BEFORE THE IOWA BOARD OF MEDICINE

****

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

GLENN C. KRUG, D.O., RESPONDENT

FILE Nos. 03-97-375, 03-99-155, 03-07-198, 03-07-224 &03-07-452

****

SECOND STIPULATED ORDER

****

COMES NOW the Iowa Board of Medicine (Board), and Glenn C. Krug, D.O., (Respondent), on December 16, 2010, and enter into this Stipulated Order.

1. Respondent was issued Iowa medical license no. 01793 on May 12, 1980.

2. Respondent's Iowa medical license is active and will next expire on June 1, 2011.

3. The Board has jurisdiction in this matter pursuant to Iowa Code chapters 147, 148 and 272C.

4. Respondent formerly practiced obstetrics and gynecology in Davenport, Iowa.

5. On February 11, 2008, the Board filed disciplinary charges against Respondent alleging that he engaged in a pattern of professional incompetency and practice harmful or detrimental to the public.

6. On May 13, 2009, following a hearing, the Board issued a Findings of Fact, Conclusions of Law, Decision and Order. The Board issued Respondent a Citation and Warning and placed him on indefinite probation subject to Board monitoring.

7. On July 15, 2009, Respondent retired from the practice of medicine.

8. On September 2, 2009, Respondent entered into a Stipulated Order with the Board and he agreed not to engage in any aspect of the practice of medicine until he fully complies with the terms and conditions of the May 13, 2009, Findings of Fact, Conclusions of Law, Decision and Order, and receives prior written approval from the Board.

9. Recently, Respondent contacted the Board and indicated that he wished to voluntarily surrender his Iowa medical license.

10. **VOLUNTARY SURRENDER:** Respondent voluntarily surrenders his Iowa medical license to resolve this matter.

11. In the event Respondent practices medicine in violation of this Order, the Board may initiate appropriate action to revoke or suspend Respondent's license or to impose other licensee discipline as authorized in Iowa Code Section 272C.3(2)(a).

12. This Order is a public record.

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

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 voluntarily submits this Order to the Board for consideration.

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.

Glenn C. Krug, D.O., Respondent

Subscribed and sworn to before me on October 25, 2010.

Notary Public, State of Iowa.

LORNA KOLEHMAINEN
Commission Number 759294
My Commission Expires
07-27-2011

This Order is approved by the Board on December 16, 2010.

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

GLENN C. KRUG, D.O., RESPONDENT

FILE Nos. 03-97-375, 03-99-155, 03-07-198 & 03-07-224

****

STIPULATED ORDER

****

COMES NOW the Iowa Board of Medicine (Board), and Glenn C. Krug, D.O., (Respondent), on September 2, 2009, and enter into this Stipulated Order.

1. Respondent was issued Iowa medical license no. 01793 on May 12, 1980.

2. Respondent's Iowa medical license is active and will next expire on June 1, 2011.

3. The Board has jurisdiction in this matter pursuant to Iowa Code chapters 147, 148 and 272C.

4. Respondent practiced obstetrics and gynecology in Davenport, Iowa.

5. On February 11, 2008, the Board filed disciplinary charges against Respondent alleging that he engaged in a pattern of professional incompetency and practice harmful or detrimental to the public.

6. On May 13, 2009, following a hearing, the Board issued a Findings of Fact, Conclusions of Law, Decision and Order. The Board issued Respondent a Citation and Warning and placed him on indefinite probation subject to Board monitoring.

7. On July 15, 2009, Respondent retired from the practice of medicine.

8. Respondent agrees that he shall not engage in any aspect of the practice of medicine until he fully complies with the terms and conditions of the May 13, 2009, Findings of Fact, Conclusions of Law, Decision and Order, and receives prior written approval from the Board.

9. In the event Respondent practices medicine in violation of this Order, the Board may initiate appropriate action to revoke or suspend Respondent's license or to impose other licensee discipline as authorized in Iowa Code Section 272C.3(2)(a).

10. This Order is a public record.

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

12. 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.

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

14. 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.

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

Glenn C. Krug, D.O., Respondent

Subscribed and sworn to before me on 2 SEP, 2009.

Notary Public, State of _____.

This Order is approved by the Board on September 2, 2009.

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:	)	**DIA NO. 08DPHMB008**
	)	**CASE NOS. 03-97-375,**
	)	**03-07-198, 03-07-224**
	)	
GLENN C. KRUG, D.O.	)	**FINDINGS OF FACT,**
	)	**CONCLUSIONS OF LAW,**
Respondent	)	**DECISION AND ORDER**

On February 11, 2008, the Iowa Board of Medicine (Board) found probable cause to file a Statement of Charges against Glenn C. Krug, D.O. (Respondent) charging him with professional incompetency and engaging in practice harmful or detrimental to the public. The Statement of Matters Asserted specified that the charges relate to the care and treatment provided by Respondent in three cases. A hearing was initially scheduled for March 26, 2008, but was later continued to March 30 and 31, 2009.

The hearing was held on March 30, 2009 before the following quorum of the Board: Yasyn Lee, M.D., Chairperson; Rodney Zeitler, M.D.; Janice Galli, D.O.; Jeff Snyder, M.D.; Dana Shaffer, D.O.; and Paul Thurlow, public member. Respondent was represented by attorney Justin E. LaVan. 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 Board in conducting the hearing and was instructed to prepare a written decision, in accordance with their deliberations.

THE RECORD

The record includes the Statement of Charges, Continuance Orders and Hearing Orders, Motion to Quash, Order Granting Motion to Quash, testimony of the witnesses, State Exhibits 1-43 (See Exhibit Index for description; Exhibit 43 is an article entitled "Peripartum Cardiomyopathy" from JAMA, Vol. 283, No. 9), Respondent Exhibits A-P (see Exhibit Index for description; Exhibit P is an article entitled "Clinical manifestations and diagnosis of myocarditis in adults", from UpToDate).

FINDINGS OF FACT

Respondent Education, Licensure and Disciplinary History

1. Respondent graduated with honors from the Philadelphia College of Osteopathic Medicine and then completed a residency in Columbus, Ohio from 1976-1980. Respondent was issued Iowa medical license no. 01793 on May 12, 1980. He has practiced obstetrics and gynecology in Davenport, Iowa for twenty-nine years and was board certified in 1985. He is in a solo medical practice and is on staff at two Davenport hospitals. (Testimony of Respondent; State Exhibit 4)

2. On March 17, 1997, the Board issued Respondent a Letter of Warning following a review of investigative materials pertaining to Respondent's interactions with staff and students in a hospital operating room. The Letter of Warning did not constitute formal disciplinary action. (State Exhibit 40)

3. On February 10, 2005, the Board filed a Statement of Charges against Respondent charging him with willfully violating a lawful rule of the Board when he failed to complete a mental, physical or substance abuse evaluation as ordered by the Board. (State Exhibit 37) Respondent later complied with the evaluation order, and the assessment program recommended individual counseling, couples counseling, abstinence from alcohol and addictive drugs, drug screening, and a thorough cardiology work-up. (State Exhibit 38)

4. On June 2, 2005, Respondent and the Board entered into a Settlement Agreement and Final Order, which cited and warned Respondent for inappropriately prescribing controlled substances to members of his immediate family and for failing to maintain appropriate records for controlled substances maintained in his office. Respondent was assessed a $2,500 civil penalty, was prohibited from maintaining controlled substances in his medical office, and was required to complete no less than 15 credit hours of Category I continuing medical education for appropriate medical record keeping practices. For a period of two years, Respondent was required to fully comply with a practice monitoring program, and to fully comply with all recommendations made by the Board-approved treatment program. (State Exhibit 38)

5. On November 17, 2005, the Board sent Respondent a Letter of Warning following its review of investigative materials concerning his care of three patients. Although the Board chose not to pursue formal disciplinary action at that time, Respondent was cautioned that if further concerns were brought to the Board's attention in the future, these cases could be reopened and consider further action. The care of one of these three patients (TO) is at issue in the present case before the Board. Respondent's request for reconsideration of the Letter of Warning was denied. (State Exhibits 16, 41, 42)

6. On November 8, 2007, Respondent and the Board entered into a Statement of Charges and Settlement Agreement to resolve pending charges that Respondent failed to comply with a Board Order and engaged in unethical or unprofessional conduct in the practice of medicine. Respondent was cited and warned, assessed a $5,000 civil penalty, and placed on probation for a period of five years, subject to conditions and terms related to substance abuse. (State Exhibit 39)

Patient TO

7. TO received prenatal care from Respondent from August 19, 1996, through January 13, 1997. This was the 22-year-old patient's second pregnancy, and she had been diagnosed with gestational diabetes. During her first pregnancy, in 1992, TO was diagnosed with toxemia. The treatment decisions at issue occurred on January 12 and 13, 1997, when TO was at 35 weeks gestation. TO passed away at home the evening of January 13, 1997. (State Exhibits 4-6, 8, 9, pp. 1-4, 6)

On or about January 2, 1997, another physician prescribed antibiotics (amoxicillin) for TO as treatment for an upper respiratory infection, possibly bronchitis. TO was seen by Respondent for an obstetrical visit on January 6, 1997, and there is an entry by Respondent's nurse indicating that TO was in the office for a non stress test on January 9, 1997. The limited documentation at these visits does not include any mention of the patient's upper respiratory infection or the amoxicillin that she was taking. (State Exhibit 9, pp.3-4)

TO lived with her young son and her fiancé. TO's fiancé reported that TO's symptoms became progressively worse from Friday, January 10, 1997, through Sunday, January 12th. He reported that when he got home from work on Friday night, TO had been coughing, vomiting, and was having problems breathing. TO's condition worsened Saturday night. She was in the bathroom most of the night vomiting and had been unable to sleep. Her fiancé described her condition and appearance by Sunday morning as very pale, dizzy, and pretty weak. (Testimony of Donnie Kiddoo; State Exhibit 4, p. 2).

TO's fiancé convinced her to go to the hospital on Sunday morning, January 12th. TO was sent directly to the hospital's Obstetrical Department, where she was admitted for 23 hour observation at 9:16 a.m. and examined by a nurse. TO's fiancé testified that they both talked to the nurse, and he explained TO's recent symptoms very clearly. According to the nurse's notes, TO reported that she had:

- lower abdominal pressure secondary to continuous coughing;
- an upper respiratory infection for ten days for which she was taking amoxicillin but had worsening symptoms;
- yellow sputum and a fever of 102 degrees Fahrenheit on Saturday, January 11th.

(State Exhibit 7, p.7)

The nurse examined TO and documented that:

- her temperature was 98 degrees;
- her lungs were clear but she had diminished air exchange in the right base;
- fetal monitor tracing revealed a range of 140-150 bpm with average long term variability;
- her cervix was finger tip dilated at the external os and 50% effaced.

(State Exhibit 7, p. 7) The nurse paged Respondent at 10:40 a.m. and then reached him by telephone at home at 11:00 a.m. The nurse reported the patient's presence at the hospital and all of the information concerning her condition. Respondent did not go to the hospital to examine the patient but ordered a change of antibiotic to

Zithromax.[1] He also told the nurse to instruct the patient to keep her OB appointment for the following day. The patient was discharged from the hospital at 11:15 a.m. and sent home with instructions to pick up her prescription at Walgreen's and to keep her next obstetrical appointment. (State Exhibit 7, pp. 3, 7, 12)

8. TO's fiancé reports that on Sunday night TO continued to have nausea and vomiting. She was coughing and short of breath. Very early Monday morning, TO's fiancé started calling Respondent's office to see if he could get her an earlier appointment. He eventually arranged for her to be seen at 11:00 a.m., a half hour earlier than her scheduled appointment. TO's fiancé described TO's appearance and condition on January 13, 1997 as very pale and weak, and she had to lean on him as they walked into Respondent's office. TO was so worn out that TO's fiancé did most of the talking to Respondent's nurse and described her worsening symptoms throughout the weekend. He recalled that TO continued to cough and be short of breath. At one point, TO threw up or coughed up something that looked bloody while she was in the examination room, and her fiancé showed it to the nurse. (State Exhibit 4, p.3; Testimony of Donnie Kiddoo)

Respondent's office nurse of 19 years testified at hearing and identified the entries in the patient chart for January 13th as her handwriting. (State Exhibit 9, p. 3) The nurse did not recall that TO needed assistance walking, that she had an unsteady gait, or that TO had attempted to get an earlier appointment that morning. The nurse testified that at this point in time, she does not recall TO having shortness of breath or difficulty breathing and further testified that she would have documented those symptoms if she observed them. Her practice is to chart any problems. She knew that the patient had been at the hospital the previous day and had her antibiotics changed but could not recall how she knew this, and it is not documented in the office record. (Testimony of Melinda King; State Exhibit 9, pp. 1-4)

According to the office record, Respondent's nurse examined TO and recorded her weight, blood pressure, symptoms of nausea and vomiting and pedal edema, the fetal heart rate,

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[1] Some of the later records refer to the new antibiotic as erythromycin but the discharge instructions list Zithromax as the new antibiotic. (State Exhibit 7, p. 12) This discrepancy is not pertinent.

and laboratory results. The nurse further documented that the patient complained of nausea and vomiting "all weekend & today." The fetal heart rate was in the 150's and a fetal non-stress test was performed. The patient's blood pressure was normal at 110/72. The patient's urine sugar was negative but she had +1 albumin and +2 ketones.[2] The patient was given an injection of Droperidol 2.5 mg for her nausea. (State Exhibit 9, pp. 3-4)

Respondent saw the patient in the office following his nurse's examination, but he did not listen to or examine the patient's heart or lungs. It appears that the Respondent made the entries in the patient record for the fundus height and presentation and added his initials and word "Advised." (State Exhibit 9, pp. 3-4) Respondent explained the numerous potential side effects of the Droperidol to TO and her fiancé and told TO to call him if she had any changes. TO's fiancé was quite concerned about the side effects of the Droperidol and asked Respondent if it would be possible to take the baby early, something he had discussed with them when TO was diagnosed with gestational diabetes. (Testimony of Respondent; Donnie Kiddoo; Melinda King)

Respondent sent TO home and instructed her to sip warm flat 7-Up every half hour and then to try toast after she could keep the 7-UP down. After stopping at the grocery store for 7-UP, TO and her fiancé went home and TO went to bed. TO's fiancé got her four-year-old son ready and took him to his grandparent's house. TO's fiancé attended a court-ordered class and then stopped at a friend's house. When he arrived back home later that evening, he found TO had passed away. The medical examiner estimated her time of death at 7:00 p.m. (Testimony of Donnie Kiddoo; State Exhibit 9, p. 6; State Exhibit 4, p. 5)

9. An autopsy was performed on TO the following day. The only anatomic finding at autopsy was severe pulmonary edema. A large amount of fluid (500 ml) was removed from each lung. Microscopic examination of the heart revealed severe myocarditis with subsequent cardiac failure as the primary cause of death. The heart was moderately enlarged with a dilated right ventricle. Changes in the heart suggested a viral etiology although no virus was isolated from the lung. The autopsy report notes that death was due

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[2] These laboratory results were signs of dehydration. (Testimony of Robert Sieman, D.O.)

to natural causes because myocarditis of this magnitude can and does cause sudden cardiac death. (State Exhibit 9, pp. 7-11).

In developed countries, viral infection is the most frequent cause of myocarditis. A history of recent upper respiratory infection or enteritis may be elicited in the majority of cases of viral myocarditis. The symptoms of myocarditis are variable but typically include chest pain, shortness of breath, difficulty breathing, edema, low blood pressure, irregular pulse, nausea and vomiting. Myocarditis may present with unexpected sudden death. (Testimony of Robert Sieman, D.O.; Harry Farb, M.D.; State Exhibit 43; Respondent Exhibit P)

10. TO's case was first reported to the Board in September 1997. (State Exhibits 5, 6). An investigation was opened, medical records were obtained, TO's fiancé and Respondent were both interviewed in the spring of 1998, and TO's case was eventually referred to a peer review committee consisting of two board-certified family practice physicians. (State Exhibits 4-10). On April 23, 2001, the peer review committee issued its report and concluded that Respondent failed to exercise that degree of care ordinarily exercised by the average physician in Iowa under similar circumstances. Based on the available records, the committee concluded that Respondent's practice falls below the acceptable minimal standard. These conclusions were based on the following findings:

- Respondent insufficiently documented his primary involvement in the case;
- Respondent relied too heavily on nursing personnel to perform the basic diagnostic interventions of a history and physical examination;
- Respondent's lack of primary involvement with the patient was a significant factor in her timely demise; if Respondent had been present and had performed a thorough physical examination, the intensity of her care would have been elevated.

(State Exhibit 11)

11. In 2001, after reviewing the peer review report on TO's case, the Board decided to look at Respondent's open malpractice cases and request a practice review. For some reason this was not accomplished, and the case was not

brought back to the Board's attention until August 2004. At that time, Board staff requested and obtained further information concerning Respondent's complication rates, documented complaints, and adverse actions. (State Exhibit 12-15) This culminated in the issuance of the November 17, 2005, Letter of Warning, which was described in Finding of Fact #5. The Letter of Warning advised Respondent that the Board had various serious concerns that his care of TO was negligent and fell below the minimum standard of care in Iowa. Respondent was warned that the Board may reopen its investigation in the future. (State Exhibits 16, 41)

Patient AO and Her Infant

12. AO, a 26-year-old full-term first-time expectant mother, was admitted to Genesis Medical Center in active labor on April 21, 2003 at 5:20 p.m. AO was attended in labor by a certified nurse midwife, who consulted Respondent. AO's membranes ruptured at 7:40 p.m., revealing a moderate amount of meconium stained[3] amniotic fluid. The first stage of labor lasted 11 hours and 58 minutes. AO was completely dilated at 11:50 p.m., and duration of the second stage of labor was 3 hours and 46 minutes. A male infant weighing 8 lb. 15 oz. was stillborn at 3:44 a.m. (State Exhibit 24, pp. 22, 37, 61)

Initially the baby's heart tones were only monitored externally. An internal fetal heart monitor was applied with a scalp electrode at 1:15 a.m., after variable decelerations with a subtle late component had been noted. (State Exhibit 24, pp. 61, 135) AO was given a 1-liter bolus by IV with oxygen and changes in position. (State Exhibit 24, pp. 52, 61) The nurse-midwife and AO discussed the option of a caesarean section (C-section) delivery.

At 1:20 a.m., the nurse-midwife called Respondent and reported that the patient had been pushing for 1 hour and twenty minutes,[4] was fatigued, and that there was non-reassuring fetal heart tones. The nurse-midwife requested Respondent's immediate presence at the hospital to evaluate the patient for C-section delivery. She also called the

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[3] Meconium staining is a red flag that may or may not reflect problems with the baby. (Testimony of Dr. Robert Sieman)

[4] For a first delivery, the general benchmark second (pushing) stage is two hours, although the length of time a mother is allowed to push varies depending on the progress being made. (Testimony of

operating room staff to prepare for a C-section delivery. (State Exhibit 24, pp. 52, 61)

Respondent arrived at the birthing unit at 2:05 a.m. and performed a pelvic examination. He determined that the fetus was at station +2. He told AO to continue her pushing efforts. The fetal monitor tracing showed variable decelerations and decreased short-term variability. According to the nurse midwife's documentation, Respondent remained on the birthing unit and evaluated the fetal heart tones via the central monitor.[5]

The nurse-midwife called Respondent at 3:00 a.m. to discuss the fetus' slow descent and the fetal heart tones. Respondent examined the patient at 3:15 a.m. and noted caput with excellent pushing efforts. He recommended that the patient continue her pushing efforts and to prepare for C-section if no further progress was made in the next 15 minutes. (State Exhibit 24, pp. 61, 63)

At 3:26 a.m., the nurse midwife noted increased duration of the variable decelerations with minimum short-term variability to 55-60 bpm lasting 60-80 seconds. Dr. Prasad was called to the room and a large midline episiotomy was made. Respondent was called back into the room as the baby was crowning, and he assisted with a moderate to severe shoulder dystocia.[6] At 3:31 a.m. the fetal heart rate decreased to less than 60 bpm requiring intervention and delivery within 30 minutes. Respondent and the nurse-midwife performed maneuvers to deliver the baby when they noticed that the nuchal cord was tightly wrapped x2 around the infant's neck. The cord was cut, and Respondent performed additional maneuvers to deliver the anterior shoulder. About 3 minutes passed between cutting the cord and delivery of the infant at 3:44 a.m. The infant had 0/0 Apgar scores and was taken to the warmer for resuscitation by Dr. Prasad. Resuscitative efforts failed, and the infant was pronounced dead 23 minutes after delivery. (State Exhibit 24, pp. 24, 62)

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[5] However, Respondent testified that he went to lie down in a room approximately fifty feet away from the patient and did not monitor what was going on with the fetal heart pattern until he was called again by the nurse-midwife between 3:00 and 3:15 a.m. (Testimony of Respondent)

[6] Shoulder dystocia is when the infant's shoulders impinge upon the bony pelvis requiring maneuvering in order to deliver the baby. Shoulder dystocia is usually not predictable and has been described as the obstetrician's nightmare. (Testimony of Robert Sieman, D.O.)

This case was brought to the Board's attention when an insurance company provided notice that it had settled a malpractice claim and paid $100,000 to AO and her husband on Respondent's behalf. (State Exhibits 19-23)

Patient QY

13. In March 2007, the Board was notified of a pending malpractice suit alleging that Respondent failed to diagnose and properly treat pre-term labor in patient QY, resulting in the baby's death after 15 days. (State Exhibits 28, 29) Respondent was sent a letter of inquiry on April 9, 2007, and Respondent's attorney responded and submitted the requested records on April 27, 2007. (State Exhibits 30-36)

14. QY, a 22-year-old expectant mother, received prenatal care from Respondent from September 21, 2004 though February 9, 2005. (State Exhibit 32, pp. 1-2). On February 8, 2005, QY was at 26 and 6/7 weeks gestation when she presented to Genesis Medical Center reporting intermittent contractions since February 5, 2005. (State Exhibit 32, p. 4)

The patient was admitted at 11:25 p.m. and orders were obtained by telephone from Respondent for staff to obtain a fetal fibrenectin[7] test and to perform a cervical examination. The fetal fibrenectin was negative and a cervical examination at 11:42 a.m. revealed that QY had a closed cervix, with 50% effacement and -2 station. (State Exhibit 32, pp. 12, 16, 19, 21)

At 1:26 a.m. on February 9, 2005, nursing staff notified Respondent at home that QY had a negative fetal fibronectin test, a closed cervix, contractions occurring every 4-5 minutes and lasting 3-4 seconds, and a negative urinalysis. (State Exhibit 32, pp. 11-12) Respondent gave orders of 20 mg of nifedipine sublingual stat, reevaluate in one hour, and call with a report. At 2:20 a.m., the nursing note states that QY had not had any contractions since receiving the medication and requested discharge home to care for her two children. (State Exhibit 32, p. 19) At 2:32 a.m.

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[7] The fetal fibrenectin test is performed using a Q-Tip and swabbing the patient's cervix for a period of ten seconds to obtain a sample. A negative test is reportedly 99.5% predictive that the patient will not deliver within the next 12 weeks. (Testimony of Harry Farb, M.D.)

Respondent ordered Procardia XL, an oral tocolytic[8], and discharge home. The patient was discharged at 2:40 a.m. on February 9, 2005 and reminded to keep her regularly scheduled appointment with Respondent on February 9, 2005 at 3:00 p.m. (State Exhibit 32, pp. 9-10, 12, 29)

Respondent saw QY in his office on February 9, 2005 but did not perform his own cervical evaluation. The patient's only recorded complaint was nausea, and the tocolytic agent was not continued. (State Exhibit 32, p. 2)

On February 10, 2005 at 5:39 p.m., QY was again admitted to the hospital for contractions. (State Exhibit 33, p. 1) The nursing flow sheet documents that at 7:14 p.m. the patient's cervix was 1.5 cm dilated with 30% effacement, and the fetus was at a high station. At 7:20 p.m., Respondent was notified that the patient had arrived and oral hydration had been started. QY was not very uncomfortable and wanted to go home to eat her birthday dinner. However after a clean catch urine specimen was collected, QY was suddenly very uncomfortable with contractions. The external fetal monitor was not tracing the contractions, and the patient reported that they were lower in her abdomen. Respondent gave orders for the nurse to stand at QY's bedside and palpate the contractions and call back when the UA results were available. (State Exhibit 33, pp. 6, 9)

The urinalysis results revealed cloudy urine, increased white blood cells, positive white blood cell esterase, increased red blood cells, and moderate bacteria. (State Exhibit 33, p. 19) A prescription for antibiotics was called into a pharmacy for the patient's urinary tract infection, and she was discharged home at 8:30 p.m. (State Exhibit 33, pp. 6-7)

QY spent the night with a relative. During the night she started feeling pressure, went into the bathroom, and noticed that the baby's head was presenting. She delivered the baby herself and called for help. The baby cried right away and paramedics arrived within five minutes, tied the cord, and brought the baby to the hospital. The baby's Apgar scores were 7 and 9. However, the baby passed away approximately two weeks later due to complications from the

[8] A medication to stop labor. (Testimony of Robert Sieman, D.O.)

premature birth. (State Exhibits 34, pp. 10-17; State Exhibit 29)

Summary of Expert Opinions

15. The Board submitted five of Respondent's cases to Robert Sieman, D.O., a board-certified OB/GYN, for his review and opinion concerning Respondent's compliance with the applicable standard of care. Dr. Sieman submitted a written report on January 13, 2008, in which he concluded that Respondent failed to exercise, in a substantial respect, that degree of care which is ordinarily exercised by the average physician in Iowa acting in the same or similar circumstances, in his care and treatment of TO, AO, and QY. The hearing record also includes Dr. Sieman's deposition and his testimony. (Testimony of Robert Sieman, D.O.; State Exhibits 2, 3; Respondent Exhibit H)

a. Dr. Sieman concluded that Respondent substantially deviated from the standard of care when he decided not to see patient TO while she was at the hospital on January 12, 1997, failed to perform a pulmonary or cardiac evaluation when she was seen in his office on the following day, and failed to document a patient evaluation, other than an obstetrical evaluation, at the office visit. Dr. Sieman conceded that at this point in time there is no way to know whether the patient's death from myocarditis was preventable. However, the patient's ongoing and worsening symptoms over a period of more than ten days, including nausea and vomiting, coughing, and shortness of breath, required Respondent to evaluate her respiratory and cardiac status, at least by listening to her lungs and heart, when she presented in his office on January 13, 1997. If he had done so, it may have led to a consultation with a pulmonologist or cardiologist and her death might have been prevented.

b. With respect to AO, Dr. Sieman concluded that Respondent's failure to intervene sooner to deliver AO's infant, either by caesarean section or by an operative delivery with forceps or vacuum, constituted a substantial deviation from the standard of care. This opinion was based on the fetal monitoring tracings which showed persistent variable decelerations with a late component[9] and

[9] When type 1 decelerations occur during the pushing stage, typically the fetal heart tones coincide with the contractions. When there is a

a decrease in beat to beat variability as well as the slow progress of AO's labor. Beat to beat variability is a key factor in determining fetal well being, and poor variability signifies that the baby's oxygenation could be compromised. The variable decelerations with the late component could be a sign of cord compression or nuchal cord.[10] Based on the fetal monitor tracings and slow progression in labor, Dr. Sieman believed that Respondent should have made a decision on whether to proceed with a C-section or an operative delivery by 2:30 a.m.

c. With respect to QY, Dr. Sieman initially concluded that it was a substantial deviation from the standard of care on February 10, 2005 when Respondent failed to perform a cervical evaluation, prescribe tocolytic agents, and admit the patient for observation to monitor her contractions and evaluate her for preterm labor. At hearing, Dr. Sieman reiterated his opinion that despite the negative fetal fibrenectin test, the failure to perform a cervical evaluation and admit the patient for observation on February 10, 2005 was a deviation from the standard of care but agreed that it was not a substantial deviation.

16. All three patient cases were reviewed by Respondent's expert witness, Harry F. Farb, M.D., who is a board certified OB/GYN. Dr. Farb submitted a written report and an affidavit, was deposed prior to hearing, and testified at hearing. For all three patients, Dr. Farb concluded that Respondent conformed to the degree of skill, care, and learning ordinarily possessed and exercised by other obstetricians in similar circumstances. (Testimony of Harry F. Farb, M.D.; Respondent Exhibits A-D)

a. Dr. Farb concluded that Respondent did not have reason to believe that TO was seriously ill when she appeared for her regular OB appointment on January 13, 1997 because her hospital and clinical records do not indicate symptoms of acute distress, congestive heart failure, pulmonary edema, or other cardiac or pulmonary conditions. He considered her symptoms of nausea and vomiting and pedal edema to be common symptoms of pregnancy and noted that her blood pressure was within normal limits. In his opinion it

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late component, the fetal heart rate continues to be down even after the contraction is going down. (Testimony of Dr. Robert Sieman)

[10] Umbilical cord around the baby's neck. (Testimony of Dr. Robert Sieman)

was within the standard of care to prescribe Droperidol for nausea and vomiting, perform only a standard obstetrical evaluation, and send her home.

b. Dr. Farb concluded that there were no indications that AO's fetus was in acute distress when Respondent reviewed the fetal monitor tracings at 2:05 a.m. when he arrived at the hospital. In his opinion, it was within the standard of care for Respondent to leave the patient's bedside and entrust her to the nurse-midwife. He further opined that when Respondent was called again at 3:00 a.m., the tracings were indeterminate[11] rather than ominous and were not indicative of significant fetal hypoxia with significant acidosis. He further opined that since the shoulder dystocia was not predictable or preventable, it was a judgment call whether to proceed with a C-section, operative delivery, or continued pushing. Dr. Farb did not believe that standard of care required intervention and delivery until the fetal heart tones dropped to 60 bpm at 3:31 a.m. He concluded that Respondent satisfied the standard of care because the baby was delivered within thirty minutes at 3:44 a.m.

c. Dr. Farb concluded that Respondent's care and treatment of QY conformed to the standard of care because he had no reason to suspect QY was suffering from pre-term labor when she complained of contractions on February 8-9, 2005 because the fetal monitor tracings showed minimal uterine activity, the nurse's pelvic exam revealed that the patient's cervix was closed, the fibronectin test was negative, and the urinalysis test was negative. In Dr. Farb's opinion, Respondent's decision to prescribe Procardia for the patient's contractions went above and beyond the standard of care. Dr. Farb further concluded that the patient's condition was not significantly different when she returned to the hospital on February 10, 2005, that Respondent appropriately ordered a nurse to attempt to manually palpate the patient's contractions when

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[11] Dr. Farb referred to the September 2008 National Institute of Child Health and Human Development (NICHD) Workshop Report on Electronic Fetal Monitoring, which recommended a three-tier system for categorizing fetal heart rate (FHR) tracings as Category I (normal), Category II (indeterminate) and Category III (abnormal). In his opinion, the fetal heart tracings were indeterminate because there was no tachycardia, bradycardia, and no severe repetitive decelerations. According to Dr. Farb, in order to be considered severe, the heart rate has to drop to at or below 70 bpm and persist at that level for at least a minute. (Testimony of Harry Farb, M.D.; State Exhibit J)

they were not being traced on the monitor, and that he properly treated the patient's urinary tract infection with antibiotics. Dr. Farb concluded that it was appropriate to send QY home without prescribing additional tocolytics.

17. In addition, Respondent submitted the affidavits of three physicians (a board-certified pathologist, a board-certified OB/GYN, and a board-certified pediatrician), which had been submitted in the civil lawsuit filed by QY against Respondent. The pathologist examined the placenta tissue of QY's infant and determined that the preterm delivery was associated with amniotic fluid infection. (Respondent Exhibit E) The OB-GYN and pediatrician both stated that tocolytic therapy is contraindicated and below the standard of care when the patient has evidence of chorioamnionitis. They further stated that even if Respondent had continued tocolytic therapy and precautions to delay labor, it is likely that baby would have been born prematurely within 2 and 7 days and would still have a higher or similar risk of developing necrotizing enterocolitis. (Respondent Exhibits F, G)

CONCLUSIONS OF LAW

As pointed out by Respondent, the state has the burden of establishing by a preponderance of the evidence[12] that Respondent has demonstrated one or more of the following:

A. A *substantial* lack of knowledge or ability to discharge professional obligations within the scope of his practice;[13]

B. A *substantial* deviation from the standards of learning and skill ordinarily possessed and applied by other physicians or surgeons in the state of Iowa acting in the same or similar circumstances;[14]

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

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[12] *Eaves v. Iowa Bd. Of Medical Examrs., 467 N.W.2d 234, 237 (Iowa 1991).*

[13] Iowa Code section 147.55(2), 272C.10(2), 653 IAC 23.1(2)"c." [Note: The substance of the Board's statutes and rules concerning professional incompetency did not change in the time period relevant to this decision and order, 1997 through 2005, although the Board's rules have been renumbered and were previously found at 653 IAC 12.4.]

[14] Iowa Code section 147.55(2), 272C.10(2), 653 IAC 23.1(2)"d."

the state of Iowa acting in the same or similar circumstances.[15]

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.[16]

E. Engaging in practice harmful or detrimental to the public.[17]

The rules referred to in paragraphs A-C require proof of a substantial deviation from the standard of care, but the rule referred to in paragraph D provides that ordinary negligence is grounds for discipline if it is either willful or repeated.

Patient TO

The Board reviewed the patient records, autopsy report, medical literature, and the expert witness opinions concerning Respondent's care and treatment of TO and concluded that Respondent violated Iowa Code section 147.55(2), 272C.10(2), and 653 IAC 23.1(2)"e" by failing to exercise, in a substantial respect, that degree of care which is ordinarily exercised by the average physician or surgeon in Iowa acting in the same or similar circumstances. The Board agreed with the conclusions reached by Dr. Sieman and by the previous peer review in 2001. The Board strongly disagreed with Dr. Farb's conclusion that the standard of care did not require Respondent to perform a heart and lung examination of TO on January 13, 1997. The Board notes that in reaching this conclusion, Dr. Farb discounted Donnie Kiddoo's descriptions of TO's condition on January 13 and relied, at least in part, on the absence of documented symptoms in Respondent's record.

The patient's constellation of symptoms, including an upper respiratory infection with persistent coughing that was continuing to get worse after more than ten days of treatment with antibiotics, an evaluation by the nurse that revealed diminished breath sounds in the right lung base, ongoing nausea and vomiting, weakness, and pedal edema

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[15] Iowa Code section 147.55(2), 272C.10(2), 653 IAC 23.1(2)"e."
[16] Iowa Code section 147.55(2), 272C.10(2), 148.6(2)(g)and (i); 653 IAC 23.1(2)"f."
[17] Iowa Code section 147.55(3); 653 IAC 23.1(3).

required Respondent to perform and document examinations of the patient's heart and lungs. Although nausea and vomiting are common early in pregnancy, they are far less common at 36 weeks. Respondent should have explored whether the patient's nausea and vomiting were secondary to her bronchitis rather than caused by her pregnancy.

The Board believed Donnie Kiddoo's detailed description of TO's very poor physical condition on January 12 and 13, 1997, and his efforts to communicate his concern to Respondent and his nurse. When Respondent did not go to the hospital to examine TO on January 12, 1997, prior to changing her antibiotics, he clearly should have evaluated her respiratory and cardiac status when he saw her in his office the following day. However, Respondent's record and his testimony reveal that he did not perform or document any examination of the patient other than an obstetrical exam. His examination and documentation reflect a lack of attention to detail in caring for this patient.

The patient's condition and her antibiotic change on January 12th clearly required Respondent to document the patient's respiratory symptoms and his treatment in a standard SOAP format, including documentation of the absence of pertinent symptoms relating to her upper respiratory infection if there were none. Respondent's care and treatment of TO constituted a substantial deviation from the standard of care regardless of whether an appropriate heart and lung examination would have changed the patient's outcome. Nevertheless, if Respondent had performed a heart and lung examination and properly assessed the patient's respiratory status, it is possible that Respondent would have referred the patient on for further evaluation and the outcome may have been different.

Patient AO and Her Infant

The Board reviewed the patient records and expert witness opinions concerning Respondent's care and treatment of AO and her infant and concluded that Respondent violated Iowa Code section 147.55(2), 272C.10(2), and 653 IAC 23.1(2)"f" by his repeated departure from or failure to conform to the minimal standard of acceptable and prevailing practice of medicine and surgery in the state of Iowa. The Board generally agreed with the conclusions reached by Dr. Sieman and with his review of the fetal monitor tracings. The Board concluded that once Respondent was called in by the

nurse-midwife to evaluate AO for immediate C-section, he was responsible for her care and should have been actively monitoring both the mother and the fetal heart tracings.

The Board concluded that the fetal monitor tracings began to show significant deterioration at 2:20 a.m. and that the standard of care required intervention and delivery of the infant no later than 2:37 a.m. Dr. Farb conceded that if the infant had been delivered by 2:30 a.m. and before the shoulder dystocia occurred, he would likely have survived though with some risk of spastic quadriparesis due to the nuchal cord. The Board disagreed with Dr. Farb's conclusion that the standard of care did not require Respondent to intervene and deliver the baby prior to 3:31 a.m.

Patient QY

The Board reviewed the patient records and expert witness opinions concerning Respondent's care and treatment of QY and concluded that Respondent violated Iowa Code section 147.55(2), 272C.10(2), and 653 IAC 23.1(2)"f" by his repeated departure from or failure to conform to the minimal standard of acceptable and prevailing practice of medicine and surgery in the state of Iowa. The Board agreed with the conclusions reached by Dr. Sieman that when QY returned to the hospital on February 10, 2005, with contractions, Respondent should have evaluated the patient's cervix for preterm labor. If this evaluation had been negative, the patient could have been discharged. If not, the patient should have been prescribed tocolytics and admitted for observation. The Board concluded that Respondent and Dr. Farb placed far too much reliance on the negative fetal fibrenectin test when the method for collecting the sample leaves much room for error and Respondent did not personally collect the sample.

The Board further concluded that Respondent's practice in these three cases constituted practice that is harmful or detrimental to the public, in violation of Iowa Code section 147.55(3) and 653 IAC 23.1(3). Although the ultimate outcomes in any or all of these cases may not have been substantially different if Respondent had provided treatment in conformance with the applicable standards of care, it is not necessary to show actual injury to the public to establish a violation under these provisions.

The risk of harm to the patients as a result of substandard practice is sufficient to establish the violation.

Sanction

The Board seriously considered the state's request to send Respondent for a comprehensive competency evaluation at a nationally recognized competency assessment program. However, the majority of the Board was persuaded that Respondent possesses sufficient professional knowledge and skill to permit him to practice competently. In addition, Respondent has already completed a comprehensive recordkeeping course pursuant to a prior Board Order. The competency issues established by these three cases pertain to Respondent's failure to exercise that degree of care and attention to detail required for him to actually apply his professional knowledge and skill in a consistent and organized manner. The Board concluded that the competency concerns raised by these three cases may be addressed and remediated through the issuance of a citation and warning, a civil penalty, an indefinite period of probation, and practice monitor requirement.

DECISION AND ORDER

IT IS THEREFORE ORDERED that Respondent Glenn Krug, D.O., is hereby **CITED** for engaging in professional incompetence and practice harmful and detrimental to the public in his obstetrical practice. Respondent is hereby **WARNED** that such practice in the future may result in further disciplinary action, including suspension or revocation of his Iowa medical license.

IT IS FURTHER ORDERED that Respondent shall pay a civil penalty of $10,000. The civil penalty shall be paid within thirty (30) days of the date of this Order and 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 in the State General Fund.

IT IS FURTHER ORDERED that Respondent shall be placed on **Indefinite Probation**, subject to the following terms and conditions:

A. **Monitoring Program:** Respondent shall contact Shantel Billington, Monitoring Programs, Iowa Board

of Medicine, 400 SW 8th Street, Suite C, Des Moines, IA 50309-4686, Ph.#515-281-3654 to establish a monitoring program. Respondent shall fully comply with all requirements of the monitoring program.

B. **Practice Requirements:** Respondent must perform and fully document all examinations required by the acceptable and prevailing standard of care and shall fully document his discussion with the patient of all treatment options and the risks and benefits of those options. When a patient presents with other than routine obstetrical care, Respondent must perform a complete history and physical exam (H&P) and shall complete SOAP-formatted (subjective, objective, assessment, and plan) documentation of the visit.

C. **Practice Monitor:** Respondent shall submit for Board approval the name and CV of an Iowa-licensed, board-certified obstetrician and gynecologist to serve as practice monitor. The Board shall provide the practice monitor a copy of all Board orders relating to this matter. The practice monitor shall provide a written statement indicating that the practice monitor agrees to serve as the practice monitor under the terms of this Order. The Monitor shall review randomly selected patient records representing 10% of all of Respondent's patients in each setting in which Respondent provides patient care.

1) The Monitor shall review Respondent's medical practice to determine if the care provided conforms to the prevailing standard of care, and in particular, the monitor shall review the following areas of concern to ensure that Respondent:
   a) Fully documents all examinations, including his discussion with the patient of all treatment options and the risks and benefits of those options; and
   b) Performs a complete history and physical exam (H&P) and shall complete SOAP-formatted (subjective, objective, assessment, and plan) documentation of the visit when a patient presents with other than routine obstetrical care.

2) The Monitor shall meet in-person with Respondent at least once every two weeks to discuss the records reviewed and the care provided by Respondent.
3) The Monitor shall submit monthly reports to the Board which describe Respondent's compliance with the monitoring agreement and any recommendations made to Respondent.
4) Respondent shall fully comply with any recommendations made by the Monitor or the Board.
5) The Monitor shall notify the Board immediately of any evidence of deviation from the standard of care, violation of the laws or rules governing the practice of medicine in Iowa or a violation of the terms of this Order.

D. **Quarterly Reports:** Respondent shall file sworn quarterly reports attesting to his compliance with all the terms of this Decision and Order. The reports shall be filed not later than 1/10, 4/10, 7/10, and 10/10 of each year of Respondent's probation.

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: Coordinator of Monitoring Programs, 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 the Indefinite Probation imposed by this Decision and Order does not affect or diminish the five-year probation imposed on Respondent, pursuant to the November 8, 2007 Statement of Charges and Settlement

Agreement. Respondent remains independently obligated to fully comply with the terms of that prior Board Order.

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 (30) days of the issuance of a final decision.

Dated this 13th day of May, 2009.

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

cc: Justin E. LaVan
LaMarca & Landry, P. C.
1820 N.W. 188th Street, Suite 200
Des Moines, IA 50325 (CERTIFIED)

Theresa O'Connell Weeg, Assistant Attorney General
Hoover State Office Building
Des Moines, Iowa 50319 (LOCAL)

Judicial review of the board's action may be sought in accordance with the terms of the Iowa administrative procedure act, from and after the date of the Board's order.

BEFORE THE IOWA BOARD OF MEDICINE

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IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

GLENN C. KRUG, D.O., RESPONDENT

FILE Nos. 03-97-375, 03-99-155, 03-07-198 & 03-07-224

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STATEMENT OF CHARGES

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COMES NOW the Iowa Board of Medicine on February 11, 2008, and files this Statement of Charges pursuant to Iowa Code section 17A.12(2)(2007). Respondent was issued Iowa medical license no. 01793 on May 12, 1980. Respondent's Iowa medical license is active and will next expire on June 1, 2009.

A. TIME, PLACE AND NATURE OF HEARING

1. Hearing. A disciplinary contested case hearing shall be held on March 26, 2008, 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 prehearing matters, and be present to assist and advise the board at hearing.

4. 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 or closed to the public at the discretion of the Respondent.

5. 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.

6. Communications. You may not contact board members by phone, letter, facsimile, e-mail, or in person about this matter. 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., Legal Director at 515-281-7088 or to Assistant Attorney General Theresa O'Connell Weeg at 515-281-6858.

B. LEGAL AUTHORITY AND JURISDICTION

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

8. 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.

9. 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

10. 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; 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

11. Respondent is charged under Iowa Code section 147.55(3) and 653 IAC 23.1(3) with engaging in practice harmful or detrimental to the public.

D. STATEMENT OF MATTERS ASSERTED

12. Respondent practices obstetrics and gynecology in Davenport, Iowa.

13. On February 10, 2005, the Board charged Respondent for violating a Board Order when he failed to complete a comprehensive physical, neuropsychological and substance abuse evaluation ordered by the Board. On June 2, 2005, Respondent entered into a Settlement Agreement with the Board and he had certain restrictions placed on him by the Board for a period of two years. He was also issued a Citation and Warning for inappropriately prescribing controlled substances to family members and failing to maintain appropriate records for controlled substances maintained in his office.

14. On November 8, 2007, the Board charged Respondent for violating the terms of the June 2, 2005, Settlement Agreement. Respondent was placed on probation subject to certain terms and conditions for a period of five years and he was issued a Citation and Warning and ordered to pay a $5,000 Civil Penalty for violating the terms of the Settlement Agreement that he entered into with the Board.

15. The Board alleges that Respondent has demonstrated a pattern of professional incompetency and practice harmful or detrimental to the public in the practice of medicine by:

A. Failing to timely intervene to provide appropriate care and treatment to an infant who became compromised during labor;

B. Failing to provide appropriate evaluation and treatment to an expectant mother who presented with a history of pre-term labor; and

C. Failing to properly evaluate the pulmonary or cardiac status of an expectant mother who presented with a history of upper respiratory infection;

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 settlement, contact Kent M. Nebel, J.D., Legal Director at 515-281-7088.

F. PROBABLE CAUSE FINDING

17. On February 11, 2008, the Iowa Board of Medicine found probable cause to file this Statement of Charges.

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