

BEFORE THE IOWA BOARD OF MEDICINE

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

DOUGLAS CODY, II, M.D. RESPONDENT

FILE Nos. 02-03-026, 02-03-028, 02-03-047, 02-03-105, 02-05-806 & 02-05-848

TERMINATION ORDER

Date: March 9, 2012.

1. On November 10, 2005, the Board filed formal disciplinary charges against Respondent alleging that he engaged in professional incompetency and practice harmful or detrimental to the public in the practice of medicine in violation of the laws and rules governing the practice of medicine in Iowa.

2. On June 18 & 19, 2007, an evidentiary hearing was held before a panel of the Board.

3. On July 31, 2007, a Proposed Decision of the Panel was issued. Respondent and the State appealed the Proposed Decision of the Panel.

4. On January 16, 2008, an appeal hearing was held before a quorum of the Board.

5. On January 28, 2008, the Board issued a Final Decision. The Board concluded that Respondent closed his medical practice without providing proper notice to patients, failed to provide appropriate treatment to patients and engaged in a pattern of disruptive behavior in his medical practice. Respondent's Iowa medical license was suspended,

however, the suspension was stayed and he was required to successfully complete a Board-approved disruptive physician evaluation, submit a practice improvement plan and complete a Board-approved record keeping course. The Board issued Respondent a Citation and Warning and ordered him to pay a \$5,000 civil penalty. Respondent was also placed on probation subject to Board monitoring for a period of five years.

6. Recently, Respondent requested early termination of the terms of probation.

7. On March 1, 2012, the Board reviewed Respondent's request for termination of the terms of his probation. After careful consideration, the Board voted to terminate the terms of Respondent's probation.

THEREFORE IT IS HEREBY ORDERED: that the terms and conditions of Respondent's probation are terminated and Respondent's Iowa medical license is returned to its full privileges, free and clear of all restrictions.

IOWA BOARD OF MEDICINE


Siroos S. Shirazi, M.D., Chairman
400 SW 8th Street, Suite C
Des Moines, Iowa 50309-4686

March 9, 2012
Date

BEFORE THE IOWA BOARD OF MEDICINE

IN THE MATTER OF THE)	FILE NOS. 02-03-026,02-03-028
STATEMENT OF CHARGES)	02-03-047,02-03-105
AGAINST:)	02-05-806,02-05-848
)	DIA NO. 05DPHMB031
)	
DOUGLAS CODY II, M.D.)	FINAL DECISION OF THE BOARD
)	ON APPEAL

To: Douglas Cody, II, M.D.

Date: January 28, 2008.

On November 10, 2005, the Iowa Board of Medicine (Board) filed a Statement of Charges against Douglas Cody II, M.D. (Respondent) alleging:

Count I: Professional incompetency, in violation of Iowa Code sections 147.55(2), 148.6(2)(g) and (i), 272C.10(2) (2005) and 653 IAC 12.4(2)(a), (b), (c), and (d); and

Count II: Practice harmful or detrimental to the public, in violation of Iowa Code section 147.55(3) and 272C.10(3) (2005) and 653 IAC 12.4(3).

The hearing was initially scheduled for January 25, 2006, but was continued at Respondent's request and later rescheduled for October 31, 2006. Respondent's second continuance request was also granted. On November 6, 2006, the State filed a Motion To Amend Statement of Charges, which Respondent resisted. The Motion to Amend was granted on November 27, 2006. The hearing was rescheduled for June 18 and 19, 2007. On June 11, 2007, the Board issued an Amended Statement of Charges, incorporating the amendments previously granted on November 27, 2006.

The evidentiary hearing was held on June 18 and 19, 2007, before the following panel of the Board: Yasyn Lee, M.D., Chairperson; Blaine Houmes, M.D.; and Tom Drew, public member. Respondent Douglas Cody, II, M.D. appeared and was represented by attorneys Ralph H. Heninger and Ralph W. Heninger. Assistant Attorney General Theresa O'Connell Weeg represented the State. The hearing was closed to the public, pursuant to Iowa Code section 272C.6(1) and 653 IAC 25.18(12). The hearing was recorded by a certified court reporter. Administrative Law Judge Margaret LaMarche assisted the panel in conducting the hearing and was instructed to prepare the panel's proposed decision, in accordance with their deliberations.

The panel issued its Proposed Decision on July 31, 2007. The State filed a Notice of Appeal on August 16, 2007, and an Amended Notice of Appeal on August 21, 2007. Respondent filed a Notice of Cross Appeal and Request To Present Additional Evidence on August 27, 2007. The State did not object to Respondent's request to submit additional evidence. (Respondent Exhibit T) On October 16, 2007, the Board issued an Order Setting Briefing Schedule and Rehearing. The parties both filed briefs in support of their appeals and responsive briefs. An Amended Hearing Schedule was issued on December 14, 2007.

On January 16, 2008, an appeal hearing was held before the Board. The State was represented by Assistant Attorney General Theresa O'Connell Weeg. Respondent was represented by attorney Ralph H. Heninger. Respondent presented Exhibit T and testimony from Donna Oliver, President and CEO of Mercy Medical Center-Canton, and Linda Hoppe, Mercy Hospital Director of Quality. Both parties presented oral arguments. Upon review of the entire record before the panel and upon consideration of the additional evidence submitted by Respondent and the oral arguments, the Board voted to affirm the panel's decision, with some modifications to the findings, as requested by the State in its appeal brief. The Board concluded that Respondent's current employment arrangement and the additional evidence submitted by Respondent do not obviate the need for a disruptive physician evaluation.

THE RECORD

The record includes the Statement of Charges and Notice of Hearing; Continuance Orders; Motion To Amend Statement of Charges, Resistance and Ruling; Amended Statement of Charges; testimony of the witnesses, State Exhibits 1-79 (See State's Exhibit Index for description of 1-77; Exhibits 78 and 79 are internet search results for Audiologists in Keokuk); the post hearing notices and motions, the state's Appeal Brief; Respondent's Response to State's Appeal Brief; Respondent's Cross Appeal Brief and Supplemental Brief; State's Brief In Response to Respondent's Appeal; Reply To State's Brief; and the following exhibits submitted by Respondent:

Exhibit A:	Patient records
Exhibit B:	Curriculum Vitae, Thomas J. McDonald, MD
Exhibit C:	Letter, 6/5/06 (Dr. McDonald To Board)
Exhibit D:	Letter, 5/23/07 (Dr. McDonald To Board)
Exhibit E:	Diagram of the Ear
Exhibit F:	Table 1-2 Tuning Fork Testing

Exhibit G: K.A.H. Medical Staff Meeting Minutes
Exhibit H: Letter, 6/5/07 (Oliver to Board)
Exhibit I: Letter, 1/10/06 (Ames to Respondent)
Exhibit J: Letter, 10/31/06 (Dornbush, NCMA to
Heninger)
Exhibit K: Letter, 10/9/06 (Creech, RN, BS to Heninger)
Exhibit L, M: Letter, 10/31/06 (Davis to Heninger)
Exhibit N: Letter (Jewell, CRNA to Heninger)
Exhibit O: Letter, 10/14/06 (Kiernan to whom it may
concern)
Exhibit P: Letter, 10/31/06 (Lauritzen, NCMA to
Heninger)
Exhibit Q: Letter, 11/1/06 (Rogers to whom it may
concern)
Exhibit R: Letter, 1/12/07 (Spooner, NCMA to whom it
may concern)
Exhibit S: Letter, 9/13/06 (Joyce, M.D. to Board)
Exhibit T: Letter dated 11/14/07 (Oliver to Board) and
attachments.

FINDINGS OF FACT

Overview of Respondent's Education, Licensure and Practice History

1. Respondent graduated from Bowman Gray School of Medicine in Winston-Salem, North Carolina in June 1991. He then went to the Mayo Clinic in Rochester, Minnesota, where he completed a general surgery internship in June 1992 and a residency in Otorhinolaryngology in June 1996. There were no complaints against Respondent during his residency, and he served as the Chief Resident from June 1995 to June 1996. Thomas J. McDonald, M.D., who was the chair of the Otorhinolaryngology Department at Mayo for many years including during Respondent's residency, described Respondent as one of the best residents that he has ever trained. Dr. McDonald acknowledges that he was a good friend of Respondent's father and has known Respondent most of his life, but believes that this has not affected his objectivity. Following his residency, Respondent completed two fellowships at the University of Iowa Hospitals and Clinics: one in Molecular Biology, Hematology, and Oncology and one in Microvascular and Plastics and Reconstructive Surgery, Skull Base and Oncologic Surgery. Respondent is certified by the American Board of Otolaryngology and by the Joint Council of Head and Neck Surgery. (Testimony of Respondent; Dr. Thomas J. McDonald; Respondent Exhibits B, C; State Exhibit 34)

2. Respondent was issued Iowa medical license number 31264 to practice medicine and surgery in the state of Iowa on June 10, 1996. Respondent's Iowa medical license is active. Respondent is also licensed in Illinois and has inactive licenses in Florida and Minnesota. (State Exhibit 10, 34)

3. Following completion of his fellowships in July 1998, Respondent was hired by Southern Illinois University as an Assistant Professor. Respondent's duties at Southern Illinois included starting a molecular biology research laboratory and developing a Head and Neck training program. Respondent enjoyed his academic positions but they required him to put in long hours, seven days a week. When Respondent and his fiancé became engaged, they decided that he should look for a position that would involve fewer work hours and allow more family time.

In the summer of 2000, Respondent was recruited by the Keokuk Area Hospital (KAH) to open a solo otolaryngology practice in Keokuk.¹ In addition to his practice, Respondent served on the Board of Keokuk Health Systems and as chairman of the hospital's Quality Improvement Committee. Respondent felt that when he expressed concern about what he perceived as serious deficiencies in the KAH ambulatory surgery department, hospital administration received his concerns with an "air of hostility and animosity." Respondent further claims that the hospital administration became "infuriated" by his actions as an arbitrator in another physician's medical staff appeal.

There were additional issues. KAH was having difficulty retaining physicians who were essential to Respondent's referral base. Respondent was unhappy because he felt that the Emergency Room was calling him day or night, sometimes for patients outside of his specialty. In January 2002, Respondent decided to begin performing his surgeries at the hospital in Fort Madison rather than KAH. After making this decision, Respondent

¹ Prior to accepting the position with KAH, Respondent was interviewed by Dr. Douglas Henrich for a position with Burlington Ear, Nose and Throat Clinic, which had satellite clinics in Ft. Madison and Mt. Pleasant and was considering opening a new satellite clinic in Keokuk. Dr. Henrich and his partners chose a different applicant for the opening and later decided against opening the Keokuk satellite when Respondent accepted the position with KAH. Respondent claimed that Dr. Henrich was extremely upset by his decision to accept a position at KAH and suggests that this motivated Dr. Henrich's later complaint against him. However, Dr. Henrich credibly testified that while he was a little surprised when Respondent took a position at KAH, he was not upset or angry and even offered to share call with Respondent. However, he never received a response to this offer. (Testimony of Respondent; Dr. Douglas Henrich)

perceived that the hostilities toward him at KAH increased tremendously.² After the summer of 2002, Respondent and his wife agreed that he needed to start looking for a different position in Iowa. Their resolve to move increased after they had twins in October 2002. (Testimony of Respondent; State Exhibits 34, 75; Respondent Exhibit G)

4. In the fall of 2002, Respondent was recruited by Ahmed Elahmady, M.D. to join Quality Care Surgery Center (QCSC) in Clinton, Iowa. Respondent testified that in November 2002, he made the decision to leave KAH and join QCSC. Respondent's last day of practice in Keokuk was December 19, 2002, and he started work at QCSC in January 2003. According to Respondent, Dr. Elahmady promised him a state of the art ambulatory surgery center and they entered into a contract specifying the exact facilities, equipment, and staff to be provided. However, it appears that their relationship went downhill rather quickly. Respondent felt that Dr. Elahmady was not complying with the contract terms and not providing what he promised. In Respondent's opinion, Dr. Elahmady frequently belittled and berated staff. Respondent testified that Dr. Elahmady fired 41 staff members in just one year. Respondent worked at QCSC for three years; his last day at QCSC was January 15, 2006. (Testimony of Respondent; State Exhibits 34, 75)

5. Respondent opened Clinton Ear, Nose & Throat Specialists, a solo otolaryngology practice in Clinton, Iowa, in January 2006. He is on staff at Mercy Medical Center in Clinton, Iowa. (Testimony of Respondent; State Exhibit 75; Respondent Exhibits H-S)

Complaints, Investigations, Peer Review Conclusions

6. From January 2003 through December 14, 2005, the Board received a number of complaints from physicians, patients, and others concerning Respondent's practice as a physician in Keokuk and at QCSC in Clinton. In relevant part, the complaints alleged that Respondent:

- Closed his Keokuk practice without adequate notice and without adequately providing for the continuing care of his patients;

² Respondent further claimed that Dr. Henrich was outraged by his decision to perform surgeries at the Ft. Madison hospital, and considered it as an invasion of his turf. Dr. Henrich denies he was "outraged" but admits that Respondent was competition for him. (Testimony of Respondent; Dr. Henrich)

- Performed surgical procedures without appropriate testing and evaluation;
- Failed to provide postoperative care to numerous patients, including patients who presented to the emergency room;
- Performed surgery in an outpatient surgical center when hospital-based surgery was indicated; and
- Engaged in a pattern of disruptive behavior, including inappropriate behavior toward other physicians and health care providers.

The complaints were assigned to Board Investigator David Smith, who obtained relevant patient records, interviewed witnesses, and prepared a series of investigative reports. (Testimony of David Smith; State Exhibits 7-19, 29-A, 45-51, 62-63)

7. The Board referred the complaints, investigative reports, and patient records to a peer review committee consisting of two board-certified otolaryngologists: Ann Bell, M.D. and David Wagner, M.D. The peer reviewers independently reviewed the information, conferred by telephone to discuss their findings, and issued three written peer review reports. Dr. Wagner wrote the first two reports and Dr. Bell wrote the third report. In both of the first two reports, Dr. Wagner expressed concerns about Respondent's quality of practice, his commitment to his patients, and evidence that demonstrates repeated substantial deficiencies in Respondent's standard of care. Dr. Bell concurred in this conclusion. In the third written report, Dr. Bell concluded, "We do not feel he should continue as a licensed physician in the state of Iowa." Dr. Bell signed the report for Dr. Wagner, with his permission. At hearing, however, Dr. Wagner clarified that he did not agree with Dr. Bell's opinion that Respondent should lose his license. (Testimony of Ann Bell, M.D.; David Wagner, M.D.; State Exhibits 2-6)

Closure of Keokuk Practice

8. Respondent's last day of practice in Keokuk was December 19, 2002. Although Respondent was moving to a practice location several hours away, he did not send any letters to his patients or place any advertisements in newspapers informing his patients of his plans to close his practice and providing information concerning their options for continuing care or obtaining medical records. Respondent did not provide notice to the KAH Medical Staff Secretary or Administration that he was closing his practice.

KAH administration first learned of Respondent's move when 6-8 patients called the hospital to ask why Respondent was not available for his scheduled appointments. The Board subsequently received complaints from patients, physicians, and KAH that Respondent had closed his practice abruptly without proper notice and without providing for the continuing care of his patients, including some who had surgery in the week before his departure. Patients who went to Respondent's office after he left found a posted notice consisting of Respondent's new business card from the Quality Care Surgery Center in Clinton and a handwritten statement to send payments to an address in Keokuk. When patients called the Keokuk office, there was a voice mail message to call Respondent's Clinton office. There was apparently a list of physicians who might be willing to assume the care of Respondent's patients but no one had clear instructions on how to handle referrals. (Testimony of Respondent; David Smith; State Exhibits 8, 12-14, 19-A, 29, 46, 47)

9. Dr. Douglas Henrich, an otolaryngologist who practiced in West Burlington and Fort Madison, and his associate, Dr. Jennifer K. Berge, were contacted in late December 2002 and in January 2003 to care for a number of Respondent's Keokuk surgical patients. Many of the patients were upset and some specifically complained that they felt abandoned because they were not informed prior to their surgeries that Respondent would be closing his practice and would not be available to provide their post-operative care. Several patients had difficulty obtaining their medical records from Respondent. The peer review committee appropriately concluded that Respondent deviated from the applicable standard of care by closing his practice without providing adequate notice to his patients, without providing for the post-operative care of his patients, especially those upon whom he had recently operated, and without making specific arrangements for the prompt transfer of medical records. (Testimony of David Smith; Dr. Ann Bell; Dr. David Wagner; State Exhibits 4-6; 8-14) The record includes the following specific examples:

a. On December 16, 2002, Respondent performed surgery on patient JB at the Ft. Madison hospital to remove a nasal polyp. The patient was given a follow-up appointment for December 19th, but Respondent was unable to see her that day because he was in emergency surgery. The patient was still passing large clots at this time and had not healed; she had informed Respondent prior to surgery that she had prior bleeding problems. When the patient asked for another appointment, she was told she would

have to see another (out of town) physician or her family physician, because December 19th was Respondent's last day. The patient was provided a list of three ENT physicians, including two physicians in Illinois and Dr. Henrich. Respondent had not asked Dr. Henrich if he would be willing to assume post-operative care of his surgical patients. A family physician would not be equipped to provide the proper post-operative care, which would typically include an endoscopy to be sure the patient is healing properly. Dr. Henrich saw the patient for initial evaluation on December 26, 2002 but did not have any medical records for her at the time. Dr. Henrich assumed the patient's post-operative care, provided postoperative sinus instructions and performed an endoscopic cleaning on January 9, 2003. (State Exhibits 13, 19; Testimony of Dr. Ann Bell; Dr. David Wagner)

b. On July 19, 2002, Respondent performed a right mastoidectomy surgery for presumed cholesteatoma on patient KB. Respondent performed a second ossicular reconstruction surgery on December 13, 2002. Approximately one week later, the patient presented for follow-up at Respondent's office, was advised that Respondent had an emergency, and was provided a list of ENT providers because that was Respondent's last day in his Keokuk office. The patient sought follow-up care from Dr. Henrich on December 20, 2002. (State Exhibits 13, 20)

c. On December 18, 2002, Respondent performed an excision of a cervical lymph node on patient KF. The patient had no contact with Respondent following surgery and when she called for a follow-up appointment was advised to seek care by another physician. Respondent did not provide the patient with the surgery outcome, even though he had the biopsy report by December 19, 2002. Dr. Henrich eventually saw the patient on January 8, 2003. (State Exhibits 13, 21)

d. On December 13, 2002, Respondent performed surgery on Patient MM for a left TM perforation. After surgery, the patient went to Respondent's office and was told that he was no longer available for follow-up. Respondent's nurse looked in the patient's ear and told her it was "fine." The patient was given the same list of physicians, and she followed up with Dr. Henrich on February 27, 2003. His examination on that date revealed a 50-60% perforation on the left ear, which was still causing considerable hearing loss. (State Exhibits 13, 22)

e. Patient ME filed a complaint with the Board on February 16, 2003. She had her first appointment with Respondent on December 2, 2002 for chronic sinusitis, and Respondent scheduled a CAT scan. On December 5, 2002, the patient saw Respondent for her CAT scan results and was placed on 40 days of Augmentin and a sodium nasal rinse. Respondent scheduled the patient for a follow-up CAT scan on January 8, 2003. After the CAT scan, the patient went to Respondent's office the following day for follow-up, only to learn that he had closed his office. The patient sought follow-up care with Dr. Berge on January 21, 2003. (State Exhibit 29; Testimony of Jennifer Berge, M.D.)

f. Respondent last treated patient CB in October 2002 following a revision of her right ear for apparent hearing loss. At that time the patient still had debris in the ear. Respondent treated her with drops for drainage and gave her a follow-up appointment for after the first of the year. On February 5, 2003, another health care provider referred the patient to Dr. Jennifer Berge for evaluation of a right ear infection. Dr. Berge requested the patient's records from Respondent and scheduled a follow-up appointment for February 18th. Respondent did not provide the records by February 18th. Dr. Berge made a second request for the records and scheduled another appointment for March 4, 2003. As of that date, Respondent still had not provided the patient's records and another request was made. Dr. Berge finally received some patient records on March 11, 2003. (State Exhibit 26; Testimony of Dr. Ann Bell)

g. EA is an 89-year-old patient who sought follow-up care with Dr. Berge in January 2003 after Respondent performed a bilateral myringotomy and tube placement on November 6, 2002. Dr. Berge requested Respondent's records for the patient on January 7, 2003 but had not yet received any records as of March 12, 2003. (State Exhibit 14, 24-C)

10. On June 12, 2003, the Board's investigator wrote to Respondent asking for his response to a number of complaints received by the Board, including the complaints concerning his closure of his Keokuk office. (Testimony of David Smith; State Exhibit 32) In his written response to the Board's investigator and in his testimony at hearing, Respondent provided inconsistent and unsatisfactory explanations for the procedures he used to close his office. For example:

- In his written response to the Board's investigator, Respondent stated that he made the decision to close his Keokuk office on short notice because his contract with the hospital was up and their negotiations did not end until December. In his testimony, however, Respondent stated that the decision to go to QCSC was made in November 2002.
- In his written response, Respondent stated that he posted a sign in his office one month before the office closed and that the sign remained on the wall after he left. However, the sign that was posted after closure consisted solely of his new business card and a notation where to send payments. Furthermore, Respondent testified that he posted a sign in his office *five to six weeks* prior to his departure, informing patients that his office was closing and providing a map to his new practice location in Clinton. Respondent could not produce a copy of this sign.
- In his written response, Respondent stated "we told every patient we encountered." However at hearing Respondent claimed that he directed his office staff to personally call all active patients and any patients with follow-up appointments or who might potentially need follow-up. However, Respondent did not provide any verification or corroboration from his staff or records that this was accomplished, numerous patients reported that they were not contacted or informed of Respondent's departure from Keokuk.
- Respondent testified that a local newspaper advertisement would have been ineffective since 60-75% of his patients resided outside of the Keokuk area, including many from Illinois and Missouri. However, Respondent later testified that Dr. Elahmady was supposed to place the appropriate newspaper advertisements for him. It was Respondent's responsibility, not Dr. Elahmady's responsibility, to ensure that proper notification was provided to the Keokuk patients.
- Respondent testified that after closing his practice, he left a secretary at his Keokuk office for 5-6 months to answer any patient questions. Respondent did not provide the name of the secretary. This testimony was not credible. Respondent had never provided this highly relevant information in his previous responses to the Board or during his deposition. Patients who went to his office

did not get appropriate answers to their questions about follow-up care.

(State Exhibit 33; Testimony of Respondent)

11. The preponderance of the evidence established that Respondent failed to take appropriate steps when he closed his office. When Respondent closed his Keokuk practice, the Board's rules on professional ethics provided that having undertaken the care of a patient, the physician may not neglect the patient; and unless the patient has been discharged they may discontinue their services only after giving adequate notice.³ The minimum standard of care for a surgeon specialist closing a medical office includes fair notice to all patients, especially potential surgical patients, and clearly established arrangements for continuation of care for the patients. This must include a plan for the prompt transfer of medical records and direct communication with any physician/surgeon assuming the patient's care. It is highly inappropriate for a surgeon to continue to perform surgery up to the date of closing, unless patients are properly informed and all parties understand who will be responsible for their post-operative care.

Physicians closing a practice typically send letters to all active patients to notify them of the planned closing and to advise them how to obtain their medical records. Advertisements are typically placed in the appropriate newspaper(s). It is also standard to notify all referring physicians and any affected hospitals. It is not appropriate to expect patients to travel several hours to the physician's new location for post-operative care. Respondent's expert conceded that Respondent did not provide appropriate notice to patients or access to records when he closed his Keokuk practice. (Testimony of Ann Bell, M.D.; David Wagner, M.D.; Thomas J. McDonald, M.D.; State Exhibits 5, 6)

Failure To Respond To Calls From Hospital/Other Physicians

12. On March 25, 2003, the Board received letters from Dr. Jerry Karr, a board-certified emergency room physician at the Keokuk Area Hospital (KAH) and from James Vandenberg, M.D., the medical director of the emergency rooms at KAH and Great River Medical Center. Both physicians complained that Respondent refused to respond to calls from the hospital concerning patients, including his own post-operative patients, unless he was "on call." (State Exhibits 15, 16)

³ 653 IAC 13.10(6).

In his testimony at hearing, Dr. Karr explained that he initially had an excellent professional relationship with Respondent, and he was ecstatic to have someone with Respondent's training in Keokuk. Respondent initially made himself available 24/7 to consult on all ENT cases. As time went on, Respondent decreased his call to the mandatory 10 days per month required of all medical staff. On the days Respondent was not on call, it became difficult to contact him even for the care of his own patients. If Respondent was not on call and emergency room staff attempted to contact him at the office or at home, either staff or his wife would respond that Respondent was not on call and was not available. (Testimony of Dr. Jerry Karr)

Dr. Karr eventually took his concerns about Respondent's unavailability to his supervisor, Dr. James Vandenberg. In a letter to the Board, Dr. Vandenberg explained that it was standard practice at the hospital for the emergency room physicians to care for ENT emergencies and then refer to the next available hospital if the emergency required ENT expertise beyond their scope of practice. Dr. Vandenberg had no personal experience with Respondent refusing to respond to his calls but he named several other physicians (Dr. Karr, Dr. Hakes, Dr. Schulte, and Dr. Henrich) who told Dr. Vandenberg that they had tried to reach Respondent when he was not on call, and he made it clear to them that he was not available. (State Exhibit 16)

Dr. Vandenberg was sufficiently concerned with Respondent's call schedule and availability that he arranged a meeting with Respondent and Dr. Foad, Chief of Surgery at KAH. According to Dr. Vandenberg, the outcome of the meeting was that Respondent would only officially be available for consultation concerning his or any other ENT patient requiring emergency ENT care on his posted call days, and emergency room physicians were told to care for the patients the best they could if he was not available. If the patient's problem was life-threatening, the ER physicians could try to call Respondent. Dr. Vandenberg asked Respondent to put this in writing, but he never did. However, in a separate letter to the Board, Dr. Foad recalled that the outcome of the meeting was that Respondent would respond to calls from his own patients at any time, regardless of whether he was on call. This recollection was consistent with Respondent's testimony.

The preponderance of the evidence established that Respondent did not always respond to calls from the hospital concerning his

own patients. The Board agreed with the peer review's opinion that the standard of care requires Respondent to take responsibility for the post-operative care of his own patients, regardless of whether he is on call. Respondent must be responsive to calls concerning his own patients regardless of his call schedule, unless he has a formal call sharing relationship with another ENT physician. (Testimony of Dr. Jerry Karr; Dr. Ann Bell; Dr. David Wagner; State Exhibits 15, 16)

In his letter to the Board and in his testimony at hearing, Dr. Karr discussed his follow-up care of two of Respondent's patients. While there was inadequate evidence of patient neglect by Respondent in these two specific cases, they illustrate Respondent's failure to effectively communicate with other physicians and how these communication issues may adversely affect patient care.

a. DL presented to the emergency room with pain complaints several weeks following his surgery by Respondent. It was Dr. Karr's recollection that he attempted to call Respondent concerning DL, but Respondent's staff refused to put the call through because Respondent was not on call. However, the Board was unable to give persuasive weight to Dr. Karr's recollection of this specific incident because his call to Respondent's office was not documented at the time and because Dr. Karr was not asked to write a letter to the Board concerning the incident until fifteen months after it occurred.

b. LC presented to the emergency room with serious bleeding⁴ ten days following her tonsillectomy by Respondent. Dr. Karr indicated that he did not attempt to call Respondent because the patient needed immediate intervention and based on his past experiences, he felt it would have been a waste of precious time to call Respondent. The Board believes that Dr. Karr's past experiences calling Respondent and his staff led him to believe that Respondent would not respond to his call, unless he was on the call schedule. (Testimony of Dr. Jerry Karr; State Exhibits 15, 31, 31a)

Additional Surgical Practice/ Standard of Care Issues

⁴ Respondent contends that LC was not actively bleeding and was hemodynamically stable and he criticized the care that she received in the emergency room. (Testimony of Respondent; Respondent Exhibit 33) To the contrary, the patient's hospital record and Dr. Karr's testimony clearly indicates that the patient was actively bleeding and was not stable. (State Exhibit 31-B, 31-C; Testimony of Dr. Jerry Karr)

13. The minimum standard of care for middle ear surgery requires performance of a pre-operative audiogram (hearing test) in most cases. This hearing testing would include measurement of hearing thresholds with air conduction and bone conduction performed in a certified sound room with properly calibrated audiometric equipment. In addition, otolaryngologists also typically obtain an audiogram post-surgery to compare to the pre-surgery audiogram, after allowing adequate time for healing.

Respondent failed to obtain pre-operative and post-operative audiograms prior to numerous middle ear surgeries.⁵ Respondent claimed that he performed tuning fork (Weber) tests in all cases, but several of Respondent's patient records do not document Weber tests.⁶ While tuning fork tests can be fairly exact and provide useful information when properly performed, they are less accurate than audiograms and are typically used in conjunction with audiograms to verify findings, and not as a substitute for audiograms. (Testimony of Ann Bell, M.D.; David Wagner, M.D.; Thomas McDonald, M.D.; State Exhibits 4, 5; 13, 14; Respondent Exhibit C)

Respondent claimed that he did not order audiograms routinely after his first year⁷ in Keokuk because audiology services were not available in the area and his patients were unwilling to travel to obtain an audiogram. However, the preponderance of evidence in the record rebuts Respondent's claim that audiology services were not reasonably available to his Keokuk patients. Audiology services were available in Ft. Madison through Concha Audiology, and Respondent used these services on at least two

⁵ Examples of patients who did not have pre- or post-op audiograms include but are not limited to KB (Exhibit 20, two major ear operations for cholesteotoma); MM (Exhibit 22, surgery for left TM perforation); EA (Exhibit 24, bilateral myringotomy and tube placement); RJ (Exhibit 25, middle ear exploration and tympanoplasty with ossicular reconstructive prosthesis on 9/11/02); CB (Exhibit 26, middle ear exploration and tympanoplasty with ossicular chain reconstruction); SP (Exhibit 28, patient complained of hearing loss, had tube placement); LP (Exhibit 30, tube placement); KB (Exhibit 38, patient complained of hearing loss; left middle ear exploration and tympanomastoid on 8/14/02 and left middle ear exploration with ossicular reconstruction on 11/20/02).

⁶ Examples include KB (Exhibit 20); KF (Exhibit 21); and MD (Exhibit 23).

⁷ During his first year in Keokuk, Respondent had audiology services available within his office. When that audiologist (Michelle) moved away, Respondent claims that he tried to recruit an audiologist who worked part-time for Dr. Henrich to come to Keokuk a few days a week. Respondent claims that Dr. Henrich went "ballistic" when he heard this and threatened to fire her. However, Dr. Henrich denies that he threatened to fire his audiologist and further stated that he employed the audiologist full-time, and it would have been impractical for her to travel to Keokuk. (Testimony of Respondent; Dr. Henrich)

occasions. (State Exhibits 23, p.K106, K152; 44, pp. HH72-73) In addition, Dr. Henrich testified that Great River Audiology had an outreach clinic in Ft. Madison and that Concha Audiology had a location in Keokuk during the time of Respondent's practice. Concha Audiology's current website shows locations in Ft. Madison and Keokuk. It should be noted that while Respondent's patient records are verbose, he does not document that patients were offered audiograms and refused them. Moreover, the Board did not believe that the majority of patients would refuse audiograms if they were properly informed of the test's importance and its purpose. (Testimony of Respondent; Dr. Douglas Henrich)

14. Patient DJ was a 46 year-old diabetic who was taking blood thinning medications. On October 19, 2004, Respondent inappropriately performed a ten-hour surgery for Stage 2 epiglottic cancer at Quality Care Surgery Center, an outpatient facility. At the end of the procedure, the patient had extensive bleeding requiring ligation of an artery and a tracheostomy. The patient was then transferred by ambulance to the hospital. This complication was completely foreseeable given the nature of the surgery and the patient's risk factors. This lengthy surgery should have been performed in a hospital setting, not in an ambulatory surgical center. (Testimony of Dr. Ann Bell; Dr. David Wagner; Dr. Yasser Shaheen; State Exhibit 55)

In January 2003, Respondent removed the left tonsil of patient EP and diagnosed squamous cell carcinoma. In February 2003, Respondent performed a radical neck dissection at QCSC because cancer cells were found in the enlarged lymph node on the left side of the patient's neck. The patient reported that Respondent followed him home after surgery and came to his house to check on him for three days following the surgery. The Mayo Clinic later informed the patient that this surgery should not have been performed as an outpatient. In his written response to the Board, Respondent denied that this surgery should have been performed in the hospital or that the patient met criteria for hospital admission following surgery. He did not deny visiting the patient at home and stated that he often visits patients at home. (Testimony of David Smith; State Exhibits 63-66)

15. Respondent's patient records are excessively verbose, redundant, frequently included irrelevant information, and yet sometimes failed to include important details or descriptions. These deficiencies make Respondent's records confusing, make it difficult to locate the pertinent information for a particular

visit, and raise questions about the accuracy and authenticity of the records. Respondent typically includes a review of all systems at the beginning of the record for each patient visit, even though it is obvious that he did not actually review all systems at each visit.

As one specific example, Respondent's record for a two month old infant who was evaluated for nasal congestion and difficulty breathing states that the patient's comprehensive past medical history was negative for conditions like anxiety, depression, mental illness, and prior cosmetic surgery. Respondent further noted that the patient denied use of dentures, hearing aids, or changes in olfactions. At the same time, Respondent failed to document important information such as whether the infant had difficulty breathing and swallowing or whether he observed the infant while being fed. (State Exhibit 56-A) Respondent's social histories, even for infants, include notations on caffeine, tobacco, alcohol, and street drug use. Respondent attributes the verbosity of his records and inclusion of irrelevant information to the forms and templates that he uses, but these problems could easily be avoided by proper editing of both the templates and the records.

Finally, Respondent's patient records did not document that he informed specific patients of his plans to close his practice, did not document that he offered audiograms and patients refused them, and did not document the results of many Weber tests that he claims were administered. (Testimony of Dr. Ann Bell; See, e.g. State Exhibits 19B, 20A 53, 54, 56-A)

Disruptive Behavior

16. The American Medical Association has defined "disruptive behavior" as personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care. (E-9.045, updated 8/29/05; State Exhibit 67). Disruptive, intimidating, or abusive behavior may increase the likelihood of errors by leading nurses, residents, or colleagues to avoid the disruptive physician, to hesitate to ask for help or clarification of orders, and to hesitate to make suggestions about patient care. (State Exhibit 68). Respondent has displayed a pattern of behaviors that have been recognized as typical of a disruptive physician. Respondent's disruptive behaviors include:

- Intimidating or demeaning staff or other professionals;
- Blaming or shaming others for possible adverse outcomes;

- Being uncooperative, defiant, rigid or inflexible in responses to requests from patients and staff;
- Inadequate communication in quantity, quality and promptness;
- Recurrent conflict with others.

The disruptive physician lacks the ability of self-observation. Disruptive physicians see themselves as clinically superior (and they often are) and see other members of the health care team as less competent or incompetent, weak, and vulnerable. They see themselves as champions for their patients. The actions of disruptive physicians can cause a decrease in morale, an increase in the level of workplace stress, inordinate time spent by staff appeasing or avoiding the physician, increased risk of errors due to communication breakdown, and an increased potential for malpractice litigation. (State Exhibits 67-74; Testimony of Respondent)

17. While he was in practice in Keokuk, Respondent exhibited patterns of poor communication and provided rigid and inflexible responses when he was contacted by other physicians concerning his call schedule and post-operative care arrangements in Keokuk. Respondent failed to properly communicate with both his patients and his colleagues when he closed his Keokuk practice. Respondent failed to take responsibility for ensuring that his surgical patients obtained proper continuing care and failed to take appropriate steps to ensure that all patients had access to their patient records.

18. Respondent's communication problems continued after he joined the Quality Care Surgery Center (QCSC) in January 2003. In November 2005, Dr. Ahmed Elahmady, the owner of QCSC, provided the Board with information concerning complaints made by two of Respondent's colleagues at QCSC: anesthesiologist Yasser Shaheen, M.D. and nurse Marcia Duval. Both complained about Respondent's behavior and lack of appropriate communication. (Testimony of David Smith; State Exhibits 48, 50, 51)

In reviewing the complaints from QCSC and making its findings, the Board considered the pending contract dispute between Dr. Elahmady and Respondent as a motive for Dr. Elahmady's complaint as well as additional evidence in the record suggesting that Drs. Elahmady and Shaheen also contributed to creating a difficult work atmosphere at QCSC. In addition, Dr. Shaheen and Respondent had an emotionally charged relationship, which was evident from their testimony at hearing.

Nevertheless, the Board was convinced that Respondent, as the responsible surgeon, did not appropriately communicate with Dr. Shaheen and others when there were problems or disagreements. Respondent's testimony at hearing was replete with emotionally charged and exaggerated statements holding himself out as more competent and efficient than others, including those who have complained about his behavior, while blaming others for his own deficiencies.⁸ The preponderance of the evidence in this record established that Respondent has exhibited a pattern of inappropriate communication and disruptive behavior, which some co-workers perceived as threatening. These disruptive behaviors increased stress in the workplace and could have a negative impact on patient care.

a. Nurse Marcia Duval worked for Respondent as his assistant in early 2003. She reported that Respondent was very difficult to work with, did not want to be bothered by lab results or phone calls, expected his staff to protect him from interruptions, and did not want to take calls from physicians that he did not know, including calls concerning his own patients. This complaint was credible because it was consistent with the complaints received concerning Respondent's practice in Keokuk and Duval's observations were confirmed by medical assistant Angela Spooner in her interview with the Board's investigator.⁹ Duval eventually resigned her position because she felt humiliated by Respondent's criticisms of her work performance. (State Exhibits 51-C; 50, p. 12; Testimony of David Smith)

b. Marcia Duval and office manager Lisa Hoppe also reported that Respondent did not speak to patients or families following surgery and would not give specific post-op medication

⁸ For example, Respondent suggests that Dr. Henrich's complaints were motivated by professional jealousy and that Dr. Henrich somehow bore responsibility for Respondent not obtaining audiology services. Respondent blamed Dr. Elahmady for not placing advertisements concerning Respondent's closure of his Keokuk office and suggested that Dr. Elahmady was responsible for providing medical records to Respondent's Keokuk patients following the closure of his office.

⁹ Angela Spooner worked for Respondent as his medical assistant at QCSC from February 2002 until April 2005 and later helped him set up his new practice in Clinton. Respondent submitted a recent letter from Spooner, in which she takes issue with how the Board's investigator portrayed her comments. Spooner blamed Dr. Elahmady's poor management for many of the problems at QCSC and noted that after Respondent opened his new practice in Clinton, she never witnessed any of the anger she had seen previously at QCSC. Ms. Spooner has not been employed by Respondent since early in 2006. (Respondent Exhibit R; State Exhibit 50, pp.9-13)

orders but just told them to "pick one" of the medications he had listed for pain and an antibiotic. Medical Assistant Angela Spooner told the Board's investigator that for post-op medications Respondent would tell her to "do whatever you want" or "pick one." (State Exhibit 50, p. 11) Respondent admitted that he did not speak to patients or families before or after surgery but stated that all patients are provided his written policy that a nurse will talk to the family following the surgery unless they wait until all of the day's surgeries are completed. Respondent did not submit a copy of this written policy and there were no signed copies of the policy in the surgical patients' records. Respondent's flip response to staff requests for guidance on post-op medications and his practice of not speaking to patients or their families following surgery reflect a poor attitude about his responsibility to effectively communicate with staff, patients, and their families. (State Exhibit 51-C; 51-D; Testimony of Respondent)

c. Anesthesiologist Dr. Yasser Shaheen complained about several incidents involving Respondent. On October 5, 2004, patient DJ was scheduled for a biopsy of an airway tumor. During the procedure, Dr. Shaheen and Respondent disagreed on how to proceed with the intubation. Dr. Shaheen felt they should have done fiberoptic intubation prior to induction of anesthesia but Respondent believed he would have no problem intubating the patient following induction. Dr. Shaheen reports that Respondent was offended by his concerns and started shouting there was no airway he could not get. Dr. Shaheen further claims that Respondent ran out of the operating room shouting and then ran into a colleague's room and started kicking the furniture. (Testimony of Dr. Yasser Shaheen; State Exhibits 51-B; 55-B)

Respondent recalled the disagreement and admits leaving the operating room and going to the surgicenter office for help when Dr. Shaheen refused to intubate in the middle of the procedure. Respondent further admits that while in the office he probably used strong language to express his concern and urgency but denies kicking furniture. Records show that Laurie Ernst, RN, was the circulating nurse for the procedure. Ernst told the Board's investigator that she learned to "ignore" doctors when they started fighting "unless it affects patient care," and then she tells them to "knock it off." (Testimony of Dr. Shaheen; Respondent; Kim Bush; State Exhibits 50, 51-B, 55-B, 60, 61)

On October 19, 2004, the same patient was scheduled for surgery to remove the epiglottic tumor. Respondent did not speak to Dr.

Shaheen prior to surgery or discuss any possible complications. Dr. Shaheen expected the surgery to last a few hours; it lasted ten hours. Dr. Shaheen was surprised and upset when Respondent did not say a word to him during the entire ten-hour procedure. (Testimony of Dr. Shaheen; Respondent; State Exhibits 55-C)

It is apparent that there was a serious conflict between Respondent and Dr. Shaheen in the operating room, which could have negatively affected patient care. As the surgeon, Respondent was responsible for behaving professionally and ensuring that the lines of communication remained open with the anesthesiologist. Leaving the operating room, using foul language, and later refusing to speak to the anesthesiologist during a ten-hour surgery was an immature and ineffective response.

c. One of the recurrent issues between Respondent and Dr. Shaheen concerned taping the endotracheal tube during surgery. Dr. Shaheen reported that during a tonsillectomy on a seven-year-old patient on February 1, 2005, Respondent aggressively told him that he should not tape the tube in the future. Dr. Shaheen believed that the standard of care required the tube to be taped, but the testimony and statements of numerous otolaryngologists clearly indicate that taping the tube is a matter of preference.

Respondent and one of the nurses, Kim Bush, recalled the tube taping incidents somewhat differently from Dr. Shaheen. Respondent testified that Dr. Shaheen had not been trained to tape the tube to the midline and had repeatedly taped the tube to the side. According to Respondent, it was Dr. Shaheen who became agitated and upset when Respondent told him to tape the tube at the midline or not at all. As the surgeon, Respondent was responsible for ensuring that any disagreement over taping the tube is resolved in a calm and appropriate manner, preferably prior to the start of the surgery. It is not in the best interests of the patient for the surgeon and the anesthesiologist to be arguing about this issue during the procedure. (Testimony of Dr. Yasser Shaheen; Respondent; Dr. David Wagner; State Exhibits 50, 51-B, 53, 59, 60, 61)

d. Also on February 1, 2005, Respondent scheduled a ten-year-old patient for an ear tube removal. Dr. Shaheen was the anesthesiologist, and he wanted to use IV induction of anesthesia because he was concerned that the patient would fight the mask. However, when the nurse was unable to place an IV, Dr. Shaheen used general anesthesia via the mask. According to

Dr. Shaheen, Respondent started shouting toward the end of the procedure and asking who ordered an IV for the child without his permission. Dr. Shaheen alleged that Respondent yelled at him in front of the OR staff, called him incompetent, and used the "F" word. Dr. Shaheen further alleged that Respondent "charged" at him and then ran out of the OR, cursing and shouting "you are on my shit list! If you do this again you will be out of here!" Medical Assistant Angela Spooner told the Board's investigator that she recalled this incident and that Respondent became "very belligerent and degrading." Spooner further stated that Dr. Shaheen and Respondent did not work well together. Laurie Ernst was listed as the primary circulating nurse for the procedure, but she could not recall this particular patient. (State Exhibit 50, pp. 5, 10; Exhibit 54-D; Testimony of David Smith; Dr. Shaheen)

Respondent provides a different version of the incident, claiming that he only approached Dr. Shaheen about the IV after the procedure was completed and he had changed out of his scrubs. Respondent complained that Dr. Shaheen became argumentative and Respondent left to avoid further conflict but informed all staff that in the future no IV should be placed in a child under 12 without his permission. While Dr. Shaheen's perceptions and recollections of this incident may have been affected by his personal involvement in the dispute, the Board was also convinced that Respondent failed to appropriately communicate with Dr. Shaheen in a professional manner to ensure that his patients received the care that they needed. (Testimony of Dr. Yasser Shaheen; Respondent; State Exhibits 48, 51-B, 60)

19. On one occasion, Respondent cancelled an entire day of surgeries because he did not want to work with the assigned anesthesiologist. Respondent reports that in a previous case the anesthesiologist (not Dr. Shaheen) had difficulty intubating a patient and he had requested not to work with him anymore. The last minute cancellation of the surgeries inconvenienced numerous patients who had made work and family arrangements. This unfortunate result could have been avoided if Respondent had followed appropriate channels and had effectively communicated his concerns to those in charge of scheduling. (Testimony of Dr. David Wagner; David Smith; State Exhibits 50, p. 4; 60, 61)

On November 9, 2004, Dr. Shaheen placed one of Respondent's patients under general anesthesia for a surgical procedure, and then learned that Respondent had left the surgical center. By the time the staff located Respondent at home and he returned to

the surgical center to perform the procedure, the patient had been anesthetized for an hour. The **Board** was unable to conclude that Respondent was at fault in this situation because there was conflicting evidence from staff members concerning whether the patient appeared on Respondent's surgery schedule or was a late add-on. Procedures were put into place to prevent similar problems in the future. (Testimony of Dr. Yasser Shaheen; Respondent; Kim Bush; State Exhibits 48, 50, p. 10; 51-A, 52, 61)

20. Respondent submitted a number of supportive letters from his current employees and from his colleagues at Mercy Medical Center. The authors of the letters all state that Respondent is highly regarded by nurses and staff and they have not observed any disciplinary or behavioral problems. Respondent's office manager, Tammy Davis, authored one of these letters, which was dated October 31, 2006. Davis stated that Respondent was a pleasure to work with, is professional, and never has a harsh word to say to any of his employees. However, on or about March 8, 2007, Davis called the Board's investigator and asked to "rescind" her letter, stating that shortly after she provided it Respondent started treating her and other employees differently. Davis stated that Respondent "yells, screams, cusses, and calls us idiots." She further reported that Respondent had her fire four employees for no good reason other than he thought they were incompetent. Davis told the Board's investigator that she was fearful of talking to him due to possible retaliation if Respondent found out. (Testimony of Respondent; David Smith; Respondent Exhibits H-S; State Exhibit 76)

Respondent has been an employee of Mercy Medical Center-Clinton since July 2005. As an employee, Respondent is subject to all of hospital's policies and procedures applicable to medical staff and to employees, including the policy on disruptive behavior. During his employment at Mercy, Respondent has had no reported incidents of disruptive behavior. He is well liked and respected by administration and staff. (Testimony of Donna Oliver; Linda Hoppe; Respondent Exhibit T)

Competency Evaluation

21. On March 22-23, 2007, Respondent voluntarily submitted to a confidential comprehensive clinical competency evaluation at the Center for Personalized Education for Physicians (CPEP). The assessment included three clinical interviews with board certified otolaryngologists based on patient charts from Respondent's practice as well as hypothetical case discussions.

Simulated patients represented clinical cases typically seen in otolaryngology practices. CPEP evaluated medical knowledge, clinical reasoning, application of knowledge, documentation, and communication. At the conclusion of the evaluation, CPEP prepared a detailed written report. (State Exhibits 28, 29)

CPEP concluded that Respondent demonstrated good medical knowledge on all relevant topics and demonstrated only minimal educational needs that could be addressed independently, without need for an education intervention. During the evaluation, Respondent demonstrated good overall clinical judgment and reasoning and consistently professional communication skills. CPEP found that Respondent had acceptable documentation skills, with the following important exceptions: lack of problem lists, medication lists and data base documents in his charts; use of medical jargon on consent forms and lack of signatures on consent forms; and inadequate detail in operative notes. CPEP further found that Respondent's failure to distinguish portions of his notes copied from previous encounters from newly acquired information led to a flavor of lack of authenticity in his records and resulted in difficulty identifying new and important information gathered at a given visit. (State Exhibit 75).

CONCLUSIONS OF LAW

COUNT I

Respondent is charged with professional incompetency, pursuant to Iowa Code section 147.55(2), 148.6(2)(g) and (i), 272C.10(2)(2005)¹⁰ and 653 IAC 12.4(2)"a," "b," "c," and "d." Iowa Code section 147.55(2) and 272C.10(2) both provide for the revocation or suspension of a license when the licensee is guilty of professional incompetency.

Iowa Code section 148.6 provides in relevant part:

148.6 Revocation.

2. Pursuant to this section, the board of medical examiners may discipline a licensee who is guilty of any of the following acts or offenses:

...

g. Being guilty of a willful or repeated departure from, or the failure to conform to, the minimal standard of acceptable and prevailing practice of

¹⁰ While the Amended Statement of Charges cites to the 2005 Code, the same statutory provisions have been in effect since prior to 2001.

medicine and surgery, osteopathic medicine and surgery, or osteopathy in which proceeding actual injury to a patient need not be established;...

...

i. Willful or repeated violation of lawful rules or regulation adopted by the board...

653 IAC 12.4¹¹ provided in relevant part:

653-12.4(2)(272C) Grounds for discipline. The board has authority to discipline for any violation of Iowa Code chapter 147, 148,...272C or the rules promulgated thereunder. The grounds for discipline apply to physicians...The board may impose any of the disciplinary sanctions set forth in rule 12.25(1), including civil penalties in an amount not to exceed \$10,000, when the board determines that the licensee is guilty of any of the following acts or offenses:

...

12.4(2) Professional incompetency. Professional incompetency includes, but is not limited to, any of the following:

a. A substantial lack of knowledge or ability to discharge professional obligations within the scope of the physician's or surgeon's practice;

b. A substantial deviation by the physician from the standards of learning or skill ordinarily possessed and applied by other physicians or surgeons in the state of Iowa acting in the same or similar circumstances;

c. A failure by a physician or surgeon to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician or surgeon in the state of Iowa acting in the same or similar circumstances.

d. A willful or repeated departure from or the failure to conform to the minimal standard of acceptable and prevailing practice of medicine and surgery, osteopathic medicine and surgery, or osteopathy in the state of Iowa.

¹¹ These administrative rules are now found at 653 IAC 23.1.

The preponderance of the evidence established that Respondent violated Iowa Code sections 147.55(2), 148.6(2)(g), 272C.10(2)(2005) and 653 IAC 12.4(2)"c" and "d." While Respondent appears to have adequate knowledge and skill as a physician and surgeon, he has repeatedly failed to exercise, in a substantial respect, that degree of care ordinarily exercised by the average physician acting in the same or similar circumstances. In addition, he has repeatedly failed to conform to the minimal standard of acceptable and prevailing practice of medicine and surgery. The standard of care violations include Respondent's failures to:

- Provide proper notice to his patients and colleagues when he closed his Keokuk office;
- Adequately provide for the continuing care of his patients, including patients who recently had surgery;
- Provide patients proper access to their medical records after closing his Keokuk office;
- Provide adequate post-operative care to some of his own surgical patients when he was not "on call;"
- Effectively communicate his plan for post-operative care of his patients;
- Provide pre- and post-operative audiograms to numerous patients who had middle ear surgery;
- Maintain appropriate patient records;
- Perform surgeries in the appropriate setting;
- Maintain professional decorum and communication with colleagues, co-workers, and employees.

COUNT II

Iowa Code section 147.55(3)(2005) and 653 IAC 12.4(3) authorize the Board to discipline a licensee for engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

Engaging in unethical conduct includes, but is not limited to, a violation of the standards and principles of medical ethics and code of ethics set out in rules 653-13.10 and 13.11, as interpreted by the board. 653 IAC 12.4(3)"b." In 2002, 653 IAC 13.10(6) provided, in relevant part, that "...[h]aving undertaken the case of a patient, the physician may not neglect the patient; and unless the patient has been discharged they may discontinue their services only after giving adequate notice..."

Practice harmful or detrimental to the public includes, but is not limited to, the failure of a physician to possess and

exercise that degree of skill, learning and care expected of a reasonable, prudent physician acting in the same or similar circumstances in this state...653 IAC 12.4(3)"c."

The preponderance of the evidence established that Respondent violated Iowa Code sections 147.55(3), 272C.10(3), and 653 IAC 12.4(3)"b" and "c" when he closed his practice without adequate notice to his patients and without making adequate provisions for their continuing care and when he engaged in behavior and communication that was disruptive to the appropriate care of his patients. Respondent has displayed a pattern of demeaning, blaming, or shaming selected co-workers and colleagues. Respondent has been uncooperative and inflexible when responding to colleague communications and requests for assistance or information. Respondent's inappropriate communication style has resulted in recurring conflicts and difficulties in three different work settings over the past seven years. While a number of Respondent's colleagues, co-workers, and patients strongly recommend him as an excellent physician and surgeon, he has had serious conflicts with a significant number of co-workers and colleagues. The Board believes that Respondent's disruptive behavior may be a response to increased stress, both professionally and personally. Nevertheless, these types of disruptive behaviors can have significant adverse effects on patient care and must be addressed by the Board.

DECISION AND ORDER

IT IS THEREFORE ORDERED that Respondent Douglas Cody II, M.D. is hereby **CITED** for failing to conform to the prevailing standard of care and for engaging in practices harmful and detrimental to the public in Iowa. Respondent is hereby **WARNED** that similar violations in the future may result in further disciplinary action, including revocation of his Iowa medical license.

IT IS FURTHER ORDERED that Respondent shall pay a civil penalty of \$5,000 within thirty (30) days of the date of the Board's Decision and Order.

IT IS FURTHER ORDERED that license no. 31264, issued to Respondent Douglas Cody II, M.D. is hereby **SUSPENDED**. However, said **SUSPENSION** is immediately **STAYED** and license no. 31264 is hereby placed on **PROBATION**, subject to the following terms and conditions:

- A. **Disruptive Physician Evaluation:** Within sixty (60) days of the date of this Order, Respondent shall complete a

disruptive physician evaluation at a facility approved by the Board. Respondent shall follow all recommendations made as a result of the disruptive physician evaluation, including any recommendations for counseling or treatment.

B. Practice Plan: Within sixty (60) days of the date of the Board's Decision and Order, Respondent shall submit a Practice Plan for Board approval. The Practice Plan must include, at a minimum, the following elements:

1. **Patient Satisfaction Surveys:** Respondent shall utilize patient satisfaction surveys in his medical practice. The staff at each location where Respondent practices medicine shall provide the surveys to all patients for one week beginning January 1, April 1, July 1, and October 1 of each year of Respondent's probation. Staff shall mail a copy of the surveys directly to the Board's Monitoring Coordinator and Respondent's counselor.

2. **Staff Surveillance Forms:** Respondent shall ensure that all health professionals who work with him in the future complete the staff surveillance form provided by the Board at the end of the month. The staff surveillance forms shall be mailed directly to the Board's Monitoring Coordinator and Respondent's Counselor and must be received by the 15th of each month.

3. **Work Site Monitor:** Respondent shall submit for Board approval the name of a physician or other Board-approved healthcare professional who regularly observes and/or supervises Respondent in the practice of medicine to serve as worksite monitor. The Board shall provide the worksite monitor a copy of all Board orders relating to this matter. The worksite monitor shall provide a written statement indicating that the monitor has read and understands the Board orders relating to this disciplinary action and agrees to act as the worksite monitor under the terms of this agreement. The worksite monitor shall agree to inform the Board immediately if there is evidence of professional incompetency, disruptive behavior, a violation of the terms of this Order, or any violation of the laws and rules governing the practice of medicine. The monitor shall agree to submit written quarterly reports to the Board concerning

Respondent's progress not later than 1/20, 4/20, 7/20, and 10/20 of each year of this Order.

4. **Call Schedule:** Respondent shall include a description of his call schedule and a detailed plan for continuing care of his own patients when he is not available.

5. **Record Keeping:** Respondent's practice plan shall address his plans and procedures for handling record keeping.

6. **Personnel Issues:** Respondent's practice plan shall address his plans and procedures for handling personnel issues.

7. **Equipment:** Respondent's practice plan shall address his plans and procedures for handling equipment.

8. **Office Management:** Respondent's practice plan shall address his plans and procedures for handling office management.

C. **Continuing Medical Education:** Within sixty (60) days of the date of the Board's Decision and Order, Respondent shall submit a proposed record-keeping course for Board approval. Respondent shall submit verification of his completion of the Board-approved course.

D. **Quarterly Reports:** Respondent shall file sworn quarterly reports attesting to his compliance with all the terms of the Board's Decision and Order. The reports shall be filed not later than 1/10, 4/10, 7/10, and 10/10 of each year of probation. If Respondent is required to participate in counseling or treatment, he shall be responsible for ensuring that his counselor or treatment provider also submits quarterly reports to the Board according to the same schedule.

E. **Board Appearances.** Respondent shall appear before the Board annually or upon request of the Board during the duration of this Order. Respondent shall be given reasonable notice of the date, time and location for the appearances.

F. **Monitoring Fee:** Respondent shall make a payment of \$100 to the Board each quarter for the duration of this Order to cover the Board's monitoring expenses in this matter. The

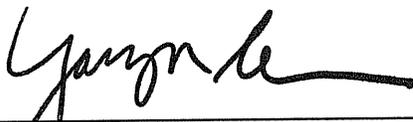
monitoring fee shall be received by the Board with the quarterly report required under this Order. The monitoring fee shall be sent to: Shantel Billington, Compliance Monitor, Iowa Board of Medicine, 400 SW 8th Street, Suite C, Des Moines, IA 50309-4686. The check shall be made payable to the Iowa Board of Medicine. The monitoring fee shall be considered repayment receipts as defined in Iowa Code section 8.2.

IT IS FURTHER ORDERED that Respondent's Iowa medical license shall be immediately suspended if he fails to fully comply with the terms and conditions established in A - C above.

IT IS FURTHER ORDERED that Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in Iowa.

IT IS FURTHER ORDERED, in accordance with 653 IAC 25.33, that Respondent shall pay a disciplinary hearing fee of \$75.00. In addition, Respondent shall pay any costs certified by the executive director and reimbursable pursuant to subrule 25.33(3). All fees and costs shall be paid in the form of a check or money order payable to the state of Iowa and delivered to the department of public health, within thirty days of the issuance of a final decision.

Dated this 28th day of January , 2008.



Yasyn Lee, M.D., Chairperson
Iowa Board of Medicine

Judicial review of the board's action may be sought in accordance with the terms of the Iowa administrative procedure Act (Iowa Code chapter 17A), from and after the date of the Board's order. 653 IAC 25.31.

cc: Ralph H. Heninger
Ralph W. Heninger
Heninger and Heninger, P.C.
101 W. 2nd Street, Suite 501
Davenport, IA 52801

DIA No. 05DPHMB031

Page 30

Theresa O'Connell Weeg
Office of the Attorney General
Hoover Building
Des Moines, Iowa 50319

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF IOWA

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

DOUGLAS CODY, II, M.D. RESPONDENT

FILE Nos. 02-03-026, 02-03-028, 02-03-047, 02-03-105, 02-05-806 & 02-05-848

AMENDED STATEMENT OF CHARGES

COMES NOW the Iowa Board of Medical Examiners (the Board), on June 11, 2007, and files this Amended Statement of Charges against Douglas Cody, M.D. (Respondent), a physician licensed pursuant to Chapter 147 of the Code of Iowa and alleges:

1. Respondent was issued Iowa medical license number 31264 on June 10, 1996.
2. Respondent's Iowa medical license is active and will next expire on May 1, 2008.
3. The Board has jurisdiction in this matter pursuant to Iowa Code Chapters 147,148 and 272C.

COUNT I

4. Respondent is charged with professional incompetency pursuant to Iowa Code sections 147.55(2), 148.6(2)(g) and (i), and 272C.10(2) (2005), and 653 IAC sections 12.4(2)(a), (b), (c), and (d), by demonstrating one or more of the following:

- a) A substantial lack of knowledge or ability to discharge professional obligations within the scope of the physician's or surgeon's practice;
- b) A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other physicians or surgeons in the state of Iowa acting in the same or similar circumstances;
- c) A failure by a physician or surgeon to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician or surgeon in the state of Iowa acting in the same or similar circumstances; and
- d) A willful or repeated departure from, or the failure to conform to, the minimal standard of acceptable and prevailing practice of medicine and surgery in the state of Iowa.

COUNT II

5. Respondent is charged under Iowa Code sections 147.55(3) and 272C.10(3) (2005) and 653 IAC sections 12.4(3) with engaging in a practice harmful or detrimental to the public.

CIRCUMSTANCES

6. Respondent is an Iowa licensed physician who practiced otolaryngology in Keokuk, Iowa.

7. Respondent in several cases inappropriately performed surgical procedures on the middle ear without performing proper pre- and postoperative testing.

8. Respondent inappropriately failed to provide proper postoperative care to numerous patients.

9. Respondent inappropriately failed to provide proper postoperative care to at least one tonsillectomy patient.

10. Respondent inappropriately closed his medical office without providing proper notice to his patients.

11. Respondent inappropriately closed his medical office without making proper arrangements for continuation of postoperative care for his surgical patients with another physician.

12. Respondent inappropriately failed to provide proper copies of patient medical records to other physicians to ensure appropriate continuation of care after Respondent discontinued treatment of his patients.

13. Respondent did not perform appropriate pre-operative evaluations in several cases, and did not exercise appropriate judgment or operate with appropriate indications for surgery in several cases.

14. Respondent on at least two occasions inappropriately performed surgery in an outpatient surgical center in cases where hospital-based surgery was indicated.

15. Respondent in several cases did not maintain accurate or inappropriate medical records.

16. Respondent failed in several cases to care for surgical patients who presented to the emergency room with postoperative problems.

17. Respondent engaged in a pattern of disruptive behavior, including inappropriate behavior toward other physicians and health care providers.

On this the 11th day of June, 2007, the Iowa Board of Medical Examiners finds cause to file this Statement of Charges.



Yasyn Lee, M.D., Chairperson
Iowa Board of Medical Examiners
400 SW 8th Street, Suite C
Des Moines, Iowa 50309-4686

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF IOWA

IN THE MATTER OF THE) DIA NO: 05DPHMB031
STATEMENT OF CHARGES AGAINST) FILE NOS.02-03-026,
) 02-03-047, 02-03-105,
) 02-05-806 & 02-05-8480
DOUGLAS CODY II, M.D.)
) RULING ON MOTION TO AMEND
Respondent) STATEMENT OF CHARGES

11-28-06P01:21 RCVD

On November 10, 2005, the Iowa Board of Medical Examiners (Board) filed a Statement of Charges against Douglas Cody II, M.D., (Respondent), charging him with two counts: professional incompetency and practice harmful or detrimental to the public. A hearing was initially scheduled for January 25, 2006 but was continued at Respondent's request. The hearing was rescheduled for October 31, 2006, but was again continued at Respondent's request. The hearing was then rescheduled for December 12, 2006 but was continued by order of the Board.

On November 6, 2006, the state of Iowa filed a Motion to Amend the Statement of Charges to include new factual allegations to support the two counts. On November 13, 2006, Respondent filed a Resistance To Motion To Amend Statement of Charges. The Board has authority to determine whether the Statement of Charges should be amended and has delegated ruling on the Motion to Amend to the undersigned administrative law judge.

Respondent resists the proposed amendments because they have not been approved by the Board, because paragraphs 7 and 8 are confusing and vague and do not set forth sufficient facts to allow a response, and because the amendment refers to a new file no. 02-05-848, which has not yet been provided to Respondent.

The disciplinary hearing has been continued and has not yet been rescheduled by the Board. It would be an unnecessary duplication of time and resources to require initiation of an entirely new proceeding to address new factual allegations. The Motion to Amend Statement of Charges should be granted, and the state should provide Respondent a copy of the Amended Statement of Charges and all

investigative information in its possession relevant to the new factual allegations. If necessary, Respondent may file a request for more definite statement after receipt of the amended Statement of Charges and the investigative information supporting the new allegations.

ORDER

IT IS THEREFORE ORDERED that the Motion to Amend the Statement of Charges, filed by the state of Iowa in the above-captioned disciplinary action, is hereby GRANTED.

IT IS FURTHER ORDERED that the State shall provide Respondent and the Board with the Amended Statement of Charges and shall provide Respondent with all investigative information relevant to the new factual allegations. Respondent may file an Answer within 20 days of receipt of the Amended Statement of Charges.

Dated this 27th day of November , 2006.



Margaret LaMarche
Administrative Law Judge
Iowa Department of Inspections and Appeals
Administrative Hearings Division
Lucas State Office Building-Third Floor
Des Moines, Iowa 50319

cc: Theresa O'Connell Weeg, Assistant Attorney General
Hoover Building (LOCAL)

Ralph Heninger
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Kent Nebel, Director of Legal Compliance
Iowa Board of Medical Examiners
400 SW 8th Street, Suite C
Des Mo

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF IOWA

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

DOUGLAS CODY, II, M.D. RESPONDENT

FILE Nos. 02-03-026, 02-03-028, 02-03-047 & 02-03-105

STATEMENT OF CHARGES

COMES NOW the Iowa Board of Medical Examiners (the Board), on November 10, 2005, and files this Statement of Charges against Douglas Cody, M.D. (Respondent), a physician licensed pursuant to Chapter 147 of the Code of Iowa and alleges:

1. Respondent was issued Iowa medical license number 31264 on June 10, 1996.
2. Respondent's Iowa medical license is active and will next expire on May 1, 2006.
3. The Board has jurisdiction in this matter pursuant to Iowa Code Chapters 147,148 and 272C.

COUNT I

4. Respondent is charged with professional incompetency pursuant to Iowa Code sections 147.55(2), 148.6(2)(g) and (i), and 272C.10(2) (2005), and 653 IAC sections 12.4(2)(a), (b), (c), and (d), by demonstrating one or more of the following:

- a) A substantial lack of knowledge or ability to discharge professional obligations within the scope of the physician's or surgeon's practice;
- b) A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other physicians or surgeons in the state of Iowa acting in the same or similar circumstances;
- c) A failure by a physician or surgeon to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician or surgeon in the state of Iowa acting in the same or similar circumstances; and
- d) A willful or repeated departure from, or the failure to conform to, the minimal standard of acceptable and prevailing practice of medicine and surgery in the state of Iowa.

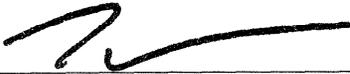
COUNT II

5. Respondent is charged under Iowa Code sections 147.55(3) and 272C.10(3) (2005) and 653 IAC sections 12.4(3) with engaging in a practice harmful or detrimental to the public.

CIRCUMSTANCES

6. Respondent is an Iowa licensed physician who practiced otolaryngology in Keokuk, Iowa.
7. Respondent inappropriately performed surgical procedures on the middle ear without performing proper pre- and postoperative audiometric testing on at least four patients.
8. Respondent inappropriately failed to provide proper postoperative care to at least two sinonasal patients.
9. Respondent inappropriately failed to provide proper postoperative care to at least one tonsillectomy patient.
10. Respondent inappropriately closed his medical office without providing proper notice to his patients.
11. Respondent inappropriately closed his medical office without making proper arrangements for continuation of postoperative care for his surgical patients with another physician.
12. Respondent inappropriately failed to provide proper copies of patient medical records to other physicians to ensure appropriate continuation of care after Respondent discontinued treatment of his patients.

On this the 10th day of November, 2005, the Iowa Board of Medical Examiners finds
cause to file this Statement of Charges.



Bruce L. Hughes, M.D., Chairperson
Iowa Board of Medical Examiners
400 SW 8th Street, Suite C
Des Moines, Iowa 50309-4686