BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
	)	
DAVID B. KEMP, M.D.	)	**Docket No. 04-HA-32**
Kansas License No. 4-29504	)	**05-HA-61**
	)	

FINAL ORDER

NOW ON THIS 10th Day of December 2005, this matter comes before the Board to review the Initial Order issued by Roger D. Warren, M.D., Presiding Officer. Respondent David B. Kemp, M.D. appears in person and through Thomas E. Wright. Petitioner appears through Kelli J. Benintendi Stevens, Litigation Counsel.

After hearing the arguments of the parties, and having the agency record before it, the Board adopts the findings of fact and conclusions of law as stated in the Initial Order as the findings of fact and conclusions of law of the Board, and as appears below. The Board adopts the order as stated in the Initial Order with modifications as appears below.

A. Background

1. The respondent was issued a permanent license to practice medicine and surgery in the state of Kansas on February 23, 2002.

2. Prior to granting Respondent a license, Respondent's application was denied due to six medial liability claims settled against him since 1990. Four of those claims involved allegations of negligence for patient injuries which occurred while Respondent performed gynecological surgeries.

3. A Petition for Reconsideration and an offer of settlement ensued and the Board granted Respondent a license to practice medicine and surgery on November 20, 2001 with conditions, in part, to remain in place for twenty-four months:

> "Applicant shall have his surgical practice monitored by an independent physician monitor, which shall be approved by the Board's designee, Howard Ellis, M.D.

"The monitor will randomly choose five patient surgical charts every four months to review and submit monitoring reports to Board staff. The monitoring reports shall be on a form provided by Board staff and must include an assessment of each patient surgical chart reviewed indicating whether Applicant's performance of surgery and associated treatment of each patient is within that level of care, skill and treatment which is recognized by a reasonable prudent practitioner as being acceptable under similar conditions and circumstances;

"The monitor must immediately notify Board staff if the monitor finds any patient case where he reasonably believes Applicant may have been negligent or otherwise acted outside the standard of care in the performance of surgery or other associated treatment of a patient; and

"Each monitoring report shall be due within thirty days of the conclusion of each four-month period. Applicant shall be responsible for ensuring the timely submission of the monitor's reports to Board staff."

4. Joseph Bosiljevac, M.D., Surgery Section Chief for Newman Regional Health (NRH), was the appointed monitor from the November 21, 2001 Final Order.

5. Dr. Bosiljevac wrote a letter to Board counsel in June of 2003 notifying the Board that Respondent had five patient charts that fell out of the quality assurance and risk management criteria at Newman Regional Health. Several of Respondent's patients returned to the Operating Room (OR) for postoperative bleeding and seven of Respondent's surgical patient cases were subject to peer review.

6. Petitioner alleges that Respondent practiced the healing arts below the standard of care by ordering Toradol preoperatively. There is no dispute that Respondent ordered Toradol preoperatively in the seven surgeries described in the first Petition. It is also undisputed that Respondent no longer uses Toradol.

7. The Presiding Officer is member of the State Board of Healing Arts, licensed to practice medicine and surgery, and actively practices surgery. While basing the findings of fact upon the evidence in the record, the Presiding Officer also relies upon his own professional expertise to understand the evidence and to determine whether violations of the healing arts act have occurred.

8. The facts regarding Toradol are not generally disputed. The Physicians' Desk Reference (PDR) for 2002 has a "black box warning" by the U.S. Food and Drug Administration (FDA) for Toradol. In part, it reads, "Toradol is contraindicated as a prophylactic analgesic before any major surgery. It is contraindicated inter-operatively when hemostasis is critical because of increased risk of bleeding."

9. Toradol is most often used for pain relief. It is a non-steroidal, anti-inflammatory medicine that is unique because of its intravenous form. Toradol is often used in place of narcotics. The greatest concern for side effects with Toradol occurs in the operative setting regarding the ability to stop bleeding. Toradol inhibits platelet aggregation and increases bleeding time. The Presiding Officer considers the risk of excessive bleeding in light of the benefits to using Toradol. The Presiding Officer does not find that excessive postoperative bleeding is a certainty when Toradol is used, or that administering Toradol preoperatively in gynecological surgeries is *per se* a deviation from the standard of care. The Presiding Officer does find and conclude that when using Toradol in major gynecological surgeries, the surgeon must exercise a higher degree of judgment and due care in accounting for and addressing bleeding sources.

10. After this proceeding was initiated, Respondent agreed to an evaluation at the Center for Personalized Education for Physicians. He completed that evaluation in September 2004. The CPEP report states that the evaluators found flawed clinical judgment and reasoning with important gaps in medical knowledge. Additionally, his documentation was not supported by operative findings or pathology reports. Additionally, the documentation lacked important information.

B. Docket No. 05-HA-32

Patient 1

11. In Count I of the Petition, the Board alleges that Respondent performed below the standard of care by continually ordering Toradol. In count one, the Board alleges that Respondent performed below the standard of care by ordering Toradol preoperatively and by continuing to order Toradol postoperatively when Patient 1 returned to surgery from hypotension and bleeding sources that were discovered. Additionally, count one alleges that Respondent failed to sufficiently document Patient 1's History and Physical (H&P) and progress notes.

12. Patient 1 was admitted to NRH for surgery on October 11, 2002. Respondent performed a laparoscopic assisted vaginal hysterectomy (LAVH) with bilateral salpingo-ophorectomy (BSO). Respondent ordered Toradol 30 mg IV to be given preoperatively in the holding area, and again in the same dosage in the operating room. Patient 1 had blood loss of 650 cc during the LAVH and BSO surgery. Respondent ordered Toradol to be given at 30 mg IV every six hours postoperatively.

13. Patient 1 became hypotensive following surgery and was returned to surgery. Respondent performed a laparotomy with repair of epigastric vessel lacerations and vaginal cuff bleeding. The patient had an estimated blood loss of 2000cc and received four units of packed red blood cells. The sources of bleeding included an arterial injury on the placement of the laparoscopic port and the vaginal cuff. Patient 1's

preoperative outpatient hemoglobin was 14.2 and it was 6.5 prior to the start of the second surgery.

14. Respondent ordered Toradol 30 mg IV every six hours upon Patient 1's admission to the Intensive Care Unit on October 11, 2002.

15. Following the second surgery, Respondent ordered the continuation of Toradol 30 mg IV four times a day on October 12, 2002, and as needed on October 13. The patient's hemoglobin was 8.2 on October 14. In total, Patient 1 received six units of blood.

16. Dr. Bradley testified that Respondent's preoperative and postoperative care was below the standard of care. The Presiding Officer finds that the testimony of Dr. Bradley is credible and persuasive. Respondent's preoperative order for Toradol required him to use greater care in managing bleeding. The Presiding Officer finds that Respondent failed to manage the bleeding appropriately. During that time when the patient was receiving blood transfusions for bleeding, Respondent continued to order a drug that is known to increase bleeding by inhibiting platelet aggregation. In doing so, Respondent failed to meet the standard of care to a degree constituting ordinary negligence.

17. Dr. Bradley testified that Respondent's documentation in Patient 1's H&P was outside the standard of care because Respondent did not indicate that Patient 1 took any medications, had any allergies, smoked, wore dentures, or suffered from chemical and IV drug abuse. A preoperative nursing intake was performed for Patient 1 on October 12, 2002, which indicated that Patient 1 had wheezes in her right lung, suffered from a smoker's cough, used an Advair inhaler, and had a history of alcohol and chemical abuse.

18. Respondent placed an operative port injuring an inferior epigastric artery. The course of the inferior epigastric artery is anatomically predictable. Respondent knew or should have known that one of the operative ports was placed in close proximity to the inferior epigastric artery and he should have observed both the entry of the port into the abdomen and its removal. No mention of such observation is in the operative record of October 11. Additionally, Respondent did not make note of the number of ports or the number of incisions in the abdomen.

19. Also in regard to the first surgery on October 11, the Anesthesia Report indicated that Patient 1 had blood loss of 2000 cc and was given four units of packed red blood cells whereas the Operative Report showed 1000 cc blood loss.The Presiding Officer finds that the testimony of Dr. Bradley is credible and persuasive and that Patient 1's H&P and progress notes were difficult to follow and incomplete. Respondent failed to keep adequate medical records with regard to Patient 1.

Patient 2

20. The Board alleges in Count II of the Petition that Respondent performed below the standard of care with regard to Patient 2 by using Toradol preoperatively and again postoperatively when Patient 2 returned to the OR for bleeding, and additionally four days later when Patient 2 went to the Emergency Room (ER) for chronic blood loss. In addition, the Board alleges that Respondent failed to sufficiently document Patient 2's H&P and progress notes.

21. On May 19, 2003, Respondent admitted Patient 2 to NRH to treat dysmenorrhea, pelvic pain and high-risk endometriosis. Respondent ordered Toradol to be given at 30 mg IV preoperatively to Patient 2. Respondent performed a diagnostic laparoscopy with laser vaporization of endometriosis and a laparoscopic uterosacral nerve ablation (LUNA). During the surgery, Respondent injured an artery in the rectus muscle. This complication would have been less likely if Respondent had directly observed the removal of that laparoscopic port. Again, the absence of any mention of such observation makes the conclusion more tenable that Respondent conducted that portion of the procedure without due care.

22. Patient 2 returned to surgery later that same day with a preoperative diagnosis of postoperative hypotension and pelvic pain. Respondent performed a diagnostic laparoscopy with mini-laparotomy and evacuation of suprapubic hematoma. Estimated blood loss was 300cc. The source of bleeding was an artery in the rectus muscle injured by the placement of a laparoscopic port. Respondent ordered Toradol to be given at 30 mg IV every six hours as needed. Patient 2 was discharged on May 20, 2003.

23. On May 22, 2003, Patient 2 called Respondent's office with a complaint of a fever of 102.5 degrees Fahrenheit, nausea, and vomiting. Respondent ordered Levaquin to treat a urinary tract infection. Two days later, Patient 2 went to the Emergency Room with complaints of dizziness, paleness, lips discolored to white, lower abdomen pain, and a reported temperature of 101 degrees Fahrenheit. Her hemoglobin was 7.8 and her temperature taken in the ER was 100.6 degrees Fahrenheit. Respondent ordered that Toradol be given to Patient 2 in the ER and thereafter every six hours as needed at a dose of 15 mg IV. Patient 2 received IV fluids for re-hydration and had blood work taken.

24. Dr. Bradley expressed concern that Respondent handled Patient 2's fever via the phone and prescribed an antibiotic without a real diagnosis only two days post operation.

25. The Presiding Officer finds that the testimony of Dr. Bradley is credible and persuasive. When Respondent ordered Toradol preoperatively, he owed a higher degree of care to manage bleeding. When Patient 2 returned to the OR for bleeding, Respondent again had that greater responsibility to manage the bleeding. The failure to adequately manage the bleeding resulted in Patient 2 going to the ER for chronic blood

loss. Though Dr. Bradley did not specifically state that Respondent deviated from the standard of care regarding Patient 2's fever and how Respondent handled this over the phone by prescribing an antibiotic without a real diagnosis two day post operation, the Presiding Officer is able to make the necessary findings based upon Dr. Bradley's and Respondent's testimony, and relying upon the Presiding Officer's expertise as a physician. The Presiding Officer finds that Respondent deviated from the standard of care concerning Patient 2's fever following the first operation.

26. Dr. Bradley also testified that Respondent's H&P for Patient 2 were not adequate. The record did not indicate that Patient 2 recently was a smoker, and the documentation listed no medications, allergies, or social history. Only one vital sign was listed, blood pressure.

27. Dr. Bradley also stated that Respondent failed to write the time down on his progress notes. The office visit note from May 14, 2003 did not indicate what occurred during the remainder of the exam. Additionally, the blood pressure results written on the May 16, 2003 H&P referenced the May 14, 2003 office visit note but nothing was written on that note regarding blood pressure. Two operative notes from the May 19, 2003 surgery existed and but no dismissal note was written. The Presiding Officer finds that the testimony of Dr. Bradley is credible and persuasive, and that Respondent failed to keep adequate patient records.

Patient 3

28. The Board alleges in Count III that Respondent performed below the standard of care with regard to Patient 3 by ordering Toradol preoperatively to major gynecological surgery, and postoperatively when Patient 3 returned to the hospital for a suspected hematoma. In addition, the Board alleges that Respondent failed to sufficiently document Patient 3's H&P, office visit, and operative report, which also do not correlate to one another.

29. On April 11, 2003, Respondent admitted Patient 3 for surgery to treat pelvic pain, sacral fixation and severe dyspareunia with suspected endometriosis. Respondent ordered Toradol to be given at 30 mg IV preoperatively. Respondent then performed a diagnostic laparoscopy, LAVH, and lysis of adhesions. Postoperatively, Respondent ordered Toradol to be given at 30 mg IV every six hours.

30. Patient 3 was discharged on April 13, 2003. At the time of discharge, the patient had a temperature of 101.5 degrees Fahrenheit and told to call if the fever got over 101 degrees Fahrenheit. Dr. Bradley was troubled that Patient 3 was dismissed with this temperature. Patient 3 had the 101.5 fever at 8:00 a.m. The patient record indicates that Respondent signed the discharge order on April 13, but he did not enter the time of the order, and he dictated the discharge summary at 9:08 a.m., noting a fever. The nurse received the discharge order at 9:35 a.m., and the patient was then discharged about an hour later.

31. Respondent said that he would never discharge a patient with a 101.5-degree fever and that he did not know that Patient 3 was discharged with a 101.5-degree fever. The Presiding Officer finds that Respondent was not aware that the patient had the 101.5 degree fever when he ordered the patient's discharge. The Presiding Officer further finds that the information regarding the fever was available, and that Respondent should have known this information. While there might have been a responsibility on the system to prevent the patient's discharge with the fever, this responsibility is shared with the physician. The Presiding Officer finds that Respondent failed to adhere to the standard of care in discharging the patient with the fever.

32. Four days later, on April 17, 2003, Patient 3 went to Respondent's office with pain in her right chest, deep breathing and a low-grade temperature. Respondent gave Patient 3 antibiotics for the suspected low-grade pneumonia.

33. On April 19, 2003, Patient 3 went to the ER with pale lips, difficulty breathing, right upper quadrant pain, and a temperature of 99.4 degrees Fahrenheit. Her hemoglobin was 8.1. Patient 3 was dismissed from the ER. On April 23, 2003, the patient went to Respondent's office where Respondent diagnosed her with the flu.

34. Patient 3 called Respondent's office on April 24, 2003, and discussed seeing Respondent due to an increased temperature and informed Respondent that he had not checked her vaginal area in two weeks.

35. Patient 3's primary care doctor performed an abdominal and pelvic CT, which showed a nine-centimeter, fluid-filled mass on the pelvic CT. On April 29, 2003, Patient 3 went to Respondent's office and stated that she had a possible hematoma identified via ultrasound.

36. Respondent admitted Patient 3 to the hospital on April 30, 2003, and performed a diagnostic laparoscopy and drainage of a pelvic cuff hematoma. Respondent ordered Toradol to be given postoperatively at 30 mg IV before surgery. Respondent ordered Toradol to be given at 30 mg IV every six hours. Patient 3 was discharged on May 1, 2003.

37. Patient 3 went to the ER on May 9, 2003, with a fever, which she had the past two days, pain in the right side of her lower abdomen, and difficulty breathing.

38. Dr. Bradley expressed concern regarding Respondent's postoperative care of Patient 3, specifically the follow-up concerning Patient 3's fever and hemoglobin drop. Dr. Bradley testified it is below the standard of care to order Toradol before major gynecological surgery when there is a possible hematoma. He also testified that to follow-up with Toradol after major gynecological surgery for a hematoma violates the standard of care.

39. The Presiding Officer finds that the testimony of Dr. Bradley is credible and persuasive and that the Respondent violated the standard of care by prescribing Toradol postoperatively following a hematoma. Though Dr. Bradley did not specifically state that Respondent deviated from the standard of care in terms of Patient 3's postoperative and follow-up care, the Presiding Officer is able to make findings based upon Dr. Bradley's and Respondent's testimony, and relying upon the Presiding Officer's expertise as a physician. The Presiding Officer finds that Respondent deviated from the standard of care regarding Patient 3's postoperative and follow-up care.

40. The H&P for Patient 3 indicated a complete examination occurred but this could not be correlated to an office visit. The H&P lists Patient 3's blood pressure at 110/80 but there is no correlating blood pressure documentation in Respondent's office record. Respondent's office visit notes only document a pelvic exam and there is nothing in Respondent's progress notes regarding Patient 3's fever and why she was discharged with a fever. Respondent's operative report for the April 30, 2003 surgery does not indicate that a source of bleeding was found.

41. Dr. Bradley expressed concern about Respondent's record keeping regarding Patient 3, which he did not specifically say were below the standard of care. Dr. Bradley did not comment on Respondent's documentation in the progress notes for the second admission of Patient 3.

42. The Presiding Officer finds that the testimony of Dr. Bradley is credible and persuasive and that Respondent failed to keep medical records regarding Patient 3 accurately describing the patient's history and pertinent findings, and that the records lacked detail and correlation.

Patient 4

43. The Board alleges in Count IV that Respondent performed below the standard of care by ordering Toradol preoperatively and perioperatively, and by continuing to order Toradol postoperatively after Patient 4 had three surgeries, two of which were because of bleeding. Additionally, the board alleges that Respondent failed to sufficiently document Patient 4's office notes, H&P, and postoperative note after the second return to surgery.

44. Patient 4 arrived at NRH for surgery to treat symptomatic pelvic floor descensus on December 16, 2002. The hospital record establishes that Toradol was to be given at 30 mg IV preoperatively. The record does not disclose who ordered the drug, and no inference against Respondent is made. Respondent does not know who ordered Toradol to be given preoperatively. Respondent performed an enterocele repair with sacrospinous ligament suspension and posterior colporrhaphy. Toradol was ordered for Patient 4 perioperatively at 30 mg IV and postoperatively every six hours times three at a dose of 30 mg IV. Patient 4 experienced bleeding after the surgery and Respondent ordered that Toradol be continued at 30 mg IV every six hours.

45. On December 17, 2002, Patient 4 told Respondent that she thought she had a possible hematoma forming. The nurse later reported a gush of vaginal bleeding after the packing was removed and also informed Respondent that a possible hematoma was forming. Patient 4 was dismissed. That evening the patient called Respondent regarding the pain she was experiencing. Respondent instructed Patient 4 to take a warm bath. Patient 4 saw blood "running out of her." She went to the ER where she was seen by Respondent. He ordered Toradol to be given preoperatively at 30 mg IV. At 2145 on December 17, 2002, Respondent made an incision and removed the hematoma.

46. Dr. Bradley testified that it was below the standard of care for Respondent to order preoperative Toradol before Patient 4's return to surgery for bleeding. The Presiding Officer finds that Respondent owed a high duty of care to manage the patient's bleeding when Toradol had been administered pre- and perioperatively. Respondent failed to meet that duty.

47. At 0230 on December 18, 2002, a nurse informed Respondent that Patient 4 was bleeding. Patient 4 was returned to surgery for bleeding and another hematoma was removed. Post surgery, Respondent ordered Toradol to be given at 30 mg IV every six hours and the time of the order was not written down. Patient 4's postoperative hemoglobin was 6.3, and on December 19, 2002 it was 7.9.

48. Patient 4 subsequently asked to be seen by Dr. James Barnett, M.D. He ordered a CT scan, which showed a small hematoma.

49. Dr. Bradley testified that Respondent deviated from the standard of care by again ordering Toradol for Patient 4 after three surgeries, two of which were for bleeding. Dr. Bradley testified that a reasonable physician knows that a non-steroidal drug can increase bleeding.

50. The Presiding Officer finds that the testimony of Dr. Bradley is credible and persuasive. The Presiding Officer finds that Patient 4 received Toradol preoperatively. The record does not clearly disclose who ordered the drug. Based on the testimony of Dr. Bradley, the Presiding Officer finds that Respondent's continued use of Toradol for Patient 4 after three surgeries, two of which were for bleeding, deviates from the standard of care.

51. The H&P dictated for Patient 4 did not mention that Patient 4 had Multiple Sclerosis, fibromyalgia, asthma as a child, previous breast implant surgery or removal surgery, previous blood transfusions or removal of an ovary in 1989. Additionally, the H&P did not mention what, if any, medications and supplements Patient 4 took. In addition, no source of bleeding for the return to surgery on December 18, 2002, was listed in the Operative Report. Respondent failed to document a postoperative note after the second return to surgery.

52. Dr. Bradley testified the lack of documentation in Patient 4's H&P was below the standard of care. The Presiding Officer finds that the testimony of Dr. Bradley is credible and persuasive and concludes that Respondent failed to keep adequate medical records regarding Patient 4.

Patient 5

53. In Count V, the Board alleges that Respondent performed below the standard of care by ordering Toradol preoperatively, and by continuing to order Toradol postoperatively after Patient 5 had three surgeries, two of which were because of bleeding and after Patient 5 had six units of blood transfusions. Additionally, the Board alleges that Respondent failed to sufficiently document Patient 5's office notes, H&P, and Operative Report.

54. On February 21, 2003, Respondent admitted Patient 5 to NRH for surgery to treat dysmenhorrhea with suspected endometriosis. Respondent ordered Toradol to be given preoperatively IV at 30 mg. Respondent performed a diagnostic laparoscopy, laser ablation of endometriosis, and a laser uterosacral nerve ablation.

55. Following surgery, Patient 5's blood pressure was 62/26. Dr. Bradley opined that Patient 5 was hypovelmic and that she had a hemoperitoneum. Patient 5 received two units of blood. Patient 5 was returned to surgery on February 21, 2003, where Respondent performed a diagnostic laparoscopy with extension of the suprapubic incision and suture of a muscular bleeder.

56. Dr. Bradley testified that in the initial surgery the incision or the placement of the suprapubic trocar would have caused Patient 5's injury. He testified that usually the injury would have been discovered at the close of the initial surgery when the port is removed and the physician is visualizing with the other ports. Dr. Bradley also testified that if one assumed the camera were in a different port then the physician would see the blood dripping from that site. Dr. Bradley testified that Respondent performed below the standard of care by ordering preoperative Toradol because Patient 5 had major gynecological surgery.

57. Patient 5 returned to surgery again on February 21, 2003, where Respondent performed an exploratory laparotomy and oversew of trocar sites and irrigation of the abdomen. Respondent estimated that Patient 5's blood loss was 1000 cc. Patient 5 received four units of packed red blood cells in the Operating Room and Respondent transferred Patient 5 to the ICU. The Anesthesia Record for the second return to surgery estimated that Patient 5's blood loss was 2500 cc. Postoperatively, Respondent ordered that Toradol be given at 30 mg IV every six hours on February 22, 2003. Respondent ordered the continuation of Toradol at 30 mg IV every six hours as needed on February 23, 2003. On February 24, 2003, Patient 5 was dismissed.

58. Dr. Bradley testified that it was below the standard of care to order Toradol for Patient 5 when she was in the ICU after three surgeries, two of which were for recurrent bleeding, and after six units of red blood cells were transfused.

59. The Presiding Officer finds that the testimony of Dr. Bradley is credible and persuasive and that Respondent did not maintain the standard of care when he ordered Toradol to be given preoperatively before major gynecological surgery, and when he continued to order Toradol after two surgeries for recurrent bleeding after six units of red blood cells were transfused. The Presiding Officer finds that Respondent owed a high duty of care when ordering Toradol pre- and perioperatively, and that he should have discovered the muscular bleeder injury at the close of the initial surgery. Respondent failed to adhere to that duty, and practiced below the standard of care to a degree constituting ordinary negligence.

60. On January 29, 2003, Respondent's office visit notes documented a breast, pelvic, and abdominal examination. The nursing intake indicated Patient 5's blood pressure was 100/60. Respondent's H&P for Patient 5 lists her blood pressure at 130/80, and the following exams were taken: HEENT, breasts, lungs, abdomen, pelvic and neuromuscular.

61. Dr. Bradley testified that the H&P does not note Patient 5's history of petit mal seizures and the 130/80 blood pressure documented on the H&P does not indicate the source of the blood pressure.

62. The Presiding Officer finds that the testimony of Dr. Bradley is credible and persuasive and concludes that Respondent failed keep an adequate medical record.

Patient 6

63. The Board alleges in Count VI that Respondent practiced below the standard of care with regard to Patient 6 by ordering Toradol preoperatively before major gynecological surgery and by ordering Toradol postoperatively when Patient 6 returned to surgery for bleeding. In addition, the Board alleges that Respondent failed to sufficiently document Patient 6's H&P and progress reports, failed to document other progress notes, postoperative notes and follow-up notes, and failed to complete the discharge summary in a timely manner.

64. On February 12, 2003, Respondent admitted Patient 6 to NRH for surgery to treat pelvic prolapse, a third-degree cystocele, a second-degree uterine prolapse and a second-degree rectocele. Respondent ordered Toradol to be given preoperatively at 30 mg IV. Respondent performed a total vaginal hysterectomy, a sacrospinous ligament suspension, and anterior and posterior colporrhaphy, a transvaginal taping and a cystoscopy.

65. After surgery, Respondent removed Patient 6's vaginal packing and noted bleeding. Patient 6 was returned to surgery where Respondent performed a revision of the posterior suture line for postoperative bleeding. No bleeding sites were noted in the Operative Report. Following the second surgery, Respondent ordered Toradol to be given at 30 mg IV every six hours.

66. Dr. Bradley testified that it was below the standard of care for Respondent to order Toradol to be used immediately after the patient left the second surgery, which was performed to repair the bleeding resulting from the first surgery.

67. The Presiding Officer finds that the testimony of Dr. Bradley is credible and persuasive, and concludes that Respondent owed a high duty of care to manage bleeding when ordering Toradol preoperatively for a major gynecological exam given. Additionally, the Presiding Officer finds that Respondent violated the standard of care by ordering Toradol immediately following an operation to repair continued bleeding.

68. Dr. Bradley opined that Respondent's H&P for Patient 6 was inadequate because it did not list medications, social history, smoking history, childhood transfusions, past surgical history for a tonsillectomy, or wisdom teeth removal. In addition, the record did not establish a source for the blood pressure Respondent documented. Dr. Bradley testified that Respondent's progress records for Patient 6 were insufficient because Respondent did not write any progress notes, a second postoperative note, or any follow-up documentation. Additionally, the discharge summary was written a month later.

69. The Presiding Officer finds that the testimony of Dr. Bradley is credible and persuasive, and concludes that Respondent failed to document or to document sufficiently or timely Patient 5's records.

Patient 7

70. The Board alleges in Count VII that Respondent performed below the standard of care with regard to Patient 7 by ordering Toradol postoperatively when Patient 7 returned to surgery for bleeding. In addition, the board alleges that Respondent failed to sufficiently document Patient 7's H&P, office notes, and progress reports.

71. On June 26, 2002, Respondent admitted Patient 7 for surgery to treat enterocele and vaginal vault prolapse. Respondent performed a sacrospinous ligament suspension, enterocele repair, posterior colporrhapy, paravaginal defect repair and a transvaginal taping on Patient 7. Patient 7 was later readmitted to surgery for bleeding. Respondent performed an evacuation of hematoma for vaginal bleeding and posterior vaginal hematoma. Respondent ordered Toradol to be given at a dose of 30 mg IV. Thereafter, Respondent ordered Toradol to be given at 30 mg IV every six hours as needed. Respondent did not document the time of the order. Respondent did not check Patient 7's hemoglobin postoperatively after either surgery.

72. Dr. Bradley testified that it was below the standard of care for Respondent to order Toradol immediately after Patient 7's return to surgery for bleeding. Dr. Bradley testified that most surgeons would have checked a patient's hemoglobin postoperatively when the patient is taken back to surgery for postoperative bleeding. Dr. Bradley was unable to determine whether Respondent ordered preoperative Toradol for Patient 7.

73. The Presiding Officer finds that the testimony of Dr. Bradley is credible and persuasive. The Presiding Officer finds and concludes that Respondent owed a duty to manage bleeding when he had ordered Toradol postoperatively in Patient 7's return to surgery for bleeding. Although Dr. Bradley was not able to determine whether Respondent personally ordered the preoperative Toradol for Patient 7 and he did not specifically state that Respondent violated the standard of care by not checking Patient 7's hemoglobin when the patient returned to surgery for bleeding, the Presiding Officer is able to make the necessary findings based upon Dr. Bradley's and Respondent's testimony, and relying upon the Presiding Officer's expertise as a physician. The Presiding Officer finds that when Patient 7 returned to surgery to repair bleeding that resulted from the first surgery and Toradol was ordered, Respondent deviated from the standard of care by not checking Patient 7's hemoglobin.

74. Respondent documented one office visit with Patient 7 indicating a pelvic exam and another office visit on June 19, 2002, where the future surgery was discussed. Neither office visit mentioned Patient 7's blood pressure. Patient 7's H&P was dictated on June 25, 2002 and it indicated a blood pressure of 130/80 for Patient 7, yet no source was documented. Dr. Bradley testified this was inadequate. Additionally, he testified that Respondent's documentation of Patient 7's H&P was inadequate because no allergies, social history, smoking or alcohol history or family history was documented. Dr. Bradley testified that there was no documentation in Respondent's office record for Patient 7 supporting the lung, heart and neuromuscular exam in the H&P. Respondent did not write a postoperative note after the first or second surgery and Dr. Bradley testified that this was inadequate. Respondent's first progress note is for the first day following surgery.

75. The Presiding Officer finds that the testimony of Dr. Bradley is credible and persuasive regarding Respondent's documentation. The Presiding Officer is able to make the necessary findings based upon Dr. Bradley's and Respondent's testimony, and relying upon the Presiding Officer's expertise as a physician, the Presiding Officer finds that Respondent failed to document records regarding Patient 7 in a sufficient and timely manner.

C. Docket No. 05-HA-61

Patient 8

76. Count I of the Petition alleges that Respondent failed to adhere to the applicable standard of care with regard to Patient 8. Patient 8 saw Respondent in his office on June 10, during which he performed a genitourinary and rectal exam. Respondent admitted Patient 8 to NRH for surgery to treat dysmenorrheal, pelvic pain and dyspareunia. On June 16, 2004, he performed a laparoscopic assisted vaginal hysterectomy LAVH and ablation of endometriosis and lysis. The patient was discharged from the hospital.

77. Patient 8 testified that she telephoned Respondent's nurse on June 21, 2004 to complain of a foul vaginal odor. Patient 8 left a message but did not receive a return telephone call. She called again on June 24 and spoke with Respondent's nurse, complaining of increased odor and pain while walking.

78. Patient 8 went to Respondent's office on June 25. Initially she saw Respondent's nurse, and told her of the pain. The nurse's notes documented that the patient was taking Vicodin for pain, and that the drug was not relieving the pain. Respondent told the patient that the odor was normal and was caused by stitches. He did not perform a physical examination. Patient 8 testified that after the office visit her pain worsened every day and the bleeding increased.

79. On June 30, 2004, Patient 8 called Respondent because she was experiencing chills and fever. She was scheduled for her two-week postoperative visit the next day. Respondent told the patient that she probably had a bladder infection, and to take Tylenol and he would see her the next day.

80. During the office visit, Respondent noted that the patient had fever and chills, and complained of odor and bleeding. Respondent diagnosed her with a urinary tract infection and ordered Levaquin, an antibiotic. He did not perform a pelvic examination. Later that evening, Patient 8 awoke at approximately 2:00 a.m. with bleeding and pain. She went to the emergency department at NRH. The emergency department physician performed a pelvic examination and found a retained surgical sponge. The sponge was removed, and Patient 8 was discharged at approximately 4:00 a.m.

81. On July 2, Respondent met Patient 8 at the hospital. She went to Respondent's office where he placed Surgicel on her vaginal cuff to stop bleeding.

82. At approximately 3:00 p.m. on July 3, Respondent again presented to the emergency room with increased pain odor, bleeding and fevers. Following a CT, Respondent was found to have a pelvic abscess. The emergency department physician removed the Surgicel, and the abscess was drained under anesthesia. The physician also prescribed antibiotics to treat the abscess.

83. According to the record, steps were taken to count the sponges, and the Presiding Officer finds that ordinary care was taken to prevent the occurrence. While there is speculation that Respondent was solely responsible for accounting for the particular sponge that was not removed, the Presiding Officer does not find clear and convincing evidence that Respondent failed to adhere to the standard of care on that particular issue.

84. The Presiding Officer does find that Respondent's care of Patient 8 following surgery was below the standard of care. Patient 8's recovery from surgery was significantly altered by the failure to remove the surgical sponge. The conduct of the exam on June 25 was not below the standard of care. However, the documentation for the June 25 office visit was dictated three days after the visit, and is not consistent with the patient's description of pain or with the nurse's notes. Respondent does not appear to appreciate the level of pain. At the July 1 office visit, Respondent failed to make a reasonable inquiry into the cause of the patient's pain, bleeding and odor. He did not perform a pelvic examination. The testimony of Dr. Bradley regarding this post surgical care is credible and persuasive.

85. The Presiding Officer also finds that Respondent failed to sufficiently document the patient's condition on June 25 and the office procedure on July 2.

Patient 9

86. Count II of the Petition alleges that Respondent failed to adhere to the standard of care with regard to Patient 9. This patient was a 46 year-old female who visited Respondent at his office on October 20, 2003 to discuss a hysterectomy. On October 29, Respondent performed an LAVH and other laparoscopic procedures. Toradol was administered pre- and postoperatively.

87. Following surgery, Patient 9 had significant bleeding. Her hemoglobin dropped from 14.2 to 8.9. She was returned to surgery, where 2000cc of blood was found in the abdomen. Respondent performed a laparoscopy, hemoperitoneum evacuation and revision of the trocar sites.

88. The patient was returned for a third surgery for a laparotomy and splenectomy. During that surgery, the patient had an estimated blood loss of 4000cc.

Dr. Bradley testified that Respondent's postoperative care was below the standard of care. The Presiding Officer finds that the testimony of Dr. Bradley is credible and persuasive. Respondent's preoperative order for Toradol required him to use greater care in managing bleeding. During the second surgery, Respondent did not find any bleeding sites, though there were 2000cc of blood in the abdomen. Even though he did not know the source of bleeding, he prescribed Toradol after the second surgery. The Presiding Officer finds that Respondent failed to manage the bleeding appropriately. In doing so,

Respondent failed to meet the standard of care to a degree constituting ordinary negligence.

89. Respondent did not document an exam for the October 20 visit. Dr. Bradley opined that the documentation for the preoperative office visit failed to sufficiently record a complete surgical history or the basis for vital signs. The Presiding Officer finds that Respondent failed to sufficiently document the medical record.

Patient 10

90. Count III of the Petition alleges that Respondent failed to adhere to the applicable standard of care with regard to his treatment of Patient 10. Patient 10 is postmenopausal who underwent a dilation and curettage in May 2002. The pathology report following the D & C showed a precancerous condition of the cervix. Following 90 days of Provera, she had a second D & C on August 14, 2002.

91. The surgical pathology report, dated August 15, 2002, identified atypical glandular endometrial tissue, fragments of endocervix with squamous metaplasia, and fragments of benign ectocervix. Additional sampling of the endometrium was recommended.

92. Respondent's office record does not include a copy of the pathology report. He did dictate an office note of his postoperative assessment, noting that the patient's pathology was negative.

93. During the postoperative visit on August 21, Respondent told Patient 10 that the pathology was negative and that no further therapy was needed. He also told her to return if there was any further postmenopausal bleeding.

94. Patient 10 returned to Respondent in January 2004 for recurrence of postmenopausal bleeding. A D & C was performed, and the pathology revealed Grade II endometrial carcinoma that had invaded the muscle.

95. Dr. Bradley testified that Respondent failed to adhere to the standard of care with regard to the treatment recommendation in May of 2002. Specifically, he noted that the preferred treatment and the standard of care would be to perform a hysterectomy with a bilateral salpingo oophorectomy. His opinion is consistent with medical literature that was offered. There is no indication in Respondent's notes that a hysterectomy was offered to the patient.

96. Dr. Bradley also testified that Respondent failed to adhere to the standard of care with regard to his treatment of Patient 10 following the second D&C. This opinion was based upon his failure to obtain the pathology results and to accurately advise the patient. There is no documentation that Respondent ever referred to the written report or had a verbal report from the pathologist.

97. The Presiding Officer finds the testimony of Dr. Bradley to be credible and persuasive, and that Respondent failed to adhere to the applicable standard of care to a degree constituting ordinary negligence by not recommending that Patient 10 undergo a hysterectomy and documenting that recommendation, and by not giving Patient 10 accurate pathology results following the second D & C. The Presiding Officer further finds that as a result of these instances, Patient 10 required a greater amount surgery to remove the cancer than if she had undergone a timely hysterectomy.

Patient 11

98. Count IV of the Petition alleges that Respondent failed to adhere to the applicable standard of care with regard to Patient 11. Respondent performed surgery to remove a very large uterus and fibroid. The surgery was performed on October 21, 2003.

99. Respondent initiated an LAVH, using four trocar sites rather then three. The extra site was due to difficulty in visualization. After the anterior colpotomy was completed, the surgery was converted to a laparotomy because the size of the uterus did not allow it to be removed vaginally. Respondent closed the trocar port sites beneath the skin, but did not close the fascia at the conclusion of the surgery. The port sites were 12 millimeters.

100. Patient 11 suffered a bowel and omentum herniation through the trocar site. This is a foreseeable consequence of failing to close 12 millimeter port sites in the fascia of the lower abdomen.

101. Dr. Bradley testified that Respondent practiced below the applicable standard of care by attempting an LAVH knowing the size of the uterus and fibroid and after placement of the initial port. He also testified that Respondent practiced below the applicable standard of care by failing to close the fascia port sites because of the size of the ports. The Presiding Officer finds the testimony of Dr. Bradley credible and persuasive, and further finds that Respondent failed to adhere to the applicable standard of care to a degree constituting ordinary negligence by continuing an attempted LAVH following placement of the initial port, and by failing to close 12 millimeter port sites at the fascia.

Other Findings of Fact and Conclusions of Law

102. The Board is authorized to revoke, suspend, or limit a license, or to censure a licensee as provided by K.S.A. 65-2836.

103. Subsection (b) of K.S.A. 65-2836 states as grounds for a disciplinary order that the Board has found a licensee to have committed an act of professional incompetency. The phrase professional incompetency is defined at K.S.A. 65-2837(a)(2) to include "[r]epeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board." The phrase is defined at K.S.A. 65-2837(a)(3) to further include a "pattern of practice or other

behavior which demonstrates a manifest incapacity or incompetence to practice medicine."

104. Subsection (b) of K.S.A. 65-2836 states as additional grounds for a disciplinary order that the Board has found a licensee to have committed an act of unprofessional conduct. The phrase unprofessional conduct is defined at K.S.A. 65-28376(b)(25) as the "[f]ailure to keep written medical records which accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination and test results." The Board promulgated a rule, appearing at K.A.R. 100-24-1, which defines the minimal requirements for a patient record. Among the items necessary for a patient record to be adequate, paragraph (b)(6) requires the record to reflect what vital signs were obtained, what tests were performed, and to record the findings of each; paragraph (b)(9) requires the record to reflect the treatment performed or recommended; and paragraph (b)(10) requires the record to document the patient's progress.

105. Respondent has engaged in multiple instances of failure to adhere to the applicable standard of care to a degree constituting ordinary negligence with regard to preoperative care by failing to recommend or offer a hysterectomy when indicated, by failing to rely upon pathology reports, and by inaccurately reporting pathology findings to the patient.

106. Respondent has engaged in multiple instances of failure to adhere to the applicable standard of care to a degree constituting ordinary negligence with regard to postoperative care by failing to appropriately appreciate and act upon patient's reports of fever and pain.

107. Respondent has engaged in repeated instances of practice below the standard of care with regard to his management of bleeding occurring with major gynecological surgery in which Toradol has been administered pre-, inter- and postoperatively. The failure to adhere to the applicable standard of care is to a degree constituting ordinary negligence.

108. By engaging in repeated and multiple instances of practice below the standard of care to a degree constituting ordinary negligence, Respondent has committed numerous acts of professional incompetency.

109. Respondent has also failed on numerous occasions to keep written medical records that adequately document pertinent findings, test results and treatments in the patient record.

110. By failing to adequately keep written medical records that accurately describe the patient services, Respondent has engaged in acts of unprofessional conduct.

111. The findings of professional incompetency and unprofessional conduct, and the testimony and the patient records are consistent with the findings of CPEP.

Respondent shows multiple and repeated instances of flawed clinical judgment and reasoning with important gaps in medical knowledge, as well as poor documentation.

Conclusion and Order

112. The Presiding Officer has found Respondent to have practiced below the standard of care in a cluster of cases with re-operations for postoperative bleeding. Respondent has suggested that he is very prolific and therefore the percentage of cases involving returns to surgery is normal.

113. The Presiding Office does recognize that surgery involves complications that might occur even with due care. In general, individual situations requiring a return to surgery may possibly be defended on the basis that injury can occur as a result of a known complication, and that the patient accepted that risk. But in the instant case, the Presiding Officer cannot find that the eleven patients described in the hearing were simply the victims of complications, and that the reason for the high number of incidents is the high volume of surgeries that Respondent performs.

114. When the cases are considered individually, the Presiding Officer has paid close attention to the demonstrated care exercised by Respondent rather than on the sole factor of patient injury. Taken as a whole, the impression of less than adequate care in attending to the details of surgical practice emerges. Further review of all of the patients care is not necessary at this point, but as examples, in the case of Patient 11, 12 millimeter trocars were used without fascial closure with the foreseeable complication of herniation of the abdominal contents in the resulting fascial defects. In the case of Patient 4, re-operation failed to detect the source of internal hemorrhage, thus a third operation was need to finally complete the care. Respondent did not record information that would suggest he used the proper thought processes. For example, the record of the second surgery does not reflect that Respondent waited until the patient's blood pressure was back up to normal before concluding that all was well, or relieving the pnuemoperitoneum and then after waiting a bit inflating the abdomen to see if bleeding had occurred. With regard to Patient 8 involving a retained vaginal sponge, the patient's complaint was ignored until another physician examined her and removed it. Respondent could have examined her at the time of her earlier visit but he failed to do so. His excuse was that the foul order was caused by dissolving sutures. In retrospect, he acknowledges this was not the cause. The Presiding Officer believes that the error in Respondent's explanation should not be simply passed of to hindsight, but that Respondent should have recognized from the start that the odor was not caused by dissolving sutures. That explanation is neither consistent with the manufacturer's data, nor consistent with the Presiding Officer's experience.

115. Respondent has also omitted documentation of several important procedural steps in his surgical technique, the absence of which fail to assure the Presiding Officer that Respondent has used due care in the conduct of the several surgical cases considered. In laparoscopic cases, one customarily considers the possibility of bleeding from trocar sites, and in consequence monitors the insertion and removal of each trocar for bleeding or trauma to abdominal contacts.

IT IS, THEREFOR, ORDERED that the license of David B. Kemp, M.D. is hereby revoked. The Presiding Officer stays the order of revocation subject to the following conditions:

A. Respondent is censured, and Respondent's license is suspended for a period of 30 days, commencing on March 13, 2006;

B. For a period of at least 12 months and commencing with the effective date of the Board's Final Order, Respondent's license is limited to practicing medicine and surgery at a medical care facility or in a group practice approved by the Board. For purposes of this order, Newman Regional Health and Cotton-O'Neal group practices are approved;

C. For a period of at least 12 months and commencing with the effective date of the Board's Final Order, Respondent's license is limited to prohibit the performance of hospital-based surgery, and of office-based surgery of the type that prior to this order Respondent had performed in a hospital, unless each surgery is monitored by a person approved by the Board. The monitor must be actively licensed to practice medicine and surgery in the State of Kansas, without disciplinary limitation, and be certified in obstetrics/gynecology by an American specialty board. In the event a person who is certified in obstetrics/gynecology is not available to monitor a surgery, a person who is otherwise qualified under this order and who is board eligible for certification may monitor surgery. The monitor shall observe each surgery, assist as necessary, and co-sign Respondent's operative report to signify agreement and approval. Respondent is responsible for retaining copies of all operative reports, and submit each report to the Board every 60 days for peer review by a peer review officer or Board review committee of the Board's choosing.

D. Respondent may contact Board staff in advance of an office-based surgery to determine whether the Board's designated member believes such surgery must be performed in a hospital.

E. This order shall not prohibit Respondent from performing unmonitored and unplanned surgery in a bona fide emergency when a monitor is unavailable and delaying the surgery to wait for a monitor would create a risk to the patient. In any such emergency, the monitor shall review the operative record and include the review in the report to the Board.

F. Respondent is ordered to complete, at his own expense, a Board-approved educational program on documentation of patient records. Respondent shall make a written suggestion of a program to the Board's Executive Director on or before February 1, 2006. The Board will determine at its February 12, 2006 meeting whether the suggestion is approved. If no suggestion is made, the Board may select a program.

G. Respondent shall pay the costs of this proceeding, as allowed by K.S.A. 65-2846, in the amount of $7,634.05, on or before June 30, 2006.

H. The Board may remove the stay of revocation upon notice and a finding that Respondent has failed to abide by these conditions.

IT IS FURTHER ORDERED that the portions of the agency record that contain information by which patients may be identified and portions of the agency record containing the actions, findings and conclusions of a peer review committee or officer are subject to a protective order and shall not be disclosed to any third party. Those portions

of the agency record specifically include Exhibits 1, 2 and 3. This protective order shall not prohibit the parties from using or disclosing the records as necessary in review of the agency order or in any subsequent judicial review of the agency action.

PLEASE TAKE NOTICE that this is a final order. A final order is effective upon service. 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 the Board's Executive Director at 235 SW. Topeka Blvd., Topeka, KS 66603.

Dated this 14th Day of December 2005.

Kansas State Board of Healing Arts

Lawrence T. Buening, Jr.
Executive Director

Certificate of Service

I certify that a true copy of the foregoing Final Order was served this 14th Day of December 2005 by depositing the same in the United States Mail, first-class postage prepaid, and addressed to:

Thomas E. Wright
100 S.E. 9th Street, 2nd Floor
P.O. Box 3555
Topeka, KS 66601-3555

And a copy was hand-delivered to the office of

Kelli J. Stevens
235 S. Topeka Blvd.
Topeka, KS 66603