BEFORE THE BOARD OF HEALING ARTS OF THE STATE OF KANSAS

In the Matter of)
)
)
)
MERLE J. FIESER, M.D.)
Kansas License No. 4-18324)

Case No. 96-00251
97-00096

ORDER FOLLOWING EMERGENCY PROCEEDINGS

NOW, on this 9th day of January, 1997, the above-entitled matter comes on for hearing before Lawrence T. Buening, Jr., Presiding Officer, following ex parte proceedings conducted December 7, 1996 and resulting in an Emergency Order suspending the license to practice medicine and surgery of Merle J. Fieser, M.D.

The Kansas State Board of Healing Arts ("Board") appears by and through its Disciplinary Counsel, Kevin K. LaChance. Merle L. Fieser, M.D., ("Licensee") appears in person and by and through her attorneys, Brian C. Wright and Eldon Boisseau of Turner and Boisseau, Chartered. Mark W. Stafford, General Counsel for the Board, is present and provides legal counsel to the Presiding Officer.

After hearing testimony, statements and arguments of counsel and being duly advised in the premises, the Presiding Officer makes the following findings of fact and conclusions of law and orders:

HISTORY OF CASE

1. On December 7, 1996, at a regular meeting of the Board as a whole, an oral motion for an emergency suspension of Licensee's license to practice medicine and surgery was presented to the Board by its Disciplinary Counsel.

2. In presenting the motion, the Disciplinary Counsel provided justification for an emergency suspension based upon two cases - one concerned the care of a child who had a perforated appendix and the other included alegations that Licensee provided obstetrical care to a patient in violation of a Board order.

3. Based upon the oral motion, the Board issued an emergency suspension of Licensee's license and appointed this Presiding Officer to conduct a post deprivation hearing on Wednesday, December 11, 1996.

4. By agreement of the parties, the hearing scheduled for December 11, 1996 was continued and set for hearing commencing at 9:00 a.m. on January 9, 1997.

5. Prior to the commencement of the hearing, counsel for Licensee objected to this Presiding Officer conducting the proceedings and further objected to the refusal of the Presiding Officer to issue two subpoenas for attendance of witnesses at this hearing based upon a Request for Issuance of Subpoena filed by fax on January 6, 1997.

6. The objection to this Presiding Officer conducting the hearing was based solely upon the Presiding Officer being in the employment of the Board as Executive Director. The objection is overruled for the reason that this Presiding Officer does not feel that, absent some other reason, mere employment by the Board subjects him to disqualification as Presiding Officer for administrative bias, prejudice or interest.

7. The objection to the issuance of the subpoenas for the attendance of two witnesses was taken under advisement pending presentation of the case by both parties, and for the reasons to be set forth later in this order, is now overruled.

8. After opening statements from Licensee's counsel, Disciplinary Counsel offered documentary evidence comprised of exhibits number 1 through 12 and 14 through 18, which were admitted into evidence for purposes of this hearing only.

9. Licensee offered documentary evidence comprised of exhibits 1 through 6 including 3A and 8, 9 and 11 which were admitted into evidence for purposes of this hearing only and also offered the testimony of Licensee and two persons in the employment of Licensee.

10. Closing statements were not deemed necessary, the record was closed, the matter taken under advisement by the Presiding Officer is now ready for decision.

FINDINGS OF FACT

1. As agreed by the parties, this matter is limited to two cases. The patients will be referred to as BJ in the case involving appendicitis and CS in the case involving obstetrical care.

2. In the case involving BJ, records obtained from Licensee indicate Licensee had been involved in her care since birth in 1992.

3. Licensee's office notes for April 11, 1996 indicate that BJ was seen by Licensee on that date and was diagnosed with pneumonia. Office notes for that date also indicate "Occ cough", "discussed possibility of AA" and "mom refused further lab today".

4. The complainant in this case, the mother of BJ, denies BJ was coughing at all on April 11, that there was any discussion of an acute abdomen or possible appendicitis and that she refused to have any further lab work performed.

5. The Licensee's records reflect that BJ had been diagnosed and treated for pneumonia in the past and that BJ's mother had, at other times in the past, refused lab and other diagnostic tests.

6. On April 12, 1996, BJ was again seen by Licensee in her office and the records maintained by Licensee reflect a diagnosis of a "ruptured? acute appendicitis" and that the patient was admitted to the hospital for a surgical consult for appendectomy.

7. On April 12, 1996, an appendectomy on BJ was performed approximately four hours following her being seen by Licensee in Licensee's office on that date.

8. Information provided by the surgeon who performed the appendectomy indicates that in his opinion, the appendix had ruptured at least 48 hours prior to surgery.

9. The records from the hospital and other documentary evidence admitted provides numerous discrepancies with regard to post-operative care and what were the discussions between BJ's parents and the admitting physician and surgeon, but for the reasons to be stated hereafter those will not be set forth in detail.

10. As to patient, CS, on June 26, 1995, a Stipulation and Agreement and Enforcement Order was filed with the Board in which Licensee agreed not to practice obstetrics in any form. The pertinent part of this Stipulation and Agreement and Enforcement Order as it relates to the concerns raised in this particular case is as follows:

> **"i) Licensee agrees to that her license to practice medicine and surgery is hereby limited to the extent that she will not practice obstetrics in any form, nor will she undertake to treat neonates (newborns), in the State of Kansas unless certain requirements are met. This further means that, in the event a patient attends with Licensee with a diagnosis of pregnancy, or if Licensee makes a diagnosis of pregnancy, the patient will be immediately referred to another physician, and Licensee will have no further management of the**

patient during the period of the pregnancy and will not participate in the delivery. Further, once a baby is born, Licensee will not accept the neonate into her practice until some other doctor has made a diagnosis that this is a well neonate, and the neonate has been released from care from the facility in which it was born, or, if not born in a facility, has been adjudged in writing by another doctor to be a healthy neonate. For the purposes of this Stipulation, a "neonate" is defined as a baby less than twenty-nine (29) days of age."

11. According to the evidence submitted, CS presented to the hospital on September 15, 1996 in full term pregnancy and on that date delivered a child by repeat C-Section at the hospital due to ruptured membranes making the delivery imminent.

12. CS was diagnosed as pregnant on January 29, 1996 by a physician who has referred obstetrical patients from Licensee on a regular basis.

13. The medical records of the physician who diagnosed CS as pregnant reflect the notation on February 19, 1996 that "Dr. Fieser's office notified per RDD". What the extent of this notification was, whether notification was made in accordance with the notes in the medical chart, who received the notification and whether the information contained within the notification was conveyed on to Licensee are not contained in the information admitted into evidence at this time.

14. On June 18, 1996, when CS was more than 27 weeks pregnant, CS was seen by Licensee in her office at which time a herpes culture and sonogram were ordered and a diagnosis of herpes genitalia made. Also on the notes for this date, there is an indication of a referral to Wesley Medical Center. The office notes for this date also reflect that on the following date, June 19, 1996, an appointment at Wesley Women's Clinic had been made for CS for 12:30 p.m. on June 24, 1996.

15. An exhibit offered by Licensee and admitted into this hearing but not previously provided prior to the hearing indicates that Licensee saw CS on September 30, 1996 and had staples removed.

ISSUES

The issues before this Presiding Officer and raised during this hearing are as follows:

1. Did Licensee commit an act of professional incompetency as defined in K.S.A. 1996 Supp. 65-2837(a)(1) in the treatment of patient BJ, and, if so, is there cause to believe that such act or acts would make Licensee's continuation in practice an imminent danger to the public health and safety?

2. Did Licensee violate a lawful order or directive of the Board as set forth in the Stipulation and Agreement and Enforcement Order filed June 26, 1995 in her treatment of CS and did such violation give cause to believe that Licensee's continuation in practice would constitute an imminent danger to the public health and safety?

DISCUSSION OF EVIDENCE AND CONCLUSIONS OF LAW

1) These proceedings are governed by K.S.A. 65-2838(c) which vests authority in the Board to temporarily suspend or temporarily limit the license of any licensee in accordance with the emergency adjudicative proceedings under the Kansas Administrative Procedure Act.

2) To temporarily suspend a license, the Board must determine there is cause to believe that grounds exist for disciplinary action and that the licensee's continuation and practice would constitute an imminent danger to the public health and safety.

3) K.S.A. 77-536 is that portion of the Kansas Administrative Procedure Act which states when a state agency may use emergency proceedings and sets forth requirements imposed upon a state agency when emergency adjudication is justified.

4) On December 7, 1996, the Board was provided with information in an ex parte manner and requested, based upon that information, to temporarily suspended Licensee's license under K.S.A. 65-2838(c).

5) This Presiding Officer will not substitute his judgement for that of the Board, but considers his purpose in conducting this hearing is to determine whether the information which was indicated to have been available on December 7, 1996 does exist and, determining that, give the Licensee a limited reasonable opportunity to confront and respond to that information.

6) A review of the transcript of the December 7, 1996 hearing and the exhibits which have been admitted into evidence during the course of this hearing reveals that the information provided to the Board on December 7 does exist and, therefore, the action taken by the Board was proper.

7) Having determined that the information which formed the justification for the Board's decision on December 7 exists, the purpose of the hearing then turns to providing the Licensee with a reasonable opportunity to see and hear that evidence and to provide Licensee in an expedient but limited manner the opportunity to respond to that information. In other words, the burden shifted during the course of the hearing to imposing upon the Licensee the duty to show that the cause to believe that there is an emergency situation does not exist. Due to the need for expediency, requiring attendance of witnesses by subpoena is not required unless

necessary to give Licensee a reasonable opportunity to respond to the evidence. In this case, the testimony of the two witnesses for which subpoenas were requested is not required to give Licensee a reasonable opportunity to confront evidence presented by the Board.

8) In order to provide a reasonable opportunity to enable a showing of grounds in seeking emergency action to protect the public health and safety on an immediate basis and, similarly, to enable a licensee following an Ex Parte Order of Suspension to respond to that evidence, strict rules of evidence cannot be applied. Documents admitted into evidence for purposes of this hearing should not be construed as admissible in any later judicial or administrative proceeding and conversely are subject to any and all proper objections during the course of any subsequent proceedings.

9) Clearly, numerous discrepancies exist and questions remain from the information provided during the course of this hearing. However, these can best be reconciled and answered during the course of formal proceedings which provide for full discovery and for both direct and cross examination of witnesses.

10) As to the case of Licensee's treatment of BJ, whether and to what extent Licensee was negligent in the diagnosis and treatment of BJ and the discrepancies which exist in both pre-operative and post-operative discussions and records can best be determined during the course of formal proceedings which will enable fuller exploration and discovery on this issue. Whether BJ had pneumonia on April 11, 1996 and was appropriately treated for pneumonia both on that date and during her hospital stay remains unresolved. The uncontroverted facts are that Licensee failed to diagnosis appendicitis on April 11, 1996. However, when seeing the patient the

following day, Licensee did admit the patient to the hospital and seek a surgical consult. Based upon Licensee's care and treatment of BJ in this one specific instance, the Presiding Officer cannot conclude an imminent danger exists to the public health and welfare by enabling Licensee to continue practice while formal proceedings are pursued. Licensee has responded to the information provided to the Board on December 7 by providing information that BJ had a history of pneumonia and her records reflect prior refusal to further diagnostic tests which may have assisted in diagnosing appendicitis. Without determining any negligence on the part of Licensee in the treatment of BJ exists and the degree of any such negligence, the Presiding Officer cannot conclude that this case itself constitutes such that continuation of practice would constitute an imminent danger to the public. This is supported by the transcript of the December 7, 1996 hearing in which it is indicated at least some of the Board members would question whether this case in and of itself would justify the use of emergency adjudicative proceedings. Further, BJ's history of pneumonia and the parent's prior refusal of diagnostic tests, as reflected in Licensee's records, may have impaired Licensee's ability to make a proper diagnosis and these factors were not considered by the Board when it made its decision on December 7. Therefore, Licensee has provided adequate information, not heretofore considered by the Board during the hearing on December 7, to show that an emergency does not exist with regard to this particular case.

11) As to the case involving obstetrical care to CS, there is likewise a number of questions and discrepancies which remain unaddressed and unresolved. However, the issue involved and which formed the basis for emergency action by the Board is not the standard of care provided to CS by Licensee, but whether Licensee provided care to CS in violation of the

Stipulation and Agreement and Enforcement Order. A clear cut and uncontroverted violation of a Board Order would, in the mind of this Presiding Officer, constitute grounds for an emergency action in almost all cases. However, the records of Licensee do not clearly reflect Licensee's knowledge of the pregnancy of CS on June 18, 1996. Whether Licensee violated the Board order because she knew of the pregnancy of CS on June 18, 1996 or should have diagnosed her as pregnant prior to initiating any examination or treatment on that date should be left to a formal proceeding during which these issues can be more fully explored. The uncontroverted facts are that Licensee did see and examine CS on June 18, 1996. The records do not reflect any management of patient's pregnancy on that date or subsequently, but do indicate that on June 19, 1996, following receipt of the results of the sonogram, the patient was referred for further obstetrical care. Records also reflect CS had seen other physicians for management of her pregnancy prior to June 18. It is of concern to this Presiding Officer that the record of the patient's visit on September 30, 1996 were not provided pursuant to Board subpoena and were in the possession of Licensee's counsel at least 4 weeks prior to this hearing, but were not delivered to the Board until this hearing. However, the removal of the staples on September 30, 1996, as indicated from the records provided during the hearing, would constitute care of CS two weeks following delivery and would not fall within the limitations set forth in the Stipulation and Agreement and Enforcement Order. In conclusion, formal proceedings may determine Licensee's violation of the Stipulation and Agreement and Enforcement Order. This Presiding Officer cannot find such an egregious and clear violation of that Order as to justify a suspension of her license due to an immediate danger to the public health and safety.

Testimony and records provided by Licensee, while questionable, reflect a pelvic sonogram and not an obstetrical sonogram was ordered on June 18. The Board was not aware of this difference on December 7. The information provided by Licensee during the course of the hearing reflects that Licensee is well aware of the limitation that she may not be involved in obstetrics and that this has been conveyed on to her staff. Transferring care of CS to another clinic the day following the June 18 appointment may not have been immediate as anticipated by the Board order, but did show Licensee's intent not to be further involved in the management of CS during her pregnancy.

12) This Order has esolved only those issues involved in the issuance of the ex parte Emergency Order and the Board may proceed with such further proceedings under the Kansas Administrative Procedure Act at such time and in such manner as it deems appropriate.

IT IS THEREFORE by the Presiding Officer ordered as follows:

a) That the license of Licensee to practice medicine and surgery which was suspended pursuant to the Emergency Order filed December 9, 1996, be reinstated and that the Order suspending such license be set aside.

b) In light of various statutes pertaining to privilege and confidentiality of the documents admitted into evidence in this hearing and the possible inadmissibility at any future administrative or judicial proceedings, all of the exhibits admitted herein are placed under Protective Order and shall not be divulged to any person except upon order of this Presiding Officer or a lawful court order.

c) This is an emergency order under K.S.A. 77-536 and is effective upon issuance

and an aggrieved party may file a Petition for Judicial Review under the appropriate provisions of K.S.A. 77-601 et seq.

IT IS SO ORDERED this 13th day of January, 1997.

KANSAS STATE BOARD OF HEALING ARTS

LAWRENCE T. BUENING, JR.
Presiding Officer

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the above and foregoing was sent by Fax and by United State mail, first class postage prepaid, on this 13th day of January, 1997, addressed to the following:

Brian Wright
Turner and Boisseau, Chartered
3900 Broadway
(316-792-1869) Great Bend, Kansas 67530

Eldon Boisseau
Turner & Boisseau, Chartered
825 N. Waco
(316-263-0495) Wichita, Kansas 67203

and a copy was hand-delivered to

Kevin K. LaChance
Disciplinary Counsel
Kansas State Board of Healing Arts
235 S. Topeka Blvd.
Topeka, Kansas 66603

Lawrence T. Bunning Jr

LTB36/Fieser.OFH