumstances described in the findings of fact, the Board believes that the nature of Dr. Estivo's standard of care violations, occurring in the context of one patient's case, although concerning, do not reflect a relatively high severity of violation. The Board does not find a pattern of similar mistakes over Dr. Estivo's long career. Further, based on the record and comments at the hearing, the Board believes Dr. Estivo is aware of his mistakes in this patient's case and is likely to adjust his behavior appropriately in the future.

The Board concludes that the patient safety goals of the Board in this unique case would be best served by ordering that Dr. Estivo successfully complete the CPEP Medical Records Seminar, or another medicals records course approved by the Board as substantially equivalent. The Board notes an indication in the record that Dr. Estivo may have already completed this course while this case was pending. If that is the case, this requirement may be met by providing the Board with evidence of successful completion of this course. Otherwise, Dr. Estivo must successfully complete the course and provide evidence of such completion to the Board within 6 months of the date of this Final Order.

Costs

This Final Order, finding multiple violations of the Healing Arts Act, is adverse to Dr. Estivo. Therefore, it is appropriate to assess costs against him pursuant to K.S.A. 65-2846. Based on consideration of the circumstances described in this order and review of the Petitioner's statement of costs, the costs of the proceedings are assessed against Dr. Estivo in the amount of $32,129.50. These costs shall be paid in full within 30 days of the filing of this Final Order, or, in the alternative, Dr. Estivo may submit a proposed payment schedule for Board's consideration and approval.

ORDERS

IT IS THEREFORE ORDERED, BY THE KANSAS STATE BOARD OF HEALING ARTS, that Respondent, Michael P. Estivo, D.O., license No. 05-23235, shall successfully complete the CPEP Medical Records Seminar, or another medicals records course approved by the Board as substantially equivalent. This requirement may be met by providing the Board with evidence of completion of this course during the pendency of this case. Otherwise, Dr. Estivo shall successfully complete and provide evidence of such completion to the Board within 6 months of the date of this Final Order.

IT IS FURTHER ORDERED that Respondent is hereby ordered to pay **COSTS** in the amount of $32,129.50. These costs shall be paid in full within 30 days of the filing of this Final Order, or, in the alternative, may submit a proposed payment schedule for Board's consideration and approval. Payment shall be submitted to the attention of: Compliance Coordinator, Kansas State Board of Healing Arts, 800 SW Jackson Street, Lower Level, Suite A, Topeka, Kansas 66612.

IT IS SO ORDERED THIS 14th DAY OF May, 2018, IN THE CITY OF TOPEKA, COUNTY OF SHAWNEE, STATE OF KANSAS.

KANSAS STATE BOARD OF HEALING ARTS

Kathleen Selzler Lippert, Executive Director

NOTICE OF APPEAL RIGHTS

PLEASE TAKE NOTICE that this is a Final Order. A Final Order is effective upon service, and service of a Final Order is complete upon mailing. Pursuant to K.S.A. 77-529, Parties may petition the Board for Reconsideration of a Final Order within fifteen (15) days following service of the final order. Additionally, a party to an agency proceeding may seek judicial review of a Final Order by filing a petition in the District Court, as authorized by K.S.A. 77-601, *et seq.* Reconsideration of a Final Order is not a prerequisite to judicial review. A petition for judicial review is not timely unless filed within 30 days following service of the Final Order. A copy of any petition for judicial review must be served upon Kathleen Selzler Lippert, Executive Director, Kansas State Board of Healing Arts, 800 SW Jackson, Lower Level-Suite A, Topeka, KS 66612.

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that a true and correct copy of the above and foregoing **FINAL ORDER** was served this 14th day of May, 2018, by depositing the same in the United States Mail, first-class, postage prepaid, and an email courtesy copy, addressed to:

Mark Stafford
Attorney for Respondent
Forbes Law Group
6900 College Blvd., Ste. 840
Overland Park, Kansas 66211
mstafford@forbeslawgroup.com

And a copy was hand-delivered to the office of:

Susan Gering, Deputy Litigation Counsel
Kansas Board of Healing Arts
800 S.W. Jackson, Lower Level-Suite A
Topeka, Kansas 66612
Susan.Gering@ks.gov

And the original was filed with the office of the Executive Director.

Elizabeth Visocsky, Operations Manager