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KS State Board of Healing Arts

BEFORE THE KANSAS BOARD OF HEALING ARTS
FOR THE STATE OF KANSAS

IN THE MATTER OF	)	
	)	
	)	Docket No.: 05 HA 05
Victor H. Hildyard, II, MD	)	
Kansas License No. 4-15836	)	
		OAH No.: 05HA0001
Pursuant to K.S.A. Chapter 77		

INITIAL ORDER

NOW on this 5th day of October 2005, this matter comes on for hearing in formal proceedings of the Amended Petition of the Board of Healing Arts on February 14, 2005. Diane L. Bellquist, Associate Disciplinary Counsel, and David Steed appear on behalf of the Board of Healing Arts. The respondent appears in person and by and through Michael O'Neal and Shannon Holmburg.

The Board and the respondent presented witnesses and exhibits throughout this matter which concluded on October 17, 2005.

Following the conclusion of the evidentiary hearing, the parties were permitted to file Proposed Findings of Fact and Conclusions of Law. Both parties filed their Proposed Findings of Fact and Conclusions of Law on December 29, 2005.

Background

1. The respondent is licensed to practice medicine by the Board of Healing Arts. The respondent is a Board Certified Family Practitioner. The respondent has practiced in Colby, Kansas since 1974.

2. The respondent formerly had physician privileges at Citizen's Medical Center, the **(Confidential)**

   Center, the respondent's medical privileges at Citizen's Medical Center were terminated.

Applicable Law

1. Kansas Statutes Annotated (K.S.A.) 65-2836 provides as follows:
65-2836. Revocation, suspension, limitation or denial of licenses; censure of licensee; grounds; consent to submit to mental or physical examination or drug screen, or any combination thereof, implied. A licensee's license may be revoked, suspended or limited, or the licensee may be publicly or privately censured, or an application for a license or for reinstatement of a license may be denied upon a finding of the existence of any of the following grounds:
   (a) The licensee has committed fraud or misrepresentation in applying for or securing an original, renewal or reinstated license.
   (b) The licensee has committed an act of unprofessional or dishonorable conduct or professional incompetency.
   (c) The licensee has been convicted of a felony or class A misdemeanor, whether or not related to the practice of the healing arts. The board shall revoke a licensee's license following conviction of a felony occurring after July 1, 2000, unless a 2/3 majority of the board members present and voting determine by clear and convincing evidence that such licensee will not pose a threat to the public in such person's capacity as a licensee and that such person has been sufficiently rehabilitated to warrant the public trust. In the case of a person who has been convicted of a felony and who applies for an original license or to reinstate a canceled license, the application for a license shall be denied unless a 2/3 majority of the board members present and voting on such application determine by clear and convincing evidence that such person will not pose a threat to the public in such person's capacity as a licensee and that such person has been sufficiently rehabilitated to warrant the public trust.
   (d) The licensee has used fraudulent or false advertisements.
   (e) The licensee is addicted to or has distributed intoxicating liquors or drugs for any other than lawful purposes.
   (f) The licensee has willfully or repeatedly violated this act, the pharmacy act of the state of Kansas or the uniform controlled substances act, or any rules and regulations adopted pursuant thereto, or any rules and regulations of the secretary of health and environment which are relevant to the practice of the healing arts.
   (g) The licensee has unlawfully invaded the field of practice of any branch of the healing arts in which the licensee is not licensed to practice.
   (h) The licensee has engaged in the practice of the healing arts under a false or assumed name, or the impersonation of another practitioner. The provisions of this subsection relating to an assumed name shall not apply to licensees practicing under a professional corporation or other legal entity duly authorized to provide such professional services in the state of Kansas.
   (i) The licensee has the inability to practice the healing arts with reasonable skill and safety to patients by reason of physical or mental illness, or

condition or use of alcohol, drugs or controlled substances. In determining whether or not such inability exists, the board, upon reasonable suspicion of such inability, shall have authority to compel a licensee to submit to mental or physical examination or drug screen, or any combination thereof, by such persons as the board may designate either in the course of an investigation or a disciplinary proceeding. To determine whether reasonable suspicion of such inability exists, the investigative information shall be presented to the board as a whole, to a review committee of professional peers of the licensee established pursuant to K.S.A. 65-2840c and amendments thereto or to a committee consisting of the officers of the board elected pursuant to K.S.A. 65-2818 and amendments thereto and the executive director appointed pursuant to K.S.A. 65-2878 and amendments thereto or to a presiding officer authorized pursuant to K.S.A. 77-514 and amendments thereto. The determination shall be made by a majority vote of the entity which reviewed the investigative information. Information submitted to the board as a whole or a review committee of peers or a committee of the officers and executive director of the board and all reports, findings and other records shall be confidential and not subject to discovery by or release to any person or entity. The licensee shall submit to the board a release of information authorizing the board to obtain a report of such examination or drug screen, or both. A person affected by this subsection shall be offered, at reasonable intervals, an opportunity to demonstrate that such person can resume the competent practice of the healing arts with reasonable skill and safety to patients. For the purpose of this subsection, every person licensed to practice the healing arts and who shall accept the privilege to practice the healing arts in this state by so practicing or by the making and filing of a renewal to practice the healing arts in this state shall be deemed to have consented to submit to a mental or physical examination or a drug screen, or any combination thereof, when directed in writing by the board and further to have waived all objections to the admissibility of the testimony, drug screen or examination report of the person conducting such examination or drug screen, or both, at any proceeding or hearing before the board on the ground that such testimony or examination or drug screen report constitutes a privileged communication. In any proceeding by the board pursuant to the provisions of this subsection, the record of such board proceedings involving the mental and physical examination or drug screen, or any combination thereof, shall not be used in any other administrative or judicial proceeding.

(j) The licensee has had a license to practice the healing arts revoked, suspended or limited, has been censured or has had other disciplinary action taken, or an application for a license denied, by the proper licensing authority of another state, territory, District of Columbia, or other country, a certified copy of the record of the action of the other jurisdiction being conclusive evidence thereof.

(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.

(l) The licensee has failed to report or reveal the knowledge required to be reported or revealed under K.S.A. 65-28,122 and amendments thereto.

(m) The licensee, if licensed to practice medicine and surgery, has failed to inform in writing a patient suffering from any form of abnormality of the breast tissue for which surgery is a recommended form of treatment, of alternative methods of treatment recognized by licensees of the same profession in the same or similar communities as being acceptable under like conditions and circumstances.

(n) The licensee has cheated on or attempted to subvert the validity of the examination for a license.

(o) The licensee has been found to be mentally ill, disabled, not guilty by reason of insanity, not guilty because the licensee suffers from a mental disease or defect or incompetent to stand trial by a court of competent jurisdiction.

(p) The licensee has prescribed, sold, administered, distributed or given a controlled substance to any person for other than medically accepted or lawful purposes.

(q) The licensee has violated a federal law or regulation relating to controlled substances.

(r) The licensee has failed to furnish the board, or its investigators or representatives, any information legally requested by the board.

(s) Sanctions or disciplinary actions have been taken against the licensee by a peer review committee, health care facility, a governmental agency or department or a professional association or society for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(t) The licensee has failed to report to the board any adverse action taken against the licensee by another state or licensing jurisdiction, a peer review body, a health care facility, a professional association or society, a governmental agency, by a law enforcement agency or a court for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(u) The licensee has surrendered a license or authorization to practice the healing arts in another state or jurisdiction, has surrendered the authority to utilize controlled substances issued by any state or federal agency, has agreed to a limitation to or restriction of privileges at any medical care facility or has surrendered the licensee's membership on any professional staff or in any professional association or society while under investigation for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(v) The licensee has failed to report to the board surrender of the licensee's license or authorization to practice the healing arts in another state or

jurisdiction or surrender of the licensee's membership on any professional staff or in any professional association or society while under investigation for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(w) The licensee has an adverse judgment, award or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(x) The licensee has failed to report to the board any adverse judgment, settlement or award against the licensee resulting from a medical malpractice liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(y) The licensee has failed to maintain a policy of professional liability insurance as required by K.S.A. 40-3402 or 40-3403a and amendments thereto.

(z) The licensee has failed to pay the premium surcharges as required by K.S.A. 40-3404 and amendments thereto.

(aa) The licensee has knowingly submitted any misleading, deceptive, untrue or fraudulent representation on a claim form, bill or statement.

(bb) The licensee as the responsible physician for a physician assistant has failed to adequately direct and supervise the physician assistant in accordance with the physician assistant licensure act or rules and regulations adopted under such act.

(cc) The licensee has assisted suicide in violation of K.S.A. 21-3406 as established by any of the following:

(A) A copy of the record of criminal conviction or plea of guilty for a felony in violation of K.S.A. 21-3406 and amendments thereto.

(B) A copy of the record of a judgment of contempt of court for violating an injunction issued under K.S.A. 2002 Supp. 60-4404 and amendments thereto.

(C) A copy of the record of a judgment assessing damages under K.S.A. 2002 Supp. 60-4405 and amendments thereto.

2. Kansas Statutes Annotated (K.S.A.) 65-2837 provides as follows:

65-2837. Professional incompetency, unprofessional conduct; definitions. As used in K.S.A. 65-2836, and amendments thereto, and in this section:

(a) "Professional incompetency" means:

(1) One or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes gross negligence, as determined by the board.

(2) Repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board.

(3) A pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine.

(b) "Unprofessional conduct" means:

(1) Solicitation of professional patronage through the use of fraudulent or false advertisements, or profiting by the acts of those representing themselves to be agents of the licensee.

(2) Representing to a patient that a manifestly incurable disease, condition or injury can be permanently cured.

(3) Assisting in the care or treatment of a patient without the consent of the patient, the attending physician or the patient's legal representatives.

(4) The use of any letters, words, or terms, as an affix, on stationery, in advertisements, or otherwise indicating that such person is entitled to practice a branch of the healing arts for which such person is not licensed.

(5) Performing, procuring or aiding and abetting in the performance or procurement of a criminal abortion.

(6) Willful betrayal of confidential information.

(7) Advertising professional superiority or the performance of professional services in a superior manner.

(8) Advertising to guarantee any professional service or to perform any operation painlessly.

(9) Participating in any action as a staff member of a medical care facility which is designed to exclude or which results in the exclusion of any person licensed to practice medicine and surgery from the medical staff of a nonprofit medical care facility licensed in this state because of the branch of the healing arts practiced by such person or without just cause.

(10) Failure to effectuate the declaration of a qualified patient as provided in subsection (a) of K.S.A. 65-28,107, and amendments thereto.

(11) Prescribing, ordering, dispensing, administering, selling, supplying or giving any amphetamines or sympathomimetic amines, except as authorized by K.S.A. 65-2837a, and amendments thereto.

(12) Conduct likely to deceive, defraud or harm the public.

(13) Making a false or misleading statement regarding the licensee's skill or the efficacy or value of the drug, treatment or remedy prescribed by the licensee or at the licensee's direction in the treatment of any disease or other condition of the body or mind.

(14) Aiding or abetting the practice of the healing arts by an unlicensed, incompetent or impaired person.

(15) Allowing another person or organization to use the licensee's license to practice the healing arts.

(16) Commission of any act of sexual abuse, misconduct or exploitation related to the licensee's professional practice.

(17) The use of any false, fraudulent or deceptive statement in any document connected with the practice of the healing arts including the intentional falsifying or fraudulent altering of a patient or medical care facility record.

(18) Obtaining any fee by fraud, deceit or misrepresentation.

(19) Directly or indirectly giving or receiving any fee, commission, rebate or other compensation for professional services not actually and personally rendered, other than through the legal functioning of lawful professional partnerships, corporations or associations.

(20) Failure to transfer patient records to another licensee when requested to do so by the subject patient or by such patient's legally designated representative.

(21) Performing unnecessary tests, examinations or services which have no legitimate medical purpose.

(22) Charging an excessive fee for services rendered.

(23) Prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice.

(24) Repeated failure to practice healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances.

(25) Failure to keep written medical records which accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results and test results.

(26) Delegating professional responsibilities to a person when the licensee knows or has reason to know that such person is not qualified by training, experience or licensure to perform them.

(27) Using experimental forms of therapy without proper informed patient consent, without conforming to generally accepted criteria or standard protocols, without keeping detailed legible records or without having periodic analysis of the study and results reviewed by a committee or peers.

(28) Prescribing, dispensing, administering or distributing an anabolic steroid or human growth hormone for other than a valid medical purpose. Bodybuilding, muscle enhancement or increasing muscle bulk or strength through the use of an anabolic steroid or human growth hormone by a person who is in good health is not a valid medical purpose.

(29) Referring a patient to a health care entity for services if the licensee has a significant investment interest in the health care entity, unless the licensee informs the patient in writing of such significant investment interest and that the patient may obtain such services elsewhere.

(30) Failing to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

(31) Violating K.S.A. 65-6703 and amendments thereto.

(c) "False advertisement" means any advertisement which is false, misleading or deceptive in a material respect. In determining whether any advertisement is misleading, there shall be taken into account not only representations made or suggested by statement, word, design, device,

sound or any combination thereof, but also the extent to which the advertisement fails to reveal facts material in the light of such representations made.

(d) "Advertisement" means all representations disseminated in any manner or by any means, for the purpose of inducing, or which are likely to induce, directly or indirectly, the purchase of professional services.

(e) "Licensee" for purposes of this section and K.S.A. 65-2836, and amendments thereto, shall mean all persons issued a license, permit or special permit pursuant to article 28 of chapter 65 of the Kansas Statutes Annotated.

(f) "License" for purposes of this section and K.S.A. 65-2836, and amendments thereto, shall mean any license, permit or special permit granted under article 28 of chapter 65 of the Kansas Statutes Annotated.

(g) "Health care entity" means any corporation, firm, partnership or other business entity which provides services for diagnosis or treatment of human health conditions and which is owned separately from a referring licensee's principle practice.

(h) "Significant investment interest" means ownership of at least 10% of the value of the firm, partnership or other business entity which owns or leases the health care entity, or ownership of at least 10% of the shares of stock of the corporation which owns or leases the health care entity.

3. Kansas Administrative Regulation (K.A.R.) 100-16-4 provides as follows: **Grounds.** A license may be revoked, suspended, or limited when the licensee has been found to have committed any of the acts specified in K.S.A. 65-2836 and 65-2837. (Authorized by K.S.A. 65-2865; effective Jan. 1, 1966; amended Feb. 15, 1977.)

Count One
Findings of Fact

1. Count One of the Board's Petition alleges that the respondent's care and treatment of a twenty-two year old pregnant patient deviated from the applicable standard of care.

2. Specifically, the petitioner alleges that the respondent failed to adhere to the applicable standard of care in that he encouraged Patient Number One to continue pushing in an attempt to deliver the baby; that the respondent delayed the emergency C-section by refusing to call another physician; and that the respondent failed to appropriately respond to the patient's and baby's condition.

3. The Board presented expert testimony from Dr. David Hanson, who is Board Certified by the American Board of Family Practice and the American Board of Medical Examiners.

4. The respondent presented testimony of Dr. Michael E. Machen, who practices in Quinter, Kansas and who is also Board Certified in Family Practice.

5. According to the testimony of Dr. Machen, Patient Number One should have been able to deliver the baby in two pushes, since the patient was gravida three.

6. The allegation that the respondent failed to call another physician is incorrect. The record is clear that the respondent called another physician after the physician who had first been called failed to respond as quickly as the respondent would have liked.

Conclusions of Law

1. The Presiding Officer concludes, as a matter of law, that the respondent did not fail to meet the applicable standard of care.

2. The expert testimony presented by the respondent conflicts with the Board's expert testimony. The Presiding Officer has no basis to accord the Board's expert testimony more weight or credibility than the testimony of Dr. Machen. As such, the petitioner has not provided evidence that is clear and convincing that the respondent failed to meet the applicable standard of care, and therefore should be subject to discipline.

3. The Presiding Officer, in examining testimony of Dr. Hanson and Dr. Machen, finds that Dr. Hanson was operating on at least one piece of information that was incorrect. Dr. Hanson was of the belief that another surgeon was simply across the street from the hospital where the surgery was being performed. This was not the case.

4. Finally, while there was a delay in the surgeon arriving for the surgery, the evidence is not clear as to the extent of the delay. At what time should the second physician have been called? Within one minute after calling the first physician? Within five minutes? That is, how much time would have been saved by calling a second doctor to perform this surgery is unknown.

Count Two
Findings of Fact

1. Count Two of the petitioner's complaint deals with the respondent's care and treatment of a twenty-four year old pregnant woman, who presented herself to the Citizen's Medical Center on January 12, 2003, with complaints of back pain and experienced a small amount of bleeding on tissue paper.

2. Patient Number Two did have active bleeding and did not have any other complaints. The patient was examined by a nurse, who determined the patient had no active bleeding. Patient Number Two was treated for a urinary tract infection, after a urinary dipstick analysis was done.

3. The patient was seen by the respondent the following day at which time it was determined through a sonogram there had been fetal demise. Following delivery of the fetus, it was learned that the fetus had a diagnosis of Turner Syndrome and was not living at the time Patient Number Two presented herself to Citizen's Medical Center.

4. The Board again presented the testimony of Dr. Hanson regarding the issue of standard of care. The respondent again presented the testimony of Dr. Michael Machen concerning the issue of the standard of care.

5. While, Dr. Hanson was of the opinion that the applicable standard of care had not been met, Dr. Machen was of the opinion that the respondent met the applicable standard of care.

6. Dr. Hanson was of the opinion that the respondent's failure to go to the hospital to see Patient Number Two was a deviation from the applicable standard of care. Conversely, Dr. Machen was of the opinion that the respondent, in his care and treatment of Patient Number Two, did not deviate from the standard of care.

7. **(Confidential)**

8. **(Confidential)**

Conclusions of Law

1. The evidence presented to the Presiding Officer does not establish by a preponderance of the evidence that is clear and convincing that the respondent failed to meet the applicable standard of care.

2. While it is certainly clear from the testimony of Dr. Hanson (Confidential) that the better practice would have been for the respondent to personally evaluate Patient Number Two, from the testimony of Dr. Machen, the respondent met the applicable standard of care in his care and treatment of Patient Number Two.

Count Three
Findings of Fact

1. Count Three of the Board's petition deals with the respondent's care and treatment of Patient Number Three, a thirty-three year old pregnant female.

2. Patient Number Three was in an automobile accident on July 11, 2002, and thereafter presented to the Citizen's Medical Center in Colby. Following a vaginal exam and some monitoring of fetal heart tones by the respondent, the patient was discharged.

3. On July 28, 2002, the patient, who was an employee of Citizen's Medical Center, had complaints of bleeding and pain while at work.

4. Following an examination by the respondent, the patient was discharged from Citizen's Medical Center with instructions to go to Hays, Kansas. The patient was transported to Hays, Kansas by private vehicle. Soon upon the patient's arrival at Hays, she was admitted to the hospital and a cesarean section was performed. Marginal abruption was found at the time of the C-Section.

5. The Board alleges that the respondent failed the applicable standard of care in that he failed to adequately evaluate the patient following the motor vehicle accident; failed to adequately evaluate the patient for potential placenta abruption; and allowed the patient to be transported from Colby to Hays by private car.

6. In this case, Dr. Hanson provided his expert opinion that the respondent did not meet the applicable standard of care in the care of Patient Number Three. Conversely, Dr. Machen provided his expert testimony that the respondent met the applicable standard of care in his treatment of Patient Number Three.

Conclusions of Law

1. The petitioner has not shown by a preponderance of the evidence that is clear and convincing that the respondent failed to meet the applicable standard of care.

2. The evidence does not establish that the respondent failed to adequately evaluate the patient following the motor vehicle accident. The testimony of Dr. Hanson was

that there was a recommendation for 4 hours of continuous fetal heart monitoring following a motor vehicle accident. However, Dr. Machen testified as an expert that the respondent met the applicable standard of care. Further, the respondent did not fail to adequately evaluate the potential placental abruption, rather, the respondent directed the patient should go to the Hays office for that concern. Finally, while it may be argued that ambulance transportation of Patient Number Three would have been preferred to private car, the testimony of Dr. Machen confirms that the respondent met the applicable standard of care in this case.

Count Four
Findings of Fact

1. Count Four of the Board's petition involves the respondent's care and treatment of a twenty-two year old pregnant female. Patient Number Four was admitted to Citizen's Medical Center on April 22, 2002, at approximately 6:15 a.m. The patient's condition was followed throughout the day including reviews of the fetal heart tones. During the care and treatment of Patient Number Four, a Registered Nurse, who was monitoring the heart tones became concerned, and as a result had fetal heart tone strips faxed to the respondent. Between approximately 1:30 p.m. and 4:30 p.m., the nurse communicated with the respondent's office numerous times regarding her concerns with the fetal heart tones.

2. The care and treatment of Patient Number Four was reviewed by the Board's expert, Dr. Hanson, and by the respondent's expert, Dr. Machen. Dr. Hanson was of the opinion that the respondent did not adhere to the applicable standard of care because the respondent failed to immediately attend to her, and because the respondent did not order enough oxygen for the patient.

3. Dr. Machen testified conversely. Dr. Machen testified that the care provided to Patient Number Four by the respondent met the applicable standard of care.

4. The baby's APGAR scores were excellent.

Conclusions of Law

1. The respondent's care of Patient Number Four met the applicable standard of care.

2. The Board alleges the respondent failed to adequately address the patient's and the baby's condition. Testimony of Dr. Machen, as well as the APGAR score of the infant, clearly supports the position that the baby's condition was not impaired or stressed as a result of the respondent's care and treatment. Further, there is no clear evidence that the respondent in any way failed to meet the applicable standard

of care or that he failed to address Patient Number Four's condition or the baby's condition.

Count Five
Findings of Fact

1. The Board's petition in Count Five concerns the respondent's care and treatment of Patient Number Five, a pregnant female, twenty-four years of age. The expected delivery date for Patient Number Five was May 11, and she was scheduled to be induced for labor on May 15, 2003, at Hays, Kansas. Hays is approximately 110 miles from Colby.

2. In May 2003, the respondent did not have hospital privileges at Citizen's Medical Center in Colby.

3. Early in the morning of May 13, 2003, Patient Number Five went into labor. Patient Number Five was examined by the respondent at the respondent's office and was directed to go to Citizen's Medical Center in Colby for her delivery.

4. The respondent contacted a pediatrician to be present at the Citizen's Medical Center for the delivery of Patient Number Five's child. A locum tenens physician delivered Patient Number Five's infant. The respondent was present at Citizen's Medical Center throughout Patient Number Five's delivery. The pediatrician present at the request of the respondent was Dr. Raymond Kettering. Dr. Kettering is employed by the respondent. While there is an implication by some that Dr. Kettering was going to deliver Patient Number Five's child, there is not clear evidence of this. The delivering physician, Dr. Vogt, in his progress notes, said Dr. Kettering was present to attend the baby.

5. As in the previous counts, Dr. Hanson reviewed this case for the Board and Dr. Machen reviewed this case on behalf of the respondent. Again, Dr. Hanson found that the respondent deviated from the applicable standard of care, while Dr. Machen found that the respondent met the applicable standard of care.

Conclusions of Law

1. The respondent, in the care and treatment of Patient Number Five, met the applicable standard of care.

2. The Board alleges that since the respondent continued to treat patients, including Patient Number Five for pregnancy and prenatal care after his hospital privileges at Citizen's Medical Center had been revoked, that this was in violation of the applicable standard of care. There is no expert evidence as to this allegation.

While Dr. Hanson did express concerns regarding the respondent's treatment of Patient Number Five and how it might relate to medical ethics, Dr. Hanson did not give the opinion that the respondent's care of Patient Number Five fell below the applicable standard of care in that he continued to treat pregnant patients and provide them prenatal care without hospital privileges.

3. In Count Five, the Board also alleges that the respondent directed that a pediatrician (Dr. Kettering) should treat Patient Number Five during the labor and delivery. Again, while there is a suggestion of this, there is certainly no clear and competent evidence that this occurred. Indeed, as noted by Dr. Vogt, Dr. Kettering was present to provide care for the infant. That is what happened.

Count Six
Findings of Fact

1. Count Six of the Board's petition involves the respondent's care and treatment of Patient Number Six, a twenty-three year old pregnant female.

2. A sonogram done on Patient Number Six on October 18, 1996, showed a breech presentation of the baby. On November 14, 1996, a physical and pelvic examination of Patient Number Six again indicated a breech presentation, and therefore, a cesarean section was scheduled for November 15, 1996.

3. Dr. Fercha, who worked with the respondent, was scheduled to do the surgery.

4. Patient Number Six's C-Section bumped a previously scheduled outpatient colonoscopy.

5. There is an allegation by an operating room nurse that this was not a breech presentation.

6. Patient Number Six's case was reviewed on behalf of the Board by Dr. Hanson and on behalf of the respondent by Dr. Machen.

7. Dr. Hanson was of the opinion that the standard of care was not met in that the respondent subjected Patient Number Six to the risk of surgery when she may not have needed it. Dr. Hanson's opinion was based upon a belief that there was not a breech presentation.

8. Dr. Machen was of the opinion the standard of care was met with regard to Patient Number Six's care. Dr. Machen explained how a C-Section is performed and indicated that unless a nurse was in a certain position, the nurse would not be able to determine if it was a breech presentation or not. Dr. Machen testified that the

only person who knows where the baby is positioned when the surgeon reaches into the uterus, is the surgeon.

Conclusions of Law

1. The Board has not established by a preponderance of the evidence that is clear and convincing that the respondent failed to adhere to the applicable standard of care.

2. The Board argues that the respondent failed to adequately evaluate the position of the baby prior to the C-Section performed on Patient Number Six. This is in conflict with the medical records of Patient Number Six showing that she was examined by the respondent prior to the C-Section.

3. The Board also alleges that the respondent recommended an unnecessary C-Section. The operative report by Dr. Fercha clearly indicates that this was a necessary C-Section and that there was a breech presentation.

4. Finally, the Board alleges that the respondent caused a previous scheduled surgery to reschedule for Patient Number Six's C-Section. First, it is not known whose actions, whether the respondent's or Dr. Fercha's caused the previously scheduled colonoscopy to be "bumped." Second, Dr. Machen's testimony establishes that the C-Section, whether emergent or elective, takes precedence over a colonoscopy because of potential harm to the baby.

Count Seven
Findings of Fact

1. Count Seven of the Board's petition concerns Patient Number Seven, a sixty-seven year old male. Patient Number Seven had undergone a coronary artery bypass grafting at Presbyterian Saint Luke's Hospital in Denver. Approximately one week later, Patient Number Seven was found at his home as unresponsive and was transported by the Thomas County EMTs to Citizen's Medical Center.

2. Once at Citizen's Medical Center, the patient was placed on a ventilator and his condition stabilized. Patient Number Seven did not have a "do not resuscitate" directive in writing.

3. From the time Patient Number Seven arrived at Citizen's Medical Center, various family members of Patient Number Seven, including Patient Number Seven's wife, were present.

4. At the request of Patient Number Seven's family, the respondent was called to Citizen's Medical Center where he in conjunction with Dr. LaDonna Regier and

Bryan Unruh, Advance Registered Nurse Practitioner, stabilized Patient Number Seven's condition. Dr. Regier contacted Dr. Mark Landers at Presbyterian Saint Luke's Hospital in Colorado to discuss Patient Number Seven's condition. Dr. Landers performed the bypass surgery on Patient Number Seven.

5. The respondent discussed Patient Number Seven's condition with Patient Number Seven's family and thereafter a decision was made by the family to discontinue the ventilator.

6. Ultimately, Patient Number Seven's respiratory effect decreased and Patient Number Seven died.

7. The Board presented expert testimony from Dr. Hanson concerning the respondent's care and treatment of Patient Number Seven. The respondent presented expert testimony from Dr. Joseph Rainwater, a cardiologist with Aurora Denver Cardiology Associates. Dr. Rainwater formerly practiced with Dr. Mark Landers, and Dr. Rainwater is board certified in internal medicine and cardiology.

8. The family of Patient Number Seven did not want Patient Number Seven transported back to Denver for additional treatment.

9. Dr. Hanson was of the opinion that the respondent did not meet the applicable standard of care in removing Patient Number Seven from the ventilator and not transporting Patient Number Seven to Denver. Conversely, Dr. Rainwater was of the opinion that the respondent met the applicable standard of care in this case and treatment of Patient Number Seven.

Conclusions of Law

1. The petitioner has not established by a preponderance of the evidence that is clear and convincing that the respondent did not meet the applicable standard of care.

2. The petitioner in its complaint alleges that the respondent failed to adequately advise the family of treatment options so they could make an important decision. There is no evidence that the respondent failed to adequately advise the patient's family of treatment options.

3. The petitioner alleges that the respondent ordered the discontinuation of the ventilator when the patient did not have a do not resuscitate order, when the patient had pulse and blood pressure, and was responding to pain while stabilized on the ventilator. The petitioner's allegation that Patient Number Seven responded to pain is contrary to the expert opinion of Dr. Rainwater. Dr. Rainwater characterized Patient Number Seven's movement as agonal posturing.

4. Dr. Hanson's testimony concerning Patient Number Seven deals to a good degree with the process of stabilizing Patient Number Seven so that he could be transferred to Denver. If this indeed was the family's wishes to transport the patient to Denver, then Dr. Hanson's opinion might very well trump Dr. Rainwater's opinion. However, there is no evidence in the record that the family would consent to a transfer to Denver. The record is clear that the family would not have consented to a transport to Denver.

Count Eight
Findings of Fact

1. Count Eight of the Board's petition alleges that the respondent signed blank progress notes in hospital charts of patients that were seen by other practitioners. The respondent identifies three progress notes, one signed by a physician's assistant and two others signed by a Dr. Jennings, who was a third year resident being sponsored by the respondent.

2. The respondent introduced exhibits into the record establishing that Dr. Hildyard signed blank progress pages before the progress notes had been added to the charts.

3. The respondent does not deny signing progress pages before the progress notes were attached.

Conclusions of Law

1. The petitioner has established by a preponderance of clear and convincing evidence that on these three occasions the respondent had unprofessional conduct as defined by K.S.A. 65-2836(d) in that the respondent's signature on a blank progress page before the progress note was attached was deceptive from the standpoint it could easily deceive an individual reviewing the chart that Dr. Hildyard approved of the dictation note.

2. The respondent argues that at times he would hear the dictation by the practitioner and therefore signing the chart without the progress notes attached should be acceptable. This argument is rejected since although the dictation from the practitioner may be correct, it is unknown whether the dictation that is transcribed by the medical record records staff comports with the dictation of the practitioner.

3. The respondent also argues that even if he presigned notes, he would later review the notes to make sure they were correct. Again, without deciding whether this is true or not, other individuals had to rely upon the progress note before the respondent had an opportunity to review them. Inaccurate information could be

passed on to other medical providers if they relied upon inaccurate notes. The Board has established a violation of K.S.A. 65-2836(b).

Count Nine
Findings of Fact

1. In Count Nine of Board's petition, the Board alleges that the respondent made derogatory, insulting, and unprofessional comments regarding Patient Number Eight to a hospital staff member.

2. Patient Number Eight was a pregnant female under the respondent's care. An ultra sound was performed which showed a nonviable fetus.

3. Hospital staff contacted the respondent concerning Patient Number Eight and advised that Patient Number Eight was tearful.

4. The respondent replied to the hospital staff, Patient Number Eight, "Should have spent more time trying to keep herself pregnant instead of trying to pull my fucking license. She should be crying and sad, I was when she was trying to pull my fucking license."

5. The respondent does not recall making this statement to a hospital staff member but he does not deny making this statement.

Conclusions of Law

1. The Board has established by a preponderance of the evidence that is clear and convincing that the respondent committed an act in violation of K.S.A. 65-2836(b) in that the respondent's behavior concerning Patient Number Eight was dishonorable and unprofessional.

Count Ten
Findings of Fact

1. Count Number Ten of the Board's petition alleges that the respondent, on two occasions, dictated inappropriate remarks into patient records.

2. The first instance where the Board alleges the respondent dictated unprofessional and disparaging remarks involves the care and treatment of Patient Number Nine. Patient Number Nine's mother is the respondent's head nurse and the remarks made by the respondent referred to Patient Number Nine's mother.

3. The respondent did not intend for the statements regarding his head nurse to be charted in Patient Number Nine's medical chart. The respondent did not believe the transcription machine was on at the time he made the statements. Patient Number Nine's mother did not believe the dictating machine was on at the time the statement was made.

4. When the transcription was received by the medical records department, the medical records department typed both the note as dictated and a version which did not contain the respondent's remarks concerning Patient Number Nine's mother.

5. The respondent was never contacted by anyone from the medical records department or anyone else from Citizen's Medical Center regarding the dictation.

6. In the second incident, the respondent, in dictation concerning Patient Number Ten's medical records, made comments regarding the inadequacy of staffing in the radiology department of the hospital. The respondent's statement contained in Patient Number Ten's record includes the following, "Helical CT was undertaken and found to be suboptimal due to inadequate staffing on the part of the radiology department."

Conclusions of Law

1. In the case involving Patient Number Nine, the petitioner has not established by a preponderance of evidence that is clear and convincing that the respondent acted in an unprofessional or dishonorable manner. With regard to the respondent's statements concerning Patient Number Ten, the petitioner has established by a preponderance of clear and convincing evidence that the respondent's conduct was unprofessional and/or dishonorable.

2. The count concerning Patient Number Nine's mother, while perhaps bothersome to others in Citizen's Medical Center, was clearly friendly banter between the respondent and his nurse. The tape of this dictation was heard at the hearing and it is clearly done in a joking and playful manner. While the others may not see humor in it, the Presiding Officer does not conclude that this was either unprofessional or dishonorable in that the respondent did not expect this to be transcribed. Additionally, one factor that is somewhat troubling concerning this is that the administrator of Citizen's Medical Center would speak to other physicians when they would make inappropriate dictation and that in the administrator's words, he would tell them to "knock it off." In this case, the respondent was never contacted about this dictation, was never asked whether he indeed wanted it to be transcribed, was not informed that it had even been transcribed until this action was filed.

3. With regard to the respondent's dictation in Patient Number Ten's medical records, the dictation does constitute unprofessional and/or dishonorable conduct. While the

respondent may have legitimate concerns and/or complaints concerning the radiology department of Citizen's Medical Center, Patient Number Ten's record is not the proper place for lodging those complaints.

Count Eleven
Findings of Fact

1. The Board's petition in Count Eleven alleges that the respondent used profanity in the presence of hospital staff and patients, referred to female staff members as bitches and/or cunts, made sexually explicit comments, and statements containing sexual innuendos, engaged in inappropriate sexual gestures, sexual comments and inappropriate physical touching. Additionally, the petition alleges that the respondent engaged in inappropriate, sudden and unpredictable outbursts of anger, frustration, and abusive and profane language in front of subordinates and patients.

2. The examination of the record in this case clearly establishes that the respondent on frequent, if not on daily occasions, used profane words, such as fuck and bitches, in the presence of hospital staff and others. The record clearly establishes that the respondent asked co-workers if a certain individual would be "fuckable" and so forth. The respondent referred to other physicians not associated with his clinic as "twiddle dee and twiddle dumb." The respondent made sexually related statements to hospital staff regarding use of the staff for sexual gratification.

Conclusions of Law

1. The respondent has established by a preponderance of the evidence that is clear and convincing that on numerous and frequent occasions the respondent acted in an unprofessional and dishonorable manner in violation of K.S.A. 65-2836(a).

Count Twelve
Findings of Fact

1. **(Confidential)**

2. The fact surrounding Count Twelve of the petition relate and rely upon an investigation and hearing conducted by Citizen's Medical Center in Colby that led to the respondent losing his privileges at Citizen's Medical Center.

3. **(Confidential)**

4. **(Confidential)**

5. Patient Number Eleven testified at the revocation hearing as well as at this hearing. Patient Number Eleven's allegations that led to the revocation of the respondent's license are not credible. Patient Number Eleven has made the allegations, recanted the allegations, made the allegations again, recanted the allegations again, and made the allegations again. Additionally, various stories told by Patient Number Eleven change over time.

6. **(Confidential)**

7. **(Confidential)**

8. **(Confidential)**

Conclusions of Law

1. **(Confidential)**

2. **(Confidential)**

(Confidential)

3.

4. **(Confidential)**

5. **(Confidential)**

6. **(Confidential)**

7. **(Confidential)**

8. **(Confidential)**

9. **(Confidential)**

10. Because the Presiding Officer does not believe that the action taken by Citizen's Medical Center is supported by the evidence in its revocation of the respondent's clinical privileges, the Presiding Officer does not believe that it can be the basis for discipline in this case.

Count Thirteen Through Nineteen
Findings of Fact

1. Count Thirteen of the Board's petition involves the treatment of Patient Number Twelve. Patient Number Twelve was seventy-three years old and suffered from asthmatic bronchitis, chronic obstructive pulmonary disease, enlarged prostate, peripheral edema, hypertension, gout, diabetes, and degenerative arthritis.

2. From 2000 to 2002, the respondent administered approximately forty-three intramuscular injections of corticosteroids to Patient Number Twelve.

3. Count Fourteen of the Board's petition involves the treatment of Patient Number Thirteen. Patient Number Thirteen was a sixty-two year old and was being treated for cervical disease, osteoarthritis of the spine, heart disease, gastritis, colitis, and neurological damage as a result of a stroke.

4. From 2000 to 2001, Patient Number Thirteen received approximately thirty-eight intramuscular injections of corticosteroids under the direction of the respondent.

5. Count Fifteen of the Board's petition involves the treatment of Patient Number Fourteen. Patient Number Fourteen was eighty years old with a history of dermatitis, sinusitis, bronchitis, fatigue, pneumonia, hypertension, osteoarthritis, heart disease, breast cancer, and chronic obstructive pulmonary disease.

6. Between 2000 and 2004, Patient Number Fourteen received approximately thirty intramuscular injections of corticosteroids under the respondent's direction.

7. Count Sixteen of the Board's petition involves the treatment of Patient Number Fifteen. Patient Number Fifteen was fifty-five years old and suffered from mental retardation, cerebral palsy, diverticulosis, hypertension, osteoarthritis, and degenerative back pain, esophagitis, gastritis, cirrhosis, and congestive heart failure.

8. Thirty-three injectable corticosteroids were administered to Patient Number Fifteen by the respondent between 2000 and 2004.

9. Count Seventeen of the Board's petition involves the treatment of Patient Number Sixteen. Patient Number Sixteen was a seventy-seven year old patient who suffered from hypertension, osteoarthritis, diverticulosis, reflux, malabsorption, atrial fibrillation, heart disease, hyperlipidemia, and anemia. Patient Number Sixteen also had a history of gastro intestinal bleeding.

10. Patient Number Sixteen received forty-two intramuscular injections of corticosteroids, between 2000 and 2004.

11. Count Eighteen of the Board's petition involves the treatment of Patient Number Seventeen. Count Patient Number Seventeen had history of chronic lung disease, osteoporosis, and osteoarthritis, depression and various functional gastrointestinal intestinal difficulties.

12. This seventy-two year old patient received approximately forty-four intramuscular injections of corticosteroids between 2000 and 2003. Patient Number Seventeen also received narcotic injections from the respondent.

13. Count Number Nineteen of the Board's petition involves the treatment of Patient Number Eighteen. Patient Number Eighteen had asthma, diabetes, obesity, degenerative lumbar disc disease, gastroesophagus reflux disease, irritable bowel syndrome, hyperlipidemia , hyperthyroidism, and retardation.

14. Patient Number Eighteen, was forty-two years of age and between 2000 and 2004, received approximately eighty-six intramuscular steroid injections at the direction of the respondent.

15. Dr. Thomas Simpson testified on behalf of the Board regarding Counts Thirteen through Nineteen. Dr. Simpson is Board certified in Family Practice.

16. Dr. Michael Machen again testified on behalf of the respondent concerning Counts Thirteen through Nineteen.

17. There is no definitive literature or guidelines that establishes the maximum number of intramuscular corticosteroids injections per patient. The injection of corticosteroids is patient specific.

18. Dr. Simpson believed that the respondent deviated from the applicable standard of care in the treatment of these patients by over utilization of injectable corticosteroids and in the case of Patient Number Seventeen the narcotic injections.

19. Dr. Machen reviewed each of the respondent's patient charts concerning these patients and concluded, based upon their specific medical conditions and needs, that the respondent's treatment of these patients fell within the applicable standard

of care. Dr. Machen acknowledged that there were side effects and potential harmful effects by use of injectable corticosteroids; however, Dr. Machen explained that in these type of patients the corticosteroids injections were necessary to simply allow the patients to continue daily functioning.

Conclusions of Law

1. The evidence presented to the Presiding Officer fails to establish by a preponderance of the evidence that is clear and convincing that the respondent failed to meet the applicable standard of care.

2. The Board alleges that the respondent used injectable corticosteroids without trying other treatment options, that the respondent used injectable doses of steroids instead of the oral steroids, and that the number of injections administered by the respondent was excessive which led, in some cases, to steroid dependency.

3. The respondent's use of steroids was dictated by the needs of the respondent's patients. While it certainly appears that these patients required more injectable corticosteroids use than other patients, Dr. Machen explained their treatment was patient specific. The treatment was required by the individual's particular medical condition.

Conclusions

1. A variety in individuals testified at the hearing of this matter regarding the care and treatment of the various patients. All testimony and exhibits have been reviewed and considered. However, as to the cases involving a determination of whether the applicable standard of care was met, the Presiding Officer relies heavily upon the testimony of Dr. Hanson, Dr. Simpson, Dr. Machen, and Dr. Rainwater. First, these are the experts both sides called. Second, none of these four doctors are part of the Colby medical community and are therefore removed from the controversy concerning the respondent.

2. First, turning to the allegations of the Board concerning the respondent's failure to adhere to the applicable standard of care, both sides presented credible evidence concerning their relative positions. The questions that the Presiding Officer must ask is whether there is a compelling reason to give the Board's medical expert more credibility than the respondent's; Is there something in the testimony of the Board's experts that leads the Presiding Officer to conclude that the respondent deviated from this standard of care and to discount the opinion of the respondent's experts?; Did the respondent's experts rely upon incorrect information?; Are the respondent's experts biased or prejudiced?; Do the respondent's experts lack the necessary

training, education, and experience to render a valid opinion? The answer to all of these questions is "no."

3. The Presiding Officer has reviewed all expert opinions in this case and has analyzed whether there is any compelling reason to accept the Boards evidence as superior or more persuasive than the respondent's. The Presiding Officer concludes that there is no reason to accept the opinions of Dr. Hanson and Dr. Simpson over those expressed by Dr. Machen and Dr. Rainwater. Therefore, a conclusion may not be reached that the respondent has failed to meet the applicable standard of care with regard to the medical issues.

4. **(Confidential)**

5. **(Confidential)**

(Confidential)

6. The Board has established that the respondent has violated provisions of the Healing Arts Act in Counts Number Nine, Ten, and Eleven. For these violations, the Presiding Officer publicly censures the respondent. The respondent is admonished that his behavior as outlined in these counts was unprofessional and dishonorable to the profession. Such behaviors are not acceptable behavior for a physician licensed by the Kansas Board of Healing Arts.

7. With regard to the remaining counts, the Presiding Officer concludes that it has not been established by the preponderance of clear and convincing evidence that the respondent violated the Healing Arts Act; and therefore, these counts are dismissed.

Pursuant to K.S.A. 77-527, either party may appeal this initial order. A petition for review must be filed within 15 days from date of this initial order. Failure to timely request review may preclude further judicial review. If neither party requests a review, this initial order becomes final and binding on the 30th day following its mailing. Petitions for review shall be mailed or personally delivered to: Lawrence T. Buening, Jr., Executive Director, Kansas Board of Healing Arts, 235 S. Topeka Blvd., Topeka, KS 66603.

Edward J. Gaschler
Presiding Officer

CERTIFICATE OF SERVICE

On Jan 27, 2006, I mailed by U.S. mail, a copy of this initial order to:

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