

**BEFORE THE IOWA BOARD OF MEDICINE**

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**IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST**

**WEI LI, M.D., RESPONDENT**

**File No. 02-03-658**

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**REINSTATEMENT ORDER**

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**COMES NOW** the Iowa Board of Medicine (Board), and Wei Li, M.D., (Respondent), on Aug 3, 2009, and enter into this Reinstatement Order.

1. Respondent was issued Iowa medical license no. 34849 on September 18, 2002.
2. Respondent's Iowa medical license is active and will next expire on September 1, 2010.
3. The Board has jurisdiction in this matter pursuant to Iowa Code Chapters 147, 148 and 272C.
4. **STATEMENT OF CHARGES:** On August 25, 2005, the Board charged Respondent with engaging in professional incompetency in the practice of medicine.
5. **FINAL DECISION OF THE BOARD ON APPEAL:** On January 28, 2008, the Board indefinitely suspended Respondent's Iowa medical license and ordered Respondent to submit a Remediation Program for approval prior to seeking reinstatement.
6. **REMEDIATION PROGRAM:** Respondent recently submitted a written Remediation Program for Board approval. On July 8, 2009, the Board approved Respondent's proposed Remediation Program.
7. **INDEFINITE PROBATION:** Respondent shall be placed on **indefinite probation** subject to the following terms and conditions:

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

Compliance Monitor, Iowa Board of Medicine, 400 SW 8<sup>th</sup> 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. Demonstration of Professional Competency:** Respondent shall demonstrate that he is capable of practicing medicine in a competent manner throughout the period of this Order. Respondent shall fully comply with all recommendations made by the Board during the period of this Order.

**C. Practice Setting:** Respondent shall submit a written plan describing any setting in which he intends to practice medicine for Board approval. Respondent shall only practice in Board-approved practice settings during the period of this Order.

**D. Remediation Program:** Respondent shall fully comply with the Board-approved Remediation Program developed by Affiliated Monitors, Inc. including, the Applied Education Program and Monitoring Program.

**E. Re-evaluation:** Following completion of the approved Remediation Program, Respondent shall be re-evaluated, either at CPEP or at another Board-approved evaluation program.

**F. Practice Monitor:** Respondent shall submit a practice monitoring plan for Board approval which includes a board-certified, Board-approved physician serve as practice monitor. The practice monitor shall agree to serve under the terms of this Order. The practice monitor shall review medical records for selected patients and meet regularly with Respondent to review cases, review specific topics and engage in a quality improvement processes. Respondent shall fully comply with all recommendations of the practice monitor. The practice monitor shall submit written quarterly reports to the Board no later than 1/20, 4/20, 7/20 and 10/20 of each year of this Order.

**G. Worksite 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 a practice setting 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 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 Respondent's probation.

**H. Quarterly Reports:** Respondent shall file sworn quarterly reports attesting to his compliance with all the terms of this Order no later than 1/10, 4/10, 7/10 and 10/10 of each year for the duration of the period of this Order.

**I. Board Appearances:** Respondent shall appear before the Board annually or upon request of the Board during the period his probation. Respondent shall be given notice of the date, time and location of the appearances. The appearances shall be subject to the waiver provisions of 653 IAC 24.2(5)(2).

**J. Monitoring Fee:** Respondent shall make a payment of \$100 to the Board each quarter for the duration of his probation to cover the Board's monitoring expenses in this matter. The monitoring fee shall be received by the Board with all quarterly reports required during his probation. The monitoring fee shall be sent to: Shantel Billington, Compliance Monitor, Iowa Board of Medicine, 400 SW 8<sup>th</sup> 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.

8. 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.

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

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

11. 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.

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

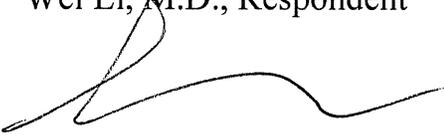
13. Respondent agrees that the State's counsel may present this Order to the Board.

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.

A handwritten signature in black ink, consisting of a stylized, cursive script, is written over a horizontal line.

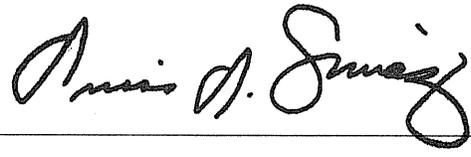
Wei Li, M.D., Respondent



Subscribed and sworn to before me on Aug 3, \_\_\_\_\_, 2009.

Notary Public, State of Serech Waketu  
Acliss Eggena exp 10/19/10

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



Siroos S. Shirazi, M.D., Chairman

Iowa Board of Medicine

400 SW 8<sup>th</sup> Street, Suite C

Des Moines, Iowa 50309-4686

BEFORE THE IOWA BOARD OF MEDICINE

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IN THE MATTER OF THE	)	FILE NO. 02-03-658
STATEMENT OF CHARGES AGAINST	)	DIA NO. 05DPHMB024
	)	
WEI LI, M.D.	)	FINAL DECISION OF THE
	)	BOARD ON APPEAL

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To: Wei Li, M.D.

Date: January 28, 2008.

On August 25, 2005, the Iowa Board of Medicine (Board) filed a Statement of Charges against Wei Li, M.D. (Respondent) alleging professional incompetency and practice harmful and detrimental to the public. A panel of the Board issued a Proposed Decision on June 5, 2007, following an evidentiary hearing. On June 25, 2007, Respondent filed an appeal from the panel's proposed decision. Pursuant to Board Order issued on September 20, 2007, Respondent was given until November 1, 2007, to file an appeal brief, the state was given until December 1, 2007, to file a responsive brief, and Respondent was given until December 14, 2007, to file a reply brief. The Order also provided that the parties would each be allowed ten (10) minutes of oral argument on January 16, 2008.

Respondent did not file an appeal brief in the time provided by Board Order. The State also chose not to file a brief. On January 16, 2008, Respondent appeared before the Board and asked to be represented by Dr. Rene Madera-Font, M.D. Dr. Madera-Font had prepared a written review of the patient cases that were the subject of the evidentiary hearing and asked to present it to the Board. Assistant Attorney General Heather Palmer objected to Respondent's representation by a non-attorney and to the proposed oral and/or written presentation by Dr. Rene Madera-Font. Ms. Palmer pointed out that the written summary was not a timely brief, that she had only recently received it, and that it contained new evidence that was not part of the record before the panel.

The Board denied both of Respondent's requests. The Board's rules do not permit representation by non-attorneys. 653 IAC 25.18(5). Respondent did not file a timely request to present new evidence. See 653 IAC 25.24(2)"e". To the extent that portions of the written summary could be

considered a brief, it was not submitted in a timely manner. Respondent was permitted to present his own oral argument. Upon review of the entire record before the panel and upon consideration of the oral arguments, the Board voted to affirm the panel's proposed decision in its entirety.

**ORDER**

**IT IS THEREFORE ORDERED** that the Proposed Decision of the Panel, issued on June 5, 2007, is hereby **AFFIRMED**.

Dated this 28<sup>th</sup> day of January, 2008.



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

cc: Heather Palmer, Assistant Attorney General

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.

BEFORE THE BOARD OF MEDICAL EXAMINERS  
OF THE STATE OF IOWA

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IN THE MATTER OF THE	)	FILE NO. 02-03-658
STATEMENT OF CHARGES AGAINST	)	DIA NO. 05DPHMB024
	)	
WEI LI, M.D.	)	PROPOSED DECISION
	)	OF THE PANEL

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Date: June 5, 2007

On August 25, 2005, the Iowa Board of Medical Examiners (Board) filed a Statement of Charges against Wei Li, 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: Engaging in practice harmful or detrimental to the public, in violation of Iowa Code section 147.55(3) (2005) and 653 IAC 12.4(3).

The hearing was initially scheduled for October 18, 2005 but was continued twice at Respondent's request. A third request for continuance was denied. The hearing was held on May 15, 2007 at 8:30 a.m. before the following panel of the Board: Yasyn Lee, M.D., Chairperson; Blaine Houmes, M.D.; and Susan Johnson, M.D. Respondent Wei Li, M.D. appeared and was represented by attorney Michael Sellers. 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 a written decision, in accordance with their deliberations.

**THE RECORD**

The record includes the Statement of Charges and Notice of Hearing; Order for Continuance; Hearing Order; Motion for Continuance, Resistance, Ruling Denying Motion for

Continuance; Hearing Order; Motion for Continuance with attachments, Resistance, Ruling Denying Continuance; testimony of the witnesses; patient name key; State Exhibits 1-33 (See Exhibit Index for description) Respondent Exhibits 1-10 (See Exhibit index for description of 1-4; Exhibits 5-8 are original x-rays for patient #2, Exhibit 9 is an original record for patient #2; and Exhibit 10 is an original x-ray for patient #7)

## **FINDINGS OF FACT**

### Respondent Education, Licensure and Practice

1. Respondent graduated from Harbin Medical University in 1983 and practiced medicine in China for over eight years, primarily in the area of occupational disease. In 1991, Respondent entered a postgraduate program in health education at the University of Nebraska in Omaha. Respondent later entered a Pediatrics Ph.D. program and conducted research for approximately four years. In 1999, Respondent entered a family medicine residency at the University of Nebraska Medical Center but he never completed the residency, due to adjustment problems during the obstetrics rotation during his third year. (Testimony of Respondent; Respondent Exhibit 1; State Exhibit 8)
2. Respondent was issued license number 34849 to practice medicine and surgery in the state of Iowa on September 18, 2002. Respondent's Iowa medical license is active and he is not licensed in any other states. (State Exhibit 1, 9)
3. From October 2002 through May 2003, Respondent worked for Acute Care Inc. throughout Iowa as a contract emergency room physician. From November 2003 to September 2005, the Indian Health Service employed Respondent as an Emergency Room Locum Physician in Montana, South Dakota, and Arizona. Respondent has not practiced medicine since September 2005 because the Indian Health Service would not provide his malpractice insurance while he had an open disciplinary case with this Board. Respondent currently resides in Lake Arrowhead, California and is employed as the vice-president for Ice Castle Training Center. (Testimony of Respondent; Respondent Exhibits 1, 4)

Complaints-DeWitt Community Hospital

4. Respondent worked as an emergency department physician at DeWitt Community Hospital from November 27, 2002 to January 1, 2003. During a two-week period, the hospital received at least seven complaints from patients and staff concerning the quality of care provided by Respondent. Due to the number of complaints, a hospital committee reviewed ten patient records and identified "significant concerns" regarding Respondent's judgment and decision making process. Respondent resigned from the hospital shortly after the complaints were reviewed, and the hospital filed a complaint with the Board. (State Exhibits 9, 10)

5. On December 17, 2003, a Board investigator wrote to Respondent and provided summaries of the ten patient charts submitted by the DeWitt Hospital. Respondent was asked to provide a narrative response explaining his care and treatment of each patient. Respondent provided his response, dated January 16, 2004, through his attorney. (State Exhibits 11, 12)

Peer Review

6. On June 8, 2004, the Board referred the ten patient cases from DeWitt Hospital to a peer review committee consisting of one board-certified family practice physician and one emergency medicine physician. On July 19, 2004, the peer review committee issued a report finding that Respondent exercised poor clinical judgment in his treatment of patient #1, 2, and 3. The peer reviewers questioned Respondent's judgment and treatment in several other cases but were unable to conclude that his care was negligent. The peer reviewers recommended additional proctoring and clinical supervision for Respondent. (State Exhibits 5-7)

7. The Board subsequently submitted the same ten patient cases to a second peer review committee consisting of two board-certified emergency medicine physicians. On January 25, 2005, the second peer review committee submitted its written report. The second peer review committee concluded that Respondent violated the standard of care in his treatment of patient #1, 2, 3, 6, and 7. With respect to patient #4, the peer review criticized Respondent's sparse documentation of the visit, which suggested that he did not perform a neurological exam. The peer review committee

noted that all ten cases arose in a two-week period between December 15 and December 29, 2002 and concluded that the pattern of violations over a short period of time suggests a practice harmful and detrimental to the public. The second peer review committee felt that Respondent should not be allowed to practice Emergency Medicine without extensive remediation. (State Exhibits 2-4; Testimony of Hans House, M.D.)

Competency Evaluation and Attempts to Enter a Residency

8. On January 25-26, 2006, Respondent submitted to a comprehensive clinical competency evaluation at the Center for Personalized Education for Physicians (CPEP) in Denver, Colorado. The assessment included three clinical interviews with physician consultants who presented hypothetical patient cases to Respondent. Respondent also answered questions about eleven electrocardiogram (ECG) tracings. Respondent's communication and documentation skills were evaluated and he submitted to a cognitive function screen and health evaluation. At the conclusion of the evaluation, CPEP prepared a detailed written report. (State Exhibit 8)

9. CPEP concluded that Respondent's overall medical knowledge was acceptable, with some gaps. He demonstrated clinical judgment and reasoning that were "variable and concerning in some respects." Respondent had good communication skills with patients but appeared to struggle in his communication with the evaluators. CPEP was only able to review patient care documentation that Respondent prepared during the evaluation. CPEP concluded that Respondent understands the important components of documentation but was inconsistent in his application of that knowledge. Respondent's cognitive function screen was within normal limits. In conclusion, CPEP recommended that Respondent participate in structured, individualized education to address the following identified areas of need:

**Knowledge**

- Impact of coronary risk factors on establishing goals of treatment;
- DKA management: interpretation of ABGs, and management of hyperkalemia in DKA;

- Pediatrics:
  - Infectious disease: microbiology and antibiotic selection for serious infection; and the approach to the febrile neonate;
  - Work-up for sepsis in a febrile neonate;
  - Fluid selection for pediatric bolus infusion;
- Potential etiologies of shortness of breath;
- Physical findings in congestive heart failure;
- Pathophysiology of abnormal heart sounds;
- Delirium tremens: role of specific components of treatment;
- Chest x-ray interpretation;
- ECG interpretation, particularly in diagnosis of acute MI.

### **Judgment**

- Thoughtful and deliberate creation of patient dispositions, based on appropriate data, along with an appropriate preparation for that disposition;
- Appropriate transport recommendations for unstable patients;
- Consistent ability to gather information in a logical and complete fashion;
- Structure in the formulation of differential diagnoses.

### **Communication**

- Improved understanding of professional communication.

CPEP further recommends:

- Educational Preceptor: Respondent should establish a relationship with an experienced educational preceptor in general medicine. This involves regularly scheduled meetings to review cases and documentation, discuss decisions related to those cases, review specific topics, and make plans for future learning.
- Continuing Medical Education and Self-Study: Respondent should engage in continuing medical education courses and self-study which include, but are not limited to, the topics indicated in areas of demonstrated need.
- Consideration of professional communication course, coaching or self-study.

Respondent submitted a two-page response to the CPEP evaluation. Overall, Respondent felt that some of his responses were misconstrued, that several of the cases presented were outside his range of experience in rural and Indian Health Service emergency rooms, and that the evaluation process had numerous interruptions that were disruptive, distracting and stressful for him. (State Exhibit 8)

10. In August 2006, the Board agreed to continue the hearing on the pending Statement of Charges to give Respondent an opportunity to informally resolve the Statement of Charges by entering a formal residency program. Respondent applied to sixty residency programs and was invited to interview at two of them: UC-Davis and Loma Linda. However, Respondent learned that he was not eligible for a California resident license because he has already had 28 months of residency training, and he cannot obtain a California medical license while disciplinary action is pending in Iowa. Respondent testified that he considered residency programs in Iowa and his attorney contacted Broadlawns Medical Center. As of the date of the hearing, Respondent has been unable to find a residency program that would accept him. Respondent has kept his continuing medical education current. (Testimony of Respondent; State Exhibit 33)

Opinions of Respondent's Expert Witness and Colleagues

11. Respondent submitted the peer review reports and patient records, including original x-rays for patient #2 and 7, for review by his own expert witness, Robert J. Hegeman, MD, JD. Dr. Hegeman is board certified in internal medicine and emergency medicine and currently practices at an internal medicine and acute care clinic in Williamsburg, Iowa. Dr. Hegeman concluded that Respondent's care of the ten patients conformed to the standard of care and that any deficiencies were not significant enough to require disciplinary action. (Testimony of Robert J. Hegeman, MD, JD; Respondent Exhibit 3)

12. Respondent also submitted letters from six physicians who worked with him in various positions with the Indian Health Service. The physicians all expressed confidence in Respondent's medical knowledge and clinical skills. (Respondent Exhibit 4)

Specific Patient Cases

The following findings are based upon the panel's review and analysis of the records for six patients who were treated by Respondent at the DeWitt Community Hospital Emergency Room in late December 2002, on the two peer review committee reports, and on the testimony of the state's expert witness (Dr. Hans House) and Respondent's expert witness (Dr. Robert Hegeman).

13. Patient #1, a 31 year-old male, presented with complaints of a sore throat that had lasted 2-3 days, a temperature of 100.3, nose and ear congestion, and tender cervical adenopathy. The patient reported a high incidence of strep throat in his home community. The patient had three of the four clinical symptoms associated with strep throat (fever, adenopathy, and absence of a cough) and most clinical guidelines recommend testing under these circumstances. However, Respondent determined that the patient likely had a viral infection and decided not to do a rapid strep screen. Respondent reasoned that antibiotics are over prescribed and many Americans carry *Streptococcus pyogenes* as normal flora, which causes a positive rapid strep screen even when the patient is not ill. Respondent's decision upset the attending nurse, who continued to "nag" Respondent to order the rapid strep screen. Respondent eventually relented and ordered the rapid strep screen, which was positive.

While the two peer review committees both concluded that the circumstances warranted the rapid strep screen and treatment of the patient with antibiotics, the panel agrees with the second peer review committee's opinion that Respondent's initial decision to forego the rapid strep screen presented minimal risk to this patient because strep throat is a self-limiting disease in adults with a low rate of complications. The panel felt that the case presented more of a failure of Respondent to adequately communicate his treatment rationale to the nurse. Respondent's expert did not discuss this case. (Testimony of Hans House, M.D.; Respondent; State Exhibits 2, 5, 9, 10, 13, 14)

14. Patient #2 was a 77-year-old male who presented with chronic obstructive pulmonary disease (COPD) and a chief complaint of shortness of breath. The patient had been treated at home with oxygen and nebulizer treatment and had recently completed a Z-pack for pneumonia. Respondent

ordered chest x-rays, read the x-ray and diagnosed the patient with pneumothorax, and then ordered a chest tube insertion. Prior to the chest tube insertion the patient was treated with albuterol/atrovent nebulizer and the patient's condition greatly improved. The patient had a saturation of 97% and respiratory rate of 20 immediately before the nebulizer treatment and a saturation of 70-82% following the treatment. The radiologist and consulting pulmonologist later read the patient's x-rays and found no evidence of pneumothorax.

Both peer review committees criticized Respondent for failing to recognize the patient's respiratory improvement following the nebulizer treatment and his decision to insert a chest tube when it was unnecessary. Respondent's expert felt that while in retrospect the chest tube placement may have been unnecessary since the patient improved with the nebulizer treatment, Respondent should be credited with providing the appropriate nebulizer treatment. In addition, he did not think it was unreasonable to place a chest tube prior to transporting the patient.

The panel agreed with the two peer review committees and concluded that Respondent violated the standard of care by failing to recognize that the patient was improving with nebulizer treatments and that it was not necessary to institute the invasive procedure of inserting a chest tube, with its recognized risks and complications.

Both peer reviews noted that Respondent misread the chest x-rays as showing a pneumothorax, although the peer reviewers did not obtain or independently review the chest x-rays. Respondent's expert witness did obtain and review the original x-rays and concluded that the x-rays show a "pseudo pneumothorax." However, the panel reviewed the original x-rays as well and could not agree with Respondent's expert's reading of the x-ray. (Testimony of Hans House, M.D.; Robert Hegeman, MD, JD; Respondent; State Exhibits 2, 5, 9, 10, 15-18; Respondent Exhibits 5-9)

15. Patient #3 was a 47 year-old female with complaint of right parietal headache and a past medical history of coronary artery disease, coronary artery bypass grafting, and carotid endarterectomy. The patient had not taken her medication in four days. At approximately 4:30 p.m., the patient's physical exam revealed a blood pressure of

153/97, temperature of 97.7, pulse of 132, respirations of 24, and pulse oximetry 98%. According to the progress notes, the patient's blood pressure had dropped to 145/89 ten minutes later.<sup>1</sup>

Respondent initially treated the patient with Lopressor 5mg IV push and Morphine 2mg IV push. The patient continued to complain of a headache. Respondent ordered Vasotec 5mg IV push, but the nurse claimed that she heard him say, "20 mg IV push." The nurse questioned such a large dose, which Respondent clarified as 5mg IV in divided doses.<sup>2</sup> According to the progress notes, the patient's blood pressure had dropped to 129/73 by 5:10 p.m., and both peer review committees criticize Respondent for administering anti-hypertensive intervention when the patient had normal blood pressure. In addition, in his written response to the Board, Respondent acknowledges that the patient did not have cerebral perfusion deficit and there was not any crisis. After the Vasotec was administered, the patient's blood pressure dropped, first to 101/60 and then to 58/34. At this point, the patient's head was lowered and her blood pressure increased to 91/59. Based on the progress notes, it appears that the patient was given the second dose of Vasotec after her blood pressure was recorded at 101/60.

Respondent's handwritten note in the file states that the patient claimed a baseline blood pressure of 80s/40s. Respondent and his expert note that if this was accurate, then the only blood pressure that was below her baseline was the 58/34 pressure recorded after the second dose of Vasotec. Respondent's expert found no significant deficit in Respondent's treatment of the patient, particularly since the patient did well after she was transferred and admitted.

The panel found the conclusions of the two peer review committees to be more convincing than the contrary opinion of Dr. Hegeman. Respondent and his expert testified that Respondent's treatment was justified because the patient was really sick and in crisis, but this testimony is inconsistent with the documentation from the patient's physical examination, and it directly contradicts

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<sup>1</sup> The accuracy of the recorded times cannot be verified because the times are cut off on the blood pressure strips. (State Exhibit 20, p. 54)

<sup>2</sup> The panel was satisfied that the nurse likely misunderstood Respondent's order.

Respondent's characterization of the patient when he provided his initial written response to the Board. Respondent's aggressive treatment with blood pressure lowering agents cannot be justified based on the patient's unverified and unlikely claim that her baseline blood pressure was 80s/40s. (Testimony of Hans House, M.D.; Respondent; Robert Hegeman, MD, JD: State Exhibits 2, 5, 9, 10, 12, 19, 20)

16. Patient #4 was a 10-month-old child who presented with a fever of 101 and reported temperatures at home that had been recorded as high as 104.9. The second peer review committee criticized Respondent's treatment of Patient #4 in two respects: a) failure to maintain an appropriate medical record for the patient by failing to document and/or perform a thorough neurological examination, and b) inappropriately alarming the patient's parents by raising the possibility of performing a lumbar puncture on the child prior to performing a thorough neurological assessment.

Respondent testified that he initially raised the possibility of a lumbar puncture with the parents because the nurse had described a severely ill child. However, after examining the child and speaking to the mother, Respondent realized that a lumbar puncture was unnecessary because the child was eating, drinking, voiding, and not lethargic. Respondent's expert, Dr. Hegeman, agreed that a neurological examination was required prior to performing a lumbar puncture but could not fault Respondent for merely discussing the possibility of a lumbar puncture. Dr. Hegeman agreed that Respondent's patient record was sparsely documented and should have included more information, including the child's breath sounds and whether the child had a stiff neck.

The panel accepted Respondent's explanation for discussing the lumbar puncture with the parents but finds that Respondent failed to properly document a thorough examination of the patient, including a neurological examination. (Testimony of Hans House, M.D.; Respondent; Robert Hegeman, MD, JD; State Exhibits 2, 5, 9, 10, 12, 19, 21)

17. Patient #6 was a four-year-old child who presented to the emergency room at 9:55 p.m. after falling six feet onto his right side while playing with his father. According to

the nurse's notes, the patient was alert but drowsy, did not suffer loss of consciousness, and was not vomiting. Respondent decided to transfer the patient to another hospital for CT testing and allowed the child's father to transfer the patient in his own car after documenting that he discussed the risks and benefits of such a transfer with the father. CT imaging later identified a fractured clavicle.

The first peer review noted that an ambulance was the preferred method of transfer. The second peer review committee concluded that Respondent failed to document performance of a sufficient examination, including plain films of the neck, chest and pelvis, in order to rule out life-threatening injuries, to establish that CT testing was necessary, and to comply with Advanced Trauma Life Support (ATLS) guidelines. They also concluded that if Respondent was concerned about a possible life-threatening injury, he should have transferred the patient to a trauma center rather than sending him to another hospital for CT testing. They further concluded that while Respondent documented that he explained the risks and benefits of transportation by private car, it is inexcusable that such transportation was allowed if Respondent was really concerned about serious abdominal or intracranial injury. Finally, they concluded that Respondent's order for the CT testing was ambiguous and poorly written.

Respondent's expert agreed that it was important to stabilize the patient's C-spine before transfer but felt that this was not possible if the parent insisted on transferring the patient by private automobile.

The panel agreed with the conclusions reached by the second peer review committee. Respondent should have performed and documented a more thorough examination, including plain films of the neck, chest and pelvis to rule out life-threatening injuries, before transferring the patient to another facility. Given Respondent's stated concerns about internal injuries, he should not have permitted the patient's father to transfer him by private automobile. Respondent claims that he explained the risks to the father but he insisted on this form of transfer, possibly for financial reasons. The panel finds it difficult to believe that the parents would have chosen to transport their child in the family car if the risks were properly explained. Moreover, the patient record indicates that the family had

health insurance. Finally, Respondent's order for the CT testing is ambiguous and poorly written. It does not even give a brief description of the cause of the injury and why the CT testing was ordered. (Testimony of Hans House, M.D.; Respondent; Robert Hegeman, MD, JD: State Exhibits 2, 5, 9, 10, 12, 24, 25)

18. Patient #7 was a 71-year-old male who awakened with coughing and complained of shortness of breath. He was a high risk patient with a past medical history that included known coronary artery disease (CAD) with two prior stent placements, as well as hypertension, hyperlipidemia, and diabetes. His initial vital signs included a blood pressure of 190/108. Respondent planned to follow cardiac protocol to rule out myocardial infarction. He ordered 4 doses of Lopressor 5mg to lower the blood pressure and heart rate.

Respondent documented the patient's portable chest x-ray as "basically normal" in his dictation and as negative in his handwritten note. The radiologist over-read the x-ray as congestive heart failure with right middle lobe and right lower lobe infiltrates. Respondent diagnosed hypertension and panic attack in his dictation, but in his letter of explanation to the Board claims that he also diagnosed congestive heart failure but forgot to include it in his dictation. Respondent addressed heart failure by ordering 20 mg of intravenous lasix and then sent the patient home after two hours of observation.

Both peer review committees noted that Respondent misread the patient's x-ray. The first peer review committee fairly characterized Respondent's decision to discharge this high-risk patient as "flirting with disaster" and a "cavalier judgment" but then failed to find that Respondent was negligent. The second peer review committee found that Respondent did violate the standard of care by reading the chest x-ray as normal, by failing to include congestive heart failure in his diagnosis, and by discharging the patient after just two hours of observation. A typical course of ruling out myocardial infarction calls for 6-12 hours of observation and two separate troponin measurements.

Dr. Hegeman concluded that Respondent appropriately treated the patient's symptoms even if he did not diagnose congestive heart failure. He criticized the peer review

committees for not requesting and reviewing the original x-ray and disputed that the x-ray showed pulmonary edema or that a non-radiologist would typically be able to diagnose cardiomegaly on the PA x-ray taken on a portable machine. However, the panel reviewed the original chest x-ray and found that it showed congestive heart failure and classic signs of pulmonary edema. The panel agrees with the second peer review committee that Respondent violated the standard of care when he read and twice documented the x-ray as normal, when he failed to document a diagnosis of congestive heart failure, and when he discharged the patient after just two hours in the emergency room. (Testimony of Hans House, M.D.; Respondent; Robert Hegeman, MD, JD; State Exhibits 2, 5, 9, 10, 12, 26-29; Respondent Exhibit 10)

## 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) and 653 IAC 12.4(2)(a), (b), (c), and (d). Iowa Code section 147.55(2) provides that a license to practice a profession shall be revoked or suspended when the licensee is guilty of professional incompetency. Iowa Code section 272C.10(2) provides that a licensing board shall by rule include provisions for the revocation or suspension of a license for 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 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 12.4 provides in relevant part<sup>3</sup>:

**653-12.4(272C) Additional 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 and 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.

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)(a),(b),(c), and (d) in his treatment of patient ##2, 3, 4, 5, and 6. While there was some disagreement among the various physicians who reviewed the patient records, the panel found the testimony of Dr. House and the opinions of the second peer review

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<sup>3</sup> This rule has been renumbered and is now found at 653 IAC 23.1.

committee to be well-reasoned and supported by the patient records and to represent the most credible of the expert opinions. While the first peer review committee identified serious judgment errors in Respondent's approach to patient care, they only found deviations from the standard of care in three cases. The panel disagreed with the analysis by Respondent's expert witness. While there may not have been any poor outcomes as a result of Respondent's errors, they placed patients at greater risk for poor outcomes. Moreover, the number of errors over a very short period of time is significant and concerning. Finally, the CPEP evaluation further supports the finding that Respondent has deficiencies in his knowledge base, skill, and judgment that must be addressed in order for him to practice medicine within the standard of care.

## **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 practice harmful or detrimental to the public. Proof of actual injury need not be established. 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 engaged in practice harmful or detrimental to the public when he failed, on repeated occasions in December 2002, to possess and exercise that degree of skill, learning and care expected of a reasonable, prudent physician acting in the same or similar circumstances.

## **DECISION AND ORDER**

**IT IS THEREFORE ORDERED** that Respondent Wei Li, M.D., is hereby **CITED** for failing to conform to the prevailing standard of care in his practice of emergency medicine in Iowa. Respondent is hereby **WARNED** that failure to conform to the prevailing standard of care in the future may result in further disciplinary action, including revocation of his Iowa medical license.

**IT IS FURTHER ORDERED** that license number 34849, issued to Respondent Wei Li, M.D., is hereby **INDEFINITELY SUSPENDED**. The indefinite suspension will continue until Respondent completes all of the following requirements:

A. **Submission of Remediation Program:** Respondent must submit a Remediation Program for Board approval. The submitted Remediation Program must include either:

1. A formal residency program; or

2. A formal educational plan addressing all of the areas of demonstrated need identified in the CPEP evaluation. The formal educational plan must include an educational preceptor and continuing medical education and self study, as outlined in the CPEP report.

B. **Completion of Remediation Program:** Respondent must successfully complete the approved Remediation Program following its approval by the Board.

C. **Re-evaluation:** Following completion of the approved Remediation Program, Respondent shall be re-evaluated, either at CPEP or at another Board-approved evaluation program, to determine whether he is ready to safely practice medicine within the standard of care. Following the re-evaluation, the Board will determine if Respondent's license will be reinstated and whether terms of probation will be required.

**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.

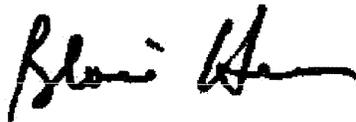
Dated this 5<sup>th</sup> day of June, 2007.

THE PANEL:



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Yasyn Lee, M.D.  
Chairperson



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Blaine Houmes, M.D.



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Susan Johnson, M.D.

A proposed decision may be appealed to the board by either party by serving on the executive director, either in person or by certified mail, a notice of appeal within 30 days after service of the proposed decision on the appealing party. 653 IAC 25.24(2)(c).

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

Michael Sellers  
One Corporate Place  
1501 42nd St., Suite 380  
West Des Moines, IA 50266-1005

BEFORE THE BOARD OF MEDICAL EXAMINERS  
OF THE STATE OF IOWA

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IN THE MATTER OF THE ) FILE NO. 02-03-658  
STATEMENT OF CHARGES AGAINST ) CASE NO. 05DPHMB024  
)  
WEI LI, M.D. ) RULING DENYING MOTION  
RESPONDENT ) TO CONTINUE

05-14-07P01:49 RCVD

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On August 25, 2005, the Iowa Board of Medical Examiners (Board) filed a Statement of Charges against Wei Li, M.D. (Respondent) alleging professional incompetence and practice harmful and detrimental to the public in Respondent's treatment of at least six patients. The initial hearing date of October 18, 2005 was continued at Respondent's request. The hearing was rescheduled for August 18, 2006, and a second continuance request was denied. However, on the date of the hearing Respondent renewed hi continuance request and the Board agreed to continue the hearing to enable Respondent to attempt to reenter a residency program. On April 4, 2007, the Board issued a Hearing Order rescheduling the disciplinary hearing for May 15, 2007 at 8:30 a.m.

On or about May 7, 2007, Respondent filed a Motion for Continuance with attachments. On May 10, 2007, the state's attorney filed a Resistance to Request for Continuance. The Board delegated ruling on the Motion to Continue to the undersigned administrative law judge.

653 IAC 12.24(2) provides that in determining whether to grant a continuance, the presiding officer may consider prior continuances, the interests of all the parties, the public interest, the likelihood of informal settlement, the existence of an emergency, any objection, any applicable time requirements, the existence of a conflict in the schedules of counsel, parties, or witnesses, the timeliness of the request, and other relevant factors.

The reasons given for the continuance request are: that Respondent relied on the Board's written commitment not to pursue a disciplinary hearing while Respondent was searching for a residency program; that Respondent has devoted full attention to finding a residency program and has not prepared for hearing; that since Respondent is unemployed the expense of preparing for hearing could not be justified until it was clear that a hearing

was going to occur; that Respondent's counsel did not receive notice of the May 15, 2007 hearing date until April 10, 2007 and was not consulted in selecting a hearing date; that more time is necessary to conduct discovery, interview witnesses, and obtain expert testimony; and that attempts to interview witnesses were delayed because the assistant attorney general advised her witnesses not to participate in an interview unless someone from the AG's office was present when this had not previously been required.

The parties agree that Respondent has agreed not to practice in Iowa while the disciplinary charges are still pending; that the Board has worked with Respondent in his efforts to obtain a position in a residency training program; and that to date Respondent has been unable to obtain a residency. The state further asserts that Board staff had recommended that Respondent contact three different residency programs in Iowa to determine if a position was available, but Respondent only contacted one of the three programs.

According to the state, the Board has consistently advised Respondent that it would wait until after the March residency match process to reschedule the hearing but that a hearing would be rescheduled if a residency position was not obtained. The state asserts that Respondent has now had an opportunity to interview the two physician witnesses he mentions in his motion as well as two nurses involved in several of the cases. The state asserts that Respondent has had almost two years to prepare, the parties have been unable to reach a settlement, and there is no basis for delaying final resolution of this matter.

The charges, which allege Respondent provided substandard medical care to seven patients, have been pending against Respondent for more than twenty-one months. Respondent has already been granted two continuances. Despite assistance from the Board, Respondent has not been successful in securing a position in a residency program. It appears Respondent was given adequate warning by Board staff that the hearing would be rescheduled if he was not successful during the March residency match process. Under the circumstances, Respondent was given adequate notice of the May 15<sup>th</sup> hearing date and has had adequate time to prepare for hearing. Given the nature of the charges and the delays that have already occurred, further delay is not

DIA No. 05DPHMB024

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in the public interest. IT IS THEREFORE ORDERED that the Motion to Continue is hereby DENIED.

Dated this 10th day of May, 2007.

*Margaret LaMarche*

Margaret LaMarche  
Administrative Law Judge  
Department of Inspections and Appeals  
Lucas State Office Building-Third Floor  
Des Moines, Iowa 50319-0083

cc: Theresa O'Connell Weeg  
Office of the Attorney General  
Hoover Building  
Des Moines, Iowa 50319 and by FAX: (515) 281-7551

Michael Sellers  
One Corporate Place  
1501 42nd St., Suite 380  
West Des Moines, IA 50266-1005 and by FAX: (515) 221-2702

Kent Nebel  
Iowa Board of Medical Examiners  
400 SW 8<sup>th</sup> Street, Suite C  
Des Moines, Iowa 50309-4686 and by FAX: (515) 281-8641

BEFORE THE BOARD OF MEDICAL EXAMINERS  
OF THE STATE OF IOWA

---

IN THE MATTER OF THE	)	FILE NO. 02-03-658
STATEMENT OF CHARGES AGAINST	)	CASE NO. 05DPHMB024
	)	
WEI LI, M.D.	)	RULING DENYING MOTION
RESPONDENT	)	TO CONTINUE

---

On August 25, 2005, the Iowa Board of Medical Examiners (Board) filed a Statement of Charges against Wei Li, M.D. (Respondent) alleging professional incompetence and practice harmful and detrimental to the public in Respondent's treatment of at least six patients. A hearing was initially scheduled for October 18, 2005 and was continued at Respondent's request. On June 8, 2006, the Board issued a Hearing Order rescheduling the hearing for August 18, 2006. On August 14, 2006, Respondent filed a Request for Continuance. The reason given for the continuance request is that the Respondent has chosen not to accept the state's settlement proposal and now requests a postponement to obtain new counsel and allow new counsel to become familiar with the case. On August 15, 2006, the state's attorney filed a Resistance to Request for Continuance. The Board delegated ruling on the Motion to Continue to the undersigned administrative law judge.

653 IAC 12.24 provides that no continuances shall be granted within seven days of the date set for hearing, except for extraordinary, extenuating, or emergency circumstances. 653 IAC 12.24(2) provides that in determining whether to grant a continuance, the presiding officer may consider prior continuances, the interests of all the parties, the public interest, the likelihood of informal settlement, the existence of an emergency, any objection, any applicable time requirements, the existence of a conflict in the schedules of counsel, parties, or witnesses, the timeliness of the request, and other relevant factors.

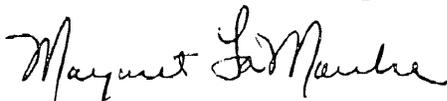
Respondent's request for continuance is untimely, and he has failed to provide sufficient grounds to continue the hearing. There are no extraordinary or emergency circumstances. This case has been pending for nearly a year, and Respondent has already received one continuance. Respondent has had adequate time to retain counsel and prepare for hearing. Given the nature of the charges, further delay is not in the public

DIA No. 05DPHMB024

Page 2

interest. IT IS THEREFORE ORDERED that the Motion to Continue is hereby DENIED.

Dated this 15th day of August, 2006.



Margaret LaMarche  
Administrative Law Judge  
Department of Inspections and Appeals  
Lucas State Office Building-Third Floor  
Des Moines, Iowa 50319-0083

cc: Theresa O'Connell Weeg  
Office of the Attorney General  
Hoover Building  
Des Moines, Iowa 50319 and by FAX: (515) 281-7551

Michael Sellers  
One Corporate Place  
1501 42nd St., Suite 380  
West Des Moines, IA 50266-1005 and by FAX: (515) 221-2702

Kent Nebel  
Iowa Board of Medical Examiners  
400 SW 8<sup>th</sup> Street, Suite C  
Des Moines, Iowa 50309-4686 and by FAX: (515) 281-8641

**BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF IOWA**

\*\*\*\*\*

**IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST**

**WEI LI, M.D., RESPONDENT**

**FILE No. 02-03-658**

\*\*\*\*\*

**STATEMENT OF CHARGES**

\*\*\*\*\*

**COMES NOW** the Iowa Board of Medical Examiners (the Board), on August 25, 2005, and files this Statement of Charges against Wei Li M.D., (Respondent), a physician licensed pursuant to Iowa Code Chapter 147 (2003) and alleges:

1. Respondent was issued license number 34849 to practice medicine and surgery in Iowa on September 18, 2002.
2. Respondent's Iowa medical license is active and will next expire on September 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 section 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 section 147.55(3) (2005) and 653 Iowa Administrative Code section 12.4(3) with engaging in practice harmful or detrimental to the public.

## CIRCUMSTANCES

6. The Board received information which raised serious concerns that Respondent failed to provide appropriate care and treatment to several patients who presented in the emergency room.

7. The Board appointed a peer review committee to review Respondent's care and treatment of several patients. On , 2005, the Board reviewed the peer review report and concluded that Respondent engaged in a pattern of professional incompetency and practice harmful and/or detrimental to the public in his treatment of several emergency medicine patients. The peer review committee and Board had particular concern that the care in question occurred over a very short period of time over a couple of weeks. The Board concluded that Respondent's medical treatment deviated from the prevailing standard of care, including but not limited to the following:

A. **Patient #1:** Patient #1, a 31 year old male presented to the emergency room with complaints of a sore throat for 2-3 days, a temperature of 100.3 degrees and tender cervical adenopathy. Patient #1 also reported a significant presence of strep throat in the community where he lived.

Respondent inappropriately determined that a rapid strep test was not warranted despite the fact that Patient #1 exhibited three significant risk factors for strep throat (fever, adenopathy, and

absence of a cough) and Patient #1 lived in a community with significant outbreak of strep throat.

B. **Patient #2:** Patient #2, a 77 year old male presented to the emergency room with chronic obstructive pulmonary disease (COPD) and a chief complaint of shortness of breath. Respondent ordered chest x-rays and diagnosed Patient #2 with a pneumothorax. The radiologist and pulmonologist read the chest x-rays and did not find a pneumothorax.

Respondent inappropriately misread the chest x-rays and diagnosed a pneumothorax. Respondent inappropriately failed to recognize Patient #2's respiratory improvement with the use of the nebulizer. Respondent inappropriately ordered a chest tube insertion when it was not necessary.

C. **Patient #3:** Patient #3, a 47 year old female presented to the emergency room with complaints of a severe headache. Patient #3 had a history of hypertension and she ran out of her medications 3-4 days earlier. She was hypertensive with an initial blood pressure of 145/89 and her heart rate was 132.

Respondent inappropriately ordered an acute blood pressure lowering agent for Patient #3 when her blood pressure had returned to normal levels, resulting in a potentially dangerous low blood

pressure, despite the fact that his own notes indicate that Patient #3 was not in crisis.

- D. **Patient #4:** Patient #4, a 10 month old male child presented to the emergency room with a fever.

Respondent inappropriately failed to document and/or perform a thorough neurological examination of Patient #4. Respondent inappropriately discussed the possibility of performing a lumbar puncture on Patient #4 prior to performing a thorough neurological assessment causing an unnecessary concern for Patient #4's family. Respondent failed to maintain an appropriate medical record of his assessment of Patient #4.

- E. **Patient #5:** Patient #5, a 4 year old child presented to the emergency room following a fall from about 6 feet on his right side.

Respondent inappropriately transferred Patient #5 to another facility to obtain CT testing without performing a thorough examination, including plain films of the neck, chest and pelvis to rule out life-threatening injuries, in violation of Advanced Trauma Life Support (ATLS) guidelines. Respondent inappropriately transferred Patient #5 to another facility to obtain CT tests without performing a thorough examination to determine whether CT testing was necessary. Respondent inappropriately transferred Patient #5 to a non-trauma center facility. Respondent's orders for the CT testing

were ambiguous and poorly written. Respondent inappropriately transferred Patient #5 to another facility by private automobile despite serious concerns about possible abdominal and head injuries. Respondent inappropriately failed to complete federally mandated patient transfer protocols in violation of the Emergency Medicine Treatment and Active Labor Act (EMTALA).

F. **Patient #6:** Patient #6, a 71 year old male presented to the emergency room complaining of shortness of breath after awakening coughing up phlegm.

Respondent inappropriately misread Patient #6's x-ray as normal when a radiologist read the x-rays as showing pulmonary edema with a superimposed infiltrate. Respondent inappropriately discharged Patient #6 after only two hours despite the fact that he noted that the patient needed to be monitored to rule out myocardial infarction. Patient #6 should have been observed for 6-12 hours with at least two separate troponin measurements.

**On this** the 25<sup>th</sup> day of August, 2005, the Iowa Board of Medical Examiners finds cause to file this Statement of Charges.



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