IN THE MATTER OF	*	BEFORE THE MARYLAND
GIDEON M. KIOKO, M.D.	*	STATE BOARD OF PHYSICIAN
Respondent	*	QUALITY ASSURANCE
License No: D08283	*	Case No: 93-0288

* * * * * * * * * * * * * *

FINAL OPINION AND ORDER

PROCEDURAL BACKGROUND

On October 17, 1991, the Maryland Board of Physician Quality Assurance (the "BPQA") charged Gideon M. Kioko, M.D. (the "Respondent") with violating Md. Code Ann., Health Occ. ("H.O.") § 14-404(a)(3) and (a)(18), which provide:

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> > (3) Is guilty of immoral or unprofessional conduct in the practice of medicine; and
> >
> > (18) Practices medicine with an unauthorized person or aids an unauthorized person in the practice of medicine.

The charges were based on the BPQA's investigation into two incidents occurring at the Hillview Clinic in Suitland, Maryland, where Respondent was employed to perform pregnancy terminations. Both incidents involved patients who went into cardiac arrest while under IV Brevital, an intravenous anesthetic. One patient died within three days, and the second suffered massive neurological damage and died several years later.

On December 3, 1991, while charges were pending, Respondent surrendered his

Maryland medical license to the BPQA to avoid prosecution on the charges. On May 19, 1992, less than six months after the surrender, Respondent petitioned the BPQA for reinstatement of his license. On October 28, 1992, the BPQA voted to initially deny reinstatement of his license. A formal Notice of Intent to Deny Reinstatement was issued on January 27, 1993, which listed as its reasons for denial the allegations set forth in the October, 1991 charges. After requesting a hearing, Respondent appeared before the BPQA's Case Resolution Conference Committee (the "CRC"). The CRC advised that it could not recommend reinstatement without a peer review of his uninterrupted practice in the District of Columbia. The Medical and Chirurgical Faculty of Maryland ("Med Chi"), the BPQA's statutory agent for peer review, declined to perform the requested review. Subsequently, an ad hoc committee of the District of Columbia Medical Society (the "D.C. Committee") agreed to perform the review. On October 26, 1993, the D.C. Committee submitted a report concluding that Respondent's practice met the standard of care for each of the 15 cases reviewed.

On January 5, 1994, Respondent again appeared before the CRC, which recommended to the BPQA that his license be reinstated, subject to certain conditions. On February 23, 1994, the BPQA rejected the CRC's recommendation and forwarded the case to the Office of Administrative Hearings for a trial on the merits.

The assigned ALJ ordered Respondent to demonstrate his fitness for reinstatement by a preponderance of the evidence and permitted the State to put on evidence to establish the factual basis for the BPQA's initial denial of reinstatement, as well as evidence in rebuttal of that presented by Respondent. A hearing on the merits commenced on August 29, 1994 and concluded on September 8, 1994. On December 19, 1994, the ALJ issued a Recommended

Decision concluding that Respondent failed to prove his fitness for reinstatement. After a hearing on exceptions, the BPQA issued an order denying reinstatement of Respondent's medical license.

Respondent appealed the BPQA's decision to the Circuit Court for Prince George's County. On July 15, 1996, the Hon. Thomas P. Smith reversed the BPQA's decision, finding that the BPQA had violated Respondent's due process by considering evidence of the Hillview incidents though the allegations stemming from those incidents had neither been admitted to nor litigated by Respondent. Judge Smith remanded the case to the BPQA for additional proceedings. BPQA reviewed the matter on July 24, 1996, and requested that the parties make efforts to resolve at least the outstanding factual issues. After lengthy negotiations, the parties appeared before the BPQA on April 23, 1997 with a proposed stipulation of fact. After an allocution hearing, the BPQA convened on that date for a final decision in the case.

FINDINGS OF FACT

Based on the proposed stipulation of facts made by the parties, the BPQA makes the following findings:

1. At all time relevant to this stipulation, the Respondent was licensed to practice medicine in Maryland. The Respondent was originally granted a license to practice medicine in 1970, having been issued License Number D08283. The Respondent subsequently surrendered his license to practice medicine in Maryland to the Board on December 3, 1991.

2. On or about April 1989, the Respondent entered into an agreement with Hillview Women's Medical Center ("Hillview"), located in Forestville, Maryland, wherein he would

perform therapeutic abortions and related procedures at Hillview, and would be compensated for these services on a case-by-case basis.

3. During the period April 1989 to November 1989, during which time the Respondent performed abortions at Hillview, both local anesthesia and intravenous Brevital (methohexital) ("IV Brevital") were utilized at Hillview as types of anesthesia during abortion procedures. The type of anesthesia utilized during a given abortion procedure was selected in advance of the procedure by the patient.

4. On July 8, 1989, Patient A, a 34 year old female, sought to obtain a therapeutic abortion at Hillview. On this date, the patient received initial abortion counseling and laboratory tests at the clinic. On July 12, 1989, an ultrasound was performed, which determined the patient's fetal gestational age at sixteen and-a-half weeks. The patient signed an undated consent form which authorized the Respondent (or his designee) to perform an abortion and to administer anesthesia.

On July 12, 1989, one or more health care providers or other individuals at Hillview made a decision to use IV Brevital during the course of the patient's abortion procedure. The medical record does not contain documentation of who administered the anesthesia, the dosage or concentration of the anesthesia administered, the patient's weight, or the amount of fluid given. The medical record further does not contain documentation that the Respondent performed a physical examination of the patient prior to the procedure, or evaluated or assessed the patient as a proper candidate for IV Brevital or other type of medication.

After the IV Brevital was administered, the Respondent started to perform the abortion. There is no documentation in the medical record of the level of anesthetic depth, the monitoring

of the patient's vital signs, the adequacy of respiration, or that qualified medical personnel were present to administer or monitor the administration of the medication.

No other operative notes exist in the medical record. A code note, dated July 12, 1989, by Dr. Raymond Taylor, states that the patient was unresponsive and hypotensive, with a deteriorating blood pressure reading, and was bradycardic. After fifteen minutes of cardiopulmonary resuscitation and advanced cardiac life support, the patient was transported by ambulance to Malcolm Grow USAF Medical Center ("MAC"). At MAC, the patient was noted to be in ventricular tachycardia, which deteriorated into ventricular fibrillation. Although the patient was successfully resuscitated, the patient did not regain neurologic function, and was pronounced legally dead on July 15, 1989. The MAC medical record narrative summary stated that the patient

> was anesthetized with 250 mg. of Brevital IV and was noted to respond rather rapidly to the anesthesia. Three minutes into the procedure, the patient's blood was noted to be very dark. The assessment was noted that she was having some 'respiratory distress.' The procedure was finished within a total of five (5) minutes with full expulsion of the products of conception.

The final diagnosis in the MAC medical record narrative summary noted "brain death secondary to anoxia as a result of possible opiate drug interaction with anesthesia or possible idiosyncratic anesthetic reaction during a voluntary abortion performed three days prior to death."

5. On September 9, 1989, Patient B, a 26 year old female, sought to obtain a therapeutic abortion of a thirteen week pregnancy at Hillview. On or about this date, the patient signed a consent form authorizing that the abortion be performed. The consent form signed by the patient does not designate the name of a particular physician as responsible for the performance of the

abortion and administration of anesthesia, although a blank space is specifically so designated on the consent form for this purpose.

On or about the above date, one or more health care providers or other individuals at Hillview made a decision to use IV Brevital during the course of the patient's abortion procedure. The Respondent did not conduct an examination of the patient to determine whether the patient was a proper candidate for IV Brevital, the anesthetic agent administered during the procedure.

At the time the Respondent and the attending nurse entered the operating room to perform the abortion procedure, the patient appeared to be unconscious on the operating room table. An intravenous line previously had been placed in the patient's arm. The Respondent measured the size of the patient's uterus and proceeded to perform the abortion procedure. During the entire course of time in which the Respondent and the nurse entered the operating room until the conclusion of the procedure, no other medical personnel were in the room either to administer or monitor the administration of the anesthesia, or to monitor the patient's vital signs. The operative record indicates that the patient received "50 cc of Brevital," although no concentration of the drug is listed. There is no documentation in the record that oxygen was administered prior to the deterioration of the patient's cardiorespiratory status.

During the course of the procedure, the attending nurse noticed that the patient's lips were turning blue. The operative note stated that "apparently patient went into respiratory depression-arrest." At that point, the Respondent continued the procedure. The attending nurse called for Barbara Lofton. After Mrs. Lofton entered the operating room, Dr. Raymond Taylor, a physician in the employment of Hillview who provided aftercare services to abortion patients

and who happened to be on the premises, was summoned, and initiated resuscitative efforts. The Respondent did not participate in the resuscitative efforts, other than attach an EKG line to one of the patient's arms.

The Prince George's County Fire and Rescue Squad was then called, arrived thereafter, and assumed control of the resuscitative efforts. The patient was then transported to Greater Southeast Community Hospital. The patient was successfully resuscitated, but suffered massive neurologic damage. The patient was subsequently transferred to a nursing facility. The patient died in 1992.

6. In a letter to the Board, dated March 29, 1990, the Respondent described his role at Hillview and in the care delivered to patients A and B above:

> I do not give, nor have I ever given, any general anesthetics. I only give local anesthetics (that is paracervical blocks).
>
> In the first two cases where Brevital was given, I did not give it, nor did I consent to it. I was not consulted or asked about it. I did not even start intravenous fluids. The decision to administer Brevital was made by the patient and the clinic, and during those [sic] time, I would be called in. I would be notified that "the patient is now asleep, Doctor. You may start the procedure." I would do the procedure, complete my part of the medical records, observe the patient for any signs of unusual bleeding for a reasonable time, and participate in the discharge. I accept no responsibility for any cause regarding potential or perceived post operative complications.
>
> I, therefore, had nothing to do with the Brevital administered to these two patients. Other contract physicians were also working under similar terms, and, like me, they had nothing to do with the administration of Brevital. I suppose that I was just unlucky at that time and happened to be there when this incident happened.
>
> Regarding specific allegations: some of these allegations are just untrue. In the case of ... [Patient A] (July 12, 1989): the decision to administer Brevital was made by the patient and the Clinic. I, as the operating surgeon, was not consulted, nor did I consent to the administration of the agent.

I understand that it was given by Dr. Barbara Lofton - Clinical Practitioner. My initial contact with the patient was the initial sizing evaluation to determine the gestational age of the pregnancy. The next contact by me with the patient was when the patient was already asleep. As I was finishing the procedure, I called the attention to the administers [sic] of the anesthetic, that the patient's blood was getting unusually dark. At that time, in my view, adequate resuscitation efforts was immediately instituted with airway established and 911 was called. EKG and Oxygen were available and were used. Dr. Taylor, a Cardiology fellow headed the resuscitation effort. It is just not true that adequate resuscitation was not done and that the equipment was not available. Incidentally, this patient had recently used Opium, though the patient had denied this in her medical history.

The case of ... [Patient B] ... is similar. The patient was put to sleep, with Brevital. I was not in the Operating Room at the time. Once again I was called in to do the procedure once the patient was deemed asleep. I was not consulted, not did I participate in the decision to give the agent, but once again, I know there was immediate and adequate resuscitation effort. (Please refer to the letter from Dr. Barbara Lofton). The only case I directly had complete responsibility for is that of ... [Patient C].

7. In a subsequent letter to the Board, dated April 18, 1990, written by Mrs. Barbara Lofton, and jointly signed by Mrs. Lofton and the Respondent, it was stated as follows:

He does not administer general anesthetics, however, he does on occasion [sic] administer I.V. sedations. He has never administered Sodium Brevital, but is aware of the drug being given by the nurse as many medications are given. Many policies existed by the clinic as they do in many circumstances, and without having a problem with the medication having been administered in the past. He made no recommendations to the clinic staff or the administration. Many dentist offices use the drug successfully without complications. We know that the drug is largely successful in providing a twilight sleep. When coming to the clinic, he was never asked about the drug, or confronted with the drug, and probably for good reason, there was never a prior complication with the medication. His role essentially was the following:

- to monitor the patient
- to complete the procedure
- to complete the medical records
- to write discharge orders or special orders
- to observe the patient for any unusual signs and symptoms, including bleeding

8. The Respondent terminated his employment at Hillview in October 1990.

9. The appropriate standard of care requires that where an ambulatory surgical center utilizes anesthesia during surgical procedures, the anesthesia should be administered only under the direction of an anesthesiologist, qualified physician, or a certified registered nurse anesthetist ("CRNA") under the direct supervision of an anesthesiologist or licensed physician or dentist.

Where a physician performs surgical procedures, such as abortions, in an ambulatory surgical center, under circumstances where anesthesia has been administered to those patients, and where no qualified anesthesia care provider is present, and that physician is the only physician providing care to the patient during the surgical procedure, the appropriate standard of care requires that the physician shall:

a) be qualified in the administration of anesthesia and other sedative drugs or medications, including preoperative and post-operative assessment of patients;

b) be knowledgeable about the type, dosage and route of the administration of anesthesia;

c) ensure that the patient is an appropriate candidate for the anesthesia used during the procedure before the patient is administered the drug;

d) ensure that the patient's vital signs and respiration are appropriately monitored before, during, and after the procedure;

e) ensure that the patient is monitored for anesthetic depth;

f) be knowledgeable and experienced in resuscitation, and ensure that the proper medical equipment, resuscitative drugs, and qualified medical personnel are immediately available in the event of a medical emergency;

g) perform a physical examination of the patient, or ensure that a physical examination of the patient was performed by qualified medical personnel prior to the administration of the anesthesia and the performance of the surgical procedure; and

h) ensure that qualified medical personnel administered the anesthesia, in the event that the physician did not administer the anesthesia.

The appropriate standard of care requires that where a physician performs surgical procedures in an ambulatory surgical center under conditions in which the physician should have known that failed to meet the appropriate standard of medical and surgical care, the physician performing the surgical procedures shall take action to correct said conditions, or, in the event that the physician is unable to correct said conditions, not perform any further procedures in the surgical center unless and until said conditions are altered, modified, or are otherwise changed to comply with appropriate standards required for the delivery of quality medical and surgical care.

10. Under the above circumstances, the Respondent failed to meet the appropriate standard of medical and surgical care, in whole or in part, for the following reasons:

a. The anesthesia was not administered by or under the direct supervision of qualified medical personnel. The anesthesia administered to the above patients, IV Brevital, was not administered by or under the direction of an anesthesiologist, qualified physician or dentist, or CRNA. The Respondent under the circumstances should have known that the medication that the patients had received had not been administered by qualified medical personnel, but nevertheless performed the surgical procedures in question in the absence of the qualified medical personnel. The Respondent should have been aware that Brevital is an intravenous anesthetic that requires appropriate monitoring of both anesthetic depth and vital signs during its administration. The Respondent should have been aware that failure to monitor these signs could lead to a state of general anesthesia and to cardiorespiratory instability and arrest.

b. The Respondent was not qualified in the administration of IV Brevital. During the

above procedures, the Respondent was the only physician present providing medical and surgical treatment during the operative procedures. Designated medical personnel were not present during the procedures who were qualified in the administration of the above described anesthetic drugs. The Physicians' Desk Reference (1989), in reference to Brevital Sodium, states, in a section entitled "Warning," that "[t]his drug should be administered by persons qualified in the use of intravenous anesthetics. Cardiac life support equipment must be immediately available during use of Methohexital." In the absence of other qualified personnel present at Hillview to participate in the administration of the anesthesia, the Respondent assumed the responsibility for the administration of anesthesia and the medical and surgical care delivered to these patients. In the case of Patient A, the patient signed a consent form in which it was specifically stated that the patient authorized the Respondent or his designee to, among other things, "administer an anesthetic of his or her choice in connection therewith."

c. The Respondent was not aware of and/or did not attempt to determine the type and dosage of administration of anesthesia delivered to the above patients. The Respondent was unfamiliar with IV Brevital, the agent utilized in connection with the surgical procedures performed. The Hillview medical record chart does not appropriately indicate the dosage or concentration of the anesthesia administered to the above patients. The appropriate standard of care requires that the medical record document dosage and time frame of the anesthesia administered. The Respondent was unfamiliar with the effects and properties of the medication that had been administered, and took no action to determine the level and effect of the medication so that the medication could be administered at an appropriate rate.

d. The Respondent did not ensure that the patients were appropriate candidates to receive

the intravenous anesthetic Brevital, prior to the administration of said anesthetic. The Respondent did not elicit a full and complete medical history, or conduct a physical examination of the patients, or ensure that these preoperative procedures were performed to determine whether the patients were appropriate candidates for the anesthesia administered. An appropriate medical history should include, but is not limited to documentation of the following: present status; NPO status; allergies; medication usage; past conditions, diseases or illnesses; gynecologic, menstrual and pregnancy history; surgeries; review of systems; general information and family history; prior anesthesia complications; and contraindications to anesthesia. Complete documentation of this data does not exist in the medical record.

e. The Respondent did not ensure that the patients were appropriately monitored before and during the surgical procedures. In the above cases, the first indication that the patients were in cardiorespiratory or respiratory distress consisted of the Respondent noting that the patient's blood was becoming "unusually dark" (Patient A) or the nurse pointing out that the patient was becoming cyanotic (Patient B). The Respondent did not ensure that the patient's vital signs were being appropriately monitored. The appropriate standard of care requires that where a patient is administered IV Brevital, qualified medical personnel must monitor the patient through frequent determinations of blood pressure (from the time preceding the induction of anesthesia, throughout its administration, and until the patient has recovered from anesthesia); respiratory function, including continuous monitoring of respiratory pattern, rate, and the absence of airway obstruction; and heart rate. In the event that the patient receives general anesthesia, the appropriate standard of care requires that qualified medical personnel perform all of the above, and also undertake continuous EKG monitoring.

There is no documentation in either medical record that the patients in question were monitored for blood pressure, respiration function, or EKG.

With respect to Patient B, prior to the time the Respondent performed the pregnancy termination, Patient B had been administered IV Brevital by one or more health care providers or other personnel at Hillview. At the time the Respondent entered the operating room to perform the procedure, no medical personnel or any other individual: was in the operating room to administer or supervise the administration of the anesthesia or to supervise its administration; or were present to monitor the patient's vital signs. The Respondent, however, undertook the surgery without ensuring that qualified medical personnel would be present to monitor the patient's vital signs during the surgical procedure.

f. Respondent did not ensure that the proper medical equipment, resuscitative drugs, or qualified medical personnel were present during the operative procedures performed. In the above patients, the Respondent did not make adequate provisions for qualified medical personnel to be actually present to monitor the patients and participate in resuscitative efforts if so required. Although another physician, Dr. Raymond Taylor, participated in resuscitation efforts, this physician, who had been employed by Hillview primarily for aftercare services for abortion patients, had not been assigned to monitor these patients during the procedures or in the event of a medical emergency. In the case of Patient B, the appropriate resuscitative drugs and equipment were not present in case of a medical emergency.

g. The Respondent did not perform, or ensure that a complete physical examination was performed on the above patients prior to the administration of anesthesia and the performance of the surgical procedure. Under the above circumstances, when a patient is scheduled for surgery

and administration of the intravenous anesthetic, Brevital, a physical examination should include, but is not limited to determination of temperature; blood pressure; heart and respiratory rate; and examination of the upper airway, heart and lungs. A baseline neurologic status should also be noted. There is no documentation in the Hillview medical record that these aspects of the physical examination were carried out prior to the administration of anesthesia to the patients or the performance of the above surgical procedures.

h. In the above cases, the Respondent performed surgical procedures under conditions that failed to meet appropriate standards for the delivery of quality medical and surgical care. The Respondent should have known that unqualified medical personnel had administered anesthesia to his patients, without proper patient evaluation or monitoring, or without proper precautions, including adequate resuscitative drugs and equipment in the event of a medical emergency. The Respondent himself was unqualified to assume these responsibilities. The Respondent failed to meet the appropriate standard of care in not ensuring that these inappropriate conditions were modified, altered or changed to comply with appropriate standards required for the delivery of quality medical and surgical care. In the event that the Respondent was unable to correct these conditions, the appropriate standard of care required that the Respondent not perform these procedures at this facility until these conditions were so corrected.

11. The Respondent practiced medicine with unauthorized person(s) at Hillview. During the time in which the Respondent performed abortions at Hillview, and in the two (2) patients referred to above, unauthorized personnel administered anesthesia to patients prior to abortion procedures performed by the Respondent. The practice of medicine includes the administration of anesthesia. The Respondent under the circumstances should have known that unauthorized

person(s) were acting in this capacity, and continued to perform abortions under these circumstances.

12. During the period February 1990 through the present, the Respondent has been employed by CYGMA Health Center ("CYGMA"), located in Kensington, Maryland. CYGMA is a health care facility that performs elective pregnancy terminations and provides family planning services. The Respondent became the Medical Director at CYGMA in November 1990.

During this period, in which the Respondent performed abortions at CYGMA, both local and general anesthesia were and are utilized during abortion procedures. In abortion procedures in which general anesthesia is used, a CRNA is on staff to administer the anesthesia. The Respondent performs abortions on patients in conjunction with the CRNA, who administer general anesthesia to patients during the procedures. During these procedures, neither an anesthesiologist nor a licensed physician or dentist is physically present who has knowledge and experience in resuscitation, anesthetic drugs, and their reactions.

13. The practice of nurse anesthesia is defined as performing acts in collaboration with an anesthesiologist, licensed physician or dentist which require substantial specialized knowledge, judgment, and skill related to the administration of anesthesia, including preoperative and postoperative assessment of patients; administering anesthetics; monitoring patients during anesthesia; management of fluid in intravenous therapy; and respiratory care. COMAR 10.27.06.01.A. An anesthesiologist is defined as a Maryland licensed physician who has had special training in the field of anesthesiology, who administers anesthesia on a regular basis, and who devotes a substantial portion of his medical practice to the practice of

anesthesiology. COMAR 10.27.06.01.F. A licensed physician or dentist is defined as a physician or dentist who has knowledge and experience in resuscitation, anesthetic drugs, and their reactions. COMAR 10.27.06.01.G.

In the event that a CRNA is employed to engage in the practice of nurse anesthesia, COMAR 10.27.06.01.A., an anesthesiologist, licensed physician, or dentist shall be physically available to the CRNA for consultation at all times during the administration of and recovery from anesthesia. COMAR 10.27.06.02.B.(1).

Where a physician performs surgical procedures, such as abortions, in an ambulatory surgical center, under circumstances where anesthesia has been administered to those patients by a CRNA, and where no other qualified anesthesia care provider is present, and that physician is the only physician providing care to the patient during the surgical procedure, the appropriate standard of care requires that the physician ensure that an anesthesiologist, licensed physician or dentist (as defined in COMAR 10.27.06.01.G.) is physically available for consultation with the CRNA at all times during the administration of and recovery from anesthesia.

The appropriate standard of care also requires that if a physician is acting in the capacity of Medical Director under the above circumstances, the physician shall ensure that the appropriate anesthesia care provider, as defined above, is physically available for consultation with the CRNA at all times during the administration of and recovery from anesthesia.

14. Under the above circumstances, the Respondent failed to meet the appropriate standard of medical and surgical care for the following reasons:

a. The Respondent, who performed abortions at CYGMA in conjunction with a CRNA who administered anesthesia during the procedure, did not ensure that an anesthesiologist or

qualified licensed physician was physically available to the CRNA for consultation at all times during the administration of and recovery from anesthesia.

b. The Respondent, acting in his capacity as Medical Director at CYGMA, did not ensure that an anesthesiologist or qualified licensed physician was physically available to the CRNA for consultation at all times during the administration of and recovery from anesthesia.

15. Based on stipulations of fact, paragraphs 1 through 14 above, in whole or in part, the Respondent engaged in unprofessional conduct in the practice of medicine. It was unprofessional conduct in the practice of medicine for a physician to perform surgical procedures, under the circumstances as described in the above stipulation of facts.

OPINION

When considering a petition for reinstatement, the BPQA considers predominantly the following factors:

> 1) the nature and circumstances of the original misconduct; 2) subsequent conduct and reformation; 3) present character; and 4) present qualifications and competence to practice medicine.

See Matter of Kahn, 328 Md. 698, 699, 616 A.2d 882, 883 (1992); Matter of Murray, 316 Md. 303, 305, 558 A.2d 710, 711 (1989).

1. Nature and Circumstances of Applicant's Original Misconduct

The conduct which led to the BPQA's charges in this case is set out in the Findings of Fact, as stipulated by the parties. BPQA's review of these events led it to conclude that Dr. Kioko demonstrated a serious lack of judgement regarding the administration of anesthesia and the obligation of a physician to insure the safety of patients undergoing surgical procedures. In

particular, the BPQA was concerned that Dr. Kioko failed to recognize either the potential for emergency situations which might arise in the surgical setting or that he lacked the training and experience to respond appropriately. Instead, Dr. Kioko assumed that his role was limited to performing technical procedures upon anesthetized patients, leaving the overall management of the patients to others. Dr. Kioko's gullibility in this regard proved fatal.

2. Dr. Kioko's Subsequent Conduct and Reformation

Dr. Kioko has been without a Maryland medical license since December 31, 1991, slightly over 5 years. During this time he continued to practice unrestricted in the District of Columbia and maintained privileges at the Columbia Hospital for Women. In October, 1993, an ad hoc committee of the D.C. Medical Society performed a peer review of Dr. Kioko's medical practice using 20 patient records and concluded that his practice met the standard of care for the District of Columbia.

In assessing Dr. Kioko's fitness for reinstatement, the BPQA has focused on rehabilitative steps taken by Dr. Kioko to insure that events similar to those that led to the surrender of his license will never recur. The BPQA has observed that, over time, Dr. Kioko has gained a recognition of his responsibility for the tragic events at Hillview and has taken appropriate remedial steps. Though currently the medical director of a clinic that performs pregnancy terminations, only local anesthetics are used. Dr. Kioko has stated to the BPQA that he has insured that the clinic has appropriate drugs and equipment necessary for resuscitation. In addition, in response to concerns expressed by BPQA members, Dr. Kioko became certified in Advanced Cardiac Life Support Resuscitation and now maintains his certification. Finally, during the period that his license has been surrendered, Dr. Kioko has completed medical

education credits in excess of those required for reinstatement of his license, in both obstetrics and gynecology as well as.....

3. Dr. Kioko's Present Character

When initially considering Dr. Kioko's petition for reinstatement of his suspended license, the BPQA was not persuaded that Dr. Kioko expressed true remorse for the Hillview victims, except to the extent that it interfered with his professional career. In fact, it was not clear that Dr. Kioko was even cognizant of his own role in the deaths of two patients. Over the past several years since Dr. Kioko appeared before the BPQA on exceptions in February, 1995, the BPQA has observed a change. Dr. Kioko appears truly remorseful for the deaths of the Hillview patients, has a better understanding both of his role in those events and the need to take responsibility to insure they are not repeated.

Dr. Kioko now apparently recognizes that he had a responsibility as a medical director to question the qualifications of Hillview personnel, particularly after the death of the first patient. Furthermore, he now seems to comprehend that his role as a surgeon goes beyond merely performing a technical procedure: he is responsible for overseeing the well being of the patient. He now admits that his prior lack in judgment in this regard contributed to the Hillview tragedies. Dr. Kioko's later and more focused rehabilitative efforts have apparently stemmed from this greater understanding.

Dr. Kioko has also performed significant pro bono community service activities in the Washington, D.C. area including quality assurance and utilization review at the D.C. General Hospital, development of a protocol for the treatment of female inmates a the D.C. jail, and volunteer work with the American Red Cross. In addition, he has applied for pro bono positions

with both the House of Ruth Domestic Violence Shelter and Montgomery and Prince George's Community Colleges.

4. Dr. Kioko's Present Qualifications and Competence

In the past two years, particularly, Dr. Kioko has made significant efforts to understand his role in the Hillview incidents and to accept responsibility for those events. His technical obstetric and gynecological competence has never been at issue. Dr. Kioko's eventual understanding of the Hillview tragedies and his rehabilitative efforts to correct deficiencies in his judgment and training in life support skills to insure that they will never happen again, persuades the BPQA that Dr. Kioko is competent to practice medicine in this State, provided he is placed on probation for a period of time and subject to certain restrictions.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, BPQA concludes as a matter of law that the Applicant meets the requirements for reinstatement of his medical license and is competent to practice medicine, subject to terms and conditions of probation.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 28th day of May, 1997, by a majority of the full authorized membership of the Board of Physician Quality Assurance considering this case

ORDERED that the license to practice of medicine in the State of Maryland for Respondent, GIDEON M. KIOKO, M.D., is hereby REINSTATED;

and it is further

ORDERED that Respondent shall be placed on PROBATION for a period of THREE YEARS, subject to the following terms and conditions:

1. Twelve months after the effective date of this Final Order, Respondent's practice in Maryland shall be subject to peer review by the Medical & Chirurgical Faculty of Maryland. At the discretion of the BPQA, Respondent shall thereafter undergo peer review annually. After the BPQA receives a peer review report, Respondent shall appear before the BPQA's Case Resolution Conference Committee which may recommend to the BPQA any additional conditions it believes necessary for Respondent's continued practice. A peer review report which concludes that Respondent's practice fails to meet appropriate standards of care shall be prima facie evidence of a violation of probation; and

2. Respondent shall not perform any medical or surgical procedure requiring general anesthesia or I.V. sedation unless such a procedure is performed in a hospital with an anesthesiologist present;

3. Respondent shall not perform outpatient abortions after twelve weeks gestation; and

4. Respondent shall perform 100 hours per year of community service approved by the BPQA for each of the three years of probation for a total of 300 hours in three years; and

5. Respondent shall at all times practice medicine in compliance with this Order and with the Maryland Medical Practice Act.

AND IT IS FURTHER ORDERED that three years from the effective date of this Order, Respondent may petition the BPQA for termination of probation and full reinstatement of his Maryland medical license, provided that he has complied with the conditions outlined above; and it is further

ORDERED that if Respondent violates any of the foregoing terms and conditions of probation, the BPQA, after notice and a hearing and a determination of a violation of probation by a preponderance of the evidence, may impose any additional disciplinary sanction it deems appropriate, including revocation of Respondent's medical license; and it is further

ORDERED that if the BPQA has reason to believe that Respondent presents a danger to the public health, safety, or welfare, the BPQA, WITHOUT PRIOR NOTICE AND AN OPPORTUNITY FOR A HEARING, MAY SUMMARILY SUSPEND RESPONDENT'S LICENSE, provided that Respondent is given immediate notice of the BPQA's action and an opportunity for a hearing within thirty days after Respondent's request for such a hearing; and it is further

ORDERED that this Order of Reinstatement is a final order of the Board of Physician Quality Assurance and as such is a PUBLIC DOCUMENT pursuant to Md. Code Ann., State Gov't §§ 10-611 et seq.

5 24 97
Date

Suresh C. Gupta, M.D.
Chair