

BEFORE THE BOARD IOWA BOARD OF MEDICINE

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

MICHAEL C. PRESCHER, M.D., RESPONDENT

FILE Nos. 02-09-323 & 02-10-180

TERMINATION OF PROBATION

Date: December 16, 2016.

1. **Iowa Medical License:** Respondent was issued Iowa medical license 31176 on April 29, 1996. Respondent's Iowa medical license is active and will next expire on December 1, 2017.

2. **Jurisdiction:** The Board has jurisdiction in this matter pursuant to Iowa Code chapters 147, 148 and 272C.

3. **Statement of Charges:** On December 11, 2011, the Board filed a Statement of Charges and Emergency Adjudicative Order against Respondent and immediately suspended his Iowa medical license. The Board filed an Amended Statement of Charges on January 9, 2012. The Board alleged that Respondent engaged in sexual misconduct, unethical or unprofessional conduct and/or professional incompetency in five cases.

4. **Findings of Fact, Conclusions of Law, Decision and Order:** A hearing was held on January 12-13, 2012, and on March 29, 2012, the Board issued a Findings of Fact, Conclusions of Law, Decision and Order.

- A. **Sexual Misconduct:** The Board concluded that the allegations of sexual misconduct were not supported by a preponderance of evidence at hearing.
- B. **Unethical or Unprofessional Conduct and/or Professional Incompetency:** The Board concluded that Respondent violated the standard of care by seeing patients under sedation without any staff member present. Each of the four patients testified to being sedated to the point of unconsciousness. Three of the four were treated in Respondent's office at a time it was closed and no one was present. Respondent created a climate in which his patients had no way to know what occurred during their treatment because there was no third person to verify what occurred.

The problems with standard of care do not end there. Respondent did not have any of the four patients sign written consents. He acknowledged that a written consent was always secured when he practiced in the hospital, but he did not do so in his clinic practice. At least two of the patients expressed confusion as to what occurred. Patient 4 thought she was meeting Respondent for a consultation only, and she ended up being sedated for an hour during a procedure that she questioned and did not understand. Patient 3 had more of an understanding of her procedure, but Respondent did not tell her she would be unconscious during the injection. One of the purposes of a written consent is to better ensure that patients fully understand the procedures that doctors perform. Respondent did not meet standard of care by failing to obtain proper consents.

Respondent likewise did not meet standard of care by failing to monitor and document vital signs. He did not attach an oximeter or blood pressure monitor to any of the four patients while conducting their procedures. This is more important because there was no one else in the room to monitor the patient while Respondent was performing the injections. The problem is exemplified by the concern that developed during Respondent's treatment of Patient 1. If the needle had perforated the colon as Respondent suspected, there may have been complications. Even as it was, Respondent was holding the needle and examining the rectum, without any staff members to assist or having ready means to monitor vital signs.

Respondent also failed to meet standard of care by allowing Patients 2 and 4 to drive home after their procedures. Both testified to feeling shaky and unsteady after their procedures. Respondent knew that both had driven to the appointment. Respondent risked their safety, and the safety of others on the road, by allowing them to drive home.

- C. **Sanctions:** The Board ordered Respondent to fully comply with the following sanctions:
1. **Civil Penalty:** Respondent shall be assessed a \$10,000 civil penalty. The civil penalty shall be paid within twenty (20) days of the date of this Order by delivery of a check or money order, payable to the Treasurer of Iowa, to the executive director of the Board. The civil penalty shall be deposited into the State General Fund.
 2. **Suspension:** The Board suspends Respondent's Iowa medical license for a period of one year from the date the Board entered its Emergency Order on December 8, 2011. Respondent may reapply for reinstatement at the end of the one year period. Prior to applying for reinstatement, Respondent shall:
 - a) **Professional Boundaries Evaluation:** Respondent shall undergo an evaluation at the Behavioral Medical Institute (BMI) in Atlanta, Georgia. The evaluation shall be at Respondent's cost. BMI shall prepare an evaluation report and submit it to the Board. Respondent shall sign any necessary releases to allow BMI to share information with the Board. Respondent is responsible for all costs associated with the professional boundaries evaluation.
 - b) **Medical Recordkeeping Course:** Respondent shall attend a Board-approved course on medical record-keeping and provide proof of completion to the Board.
 - c) **Terms and Conditions:** The Board may impose probation and other terms and conditions at the time it considers reinstatement of Respondent's Iowa medical license.
 3. Respondent shall pay a disciplinary hearing fee of \$75.00. Iowa Code section 272C.6(6); 653 IAC section 25.33(2). Respondent shall also pay any costs certified by the executive director. *See* 653 IAC 25.33(3). All sanctions, 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 Board of Medical Examiners within thirty days of the issuance of the final decision.

5. **JUDICIAL REVIEW OF BOARD'S DECISION:** Upon appeal, the District Court for Pottawattamie County upheld the Board's disciplinary action against Respondent for professional incompetency. The District Court dismissed the Board's charges that Respondent engaged in unethical or unprofessional conduct because the Board's Decision and Order failed to adequately address the allegations.

6. **APPLICATION FOR REINSTATEMENT:** Respondent petitioned the Board for reinstatement of his Iowa medical license and demonstrated the following:

- A. **Civil Penalty:** Respondent paid the \$10,000 Civil Penalty.
- B. **Professional Boundaries Evaluation:** Respondent successfully completed a professional boundaries evaluation at BMI and BMI concluded that there was no evidence that Respondent is a sexual predator. However, BMI concluded that Respondent did not practice medicine with good professional boundaries when he saw female patients after clinic hours without a chaperone and without charge. BMI concluded Respondent does not pose a significant safety threat to his patients or staff related to professional sexual misconduct. BMI made no further recommendations.
- C. **Medical Recordkeeping Course:** Respondent successfully completed a Board-approved course on medical record-keeping and provided proof of completion to the Board.
- D. **Disciplinary Hearing Fee:** Respondent paid the \$75.00 disciplinary hearing fee.

7. **REINSTATEMENT:** On January 1, 2013, the Board voted to reinstate Respondent's Iowa medical license subject to the following terms and conditions.

8. **NOTICE TO ALL HOSPITALS AND CLINICS:** Respondent shall share a copy of this order with any hospital, clinic, office, or other health care facility where he practices medicine. Respondent shall submit a written statement to the Board from each hospital, clinic, office, or other health care facility where he practices which indicates that they have read and fully understand the terms and conditions of this order.

9. **PRACTICE REQUIREMENTS:** Respondent shall fully comply with the following practice requirements:

A. **Board-Approved Group Practice Setting:** Respondent shall practice medicine in a Board-approved group practice setting only. Respondent shall seek written approval from the Board prior to practicing medicine in a new practice setting.

B. **Chaperone Requirement:** Except when he is practicing in a Board-approved hospital setting, Respondent shall have a Board-approved female healthcare professional chaperone continually present at all times while providing healthcare services to female patients, including but not limited to, patient evaluation, treatment and post-evaluation treatment directions. The chaperone shall clearly document her continued presence in each patient's chart. Respondent shall provide the Board with the names of all persons providing chaperone services for him. The chaperone shall not be related to Respondent. The Board will provide all chaperones with a copy of this Order. All chaperones shall provide a written statement to the Board indicating that they

have read this Order and agree to inform the Board immediately if there is any evidence of any misconduct or a violation of the terms of this Order.

- C. **Prohibition – Treatment Outside of Clinic Hours:** Respondent shall not treat patients in a clinic setting outside of regular clinic hours unless there is an emergency. Respondent shall clearly document the nature of the emergency.
- D. **Appropriately Trained Staff Present:** Respondent shall ensure that he has appropriately trained staff present at all times when providing care, including in emergencies.
- E. **Appropriate Level of Sedation:** Respondent shall ensure that he provides the appropriate level of sedation when providing care to patients.
- F. **Appropriate Monitoring:** Respondent shall ensure that appropriately trained staff are present to perform and document appropriate monitoring including, pulse oximetry, patient's status, level of consciousness and response to the procedure, for all patients.
- G. **Appropriate Aftercare:** Respondent shall ensure that all patients have appropriate transportation arranged following sedation.
- H. **Written Informed Consent:** Respondent shall obtain appropriate written informed consent for all patients.
- I. **Medical Records:** Respondent shall ensure that he maintains appropriate medical records for all patients.
- J. **Fees For Services:** Respondent shall charge appropriate fees for all medical services provided. If Respondent deviates from the standard charge for a

specific patient, the reason for the deviation shall be documented in the medical record.

10. **FIVE YEAR PROBATION:** Respondent shall be placed on probation for five (5) years, subject to the following terms and conditions:

A. **Board Monitoring Program:** Respondent shall establish a Board monitoring program with Mary Knapp, Compliance Monitor, Iowa Board of Medicine, 400 SW 8th Street, Suite C, Des Moines, IA 50309-4686, Ph.#515-281-5525.

Respondent shall fully comply with all requirements of the Board monitoring program.

B. **BMI Recommendations:** Respondent shall fully comply with the BMI recommendations.

C. **Practice Monitoring Plan:** Respondent shall within thirty (30) days of receipt of this Order submit to the Board for approval a written practice monitoring plan for each location where Respondent practices medicine, except for hospital settings.

1) Respondent shall fully comply with the written practice monitoring plan agreed upon by the parties. Respondent shall submit the name and CV of one or more Iowa-licensed, board-certified, anesthesiologists to serve as his practice monitor(s).

2) The Board shall provide the practice monitor a copy of the practice monitoring plan and all other relevant Board material in this matter.

3) The practice monitor shall provide a written statement indicating that the practice monitor has read and understands all Board material provided by the Board and agrees to serve as the practice monitor subject to the terms of the practice monitoring plan. The practice monitor shall meet with Respondent regularly, review selected patients records and ensure that Respondent provides appropriate care and treatment to patients and conforms to appropriate professional boundaries. The practice monitor shall contact the Board immediately if there is evidence that Respondent has provided substandard medical care and/or violated appropriate physician-patient boundaries. The practice monitor shall agree to submit written quarterly reports to the Board not later than 1/20, 4/20, 7/20 and 10/20 of each year of this order. The practice monitor may be asked to appear before the Board in-person, or by telephone or video conferencing. The practice monitor shall be given written notice of the date, time and location for the appearances. Such appearances shall be subject to the waiver provisions of 653 IAC 24.2(5)(e)(3).

D. **Worksite Monitor:** Respondent shall, for each location where he practices medicine, submit for Board approval the name of one physicians who has regular ongoing contact with Respondent, to serve as a worksite monitor. Respondent hereby gives the Board a release to share a copy of all Board orders relating to this matter with the worksite monitor. The worksite monitor

shall provide a written statement indicating that they have read and understands this order 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 any misconduct or violation of the terms of this order. The monitor shall agree to submit quarterly reports to the Board concerning Respondent's progress. The reports shall be filed with the Board not later than 1/20, 4/20, 7/20 and 10/20 of each year of Respondent's probation.

- E. **Quarterly Reports:** Respondent shall file sworn quarterly reports with the Board attesting to his compliance with all the terms and conditions of this Settlement Agreement. The reports shall be filed not later than 1/10, 4/10, 7/10 and 10/10 of each year of the Respondent's probation.
- F. **Board Appearances:** Respondent shall make appearances before the Board or a Board committee annually or upon request. Respondent shall be given reasonable notice of the date, time and location for the appearances. Said appearances shall be subject to the waiver provisions of 653 IAC 24.2(5)(e)(3).
- G. **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 submitted to the Board with Respondent's quarterly reports. 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.

11. **TERMINATION OF PROBATION:** Recently, Respondent asked the Board to terminate the practice requirements and terms of probation established by the Board in the January 11, 2013, Reinstatement Order. On December 16, 2016, the Board voted to terminate the terms of Respondent's probation. The Board concluded that Respondent has fully complied with the terms of his probation.

THEREFORE IT IS HEREBY ORDERED: that the terms of Respondent's probation described in Paragraph 10 above are terminated. However, the notice requirement in Paragraph 8 above and practice requirements in Paragraph 9 above remain in effect:

This Order is issued by the Board on December 16, 2016.



Diane L. Clark, R.N., M.A., Chair
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

MICHAEL C. PRESCHER, M.D., RESPONDENT

FILE Nos. 02-09-323 & 02-10-180

REINSTATEMENT ORDER

COMES NOW the Iowa Board of Medicine (Board) and Michael C. Prescher, M.D. (Respondent), on January 11, 2013, and enter into this Reinstatement Order.

1. Respondent was issued Iowa medical license no. 31176 on April 29, 1996.
2. Respondent's Iowa medical license is active and will next expire on December 1, 2013.
3. The Board has jurisdiction pursuant to Iowa Code Chapters 147, 148, and 272C.
4. On December 11, 2011, the Board filed a Statement of Charges and Emergency Adjudicative Order against Respondent and immediately suspended his Iowa medical license. The Board filed an Amended Statement of Charges on January 9, 2012. The Board alleged that Respondent engaged in sexual misconduct, unethical or unprofessional conduct and/or professional incompetency in five cases.

8. A hearing was held on January 12-13, 2012, and on March 29, 2012, the Board issued a Findings of Fact, Conclusions of Law, Decision and Order.

- A. **Sexual Misconduct:** The Board concluded that the allegations of sexual misconduct were not supported by a preponderance of evidence at hearing.
- B. **Unethical or Unprofessional Conduct and/or Professional Incompetency:** The Board concluded that Respondent violated the standard of care by seeing patients under sedation without any staff member present. Each of the four patients testified to being sedated to the point of unconsciousness. Three of the four were treated in Respondent's office at a time it was closed and no one was present. Respondent created a climate in which his patients had no way to know what occurred during their treatment because there was no third person to verify what occurred.

The problems with standard of care do not end there. Respondent did not have any of the four patients sign written consents. He acknowledged that a written consent was always secured when he practiced in the hospital, but he did not do so in his clinic practice. At least two of the patients expressed confusion as to what occurred. Patient 4 thought she was meeting Respondent for a consultation only, and she ended up being sedated for an hour during a procedure that she questioned and did not understand. Patient 3 had more of an understanding of her procedure, but Respondent did not tell her she would be unconscious during the injection. One of the purposes of a written consent is to better ensure that patients fully understand the procedures that doctors perform. Respondent did not meet standard of care by failing to obtain proper consents.

Respondent likewise did not meet standard of care by failing to monitor and document vital signs. He did not attach an oximeter or blood pressure monitor to any of the four patients while conducting their procedures. This is more important because there was no one else in the room to monitor the patient while Respondent was performing the injections. The problem is exemplified by the concern that developed during Respondent's treatment of Patient 1. If the needle had perforated the colon as Respondent suspected, there may have been complications. Even as it was, Respondent was holding the needle and examining the rectum, without any staff members to assist or having ready means to monitor vital signs.

Respondent also failed to meet standard of care by allowing Patients 2 and 4 to drive home after their procedures. Both testified to feeling shaky and unsteady after their procedures. Respondent knew that both had driven to the appointment. Respondent risked their safety, and the safety of others on the road, by allowing them to drive home.

C. **Sanctions:** The Board ordered Respondent to fully comply with the following sanctions:

1. **Civil Penalty:** Respondent shall be assessed a \$10,000 civil penalty. The civil penalty shall be paid within twenty (20) days of the date of this Order by delivery of a check or money order, payable to the Treasurer of Iowa, to the executive director of the Board. The civil penalty shall be deposited into the State General Fund.
2. **Suspension:** The Board suspends Respondent's Iowa medical license for a period of one year from the date the Board entered its Emergency Order on December 8, 2011. Respondent may reapply for reinstatement at the end of the one year period. Prior to applying for reinstatement, Respondent shall:
 - a) **Professional Boundaries Evaluation:** Respondent shall undergo an evaluation at the Behavioral Medical Institute (BMI) in Atlanta, Georgia. The evaluation shall be at Respondent's cost. BMI shall prepare an evaluation report and submit it to the Board. Respondent shall sign any necessary releases to allow BMI to share information with the Board. Respondent is responsible for all costs associated with the professional boundaries evaluation.
 - b) **Medical Recordkeeping Course:** Respondent shall attend a Board-approved course on medical record-keeping and provide proof of completion to the Board.
 - c) **Terms and Conditions:** The Board may impose probation and other terms and conditions at the time it considers reinstatement of Respondent's Iowa medical license.
3. Respondent shall pay a disciplinary hearing fee of \$75.00. Iowa Code section 272C.6(6); 653 IAC section 25.33(2). Respondent shall also pay any costs certified by the executive director. *See* 653 IAC 25.33(3). All sanctions, 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 Board of Medical Examiners within thirty days of the issuance of the final decision.

9. **JUDICIAL REVIEW OF BOARD'S DECISION:** Upon appeal, the District Court for Pottawattamie County upheld the Board's disciplinary action against

Respondent for professional incompetency. The District Court dismissed the Board's charges that Respondent engaged in unethical or unprofessional conduct because the Board's Decision and Order failed to adequately address the allegations.

10. **APPLICATION FOR REINSTATEMENT:** Respondent petitioned the Board for reinstatement of his Iowa medical license and demonstrated the following:

- A. **Civil Penalty:** Respondent paid the \$10,000 Civil Penalty.
- B. **Professional Boundaries Evaluation:** Respondent successfully completed a professional boundaries evaluation at BMI and BMI concluded that there was no evidence that Respondent is a sexual predator. However, BMI concluded that Respondent did not practice medicine with good professional boundaries when he saw female patients after clinic hours without a chaperone and without charge. BMI concluded Respondent does not pose a significant safety threat to his patients or staff related to professional sexual misconduct. BMI made no further recommendations.
- C. **Medical Recordkeeping Course:** Respondent successfully completed a Board-approved course on medical record-keeping and provided proof of completion to the Board.
- D. **Disciplinary Hearing Fee:** Respondent paid the \$75.00 disciplinary hearing fee.

11. **REINSTATEMENT:** On January 11, 2013, the Board voted to reinstate Respondent's Iowa medical license subject to the following terms and conditions.

12. **NOTICE TO ALL HOSPITALS AND CLINICS:** Respondent shall share a copy of this order with any hospital, clinic, office, or other health care facility where he practices medicine. Respondent shall submit a written statement to the Board from each hospital, clinic, office, or other health care facility where he practices which indicates that they have read and fully understand the terms and conditions of this order.

13. **PRACTICE REQUIREMENTS:** Respondent shall fully comply with the following practice requirements:

- A. **Board-Approved Group Practice Setting:** Respondent shall practice medicine in a Board-approved group practice setting only. Respondent shall seek written approval from the Board prior to practicing medicine in a new practice setting.
- B. **Chaperone Requirement:** Except when he is practicing in a Board-approved hospital setting, Respondent shall have a Board-approved female healthcare professional chaperone continually present at all times while providing healthcare services to female patients, including but not limited to, patient evaluation, treatment and post-evaluation treatment directions. The chaperone shall clearly document her continued presence in each patient's chart. Respondent shall provide the Board with the names of all persons providing chaperone services for him. The chaperone shall not be related to Respondent. The Board will provide all chaperones with a copy of this Order. All chaperones shall provide a written statement to the Board indicating that they have read this Order and agree to inform the Board immediately if there is any evidence of any misconduct or a violation of the terms of this Order.
- C. **Prohibition – Treatment Outside of Clinic Hours:** Respondent shall not treat patients in a clinic setting outside of regular clinic hours unless there is an emergency. Respondent shall clearly document the nature of the emergency.

- D. **Appropriately Trained Staff Present:** Respondent shall ensure that he has appropriately trained staff present at all times when providing care, including in emergencies.
 - E. **Appropriate Level of Sedation:** Respondent shall ensure that he provides the appropriate level of sedation when providing care to patients.
 - F. **Appropriate Monitoring:** Respondent shall ensure that he provides appropriately trained staff are present to perform and document appropriate monitoring including, pulse oximetry, patient's status, level of consciousness and response to the procedure, for all patients.
 - G. **Appropriate Aftercare:** Respondent shall ensure that all patients have appropriate transportation arranged following sedation.
 - H. **Written Informed Consent:** Respondent shall obtain appropriate written informed consent for all patients.
 - I. **Medical Records:** Respondent shall ensure that he maintains appropriate medical records for all patients.
 - J. **Fees For Services:** Respondent shall charge appropriate fees for all medical services provided. If Respondent deviates from the standard charge for a specific patient, the reason for the deviation shall be documented in the medical record.
14. **FIVE YEAR PROBATION:** Respondent shall be placed on probation for five (5) years, subject to the following terms and conditions:
- A. **Board Monitoring Program:** Respondent shall establish a Board monitoring program with Mary Knapp, Compliance Monitor, Iowa Board

of Medicine, 400 SW 8th Street, Suite C, Des Moines, IA 50309-4686, Ph.#515-281-5525. Respondent shall fully comply with all requirements of the Board monitoring program.

B. BMI Recommendations: Respondent has fully complied with the BMI recommendations.

C. Practice Monitoring Plan: Respondent shall within thirty (30) days of receipt of this Order submit to the Board for approval a written practice monitoring plan for each location where Respondent practices medicine, except for hospital settings.

- 1) Respondent shall fully comply with the written practice monitoring plan agreed upon by the parties. Respondent shall submit the name and CV of one or more Iowa-licensed, board-certified, anesthesiologists to serve as his practice monitor(s).
- 2) The Board shall provide the practice monitor a copy of the practice monitoring plan and all other relevant Board material in this matter.
- 3) The practice monitor shall provide a written statement indicating that the practice monitor has read and understands all Board material provided by the Board and agrees to serve as the practice monitor subject to the terms of the practice monitoring plan. The practice monitor shall meet with Respondent regularly, review selected patients records and ensure that Respondent provides appropriate care and treatment to patients and conforms to appropriate professional boundaries. The practice monitor shall contact the

Board immediately if there is evidence that Respondent has provided substandard medical care and/or violated appropriate physician-patient boundaries. The practice monitor shall agree to submit written quarterly reports to the Board not later than 1/20, 4/20, 7/20 and 10/20 of each year of this order. The practice monitor may be asked to appear before the Board in-person, or by telephone or video conferencing. The practice monitor shall be given written notice of the date, time and location for the appearances. Such appearances shall be subject to the waiver provisions of 653 IAC 24.2(5)(e)(3).

- D. **Worksite Monitor:** Respondent shall, for each location where he practices medicine, submit for Board approval the name of one physicians who has regular ongoing contact with Respondent, to serve as a worksite monitor. Respondent hereby gives the Board a release to share a copy of all Board orders relating to this matter with the worksite monitor. The worksite monitor shall provide a written statement indicating that they have read and understands this order 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 any misconduct or violation of the terms of this Order. The monitor shall agree to submit quarterly reports to the Board concerning Respondent's progress. The reports shall be filed with the Board not later than 1/20, 4/20, 7/20 and 10/20 of each year of Respondent's probation.

- E. **Quarterly Reports:** Respondent shall file sworn quarterly reports with the Board attesting to his compliance with all the terms and conditions of this Settlement Agreement. The reports shall be filed not later than 1/10, 4/10, 7/10 and 10/10 of each year of the Respondent's probation.
- F. **Board Appearances:** Respondent shall make appearances before the Board or a Board committee annually or upon request. Respondent shall be given reasonable notice of the date, time and location for the appearances. Said appearances shall be subject to the waiver provisions of 653 IAC 24.2(5)(e)(3).
- G. **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 submitted to the Board with Respondent's quarterly reports. 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.
15. Respondent voluntarily submits this Order to the Board for consideration.
16. This Order constitutes the resolution of a contested case proceeding.
17. By entering into this Order, Respondent voluntarily waives any rights to a contested case hearing and waives any objections to the terms of this Order.
18. Periods of residence or practice outside the state of Iowa shall not apply to the duration of this Order unless Respondent obtains prior written approval from the

Board. Periods in which Respondent does not practice medicine or fails to comply with the terms established in this Order shall not apply to the duration of this Order unless Respondent obtains prior written approval from the Board.

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

20. In the event Respondent violates or fails to comply with any of the terms or conditions of this Order, the Board may initiate action to revoke Respondent's Iowa medical license or to impose other license discipline as authorized in Iowa Code Chapters 148 and 272 and 653 IAC 12.2.

21. This Order becomes a public record available for inspection and copying upon execution in accordance with the requirements of Iowa Code Chapters 17A, 22 and 272C.

22. Respondent understands that the Board is required by Federal law to report this Order to the National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank.

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

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



Michael C. Prescher, M.D., Respondent

Subscribed and sworn to before me on Jan. 8, 2013.

Notary Public, State of Iowa.



This Order is approved by the Board on January 11, 2013.

Colleen K. Stockdale MD MS

Colleen K. Stockdale, M.D., M.S., Chairwoman
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
MICHAEL C. PRESCHER, M.D., RESPONDENT**

FILE Nos. 02-09-323 & 02-10-180

ORDER RE: RESPONDENT'S APPLICATION FOR STAY

Date: April 20, 2012.

1. On April 29, 1996, Respondent was issued Iowa medical license no. 31176.
2. Respondent's Iowa medical license is active and will next expire on December 1, 2013.
3. On December 8, 2011, the Board filed a Statement of Charges and an Emergency Adjudicative Order alleging that Respondent engaged in sexual misconduct, unethical or unprofessional conduct and professional incompetency in violation of the laws and rules governing the practice of medicine in Iowa and a hearing was scheduled on January 12, 2012. Under the Emergency Adjudicative Order, Respondent was prohibited from practicing medicine under his Iowa medical license until this matter is resolved.
4. On January 9, 2012, the Board filed an Amended Statement of Charges.
5. A hearing on the Amended Statement of Charges and Emergency Adjudicative Order was held before the Board on January 12-13, 2012.

6. On March 29, 2012, the Board issued a Findings of Fact, Conclusions of Law, Decision and Order. The Board concluded that Respondent violated the standard of care by seeing patients who were under sedation without any staff member present. The Board also concluded that Respondent violated the standard of care when he failed to obtain proper written consent from the patients, failed to monitor and document the patients' vital signs during the procedures and allowed two patients to drive home following deep sedation. The Board concluded that the State failed to prove by a preponderance of the evidence that Respondent committed sexual acts on the female patients. However, the Board expressed serious concerns that Respondent created a climate in which his patients had no way to know what occurred during their treatment because there was no third person to verify what occurred. Each of the four patients testified to being sedated to the point of unconsciousness. Three of the four women were treated in Respondent's office at a time it was closed and no one else was present. The Board suspended Respondent's Iowa medical license for a period of one year from the date of the original suspension, December 8, 2011. The Board also ordered Respondent to pay a \$10,000 fine and complete a Board-approved professional boundaries program and medical record keeping program. The Order also permits the Board to impose probation or other terms and conditions at the time it considers reinstatement of Respondent's Iowa medical license.

7. On or about April 18, 2012, Respondent filed an Application for Stay before the Board. Respondent requests that the Board stay enforcement of the penalties until after

the District Court has ruled. Respondent indicates that he intends to seek judicial review. Respondent argues that the penalties imposed by the Board are burdensome upon Respondent, that there is a substantial likelihood of success at the District Court level and that if he is successful and he does not have a stay, the ruling of the District Court would be moot.

8. On April 20, 2012, the State filed a Resistance to Application for Stay. The State argues that the Board is prohibited by law from issuing a stay in this case. The State indicates that the Board's rules at 653 IAC 25.27(2) state that the Board "shall not grant a stay in any case in which the district court would be expressly prohibited by statute from granting a stay. Iowa Code Section 148.7(10) states:

The board's order revoking or suspending a license to practice medicine and surgery or osteopathic medicine and surgery or to discipline a licensee shall remain in force and effect until the appeal is finally determined and disposed of upon its merits.

9. After careful consideration, the Board voted to deny Respondent's Application for Stay as the Board is prohibited by law from issuing a stay in this matter.

THEREFORE IT IS HEREBY ORDERED: that Respondent's Application for Stay is **DENIED**.


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

April 20, 2012
Date

BEFORE THE IOWA BOARD OF MEDICINE

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|-----------------------------------|---|---------------------------------------|
| IN THE MATTER OF THE |) | FILE NOS. 02-09-323, 02-10-180 |
| STATEMENT OF CHARGES |) | DIA NO. 11IBM020 |
| AGAINST: |) | |
| |) | FINDINGS OF FACT, |
| MICHAEL C. PRESCHER, M.D., |) | CONCLUSIONS OF LAW, |
| |) | DECISION AND ORDER |
| Respondent. |) | |

To: Michael C. Prescher, M.D.

Date: March 29, 2012.

On December 8, 2011, the Iowa Board of Medicine (the Board) filed a Statement of Charges against Michael C. Prescher, M.D. (Respondent). The Statement of Charges alleged that Respondent engaged in sexual misconduct, unethical or unprofessional conduct, and professional incompetency. More specifically, the Statement of Charges alleged that Respondent engaged in sexual misconduct with two patients who were under sedation while being treated. The Board also issued an Emergency Adjudicative Order immediately suspending his license to practice medicine pending a hearing before the Board. On January 12, 2012, the Board filed an Amended Statement of Charges with the same legal claims, but including three additional alleged victims.

On January 12-13, 2012, the case came on for hearing before the Board. The following Board members were present: Siroos Shirazi, M.D., Chairman, Analisa Haberman, D.O., Greg Hoversten, D.O., Joyce Vista-Wayne, M.D., Colleen Stockdale, M.D., Hamed Tewfik, M.D., and Ambreen Mian, and Tom Drew, public members.¹ Jeffrey Farrell, an administrative law judge from the Department of Inspections and Appeals, assisted the Board. Assistant Attorney General Julie Bussanmas represented the public interest. Attorneys David Richter and John French represented Respondent. The hearing was closed to the public at the election of the licensee.²

After hearing the testimony and examining the exhibits, the Board convened in closed executive session to deliberate. *See* Iowa Code section 21.5(1)(f). The Board directed the administrative law judge to prepare the decision in accordance with its deliberations.

¹ Diane Clark was present for the first day of the hearing. She had a conflict on the second day and did not participate in the decision-making.

² Iowa Code section 272C.6(1).

THE RECORD

The State's exhibits 1-48 were admitted. The State called Dr. Dana Simon, Patient 1, Patient 2, Patient 3, and Patient 4 as witnesses. Respondent's exhibits A-G, I-M, P, R, T, and V were admitted.³ Respondent called Dr. Eric Loudermilk, Catherine Russell, Douglas Mann, Kristin Evans, Kristin Balm, Dr. John Ockenbloom, Dr. John Suthard, Marilyn Burke, Tara Stevens, and Tim Smith as witnesses. Respondent testified on his own behalf.

FINDINGS OF FACT

Background: Respondent, Michael Prescher, M.D., has practiced medicine in the areas of anesthesiology and pain management in Council Bluffs, Iowa, for the past 15 years. He has been on-staff at Jennie Edmundson Hospital (JEH) since beginning his practice. He also practices pain management at a clinic office. At the time relevant to this case, Respondent's office practice was located in a building complex connected to JEH. Respondent was the only doctor who practiced at that office. (Respondent testimony; exhibit P).

Respondent normally performed anesthesia work at JEH on Mondays and Wednesdays. He saw pain management patients at his clinic office on Thursdays. He might see as many as 40 patients on a typical Thursday. On Fridays, he performed follow-up outpatient work or took referrals from the hospital. He was on-call at JEH four months of the year. He had a sleep quarters in his office while he was working on-call. (Respondent testimony).

Respondent developed his pain management practice after studying under Dr. Bob Kirby at the University of Florida during his residency. Respondent learned that narcotics were often not successful treating conditions such as migraines, but Lidocaine was effective "95 percent of the time." Respondent typically gives 3 to 5 mg of Lidocaine through an IV over a period of 45 to 60 minutes. He uses the same process to sedate patients for injections. Lidocaine relieves anxiety and most patients can talk throughout the procedure. (Respondent testimony).

Respondent performs other pain management treatments that will be discussed as necessary later in this decision. He is the only physician specializing in pain management in southwest Iowa. He does not prescribe narcotics for any of his patients. He is respected by his peers in the area, and was recently voted chief of staff by the approximate 300 doctors practicing at JEH (although that decision is pending an outcome of this legal proceeding). (Respondent testimony).

³ Other marked exhibits were not introduced.

Patient 1: Respondent treated Patient 1 for back pain on February 12, 2009. Patient 1 was a 41 year old woman who had had back problems for approximately ten years. She also had problems with depression and addiction to prescription medications. Respondent had treated Patient 1 on a number of occasions over several years. They each testified to a good physician-patient relationship to that point. Respondent had treated Patient 1 with steroid injections and attempted to steer her away from narcotics. However, she remained addicted to prescription medications and showed some drug-seeking behaviors. She admitted having gone to the emergency room approximately 20 times over the prior four to five years, as well as making visits to her family physician. She had been prescribed Darvocet as late as 13 days prior to seeing Respondent in February of 2009. (Respondent, Patient 1 testimony; Exhibit D, pp. 16-18).

On the morning of February 12, 2009, Patient 1 appeared at Respondent's office with a bag of candy and a thank-you card for Respondent and his staff. There is considerable dispute between Patient 1 and Respondent as to what transpired next. Patient 1 testified that she had appeared for a scheduled appointment, and he directed her to return at 6:00 p.m. when he could give her an injection. Respondent testified that Patient 1 appeared without an appointment and wanted an injection immediately. He told her that he could not see her at that time, but she could call back early in the afternoon to check on availability. Patient 1 called at 1:00 p.m., and he told her that he did not have time and she could set an appointment for the following week. She replied that she would just go to the emergency room at JEH and she would get medications from another physician. Respondent felt he would end up being called to treat her at the hospital, which would cost her more for the same treatment. He offered her an appointment at his office at 6:00 p.m. (Respondent, Patient 1 testimony; Exhibit 6, p. 60; Exhibit 7, pp. 86-87).

Some aspects of the appointment are undisputed. Patient 1 appeared at Respondent's clinic office around 6:00 p.m. that night. No staff member was present. Patient 1 did not think this was unusual because she had received treatments from Respondent after regular hours in the past, and there was never a staff person present during treatments. Respondent did not have Patient 1 sign a written consent prior to receiving treatment. Patient 1 had received similar treatments in the past and generally understood the procedure. Respondent escorted her to an examination room, and she took off her shoes, lowered her pants and underwear a few inches, and she laid on her stomach on the examining table. (Patient 1, Respondent testimony).

At that point, the witnesses' stories again diverge. Patient 1 testified that Respondent asked her if she wanted to be awake or asleep during the injections, and she replied that she wanted to sleep. He gave her an IV and she went to sleep. She woke up lying on her back, with an oxygen mask attached, and a blanket over her. She testified that she had never received oxygen during prior treatments. Respondent asked her if she was ready to leave, and he walked her outside the office to a bench in a common area where she could wait for her ride. (Patient 1 testimony; Exhibit 6, p. 70; Exhibit B).

Respondent testified that Patient 1 was conscious throughout the procedure. He stated that Patient 1 requested sedation and he gave her Lidocaine by IV as is his practice. Respondent's notes indicate that he also gave her Versed in the IV, but Respondent testified at hearing that he made a mistake in the notes and no Versed was administered. Respondent testified that Patient 1 was conversant and responsive throughout the procedure. After he finished, he told her to lie on her back for 20 minutes to allow the medicine to absorb. She did so, and then left the office to wait for her ride. (Respondent testimony; Exhibit 7, p. 85).

Respondent testified that when he gave the first injection to Patient 1, the needle lost resistance and went fairly deep into her body. The patient immediately had significant flatus. He was concerned that the needle may have perforated the colon. He told Patient 1 that he was going to do a rectal exam to feel for the tip of the needle. He testified that she responded "Do what you have to do, Hon". Respondent testified that he did not feel the needle, so he redirected the needle and proceeded with the injections. He noticed blood from his glove which he thought was from a hemorrhoid. He completed the procedure and noticed Patient 1 had bleeding in the area of the coccyx. He applied pressure with a sterile towel and Lidocaine jelly, which seemed to work. He denied any sexual contact. (Respondent testimony; exhibit 7, p. 85).

Respondent did not charge Patient 1 for this procedure. He testified that she was not working and had a large spenddown that she would need to pay before medical assistance would pick up the tab. Respondent testified extensively (as to this patient and other patients) about the costs of medical treatment, particularly the cost of treatment in the hospital compared with the much lower cost of an office visit. He testified to providing free care on approximately 100 to 150 occasions over his career. Respondent justified providing care at his office and without staff present as a means to help patients avoid large medical bills. (Respondent testimony).

Patient 1 went home and felt some pain in her rectum. She went to the bathroom, and noticed blood in her underwear and slime when she wiped. She felt what appeared to be a Vaseline or jelly-type substance around her rectum. She also noticed a black pubic hair on her underwear, which was significant to her because she does not have black pubic hair. She thought she smelled semen. She put the panties in a plastic bag and had a friend drive her to the emergency room for a sexual assault exam. (Patient 1 testimony; Exhibit 6, p. 70; Exhibit B).

Patient 1 was examined by Dr. Wasson Louie. Dr. Louie did not find anything unusual during his physical exam. He did not see any rectal tearing or bruising, nor did he see any trauma or tenderness to the vaginal area. He saw some dried blood in the groin area, but no bleeding from the rectum itself. A nurse at the hospital completed a sexual assault kit, and took the bag with Patient 1's underwear. (Exhibits B, C).

The matter was reported to the Council Bluffs Police Department (CBPD), who conducted search warrants at Respondent's office and home on February 13, 2009. Officers took several bed sheets and blankets from Respondent's office. They also took Patient 1's medical file and a copy of his appointment book for February 12, 2009. Respondent told officers he had not dictated his notes from the appointment on February 12, 2009. He did so and called Detective Douglas Mann on February 14, 2009, to let him know the dictation was complete and could be picked up. Officers later obtained DNA samples from Respondent for use in testing. (Exhibits 6, E; Mann testimony).

Kristin Evans from the Iowa Division of Criminal Investigation (DCI) conducted lab analysis of some of the evidence provided by CBPD. Ms. Evans found no evidence of semen in the underwear. She testified that when DCI receives the underwear originally worn by a victim, there is a "high probability" that it would produce incriminating evidence. Ms. Evans inspected the underwear for pubic hairs, but found no black hair as reported by Patient 1. From the sexual assault kit, Ms. Evans found no presence of semen on the vaginal and rectal swabs taken from Patient 1. Likewise, she found no pubic hair in the combings from Patient 1. (Evans testimony; Exhibit E, p. 38-39).

Ms. Evans consulted with the assistant county attorney who was responsible for the case to ask if he wanted her to review the sheets and blankets. She testified that it may have taken up to three days to review these items for incriminating evidence. The prosecutor told Ms. Evans not to inspect the sheets or blankets in light of the findings on the underwear and the sexual assault kit. (Evans testimony).

No criminal charges were filed against Respondent. He was interviewed by officers on at least four occasions relative to this investigation. Each interview was recorded. Respondent never asked for an attorney or refused to answer a question. He was calm and used books to explain the procedure he performed. However, his answer to one question proved to be foreboding:

Q: . . . every once and awhile see it with the celebrities type that they end up having more or less a stalker that basically wants to be around them all the time, you think that she's kind of becoming one of those type?

A: Well see I have over the years, . . . I put myself in a bad position. Which will never happen again. I did all this free work and help people out, I said I will never do that again, unless I can get somebody in there to just make sure things are the way they are. (Emphasis added).

Respondent made that statement on February 17, 2009. (Mann testimony; Exhibit 6, p. 81; Exhibit 17, p. 281).

Patient 2: Respondent treated Patient 2 for back pain on April 6, 2010. She was injured in 2009 while working with a mentally handicapped client at a health care facility. Respondent had seen her on three occasions prior to April 6, 2010. The prior appointments were at his office or at JEH. Respondent had ordered an MRI after an epidural was attempted on March 2, 2010, without success. The MRI showed no abnormality. Respondent testified that Patient 2 had asked for narcotic medications. He refused to prescribe for her and worried about secondary gain issues. (Patient 2, Respondent testimony; Exhibit 23, p. 331-32, 351; Exhibit 24, p. 416).

The evidence regarding Patient 2's visit is similar to that regarding Patient 1. Patient 2 testified that she called Respondent to discuss her continuing pain after the epidural did not work. She told him she had the day off on Tuesday, April 6, 2010, and could meet him at any time that day. Respondent later called her on short notice to state that he could fit her in at 10:00 a.m. She arrived at the office early and found the door locked. She called a phone number on his business card. Shortly thereafter, Respondent appeared down the hall from the hospital and took Patient 2 inside his clinic office. (Patient 2 testimony; Exhibit 28, p. 452).

Conversely, Respondent testified that he made an appointment with Patient 2 for one of his upcoming Thursday clinic days, but she called his billing office on April 6 demanding to be seen. Patient 2 told his staff person that she was standing outside his clinic office. Respondent was working at JEH and agreed to meet her. She was crying and upset. She already owed \$10,000 in medical bills, so he did not want her to incur another \$4,000 bill for doing an injection treatment in a hospital setting. He agreed to treat her at no cost in his clinic office. (Respondent testimony; Exhibit 23, p. 351).

There is no dispute with some aspects of the treatment. No staff member was present in the clinic when Respondent treated Patient 2 and she did not sign a written consent. Respondent had her lie down on the examination table on her stomach with her head on a pillow. He gave Lidocaine by IV. He then gave her an injection consisting of a mixture of Depo-medrol (a steroid) and Marcaine (a local anesthetic). After the procedure was complete, she waited a few minutes and drove herself home. (Respondent, Patient 2 testimony; Exhibit 23, p. 351).

Other aspects of the treatment are contested. Respondent stated in his notes that Patient 2 complained of headaches, which was one of the reasons he gave her IV Lidocaine. She denied complaining to him of headaches at any time. Patient 2 testified that she was unconscious after the IV was introduced. When she woke up, she was lying on her back with a blanket over her. Respondent testified that she was conscious and alert, and "popped right up" after he gave the injection. Patient 2 also denied Respondent's claim that insurance was in question. She testified that worker's compensation was paying her medical bills. As of the date of the hearing, she is not aware of any unpaid medical bills. (Respondent, Patient 2 testimony).

Patient 2 testified that, after she woke up, she had a white sticky substance on her face and neck. Respondent told her it was medicine and wiped it off. She later became concerned that the substance might have been semen. Respondent testified that he spilled some of the medication when he was clearing air from the syringe. Depo-medrol is a chalky white color after being mixed with Marcaine. Respondent gave a demonstration during hearing. The mixture did appear to have a white chalky color. (Patient 2, Respondent testimony; Exhibits G, J).

When Patient 2 arrived home and felt “hazy,” so she took a nap. She had intercourse with her boyfriend later that night and felt discomfort. In her words, she felt as if she had intercourse multiple times in one day. After discussing the course of events with a friend who was a mandatory reporter, she called the CBPD. She was directed to go to the emergency room (at Mercy Hospital) where a sexual assault kit was completed. The samples were sent to DCI, who later conducted an examination. DCI found physical evidence to show Patient 2 had sex with her boyfriend, but no physical evidence to show sexual contact with Respondent. The physical exam of Patient 2 showed a possible vaginal infection, which was treated by medication with the direction to follow up with her primary care physician. (Patient 2, Balm testimony; Exhibit A; Exhibit F, p. 28; Exhibit 25, p. 424).

CBPD conducted a similar investigation as it did in February of 2009. Officers conducted a search warrant of Respondent’s office on April 8, 2010. They seized bedding and swabs from the exam room table. Respondent had yet to prepare his dictation for his treatment of Patient 2. He did so on April 9, 2010. Officers interviewed Respondent on several occasions. He did not refuse any interviews and did not ask to have an attorney present. No criminal charges were filed. (Mann testimony; Exhibits 22, F; Exhibit 23, p. 351).

Post-Statement of Charges Complaints: Three additional complaints were filed against Respondent after the Board made public notice of the original Statement of Charges. Two testified at hearing. The third did not provide a last name and could not be further identified. The two identified complainants did not allege sexual abuse. However, both were troubled by aspects of their treatment, which was similar to the treatment provided to Patients 1 and 2. In particular, the testimony of Patient 4 was troubling to the Board because her treatment occurred after the criminal investigation involving Patient 1.

Patient 3: Patient 3 went to JEH on December 27, 2004, for treatment of back pain. Initial testing was negative, but she remained in pain two days later. On December 29, 2004, Respondent gave her a trigger point injection at JEH. Patient 3’s husband was present and she was fully awake during the procedure. As of the following day, the injection had not given any relief. Patient 3’s husband called Respondent and he agreed to see her at the JEH outpatient center at 6:30 p.m. on December 30, 2004. (Patient 3 testimony).

Respondent met Patient 3 in the waiting area and escorted her to an examining room. Her husband remained in the waiting area. No staff person was present in the examining room. Respondent said he would try the same injection. She pulled her pants down half-way so he could give the injection. She does not remember anything after that point until waking from unconsciousness. She stated that Respondent had given an IV, but Respondent did not tell her she would be unconscious. She thought she might have been unconscious for approximately one hour. Patient 3 did not allege any sexual contact, but always wondered why the procedure was so much different from the first one, why it was so much longer, and why Respondent did not tell her she would be unconscious. She does not recall signing a written consent or release form. (Patient 3 testimony; Exhibit 47, p. 774-75).

Patient 4: Patient 4 was treated by Respondent on October 16, 2009. She had met Respondent at a fundraising event through her then-boyfriend, who was friends with Respondent. The boyfriend mentioned that Patient 4 had troubles with migraines. They scheduled an appointment to meet at Respondent's office to discuss her pain further. She thought the appointment was merely a consultation and no treatment would be provided. (Patient 4 testimony; Exhibit 48, p. 790).

Patient 4's appointment was mid-morning at Respondent's clinic office. No staff members were present.⁴ Respondent told Patient 4 that he would not need to run the case through insurance if no one was present. This statement bothered Patient 4 because she was employed and had health insurance. (Patient 4 testimony; Exhibit 48, p. 790).

Respondent did not ask Patient 4 to sign a written consent. He verbally explained how the trigger point injection works and would give her the injection that day. She was uncomfortable and asked several questions as she texted her boyfriend. Respondent told her she would need to calm down, and that he would give her medication through an IV that would help. She lost consciousness and woke approximately an hour later lying on a bed with a blanket over her. She got up and had some difficulty walking, but Respondent allowed her to walk to her car and drive home. (Patient 4 testimony; Exhibit 48, p. 790-91).

Patient 4 does not allege sexual assault. Her complaint is better characterized as "What just happened to me?" She went to the appointment believing she would not receive any treatment. Instead, she received a treatment that she did not understand, she was alone and unconscious when it occurred, and Respondent allowed her to drive home even though she was groggy from the sedation. Patient 4, who impressed the Board as an insightful woman, best summed her concerns (and, to a large degree, the Board's concerns):

⁴ October 16, 2009 was a Friday. As discussed above, Respondent's clinic office was normally only open on Thursdays.

. . . when I saw that article [about the Statement of Charges], . . . these women are saying something else maybe happened to them. And I honestly am not saying that I think that is what could [have] happened, I don't know. I really have no idea what happened in that time frame.

(Patient 4 testimony; Exhibit 48, p. 791).

Conclusions regarding sedation: While Respondent claimed that Patients 1 and 2 were not unconscious and were responsive during their procedures, the Board does not accept this claim. The testimony of all four patients was remarkably similar. There was no evidence that any of the four knew each other. Each was believable on this point. The Board finds each was unconscious while receiving treatment.

Respondent seemed to allude to a theory during the hearing that the patients may have been responsive during the procedure, but suffered a memory loss due to the medication. The Board does not find this to be true. There is no basis in the record to believe that Respondent's method of sedation through IV Lidocaine would cause a memory loss without unconsciousness.

Expert witness testimony: The State used Dr. Dana Simon, a pain medicine specialist from Des Moines, as its peer reviewer and expert witness. Respondent used Dr. Eric Loudermilk, a pain management specialist from South Carolina, and who studied at the University of Florida with Respondent, as its expert. Dr. Simon's testimony was impacted by his failure to directly answer many questions on cross-examination, and his focus on the timeliness of Respondent's dictation of the treatment of Patient 1.

Dr. Simon was highly critical of Respondent because he did not receive Respondent's medical notes for Patient 1 until well-after the treatment was performed. However, this criticism was misguided for reasons unknown to Dr. Simon at the time he did his review. When Respondent provided his notes to CBPD, they were separated from the remainder of the investigative file. As a result, the Board did not initially receive the notes from that treatment, which led Dr. Simon to believe they had not been done (or were done significantly after the treatment was performed). Based on Detective Mann's testimony, we now know that Respondent completed his dictation on February 14, 2009, two days after the procedure. (Simon, Loudermilk testimony).

Respondent performed dictation of his notes on the procedures involving Patients 1 and 2 after learning about the allegations, but this may have been a function of the timing of the investigation. He learned about the investigation of Patient 1 one day after the procedure. He learned about the investigation of Patient 2 two days after the procedure. His dictation of those notes may have been defensive because he knew about the investigations when he dictated, but performing dictation two or three days after a procedure is not a violation of the standard of care.

There was considerable expert testimony (and testimony from Respondent himself) regarding the appropriateness of his claimed rectal exam of Patient 1. All three agreed that it would be extremely rare to perforate the colon with the needle, although it was possible to do so. Dr. Simon testified that a rectal exam could make matters worse by puncturing the finger with the needle and bleeding into the patient. With that said, Dr. Simon admitted that he could not say that a rectal exam “should never be done.” Respondent’s decision to conduct a rectal exam under the circumstances claimed does not violate the standard of care. (Simon testimony).

Drs. Simon and Loudermilk agreed that it was a violation of standard of care to treat patients under sedation to the point of unconsciousness without other medical staff present. Dr. Loudermilk testified that a chaperone must be present, not only for the protection of the physician, but also the protection of the patient. Dr. Loudermilk explained that he was not concerned about the patient’s physical well-being under the circumstances presented – the procedures performed by Respondent were low-risk and he was fully capable of handling any complications that might present. Rather, the patient protection issues concern the opportunity for abuse. Drs. Loudermilk and Simon also agreed that 3 to 5 mg of lidocaine (which is the amount Respondent claimed he used) should not cause unconsciousness.

Other witnesses: Respondent produced witnesses to confirm various aspects of his practice. For example, Marilyn Burke is a registered nurse who works with Respondent at JEH. Respondent has also treated her for back pain. She has received injections from Respondent with no one present in the room. He did not charge her for the first injection he performed. She has seen him give injections to other patients numerous times. She has no questions or concerns about his competency.

Similarly, Tara Stevens is an LPN at JEH who has been treated by Respondent for migraine headaches. Ms. Stevens testified that Respondent treats her with IV Lidocaine. His practice is to ask her to lie on an examination table, apply the IV and a pulse-oximeter, and offer her a blanket. They talk during the treatment. When the treatment is complete, she gets a ride home and takes a nap. Respondent has never charged her for treatment. She has no concerns and his completely comfortable in his care. (Stevens testimony).

CONCLUSIONS OF LAW

Merits of the Statement of Charges: The Board is a professional licensing board created to review applications for licenses and regulate the profession. *See generally* Iowa Code chapters 147, 148. The Board may discipline licensees pursuant to the standards set forth in the code. *See* Iowa Code section 147.55. The Board has adopted rules pursuant to Iowa Code chapter 17A to help define the statutory standards. *See* 653 IAC 12.4, chs. 13, 23.

The Statement of Charges alleged three counts. Count I alleged sexual misconduct. Count II alleged unethical or unprofessional conduct. Count III alleged professional incompetency. More specifically, Count III includes claims that Respondent deviated from the standards of learning or skill ordinarily possessed and applied in Iowa, failed to exercise a degree of care that ordinarily exercised by the average physician in Iowa, and willfully or repeatedly departed from, or failed to conform to, the minimal standard of acceptable and prevailing practice of medicine in Iowa.⁵ The State has the burden of proof by a preponderance of the evidence to prove the charge. *See Eaves v. Iowa Board of Medical Examiners*, 467 N.W.2d 234 (Iowa 1991).

Count I: The Board's rules prohibit physicians from engaging in sexual misconduct.⁶ Sexual misconduct includes, in the course of providing medical care, engaging in contact or touching of a sexual nature.⁷ The sexual misconduct claims relate only to Patients 1 and 2.

Many sexual misconduct cases that come before the Board involve a "he said/she said" analysis. This case is different. Respondent denies any sexual contact. Patients 1 and 2 do not know whether Respondent engaged in sexual conduct because they were unconscious at the time, but they suspect that sexual contact occurred based on the course of events during and following treatment. Their fears were justified in both instances, as there was evidence that would lead a reasonable person to believe they were or might have been victimized. However, based on the weight of the evidence presented at hearing, the Board does not find that the allegations in Count I are supported by a preponderance of the evidence.

Patient 1: Patient 1 originally went to the emergency room due to blood and a pubic hair in her underwear, a smell of semen, and finding a lubricant while wiping. That led to her concern that Respondent might have perpetrated an act of anal intercourse or some other sexual assault. She went to the emergency room within approximately four hours of her

⁵ See 653 IAC 23.1(2).

⁶ 653 IAC 23.1(5).

⁷ 653 IAC 13.7(4)(a).

appointment with Respondent, and she brought the clothes she had worn to the appointment, including the aforementioned underwear. Patient 1's relatively prompt reporting gave the hospital, police, and DCI a good opportunity to find incriminating physical evidence if there was any to be had. No such evidence was found. Dr. Louie did not find any physical injury during his examination. The hospital completed a sexual assault kit, but there was no evidence connecting Respondent with any sexual contact with Patient 1. DCI did not find any semen or other evidence indicating Respondent committed a sexual assault. DCI did not find a black pubic hair or any hair connected to Respondent.

There are alternative explanations. Respondent testified that he performed a rectal exam after becoming concerned the injection needle might have perforated the colon. Perforating the colon would be rare, but is possible. Conducting a rectal exam could be a course of action under those circumstances. That might explain the presence of a lubricant. The presence of some blood in the underwear may also be explained as having come from the injection site. If there was bleeding from that site, it may have flowed to the anal area. Dr. Louie did not see any other tear or injury, so Respondent's explanation may be a reasonable one under these circumstances.

Patient 2: The evidence regarding Patient 2 is similar, but arguably weaker from a physical standpoint because she did not go the emergency room for an examination until the following day. Once again, there was no physical evidence to connect Respondent to a sexual assault. Patient 2's vaginal soreness could have been caused by an infection that was treated during her exam at the hospital. The white sticky substance on her face was never tested, and Respondent offered a plausible explanation that it could have been spillage of the steroid he was injecting. Patient 2 had reasonable grounds to believe that something may have happened to her under the circumstances. However, there is not a preponderance of evidence to show that Respondent committed a sexual act.

Counts II and III: Counts II and III are discussed together, as they are comparable. In particular, the Board focused on questions of standard of care outlined in Count III. The standard of care issues apply to each of the four patients who testified at hearing.

Respondent violated the standard of care by seeing patients under sedation without any staff member present. Each of the four patients testified to being sedated to the point of unconsciousness. Three of the four were treated in Respondent's office at a time it was closed and no one was present. Respondent created a climate in which his patients had no way to know what occurred during their treatment because there was no third person to verify what occurred.

The problems with standard of care do not end there. Respondent did not have any of the four patients sign written consents. He acknowledged that a written consent was always secured when he practiced in the hospital, but he did not do so in his clinic practice. At

least two of the patients expressed confusion as to what occurred. Patient 4 thought she was meeting Respondent for a consultation only, and she ended up being sedated for an hour during a procedure that she questioned and did not understand. Patient 3 had more of an understanding of her procedure, but Respondent did not tell her she would be unconscious during the injection. One of the purposes of a written consent is to better ensure that patients fully understand the procedures that doctors perform. Respondent did not meet standard of care by failing to obtain proper consents.

Respondent likewise did not meet standard of care by failing to monitor and document vital signs. He did not attach an oximeter or blood pressure monitor to any of the four patients while conducting their procedures. This is more important because there was no one else in the room to monitor the patient while Respondent was performing the injections. The problem is exemplified by the concern that developed during Respondent's treatment of Patient 1. If the needle had perforated the colon as Respondent suspected, there may have been complications. Even as it was, Respondent was holding the needle and examining the rectum, without any staff members to assist or having ready means to monitor vital signs.

Respondent also failed to meet standard of care by allowing Patients 2 and 4 to drive home after their procedures. Both testified to feeling shaky and unsteady after their procedures. Respondent knew that both had driven to the appointment. Respondent risked their safety, and the safety of others on the road, by allowing them to drive home.

DECISION AND ORDER

The seriousness of this case cannot be more underscored. While the Board did not find a preponderance of the evidence to support the sexual abuse charges, the Board continues to question whether sexual abuse occurred. Respondent could have erased all questions as to what he did if he had had a chaperone present when he performed the procedures. The purpose of the chaperone is more than just covering for the doctor. Rather, as stated well by Respondent's own expert, one of the principle purposes for having a chaperone is to protect the patient. The chaperone not only protects the patient from actual harm, but from the uncertainty as to what might have occurred while under sedation.

The harm could not be better demonstrated than through the facts of this case. Patients 1 and 2 had legitimate reasons to believe that they had been sexually assaulted. Both were treated at times that the doctor's office was closed and no staff members present, both were sedated to the point of unconsciousness, and both suffered physical symptoms including bleeding and soreness that suggested sexual assaults. Respondent could have removed any doubt as to what happened if he had simply scheduled his appointments during regular business hours when at least one staff member was present to verify what he did. Respondent's failure to ensure the protection of his patients left them with the genuine fear that he engaged in a sexual act while the patients were unconscious.

But the truly striking aspect of the case is that, even after Patient 1 filed a complaint, even after the Council Bluffs Police Department conducted search warrants at Respondent's home and business, even after he was forced to give a DNA sample for testing by the Division of Criminal Investigation, and even after he told police officers that this "will never happen again" . . . it happened again, and not just once. He engaged in the same conduct of sedating patients outside of his regular office hours without any office employee present on at least two occasions after the criminal investigation involving Patient 1. One was in October of 2009, just months after the close of the criminal investigation involving Patient 1. The other was only a year later, when the memories of a full criminal investigation should have still been fresh in his mind. Respondent did not learn anything during the course of the criminal investigation. The Board sees no choice but to impose a significant sanction to deter this level of misconduct in the future.

During the hearing, Respondent repeatedly justified his brand of solo practice as part of a mission to help patients deal with chronic pain while holding down their medical costs. The Board understands that the costs of medical care are rapidly increasing and is appreciative of reasonable attempts to reduce costs. However, Respondent's practice went too far the other way. It is reminiscent of the saying "Penny-wise, Pound-foolish." Respondent's practice of seeing patients out of the hospital without any staff present may have reduced a particular bill, but only at a great cost to his personal reputation and the integrity of the medical profession as a whole. Some of the costs incurred and billed by medical providers are done so for good reasons. Respondent will need to consider the right balance if and when he practices in the future.

SANCTION

1. **CIVIL PENALTY:** Respondent shall be assessed a **\$10,000** civil penalty. The civil penalty shall be paid within twenty (20) days of the date of this Order by delivery of a check or money order, payable to the Treasurer of Iowa, to the executive director of the Board. The civil penalty shall be deposited into the State General Fund.
2. **SUSPENSION:** The Board suspends Respondent's Iowa medical license for a period of **one year** from the date the Board entered its Emergency Order on December 8, 2011. Respondent may reapply for reinstatement at the end of the one year period. Prior to applying for reinstatement, Respondent shall:
 - a) **Professional Boundaries Evaluation:** Respondent shall undergo an evaluation at the Behavioral Medical Institute (BMI) in Atlanta, Georgia. The evaluation shall be at Respondent's cost. BMI shall prepare an evaluation report and submit it to the Board. Respondent shall sign any necessary releases to allow BMI to share information with the Board. Respondent is responsible for all costs associated with the professional boundaries evaluation.

- b) **Medical Recordkeeping Course:** Respondent shall attend a Board-approved course on medical record-keeping and provide proof of completion to the Board.
- c) **Terms and Conditions:** The Board may impose probation and other terms and conditions at the time it considers reinstatement of Respondent's Iowa medical license.

3. Respondent shall pay a disciplinary hearing fee of \$75.00. Iowa Code section 272C.6(6); 653 IAC section 25.33(2). Respondent shall also pay any costs certified by the executive director. *See* 653 IAC 25.33(3). All sanctions, 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 Board of Medical Examiners within thirty days of the issuance of the final decision.

Dated this 29th day of March, 2012.



Siroos Shirazi, M.D.
Iowa Board of Medicine

cc: Julie Bussanmas
Assistant Attorney General

David Richter
John French
Respondent's Attorneys

BEFORE THE IOWA BOARD OF MEDICINE

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

MICHAEL C. PRESCHER, M.D., RESPONDENT

FILE Nos. 02-09-323 & 02-10-180

AMENDED STATEMENT OF CHARGES

COMES NOW the Iowa Board of Medicine (Board) on January 9, 2012, and files this Amended Statement of Charges pursuant to Iowa Code Section 17A.12(2). Respondent was issued Iowa medical license no. 31176 on April 29, 1996. Respondent's Iowa medical license is active and will next expire on next expire on December 1, 2013.

A. TIME, PLACE AND NATURE OF HEARING

1. Hearing. A disciplinary contested case hearing shall be held on January 12, 2012, before the Iowa Board of Medicine. The hearing shall begin at 8:30 a.m. and shall be located in the conference room at the Iowa Board of Medicine office at 400 SW 8th Street, Suite C, Des Moines, Iowa.

2. Answer. Within twenty (20) days of the date you are served this Notice of Hearing you are required by 653 Iowa Administrative Code 25.10 to file an Answer. In that Answer, you should also 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. Prehearing Conference. A prehearing conference will be held by telephone on December 21, 2012, at 9:30 a.m., before an Administrative Law Judge from the Iowa Department of Inspections and Appeals (ALJ). Please contact Kent M. Nebel, J.D., Legal Director, Iowa Board of Medicine, at 515-281-7088 with the telephone number at which you or your legal counsel can be reached. Board rules on prehearing conferences may be found at 653 Iowa Administrative Code 25.15.

5. Hearing Procedures. The procedural rules governing the conduct of the hearing are found at 653 Iowa Administrative Code Chapter 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 Iowa Administrative Code 25.16. The hearing may be open to the public or closed to the public at the discretion of the Respondent.

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

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

8. Jurisdiction. The Board has jurisdiction in this matter pursuant to Iowa Code Chapters 17A, 147, 148, and 272C (2005).

9. Legal Authority: If any of the allegations against you are founded, the Board has authority to take disciplinary action against you under Iowa Code Chapters 17A, 147, 148, and 272C (2005) and 653 Iowa Administrative Code Chapter 25.25.

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

C. SECTIONS OF STATUTES AND RULES INVOLVED

COUNT I

11. **Sexual Misconduct:** Respondent is charged pursuant to Iowa Code section 148.6(2)(i) and 653 IAC 23.1(10), 23.1(5) and 13.7(4)(a)-(c) with engaging in sexual misconduct in violation of the laws and rules governing the practice of medicine in Iowa:

- A. In the course of providing medical care, a physician shall not engage in contact, touching, or comments of a sexual nature with a patient or with the patient's parent or guardian if the patient is a minor.
- B. A physician shall not engage in any sexual conduct with a patient when that conduct occurs concurrent with the physician-patient relationship, regardless of whether the patient consents to that conduct.
- C. A physician shall not engage in any sexual conduct with a former patient unless the physician-patient relationship was completely terminated before the sexual conduct occurred. In considering whether that relationship was completely terminated, the board will consider the duration of the physician-patient relationship, the nature of the medical services provided, the lapse of time since the physician-patient relationship ended, the degree of dependence in the physician-patient relationship, and the extent to which the physician used or exploited the trust, knowledge, emotions, or influence derived from the physician-patient relationship.

COUNT II

12. **Unethical or Unprofessional Conduct:** Respondent is charged pursuant to Iowa Code sections 147.55(3) and 272C.10(3) and 653 IAC 23.1(4) with engaging in unethical or unprofessional conduct. Engaging in unethical or unprofessional conduct includes, but is not limited to, the committing by a licensee of an act contrary to honesty, justice or good morals, whether the same is committed in the course of the licensee's practice or otherwise and whether committed within this state or elsewhere; or a violation of the standards and principles of medical ethics.

COUNT III

13. **Professional Incompetency:** Respondent is charged with professional incompetency pursuant to Iowa Code sections 147.55(2), 148.6(2)(g) and (i), and 272C.10(2) and 653 IAC 23.1(2)(c), (d), (e), and (f), by demonstrating one or more of the following:

- A. A substantial lack of knowledge or ability to discharge professional obligations within the scope of the physician's or surgeon's practice;
- B. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other physicians or surgeons in the state of Iowa acting in the same or similar circumstances;
- C. A failure by a physician or surgeon to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician or surgeon in the state of Iowa acting in the same or similar circumstances; or

- D. A willful or repeated departure from, or the failure to conform to, the minimal standard of acceptable and prevailing practice of medicine and surgery in Iowa.

STATEMENT OF THE MATTERS ASSERTED

14. Respondent is an Iowa-licensed physician who practices anesthesiology, including pain management, in Council Bluffs, Iowa.

15. The Board alleges that Respondent engaged in sexual misconduct in violation of the laws and rules governing the practice of medicine in Iowa including, but not limited to, the following:

A. **Patient #1:** The Board alleges that Respondent engaged in sexual misconduct toward Patient #1, a female in her early 40s, while providing pain treatment to her in his office in February 2009:

- 1) Respondent performed an epidural injection on Patient #1 in February 2009 when the office was closed, and no other healthcare provider or other staff person was present.
- 2) Respondent did not charge Patient #1 a fee for this service.
- 3) The level of sedation reportedly provided for this procedure was unnecessary.
- 4) Respondent did not maintain a medical record for this patient.

5) Following this procedure, Patient #1 reported facts that indicate Respondent engaged in nonconsensual sexual activity with her during the procedure when she was sedated and unable to protect herself.

B. **Patient #2:** The Board alleges that Respondent engaged in sexual misconduct toward Patient #2, a female in her 20s, while providing pain treatment to her in his office in April 2010:

1) Respondent performed trigger point injections on Patient #2 in April 2010, when the office was closed and no other healthcare provider or other staff person was present.

2) Respondent did not charge Patient #2 for providing this service.

3) The level of sedation reported for this procedure was unnecessary.

4) Respondent did not maintain a medical record for this patient.

5) Following this procedure, Patient #2 reported facts that indicate Respondent engaged in nonconsensual sexual activity with her during the procedure when she was sedated and unable to protect herself.

16. The Board alleges that Respondent engaged in professional incompetency while providing pain treatment to Patient #1, including, but not limited to, the following:

A. Respondent failed to maintain appropriate medical records to support, corroborate or substantiate the care he provided to Patient #1.

- B. Respondent failed to adequately explain the level of sedation reported by Patient #1. The level and degree of sedation reported during the care provided was not indicated for such procedures.
- C. Respondent failed to obtain and/or document appropriate written consent from Patient #1 for the procedure.
- D. It was inappropriate for Respondent to perform this procedure on Patient #1 under sedation, after hours, and without a certified medical assistant or other staff person present to visualize, assist, monitor, and witness the procedure.
- E. Respondent failed to appropriately monitor and/or document the vital signs of Patient #1, including pulse oximetry, patient status determination, level of consciousness and response to the procedure.
- F. Respondent failed to adequately explain and/or justify the need for the physical examination he reportedly performed in this case. This physical examination should only be performed in the presence of appropriate other medical personnel.
- G. Respondent failed to adequately explain why he did not charge Patient #1 a fee for performing this procedure.

17. The Board alleges that Respondent engaged in professional incompetency while providing pain treatment to Patient #2, including, but not limited to, the following:

- A. Respondent failed to maintain appropriate medical records to support, corroborate or substantiate the care provided to Patient #2.
- B. Respondent failed to adequately explain the level of sedation reported by Patient #2. The level and degree of sedation reported during the care provided was not indicated for such procedures.
- C. It was inappropriate for Respondent to perform this procedure on Patient #2 under sedation, after hours, and without a certified medical assistant or other staff person present to visualize, assist, monitor, and witness this procedure.
- D. Respondent failed to appropriately monitor and/or document the vital signs of Patient #2, including pulse oximetry, patient status determination, level of consciousness and response to such procedures.
- E. Respondent failed to provide an adequate explanation for circumstances Patient #2 described at the end of the procedure.
- F. Respondent failed to provide an adequate explanation and/or justification for his reported use of Lidocaine on Patient #2 for such a procedure.
- G. Respondent failed to adequately explain why he did not charge Patient #2 a fee for performing this procedure.

18. The Board alleges that Respondent engaged in professional incompetency while providing pain treatment to Patient #3 when he performed trigger point injections on her in his office, under IV sedation, after hours, and with no staff person present to monitor the patient; and when he released that patient to drive home alone under the influence of the sedation. Respondent did not charge Patient #3 a fee for this procedure even though she had insurance.

19. The Board alleges that Respondent engaged in professional incompetency while providing pain treatment to Patient #4 when he performed procedures on her in his office, under sedation, after hours, and with no staff person present to monitor the patient.

20. The Board alleges that Respondent engaged in professional incompetency while providing pain treatment to Patient #5 when he performed a procedure on her in his office, under IV sedation, after hours, and with no staff person present to monitor the patient. Respondent did not charge Patient #5 a fee for this procedure even though she had insurance.

E. SETTLEMENT

21. Settlement. This matter may be resolved by settlement agreement. The procedural rules governing the Board's settlement process are found at 653 Iowa Administrative Code 12.25. If you are interested in pursuing settlement of this matter, please contact Kent M. Nebel, J.D., Legal Director at 515-281-7088.

F. PROBABLE CAUSE FINDING

22. On January 9, 2012, the Iowa Board of Medicine found probable cause to file this Statement of Charges.

A handwritten signature in black ink, appearing to read "Siroos S. Shirazi". The signature is written in a cursive style with a horizontal line underneath it.

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

MICHAEL C. PRESCHER, M.D., RESPONDENT

FILE Nos. 02-09-323 & 02-10-180

STATEMENT OF CHARGES

COMES NOW the Iowa Board of Medicine (Board) on December 8, 2011, and files this Statement of Charges pursuant to Iowa Code Section 17A.12(2). Respondent was issued Iowa medical license no. 31176 on April 29, 1996. Respondent's Iowa medical license is active and will next expire on next expire on December 1, 2013.

A. TIME, PLACE AND NATURE OF HEARING

1. Hearing. A disciplinary contested case hearing shall be held on January 12, 2012, before the Iowa Board of Medicine. The hearing shall begin at 8:30 a.m. and shall be located in the conference room at the Iowa Board of Medicine office at 400 SW 8th Street, Suite C, Des Moines, Iowa.

2. Answer. Within twenty (20) days of the date you are served this Notice of Hearing you are required by 653 Iowa Administrative Code 25.10 to file an Answer. In that Answer, you should also 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. Prehearing Conference. A prehearing conference will be held by telephone on December 21, 2012, at 9:30 a.m., before an Administrative Law Judge from the Iowa Department of Inspections and Appeals (ALJ). Please contact Kent M. Nebel, J.D., Legal Director, Iowa Board of Medicine, at 515-281-7088 with the telephone number at which you or your legal counsel can be reached. Board rules on prehearing conferences may be found at 653 Iowa Administrative Code 25.15.

5. Hearing Procedures. The procedural rules governing the conduct of the hearing are found at 653 Iowa Administrative Code Chapter 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 Iowa Administrative Code 25.16. The hearing may be open to the public or closed to the public at the discretion of the Respondent.

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

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

8. Jurisdiction. The Board has jurisdiction in this matter pursuant to Iowa Code Chapters 17A, 147, 148, and 272C (2005).

9. Legal Authority: If any of the allegations against you are founded, the Board has authority to take disciplinary action against you under Iowa Code Chapters 17A, 147, 148, and 272C (2005) and 653 Iowa Administrative Code Chapter 25.25.

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

C. SECTIONS OF STATUTES AND RULES INVOLVED

COUNT I

11. **Sexual Misconduct:** Respondent is charged pursuant to Iowa Code section 148.6(2)(i) and 653 IAC 23.1(10), 23.1(5) and 13.7(4)(a)-(c) with engaging in sexual misconduct in violation of the laws and rules governing the practice of medicine in Iowa:

- A. In the course of providing medical care, a physician shall not engage in contact, touching, or comments of a sexual nature with a patient or with the patient's parent or guardian if the patient is a minor.
- B. A physician shall not engage in any sexual conduct with a patient when that conduct occurs concurrent with the physician-patient relationship, regardless of whether the patient consents to that conduct.
- C. A physician shall not engage in any sexual conduct with a former patient unless the physician-patient relationship was completely terminated before the sexual conduct occurred. In considering whether that relationship was completely terminated, the board will consider the duration of the physician-patient relationship, the nature of the medical services provided, the lapse of time since the physician-patient relationship ended, the degree of dependence in the physician-patient relationship, and the extent to which the physician used or exploited the trust, knowledge, emotions, or influence derived from the physician-patient relationship.

COUNT II

12. **Unethical or Unprofessional Conduct:** Respondent is charged pursuant to Iowa Code sections 147.55(3) and 272C.10(3) and 653 IAC 23.1(4) with engaging in unethical or unprofessional conduct. Engaging in unethical or unprofessional conduct includes, but is not limited to, the committing by a licensee of an act contrary to honesty, justice or good morals, whether the same is committed in the course of the licensee's practice or otherwise and whether committed within this state or elsewhere; or a violation of the standards and principles of medical ethics.

COUNT III

13. **Professional Incompetency:** Respondent is charged with professional incompetency pursuant to Iowa Code sections 147.55(2), 148.6(2)(g) and (i), and 272C.10(2) and 653 IAC 23.1(2)(c), (d), (e), and (f), by demonstrating one or more of the following:

- A. A substantial lack of knowledge or ability to discharge professional obligations within the scope of the physician's or surgeon's practice;
- B. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other physicians or surgeons in the state of Iowa acting in the same or similar circumstances;
- C. A failure by a physician or surgeon to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician or surgeon in the state of Iowa acting in the same or similar circumstances; or

- D. A willful or repeated departure from, or the failure to conform to, the minimal standard of acceptable and prevailing practice of medicine and surgery in Iowa.

STATEMENT OF THE MATTERS ASSERTED

14. Respondent is an Iowa-licensed physician who practices anesthesiology, including pain management, in Council Bluffs, Iowa.

15. The Board alleges that Respondent engaged in sexual misconduct in violation of the laws and rules governing the practice of medicine in Iowa including, but not limited to, the following:

A. **Patient #1:** The Board alleges that Respondent engaged in sexual misconduct toward Patient #1, a female in her early 40s, while providing pain treatment to her in his office in February 2009:

- 1) Respondent performed an epidural injection on Patient #1 in February 2009 when the office was closed, and no other healthcare provider or other staff person was present.
- 2) Respondent did not charge Patient #1 a fee for this service.
- 3) The level of sedation reportedly provided for this procedure was unnecessary.
- 4) Respondent did not maintain a medical record for this patient.

- 5) Following this procedure, Patient #1 reported facts that indicate Respondent engaged in nonconsensual sexual activity with her during the procedure when she was sedated and unable to protect herself.

B. **Patient #2:** The Board alleges that Respondent engaged in sexual misconduct toward Patient #2, a female in her 20s, while providing pain treatment to her in his office in April 2010:

- 1) Respondent performed trigger point injections on Patient #2 in April 2010, when the office was closed and no other healthcare provider or other staff person was present.
- 2) Respondent did not charge Patient #2 for providing this service.
- 3) The level of sedation reported for this procedure was unnecessary.
- 4) Respondent did not maintain a medical record for this patient.
- 5) Following this procedure, Patient #2 reported facts that indicate Respondent engaged in nonconsensual sexual activity with her during the procedure when she was sedated and unable to protect herself.

16. The Board alleges that Respondent engaged in professional incompetency while providing pain treatment to Patient #1, including, but not limited to, the following:

- A. Respondent failed to maintain appropriate medical records to support, corroborate or substantiate the care he provided to Patient #1.

- B. Respondent failed to adequately explain the level of sedation reported by Patient #1. The level and degree of sedation reported during the care provided was not indicated for such procedures.
- C. Respondent failed to obtain and/or document appropriate written consent from Patient #1 for the procedure.
- D. It was inappropriate for Respondent to perform this procedure on Patient #1 under sedation, after hours, and without a certified medical assistant or other staff person present to visualize, assist, monitor, and witness the procedure.
- E. Respondent failed to appropriately monitor and/or document the vital signs of Patient #1, including pulse oximetry, patient status determination, level of consciousness and response to the procedure.
- F. Respondent failed to adequately explain and/or justify the need for the physical examination he reportedly performed in this case. This physical examination should only be performed in the presence of appropriate other medical personnel.
- G. Respondent failed to adequately explain why he did not charge Patient #1 a fee for performing this procedure.

17. The Board alleges that Respondent engaged in professional incompetency while providing pain treatment to Patient #2, including, but not limited to, the following:

- A. Respondent failed to maintain appropriate medical records to support,

corroborate or substantiate the care provided to Patient #2.

- B. Respondent failed to adequately explain the level of sedation reported by Patient #2. The level and degree of sedation reported during the care provided was not indicated for such procedures.
- C. It was inappropriate for Respondent to perform this procedure on Patient #2 under sedation, after hours, and without a certified medical assistant or other staff person present to visualize, assist, monitor, and witness this procedure.
- D. Respondent failed to appropriately monitor and/or document the vital signs of Patient #2, including pulse oximetry, patient status determination, level of consciousness and response to such procedures.
- E. Respondent failed to provide an adequate explanation for circumstances Patient #2 described at the end of the procedure.
- F. Respondent failed to provide an adequate explanation and/or justification for his reported use of Lidocaine on Patient #2 for such a procedure.
- G. Respondent failed to adequately explain why he did not charge Patient #2 a fee for performing this procedure.

E. SETTLEMENT

18. Settlement. This matter may be resolved by settlement agreement. The procedural rules governing the Board's settlement process are found at 653 Iowa Administrative Code 12.25. If you are interested in pursuing settlement of this matter, please

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

F. PROBABLE CAUSE FINDING

19. On December 8, 2011, the Iowa Board of Medicine found probable cause to file this Statement of Charges.

A handwritten signature in black ink, appearing to read "Siroos S. Shirazi". The signature is written in a cursive style with a horizontal line underneath it.

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 DISCIPLINARY CHARGES AGAINST

MICHAEL PRESCHER, M.D., RESPONDENT

FILE Nos. 02-09-323 & 02-10-180

EMERGENCY ADJUDICATIVE ORDER

COMES NOW the Iowa Board of Medicine on December 8, 2011, and finds that it was presented with evidence which establishes that Respondent's continued treatment of female patients without appropriate monitoring constitutes an immediate danger to the public health, safety, and welfare. The Board has conducted a full investigation of this matter. A summary of the evidence obtained in that investigation is as follows:

FINDINGS OF FACT

1. Respondent was issued Iowa medical license no. 31176 on April 29, 1996.
2. Respondent's Iowa medical license is active and will next expire on December 1, 2013.
3. The Board has jurisdiction in this matter pursuant to Iowa Code Chapters 147, 148 and 272C.
4. Respondent is an Iowa-licensed physician who practices anesthesiology, including pain management, in Council Bluffs, Iowa.

5. The Board alleges that Respondent engaged in sexual misconduct in violation of the laws and rules governing the practice of medicine in Iowa including, but not limited to, the following:

A. Patient #1: The Board alleges that Respondent engaged in sexual misconduct toward Patient #1, a female in her early 40s, while providing pain treatment to her in his office in February 2009:

- 1) Respondent performed an epidural injection on Patient #1 in February 2009 when the office was closed, and no other healthcare provider or other staff person was present.
- 2) Respondent did not charge Patient #1 a fee for this service.
- 3) The level of sedation reportedly provided for this procedure was unnecessary.
- 4) Respondent did not maintain a medical record for this patient.
- 5) Following this procedure, Patient #1 reported facts that indicate Respondent engaged in nonconsensual sexual activity with her during the procedure when she was sedated and unable to protect herself.

B. Patient #2: The Board alleges that Respondent engaged in sexual misconduct toward Patient #2, a female in her 20s, while providing pain treatment to her in his office in April 2010:

- 1) Respondent performed trigger point injections on Patient #2 in April 2010, when the office was closed and no other healthcare provider or

other staff person was present.

- 2) Respondent did not charge Patient #2 for providing this service.
- 3) The level of sedation reported for this procedure was unnecessary.
- 4) Respondent did not maintain a medical record for this patient.
- 5) Following this procedure, Patient #2 reported facts that indicate Respondent engaged in nonconsensual sexual activity with her during the procedure when she was sedated and unable to protect herself.

6. The Board alleges that Respondent engaged in professional incompetency while providing pain treatment to Patient #1, including, but not limited to, the following:

- A. Respondent failed to maintain appropriate medical records to support, corroborate or substantiate the care he provided to Patient #1.
- B. Respondent failed to adequately explain the level of sedation reported by Patient #1. The level and degree of sedation reported during the care provided was not indicated for such procedures.
- C. Respondent failed to obtain and/or document appropriate written consent from Patient #1 for the procedure.
- D. It was inappropriate for Respondent to perform this procedure on Patient #1 under sedation, after hours, and without a certified medical assistant or other staff person present to visualize, assist, monitor, and witness the procedure.
- E. Respondent failed to appropriately monitor and/or document the vital signs of Patient #1, including pulse oximetry, patient status determination, level of

consciousness and response to the procedure.

- F. Respondent failed to adequately explain and/or justify the need for the physical examination he reportedly performed in this case. This physical examination should only be performed in the presence of appropriate other medical personnel.
- G. Respondent failed to adequately explain why he did not charge Patient #1 a fee for performing this procedure.

7. The Board alleges that Respondent engaged in professional incompetency while providing pain treatment to Patient #2, including, but not limited to, the following:

- A. Respondent failed to maintain appropriate medical records to support, corroborate or substantiate the care provided to Patient #2.
- B. Respondent failed to adequately explain the level of sedation reported by Patient #2. The level and degree of sedation reported during the care provided was not indicated for such procedures.
- C. It was inappropriate for Respondent to perform this procedure on Patient #2 under sedation, after hours, and without a certified medical assistant or other staff person present to visualize, assist, monitor, and witness this procedure.
- D. Respondent failed to appropriately monitor and/or document the vital signs of Patient #2, including pulse oximetry, patient status determination, level of consciousness and response to such procedures.

- E. Respondent failed to provide an adequate explanation for circumstances Patient #2 described at the end of the procedure.
 - F. Respondent failed to provide an adequate explanation and/or justification for his reported use of Lidocaine on Patient #2 for such a procedure.
 - G. Respondent failed to adequately explain why he did not charge Patient #2 a fee for performing this procedure.
7. After careful consideration of all of the information obtained by the Board in this matter, the Board concluded that Respondent's continued treatment of female patients constitutes an immediate danger to the public health, safety, and welfare.

CONCLUSIONS OF LAW

8. The facts set forth above indicate that Respondent is unable to continue to practice medicine at this time.
9. The Board concludes that this matter has been fully investigated and that this investigation has been sufficient to ensure the Board is proceeding on the basis of reliable information. Respondent was given an opportunity to respond to the allegations against him.
10. The facts set forth above establish that there is a serious and immediate threat to patient health if Respondent is allowed to continue to practice medicine before the Board reaches a final resolution of the pending charges.
11. The facts set forth above establish that Respondent may not continue to practice medicine without posing an immediate danger to the public health, safety or welfare.

12. The imposition of other interim safeguards would not be sufficient to protect the public health, safety, or welfare. It is not safe for Respondent to continue to practice medicine until this matter is resolved.

13. The Board finds that suspension of Respondent's ability to practice medicine is necessary to protect the public health, safety or welfare until this case is finally resolved.

14. Respondent shall be notified immediately of this order pursuant to 653 IAC 25.29.

15. A hearing on this Emergency Adjudicative Order, and the Statement of Charges which have been filed concurrently with this order, shall be held on January 12, 2012. The hearing will begin at 8:30 a.m. and will be held at the Board office, located at 400 S.W. 8th Street, Suite C, Des Moines, Iowa.

ORDER

THEREFORE IT IS HEREBY ORDERED: that Respondent is prohibited from practicing medicine under his Iowa medical license until this matter is resolved.

This order dated December 8, 2011.



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