

BEFORE THE IOWA BOARD OF MEDICINE

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

ROBERT K. FINLEY, III, M.D., RESPONDENT

FILE Nos. 02-06-096 & 02-06-566

SETTLEMENT AGREEMENT

COMES NOW the Iowa Board of Medicine (Board), and Robert K. Finley, III, M.D., (Respondent), on June 30, 2011, and pursuant to Iowa Code sections 17A.10(2) and 272C.3(4), enter into this Settlement Agreement to resolve this matter.

1. Respondent was issued Iowa medical license No. 35787 on August 26, 2004.
2. Respondent's Iowa medical license expired due to non-renewal on October 1, 2006.
3. The Board has jurisdiction in this matter pursuant to Iowa Code chapters 147, 148 and 272C.
4. Respondent formerly practiced general surgery at Mercy Medical Center, in Des Moines, Iowa.
5. Respondent currently practices surgery at the Veterans Administration Medical Center in Huntington, West Virginia.

6. On April 9, 2010, the Board filed formal disciplinary charges against Respondent alleging that he failed to conform to the minimal standard of care in his treatment of eight patients between January 3, 2005 and January 11, 2006. The Respondent filed an answer to the charges in which he denied that he failed to conform to the standard of care and acceptable practice in the State of Iowa.

7. **REMEDIATION:** Respondent voluntarily completed a year-long remediation program from July 2007 to July 2008 in Huntington, West Virginia, with a board-certified surgeon who served as a proctor for surgical oncology and head and neck operative cases. The surgical proctor indicated that Respondent provided a high level of surgical patient care. This high level of care continues to date as recently indicated by the proctor. Additionally, Respondent provided information to the Board which indicates that he completed significant continuing medical education in pertinent surgical subjects over the past three years. Finally, in December 2008 Respondent successfully passed, and scored well on, his surgery board recertification examination. The Respondent will have an unrestricted license to practice on execution of this settlement Order.

8. **CITATION AND WARNING:** In order to resolve this matter by settlement, the Respondent is hereby CITED for failing to conform to the minimal standard of practice of medicine in Iowa. Respondent is hereby **WARNED** that such practice in the future may result in further formal disciplinary action, including suspension or revocation of his Iowa medical license.

9. **CIVIL PENALTY:** Respondent shall be assessed a civil penalty in the

amount of \$5,000. The civil penalty shall be paid by delivery of a check or money order, payable to the Treasurer of Iowa, to the executive director of the Board. The civil penalty shall be deposited into the State General Fund.

10. Respondent voluntarily submits this Order to the Board for consideration.

11. In the event Respondent fails to comply with any of the terms of this Order, the Board may initiate action to suspend or revoke Respondent's license or to impose other license discipline as authorized in Iowa Code chapters 148 and 272 and 653 IAC 25.

12. Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in Iowa.

13. This Order constitutes the resolution of a contested case proceeding.

14. By entering into this Order, Respondent voluntarily waives any rights to a contested case hearing on the allegations in the Statement of Charges, and waives any objections to the terms of this Order.

15. Respondent agrees that the State's counsel may present this Order to the Board.

16. This Order is subject to approval of the Board. If the Board fails to approve this Order it shall be of no force or effect to either party.

17. The Board's approval of this Order shall constitute a **Final Order** of the Board.

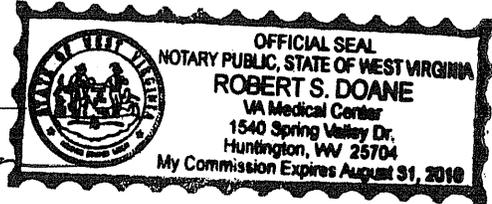
Robert K. Finley III

Robert K. Finley, III, M.D., Respondent

Subscribed and sworn to before me on June 3, _____, 2011.

Notary Public, State of West Virginia

Robert S. Doane



This Order is approved by the Board on June 30, _____, 2011.

Siroos S. Shirazi

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

BEFORE THE IOWA BOARD OF MEDICINE

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

ROBERT K. FINLEY, III, M.D., RESPONDENT

FILE Nos. 02-06-096 & 02-06-566

STATEMENT OF CHARGES

COMES NOW the Iowa Board of Medicine on April 9, 2010, and files this Statement of Charges pursuant to Iowa Code section 17A.12(2). Respondent was issued Iowa medical license no. 35787 on August 26, 2004. Respondent's Iowa medical license is inactive due to non-renewal on October 1, 2006.

A. TIME, PLACE AND NATURE OF HEARING

1. Hearing. A disciplinary contested case hearing shall be held on June 16, 2010, before the Board. The hearing shall begin at 8:30 a.m. and shall be located in the conference room at the Board office at 400 SW 8th Street, Suite C, Des Moines, Iowa.
2. Answer. Within twenty (20) days of the date you are served this Statement of Charges you are required by 653 IAC 24.2(5)(d) to file an Answer. In that Answer, you should state whether you will require a continuance of the date and time of the hearing.
3. Presiding Officer. The Board shall serve as presiding officer, but the Board may request an Administrative Law Judge make initial rulings on pre-hearing matters, and be present to assist and advise the board at hearing.

4. Prehearing Conference. A prehearing conference will be held by telephone on May 5, 2010, at 11:00 a.m., before an Administrative Law Judge from the Iowa Department of Inspections and Appeals (ALJ). Please contact Kent M. Nebel, J.D., Legal Director, Iowa Board of Medicine, at 515-281-7088 with the telephone number at which you or your legal counsel can be reached. Board rules on prehearing conferences may be found at 653 Iowa Administrative Code 25.15.

5. Hearing Procedures. The procedural rules governing the conduct of the hearing are found at 653 IAC 25. At hearing, you will be allowed the opportunity to respond to the charges against you, to produce evidence on your behalf, cross-examine witnesses, and examine any documents introduced at hearing. You may appear personally or be represented by counsel at your own expense. If you need to request an alternative time or date for hearing, you must review the requirements in 653 IAC 25.16. The hearing may be open to the public or closed to the public at the discretion of the Respondent.

6. Prosecution. The office of the Attorney General is responsible for representing the public interest (the State) in this proceeding. Pleadings shall be filed with the Board and copies should be provided to counsel for the State at the following address: Theresa O'Connell Weeg, Assistant Attorney General, Iowa Attorney General's Office, 2nd Floor, Hoover State Office Building, Des Moines, Iowa 50319.

7. Communications. You may not contact board members by phone, letter, facsimile, e-mail, or in person about this Notice of Hearing. Board members may only receive information about the case when all parties have notice and an opportunity to participate, such as at the hearing or in pleadings you file with the Board office and serve upon all parties in the

case. You should direct any questions to Kent M. Nebel, J.D., the Board's Legal Director at 515-281-7088 or to Assistant Attorney General Theresa O'Connell Weeg at 515-281-6858.

B. LEGAL AUTHORITY AND JURISDICTION

8. Jurisdiction. The Board has jurisdiction in this matter pursuant to Iowa Code chapters 17A, 147, 148, and 272C.

9. Legal Authority. If any of the allegations against you are founded, the Board has authority to take disciplinary action against you under Iowa Code chapters 17A, 147, 148, and 272C and 653 IAC 25.

10. Default. If you fail to appear at the hearing, the Board may enter a default decision or proceed with the hearing and render a decision in your absence, in accordance with Iowa Code section 17A.12(3) and 653 IAC 25.20.

C. SECTIONS OF STATUTES AND RULES INVOLVED

COUNT I

11. Respondent is charged with professional incompetency pursuant to Iowa Code sections 147.55(2), 148.6(2)(g) and (i), and 272C.10(2) and 653 IAC 23.1(2)(c), (d), (e), and (f), 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; or
- 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 Iowa.

STATEMENT OF THE MATTERS ASSERTED

12. Respondent formerly practiced general surgery at Mercy Medical Center, in Des Moines, Iowa.

13. Respondent currently practices general surgery in Huntington, West Virginia.

14. Respondent failed to update his address with the Board and the Board had difficulty locating him.

15. The Board received information which raises serious concerns regarding Respondent's treatment of nine surgical patients during a thirteen month period between January 3, 2005 and January 11, 2006, including the following:

Patient #1: The Board alleges that Respondent failed to provide appropriate post-operative care to a patient who underwent a lumpectomy and sentinel node biopsy for breast cancer and the suffered serious post-operative complications;

Patient #2: The Board alleges that Respondent failed to provide appropriate post-operative wound care to a patient who underwent complete right axillary dissection surgery and the patient died following serious post-operative complications;

Patient #3: The Board alleges that Respondent failed to exercise appropriate surgical judgment, surgical performance and post-operative management for a patient who underwent ventral hernia repair surgery and the patient died following serious postoperative complications;

Patient #4: The Board alleges that Respondent failed to exercise appropriate intra-operative and surgical performance for a patient who underwent a percutaneous insertion of subclavian venous catheter and the patient died following serious postoperative complications;

Patient #5: The Board alleges that Respondent failed to exercise appropriate surgical judgment in his care of a patient who underwent surgery to remove a large retroperitoneal mass and the patients suffered serious postoperative complications, in particular, by performing a very complex surgical procedure on a high-risk patient and by failing to refer the patient to a high volume center where such lesions are more commonly managed by a more experienced surgical team;

Patient #6: The Board alleges that Respondent failed to exercise appropriate surgical judgment, particularly performing a very complex surgical procedure on a patient who was at high risk of serious complications, and surgical performance to a patient who underwent surgery to remove a cancerous mass in the esophagus and the patient died following serious postoperative complications;

Patient #7: The Board alleges that Respondent failed to exercise appropriate surgical judgment, particularly providing overly aggressive treatment to a patient who was at high risk of serious complications, and surgical performance for a

patient who was diagnosed with a possible cancerous mass who underwent a distal esophageal endoscopy on a patient and the patient suffered serious postoperative complications;

Patient #8: The Board alleges that Respondent failed to exercise appropriate surgical judgment, particularly performing a very complex surgical procedure to a patient who was at high risk of serious complications, failure to refer the case to a high volume center where such lesions are more commonly managed by a more experienced surgical team, failure to perform greater pre-operative planning and operative performance for a patient who underwent surgery to remove a large cancerous mass in the left kidney, spleen and pancreas and the patient died following serious postoperative complications;

Patient #9: The Board alleges that Respondent failed to exercise appropriate surgical judgment, particularly performing a very complex surgical procedure on a patient who was at high risk of serious complications, failure to perform greater pre-operative planning and surgical performance to a patient with a past history of colon cancer who underwent a right hemicolectomy and ileotransverse colostomy anastomosis and the patient died following serious postoperative complications..

E. SETTLEMENT

16. Settlement. This matter may be resolved by settlement agreement. The procedural rules governing the Board's settlement process are found at 653 IAC 25. If you are interested in pursuing settlement of this matter, please contact Kent M. Nebel, J.D., Legal Director at 515-281-7088.

F. PROBABLE CAUSE FINDING

17. On April 9, 2010, the Iowa Board of Medicine found probable cause to file this Statement of Charges.

A handwritten signature in black ink, appearing to read "Siros S. Shirazi". The signature is written in a cursive style with a large, looping initial 'S'.

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