BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
	)	**Docket No.:** **16-HA0005**
Dennis M. Miller, M.D.	)	**OAH Docket No.:** **16HA0001**
Kansas License No. 04-19490	)	

CONSENT ORDER

COMES NOW, the Kansas State Board of Healing Arts, ("Board"), by and through Anne Barker Hall, Associate Litigation Counsel, and Susan R. Gering Associate Litigation Counsel ("Petitioner"), and Dennis W. Miller, M.D. ("Licensee"), by and through his attorney Diana Jordison, Horn Aylward & Bandy, LLC, and move the Board for approval of a Consent Order affecting Licensee's license to practice medicine and surgery in the State of Kansas. The Parties stipulate and agree to the following:

1. Licensee's last known mailing address to the Board is: 21 N. 12th Street #350, Kansas City, Kansas 66102.
2. Licensee is or has been entitled to engage in the practice of medicine and surgery in the State of Kansas, having been issued license number 04-19490 on approximately February 3, 1982. Licensee last renewed his license on May 18, 2015. Licensee's license is currently active.
3. The Board is the sole and exclusive administrative agency in the State of Kansas authorized to regulate the practice of the healing arts, specifically the practice of medicine and surgery. K.S.A. 65-2801 *et seq.*, and K.S.A. 65-2869.
4. This Consent Order and the filing of such document are in accordance with applicable law and the Board has jurisdiction to enter into the Consent Order as provided by K.S.A. 77-505

and 65-2838. Upon approval, these stipulations shall constitute the findings of the Board, and this Consent Order shall constitute the Board's Final Order.

5. The Kansas Healing Arts Act is constitutional on its face and as applied in the case. Licensee agrees that, in considering this matter, the Board is not acting beyond its jurisdiction as provided by law.
6. Licensee voluntarily and knowingly waives his right to a hearing. Licensee voluntarily and knowingly waives his right to present a defense by oral testimony and documentary evidence, to submit rebuttal evidence, and to conduct cross-examination of witnesses. Licensee voluntarily and knowingly agrees to waive all possible substantive and procedural motions and defenses that could be raised if an administrative hearing were held.
7. The terms and conditions of the Consent Order are entered into between the undersigned parties and are submitted for the purpose of allowing these terms and conditions to become an Order of the Board. This Consent Order shall not be binding on the Board until an authorized signature is affixed at the end of this document. Licensee specifically acknowledges that counsel for the Board is not authorized to sign this Consent Order on behalf of the Board.
8. The Board has received information and investigated the same, and has reason to believe that there may be grounds to take action with respect to Licensee's license under the Kansas Healing Arts Act, K.S.A. 65-2801 *et seq.*
9. This Consent Order incorporates herein by reference the allegations as stated in the Petition filed on July 2, 2015. Exhibit 1, Petition in the Matter of Dennis Miller, M.D. 16-HA0005.
10. Licensee acknowledges that if formal hearing proceedings were conducted and Licensee presented no exhibits, witnesses, or other evidence, the Board has sufficient evidence to

prove that Licensee has violated the Kansas Healing Arts Act with respect to the above allegations. Licensee further waives his right to dispute or otherwise contest the allegations contained in the above paragraphs in any further proceeding before this Board.

11. Licensee's acts, if proven, constitute unprofessional conduct and/or dishonorable conduct as set forth in K.S.A. 65-2836. Licensee denies any acts constitute unprofessional and/or dishonorable conduct as set forth in K.S.A. 65-2836. Licensee enters into this Consent Order to settle the disputed allegations.

12. Licensee's conduct during the care and treatment of Patient 1, Patient 2, and Patient 3 constitutes violations of the Kansas Healing Arts Act as follows:

    a. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(2), in that Licensee committed repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board;

    b. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(3), in that Licensee engaged in a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice the healing arts;

    c. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(12), in that Licensee engaged in conduct likely to harm the public;

    d. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(24), in that Licensee engaged in repeated failure to practice healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

e. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(25), in that Licensee failed to keep written medical records which accurately describe services rendered to the patient;

f. K.S.A. 65-2836(f), in that Licensee has willfully and/or repeatedly violated the Kansas Healing Arts Act; and

g. K.S.A. 65-2836(k), in that Licensee violated a lawful regulation promulgated by the board, specifically, K.A.R. 100-24-1, by failing to meet the minimum requirements for an adequate patient record.

13. Pursuant to K.S.A. 65-2836, the Board may revoke, suspend, limit, censure or place under probationary conditions Licensee's license and pursuant to K.S.A. 65-2863a the Board has the authority to impose administrative fines for violations of the Kansas Healing Arts Act.

14. According to K.S.A.65-2838(b) and K.S.A. 77-505, the Board has authority to enter into this Consent Order without the necessity of proceeding to a formal hearing.

15. All pending investigation materials in KSBHA Investigation Numbers 10-00712; 13-00318; and 13-00495 were fully reviewed and considered by the Board members who serve on the Board's Disciplinary Panel No. 28. Disciplinary Panel No. 28 authorized and directed Board counsel to seek settlement of this matter with the provisions contained in this Consent Order.

16. Licensee further understands and agrees that if the Board finds, after due written notice and an opportunity for a hearing, that Licensee has failed to comply with any of the terms of this Consent Order, the Board may immediately impose any sanction provided for by law, including but not limited to suspension or revocation of Licensee's license to practice medicine and surgery in the State of Kansas. Licensee hereby expressly understands and

agrees that, at any such hearing, the sole issue shall be whether or not Licensee has failed to comply with any of the terms or conditions set forth in this Consent Order. The Board acknowledges that at any such hearing, Licensee retains the right to confront and examine all witnesses, present evidence, testify on his own behalf, contest the allegations, present oral argument, appeal to the courts, and all other rights set forth in the Kansas Administrative Procedures Act, K.S.A. 77-501 *et seq.*, and the Kansas Healing Arts Act, K.S.A. 65-2801 *et seq.*

17. Nothing in this Consent Order shall be construed to deny the Board jurisdiction to investigate alleged violations of the Kansas Healing Arts Act, or to investigate complaints received under the Risk Management Law, K.S.A. 65-4921 *et seq.*, that are known or unknown and are not covered under this Consent Order, or to initiate formal proceedings based upon known or unknown allegations of violations of the Kansas Healing Arts Act.
18. Licensee hereby releases the Board, its individual members (in their official and personal capacity), attorneys, employees and agents, hereinafter collectively referred to as "Releasees", from any and all claims, including but not limited to those alleged damages, actions, liabilities, both administrative and civil, including the Kansas Judicial Review Act, K.S.A. 77-601 *et seq.* arising out of the investigation and acts leading to the execution of this Consent Order. This release shall forever discharge the Releasees of any and all claims or demands of every kind and nature that Licensee has claimed to have had at the time of this release or might have had, either known or unknown, suspected or unsuspected, and Licensee shall not commence to prosecute, cause or permit to be prosecuted, any action or proceeding of any description against the Releasees.

19. Licensee further understands and agrees that upon signature by Licensee, this document shall be deemed a public record and shall be reported to any entities authorized to receive disclosure of the Consent Order.

20. This Consent Order, when signed by both parties, constitutes the entire agreement between the parties and may only be modified or amended by a subsequent document executed in the same manner by the parties.

21. Licensee agrees that all information maintained by the Board pertaining to the nature and result of any complaint and/or investigation may be fully disclosed to and considered by the Board in conjunction with the presentation of any offer of settlement, even if Licensee is not present. Licensee further acknowledges that the Board may conduct further inquiry as it deems necessary before the complete or partial acceptance or rejection of any offer of settlement.

22. Licensee, by signature to this document, waives any objection to the participation of the Board members, including the Disciplinary Panel and General Counsel, in the consideration of this offer of settlement and agrees not to seek the disqualification or recusal of any Board member or General Counsel in any future proceedings on the basis that the Board member or General Counsel has received investigative information from any source which otherwise may not be admissible or admitted as evidence.

23. Licensee acknowledges that he has read this Consent Order and fully understands the contents.

24. Licensee acknowledges that this Consent Order has been entered into freely and voluntarily.

25. All correspondence or communication between Licensee and the Board relating to the Consent Order shall be by certified mail addressed to:

Kansas State Board of Healing Arts
Attn: Compliance Coordinator
800 SW Jackson, Lower Level-Suite A,
Topeka, Kansas 66612

26. Licensee shall obey all federal, state and local laws and rules governing the practice of medicine and surgery in the State of Kansas that may be in place at the time of execution of the Consent Order or may become effective subsequent to the execution of this document.

27. Upon execution of this Consent Order by affixing a Board authorized signature below, the provisions of this Consent Order shall become an Order under K.S.A. 65-2838. This Consent Order shall constitute the Board's Order when filed with the office of the Executive Director for the Board and no further Order is required.

28. Licensee shall immediately notify the Board or its designee of any citation, arrest or charge filed against him or any conviction for any traffic or criminal offense excluding speeding and/or parking violations.

29. Licensee shall immediately notify the Board or its designee of any complaint filed, or investigation opened, by the proper licensing authority of another state, territory, District of Columbia, or other country, or by a peer review body, a health care facility, a professional association or society, or by a governmental agency.

30. Licensee shall at all times keep Board staff informed of his current practice locations addresses and telephone numbers. Licensee shall provide the above information in writing to the Board within ten (10) days of any such change.
31. This Consent Order constitutes public disciplinary action.
32. The Board may consider all aspects of this Consent Order in any future matter regarding Licensee.
33. In lieu of conducting a formal proceeding, Licensee, by signature affixed to this Consent Order, hereby voluntarily agrees to the following disciplinary action against his license to engage in the practice of medicine and surgery:

RETIREMENT

34. Licensee agrees to change his licensure status from Active to Inactive or Exempt on or before March 31, 2016. Upon Licensee's designation change from Active to Inactive or Exempt, Licensee shall not perform any type of surgical procedure including gynecological surgeries and/or provide obstetric care. Licensee will be allowed to volunteer at free clinics by performing non-surgical gynecological procedures.
35. Licensee shall not accept any new patients prior to his retirement date.

LIMITATIONS/MONITORING

36. Licensee's license to practice medicine and surgery shall be limited in that he shall not practice under the Kansas Healing Arts Act unless he complies with each of the following:
    a. Licensee shall have a Board-approved, Kansas-licensed physician consult and assist on each patient case requiring any surgical procedure. The Board-approved

physician shall be physically present during the Licensee-patient interaction in every case requiring a surgical procedure.

b. Such physician shall also function as a practice monitor. The practice monitor shall conduct weekly chart reviews of all patients seen and treated by Licensee during that week. The monitor shall then submit all weekly reports to the Board on the 15th day of the each month. The report shall be on a form provided by Board staff and shall include the number of patient charts reviewed, a brief summary of Licensee's services rendered during the week and an opinion as to whether Licensee services are within the standard of care.

c. On or before October 9, 2015, Licensee shall submit the curriculum vitae of his proposed practice monitor(s) for approval of the Board. The Board designates the Disciplinary Panel's Appointed Member to approve or disapprove of the practice monitor. Such monitoring shall be conducted at Licensee's own expense.

d. For the purposes of the limitation, the term "surgery" is defined as manual or operative method that involves the partial or complete excision or resection, destruction, incision, or other structural alteration of human tissue by any means, including the use of lasers, performed upon the human body for the purpose of preserving health, diagnosing or treating disease, repairing injury, correcting deformity or defects, or for aesthetic, reconstructive, or cosmetic purposes. The limitation will also include endoscopic procedures.

37. Licensee shall notify and provide a copy of the Consent Order to every hospital or facility he currently practices in on or before November 15, 2015.

38. Licensee will voluntarily resign from the staff at Overland Park Regional Medical Center by October 31, 2015.

39. Licensee shall notify the Board in writing that he has provided the Consent Order to each hospital and facility he practices in on or before December 1, 2015.

BOARD COSTS

40. Licensee agrees to pay the Board's incurred COSTS in conducting these proceedings under the Kansas Administrative Procedure Act in the amount that is put forth by the Board in a Statement of Costs.

41. Such COSTS shall be paid in the form of a Cashier's Check or Money Order to the "Kansas State Board of Healing Arts" in full on or before December 30, 2015.

42. All monetary payments to the Board relating to this Consent Order shall be mailed to the Board by certified mail addressed to:

    Kansas State Board of Healing Arts
    Attn: Compliance Coordinator
    800 SW Jackson, Lower Level-Suite A
    Topeka, Kansas 66612

IT IS THEREFORE ORDERED that the Consent Order and agreement of the parties contained herein is adopted by the Board as findings of fact, conclusions of law, and as a Final Order of the Board.

IT IS SO ORDERED on this 13 day of Oct, 2015.

FOR THE KANSAS STATE BOARD OF HEALING ARTS:

Kathleen Selzler Lippert
Executive Director

Oct 13, 2015
Date

Dennis W. Miller, M.D.
Licensee

09 September 2015
Date

PREPARED AND APPROVED BY:

Anne Barker Hall #23672
Associate Litigation Counsel
Susan R. Gering, #25582
Associate Litigation Counsel
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
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ahall@ksbha.ks.gov
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APPROVED BY:

Diana Jordison
w/ permission - JMW KS 26539

Diana Jordison, #12917
Attorney for Licensee
Horn Aylward & Bandy, LLC
2600 Grand Ave. Suite 1100
Kansas City, MO 64108

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that I served a true and correct copy of the Consent Order by United States mail, postage prepaid, on this 13th day of October, 2015, to the following:

Dennis W. Miller, M.D.
Licensee
21 N. 12th Street #350
Kansas City, Kansas 66102

Diana Jordison
Attorney for Licensee
Horn Aylward & Bandy, LLC
2600 Grand Ave. Suite 1100
Kansas City, MO 64108

And the original was hand-filed with:

Kathleen Selzler Lippert
Executive Director
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

And a copy was hand-delivered to:

Anne Barker Hall
Associate Litigation Counsel
Susan R. Gering
Associate Litigation Counsel
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

Compliance Coordinator
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

Cathy A. Brown

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the matter of	)	
	)	**Docket No. 16-HA** 00005
Dennis Miller, M.D.	)	
Kansas License No. 04-19490	)	

PETITION

COMES NOW the Kansas State Board of Healing Arts ("Petitioner"), by and through Anne Barker Hall, Associate Litigation Counsel, and initiates these proceedings pursuant to the provisions of K.S.A. 65-2836, K.S.A. 65-2851a, and K.S.A. 77-501 et al. For its cause of action, Petitioner alleges and states:

1. Dennis Miller, M.D.'s ("Licensee") last known mailing address to the Board is: 21 N. 12th Street #350, Kansas City, Kansas 66102.
2. Licensee is or has been entitled to engage in the practice of medicine and surgery in the State of Kansas, having been issued license number 04-19490 on approximately February 3, 1982. Licensee last renewed his license on May 18, 2015. Licensee's license is currently active.
3. At all times relevant to the allegations set forth in the Petition, Licensee held a current and active license to practice medicine and surgery in the State of Kansas.
4. Since issuance of licensure in a regulated profession as a medical doctor in the State of Kansas, pursuant to K.S.A. 65-2836, *et seq.*, Licensee did commit the following act(s):

COUNT I

5. Petitioner hereby incorporates herein paragraphs one (1) through four (4) as if stated fully herein.

6. Patient 1 was a Confidential female who was admitted to Overland Park Regional Medical Center in Overland Park, Kansas, on January 2, 2009, for delivery of her first child.

7. Patient 1 underwent a Caesarean-section ("C-section") performed by Licensee on January 3, 2009, in the early morning hours for failure to progress. Patient 1 lost approximately 1000cc of blood during the C-section.

8. At approximately 0346, Patient 1 was taken to the recovery room where she continued to vaginally pass excessive amounts of blood and large clots.

9. At approximately 0440, the nursing staff in the recovery room notified Licensee of Patient 1's tachycardia and continued blood loss and requested a STAT hemoglobin and hematocrit (H & H) testing for the express purpose of checking Patient 1's hemoglobin (Hgb) and hematocrit (Hct) levels. Licensee did not want the H&H drawn at that time.

10. At approximately 0505, Licensee was notified of Patient 1's "need to pass out." Licensee then gave orders for a STAT H&H. The results showed Patient 1's Hgb was 5.4 and Hct was 16.9.

11. At 0605, Licensee was noted to be at Patient 1's bedside. Licensee failed to document any examination or assessment of Patient 1. Licensee ordered four (4) units of packed red blood cells to be transfused and repeat H&H post transfusion.

12. Licensee was notified at 0657 that Patient 1's abdomen was distended, she was receiving the third unit of blood, and continued to have unstable vital signs. Licensee stated he would be in after doing a delivery at another hospital.

13. At 0753, Licensee was again updated on Patient 1's status, vital signs, bleeding and uterus placement. Licensee stated he would be over soon.

14. At 0800, another physician examined Patient 1 and immediately ordered a STAT H&H along with an immediate increase in the rate of infusion of blood and other fluids.

15. At approximately 0819, yet another physician examined Patient 1 and ordered an immediate blood coagulation study.

16. At approximately 0900, Licensee took Patient 1 back to the operating room for an exploratory laparotomy. Following this procedure, the patient continued to bleed excessively and continued to receive additional units of blood.

17. At approximately 1121, nursing staff found Patient 1's uterus to be boggy with continued bleeding and notified Licensee of their findings. An arterial line was inserted by another physician due to Patient 1's excessive bleeding.

18. At approximately 1235, Licensee took Patient 1 back to surgery for placement of an intrauterine balloon in hope of controlling Patient 1's uncontrolled bleeding.

19. At approximately 1313, Patient 1 arrived in ICU, intubated, was not responsive to verbal stimulus, demonstrated no spontaneous movements and was continuing to suffer excessive vaginal bleeding.

20. At 1400, Patient 1's hemoglobin was 8.9, and she continued to receive transfusions of plasma.

21. At approximately 1410, Patient 1 was noted to have continued heavy vaginal bleeding, bright red drainage was noted in the intrauterine balloon, and Licensee was paged.

22. At 1430, Licensee advised to watch the patient for 30 minutes then call with blood loss amount.

23. At 1500, Licensee was again notified of Patient 1's continued blood loss. At 1535, Patient 1's Hgb was 3.0 and her Hct was 9.2.

24. At approximately 1530, Licensee took Patient 1 back to the operating room, where an emergency abdominal hysterectomy was performed.

25. Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence in his care and treatment of Patient 1, including, but not limited to, each of the following acts or omissions:

    a. Licensee failed to authorize appropriate lab testing at 0440 when notified of Patient 1's tachycardia and blood loss following a C-section during which Patient 1 had lost 1000cc of blood;

    b. Licensee failed to perform an adequate examination of Patient 1 when Licensee was at Patient 1's beside at 0605;

    c. Licensee failed to document an adequate examination or assessment of Patient 1 when Licensee was at Patient 1's bedside at 0605;

    d. Licensee failed to develop an adequate plan for Patient 1 on January 1, 2009, at 0605;

    e. Licensee failed to timely examine Patient 1 and failed to obtain a suitable substitute physician to examine Patient 1 in his absence after being notified of

Patient 1's distended abdomen, continued blood loss and continued unstable vital signs at 0657;

f. The exploratory procedure Licensee performed at approximately 0900 was inadequate given the amount of blood Patient 1 had lost during the C-section, the amount of blood Patient 1 had lost after the C-section, the unstable vital signs, and the whole clinical picture. Licensee should have placed the Bakri balloon during the first exploratory procedure when his only finding was a small bleeder.

g. Licensee failed to adequately document his findings during the exploratory procedure performed at 0900 with no description of the firmness of the uterus or whether the bleeding had improved;

h. After the exploratory laparotomy failed to stop the bleeding, Licensee had to take Patient 1 back for another surgery to place the balloon which he should have done during the exploratory laparotomy; and

i. Licensee failed to adequately document the procedure to place the Bakri balloon.

26. Licensee's conduct during the course of treating Patient 1 constitutes acts in violation of the Kansas Healing Arts Acts as follows:

a. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(2), in that Licensee committed repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board;

b. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(3), in that Licensee engaged in a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice the healing arts;

c. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(12), in that Licensee engaged in conduct likely to harm the public;

d. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(24), in that Licensee engaged in repeated failure to practice healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

e. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(25), in that Licensee failed to keep written medical records which accurately describe services rendered to the patient;

f. K.S.A. 65-2836(f), in that Licensee has willfully and/or repeatedly violated the Kansas Healing Arts Act; and/or

g. K.S.A. 65-2836(k), in that Licensee violated a lawful regulation promulgated by the board, specifically, K.A.R. 100-24-1, by failing to meet the minimum requirements for an adequate patient record.

27. Pursuant to K.S.A. 65-2836, the Board has grounds to revoke, suspend, censure, place on probation, fine, or otherwise limit Licensee's license for violations of the Kansas Healing Arts Act.

COUNT II

28. Petitioner hereby incorporates herein paragraphs one (1) through twenty-seven (27) as if stated fully herein.

29. Patient 2 was a Confidential female with significant pelvic pain and an extremely large fibroid uterus on ultrasound measuring 16.3 x 9.5 x 14.5 cm with the largest fibroid measuring 12.9 cm.

30. Patient 2 presented to Licensee for a new patient visit on or about August 20, 2012. Licensee performed an exam and noted in the patient record that Patient 2 had an enlarged uterus approximately the size of a four (4) month pregnancy.

31. Licensee documented discussing the risks and benefits of a hysterectomy, but failed to document discussion of the risks of a laparoscopic hysterectomy given a uterus this large.

32. Licensee performed laparoscopic vaginal assisted hysterectomy on or about August 22, 2012, at approximately 0730.

33. Prior to surgery, Patient 2's hemoglobin was 12.9. Per Licensee's records, the estimated blood loss during the surgery was 750ml.

34. Patient 2 received Crystalloid 1900 cc, and Colloid 500 cc during the surgery.

35. In his operative report, Licensee noted "excessive bleeding," "some increased bleeding," and a "significant amount of blood clot in the cavity." Licensee failed to document confirmation of hemostasis.

36. Postoperatively, Patient 2 was noted to be hypotensive in the PACU, and Dr. Mochacsi ordered a 500 cc fluid bolus at 1010. Postoperatively, Patient 2's hematocrit (Hct) was

16.5 and hemoglobin (Hgb) was 5.6. A drop in hemoglobin of over 50% suggests a blood loss of over half of the patient's blood volume.

37. At 1040, Patient 2's Hgb was 5.6. Licensee was notified, and he ordered transfusion of two (2) units of packed red blood cells (PRBCs).

38. Licensee saw Patient 2 at 1108 and was aware of Patient 2's hypotension.

39. Patient 2 was transferred to the floor at approximately 1200 with the second unit of blood transfusing. Following the transfer, Patient 2 remained hypotensive with tachycardia and her mean arterial pressure (MAP) was in the 40's to low 60's.

40. Licensee was present on the third floor at 1215, and he was updated as to Patient 2's condition. Licensee ordered a bolus of LR at that time. There is no documentation that Licensee examined Patient 2 or evaluated her condition.

41. At 1400, Licensee was outside Patient 2's room. Patient 2 continued to be hypotensive, with tachycardia, and low urine output. There are no notes indicating he saw Patient 2 at that time.

42. At 1415, Patient 2's Hgb was 8.9 and her Hct was 26.77. At 1420 Patient 2 complained of being uncomfortable and anxious. Her documented heart rate was 140 per the monitor.

43. Patient 2 was unresponsive and not breathing at 1515. A code was called, and Patient 2 was intubated.

44. At 1613, Patient 2's Hgb was 5.1 and her Hct was 15.8. Licensee was notified and was at Patient 2's bedside at 1625.

45. Licensee took Patient 2 back to surgery to repair the internal bleeding.

46. Patient 2 did not recover and was pronounced brain dead on or about August 25, 2012.

47. Patient 2 was continued on artificial life support until her family could arrive. Patient 2 was extubated on August 30, 2012.

48. An autopsy revealed a large hemorrhage in Patient 2's pelvis, 300ml blood in the abdominal cavity, advanced anoxic encephalopathy and acute necrosis of the ovary and pituitary gland.

49. Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence in his care and treatment of Patient 2, including but not limited to, each of the following acts or omissions:

    a. Licensee failed to adequately explain and document the risks of a laparoscopic procedure in such an enlarged uterus;

    b. Licensee failed to accurately assess the blood loss Patient 2 sustained during the initial surgical procedure;

    c. Licensee failed to confirm hemostasis during the surgical procedure after noting several instances of significant bleeding;

    d. Licensee allowed Patient 2 to transfer out of the recovery room to the medical floor when her vital signs were not stable;

    e. Licensee failed to assess Patient 2 after her transfer to the medical floor although he was on the floor and was aware of Patient 2's unstable condition;

    f. Licensee failed to order increased monitoring of Patient 2's vital signs and status upon arrival to the medical floor although he was aware of her unstable condition;

g. Licensee failed to timely recognize that all of Patient 2's symptoms indicated post-operative bleeding; and

h. Licensee failed to respond in a timely fashion when all of Patient 2's symptoms indicated post-operative bleeding.

50. Licensee's conduct during the course of treating Patient 2 constitutes acts in violation of the Kansas Healing Arts Acts as follows:

a. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(2), in that Licensee committed repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board;

b. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(3), in that Licensee engaged in a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice the healing arts;

c. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(12), in that Licensee engaged in conduct likely to harm the public;

d. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(24), in that Licensee engaged in repeated failure to practice healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

e. K.S.A. 65-2836(f), in that Licensee has willfully and/or repeatedly violated the Kansas Healing Arts Act; and

f. K.S.A. 65-2836(k), in that Licensee violated a lawful regulation promulgated by the board, specifically, K.A.R. 100-24-1, by failing to meet the minimum requirements for an adequate patient record.

51. Pursuant to K.S.A. 65-2836, the Board has grounds to revoke, suspend, censure, place on probation, fine, or otherwise limit Licensee's license for violations of the Kansas Healing Arts Act.

COUNT III

52. Petitioner hereby incorporates herein paragraphs one (1) through fifty-one (51) as if stated fully herein.

53. Patient 3 was a Confidential female who began to see Licensee for her prenatal care on or about December 6, 2010. Patient 3 had one (1) previous pregnancy resulting in one (1) live birth. Licensee documented that Patient 3 had a history of diabetes, hypertension, and preeclampsia.

54. Patient 3 was treated between December 11, 2010, and March 18, 2011, by Dr. Gibson at Swope Health. The Swope Health records were faxed to Licensee on or about April 5, 2011, and are present in Licensee's medical record for Patient 3.

55. On March 15, 2011, the patient's gestational diabetes screen was elevated.

56. On April 5, 2011, Licensee observed Patient 3 at Providence Medical Center for contractions and back pain. Licensee documented a History and Physical/Discharge Summary for Patient 3 incorrectly noting the patient was a primgravida and failing to mention Patient 3's glucose or history of hypertension and diabetes.

57. Licensee saw Patient 3 on or about May 12, 2011, and documented Patient 3's blood sugar was 169. Licensee documented a plan to perform nonstress tests at each visit and deliver the baby at 39 weeks.

58. Licensee saw Patient 3 on or about May 26, 2011, and noted the patient had swollen feet and had not been taking her medications as prescribed, and he scheduled an induction for June 14, 2011.

59. Licensee saw Patient 3 on or about June 2, 2011, and noted the patient reported her feet were getting very swollen and she felt very tired. Patient 3's Hgb was 8.7. Licensee failed to document a plan to address Patient 3's anemia.

60. On June 2, 2011, Patient 3's blood pressure was severely elevated at 161/88. Licensee failed to recheck Patient 3's blood pressure or otherwise address the hypertension and possible preeclampsia in his plan for Patient 3.

61. Patient 3's blood sugar logs were scanned into Licensee's medical record and showed poor control of her diabetes. Licensee failed to make any adjustments to Patient 3's medications.

62. Infants of diabetic mothers are known to be at risk of macrosomia and shoulder dystocia. This is most elevated in the setting of poorly controlled diabetes. There is no documentation in Licensee's medical record that he discussed the possibility of these complications with Patient 3.

63. Licensee failed to make any effort to follow the growth of the infant with serial ultrasounds. Licensee failed to document any discussion with Patient 3 regarding the desirability of such testing and failed to document Patient 3's refusal of such testing.

64. Patient 3 was admitted to Providence Medical Center for induction of labor on June 14, 2011.

65. Licensee initiated Pitocin at approximately 0600. The Pitocin was increased at intervals to16 mu/min until it was discontinued at 1223.

66. Patient 3 was documented as having severely elevated blood pressures, headache, and lower extremity edema during her induction. Patient 3 was also given Magnesium sulfate during her induction, suggesting she was suffering from severe preeclampsia.

67. Patient 3 was complete at 1223, and Licensee arrived at 1240. Patient 3 pushed for approximately 15 minutes before Licensee made a diagnosis of maternal exhaustion and documented "poor pushing effort." Licensee failed to document any extenuating circumstances to support his premature discontinuation of Patient 3's second stage of labor. There was no indication of fetal distress.

68. Licensee applied vacuum suction. There is no indication in the record that Licensee discussed options with Patient 3 prior to attempting vacuum extraction of the fetus. There is no indication in the record that Patient 3 was provided an explanation of risks and benefits regarding the use of vacuum extraction. There is no indication in the record that Licensee offered Patient 3 the option of a C-section.

69. The baby's head was delivered at 1258. The infant then sustained shoulder dystocia that Licensee was unable to resolve.

70. A labor and delivery emergency was then called, bringing several physicians and others to assist.

71. The 10lb 5oz infant was born six to seven (6-7) minutes after the head was delivered. The infant had Apgars of 1, 4 and 6. A neonatal consult was obtained, and the infant was diagnosed with multiple issues including bilateral brachial plexus injury. The infant was transferred to Children's Mercy Hospital.

72. Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence in his care and treatment of Patient 3, including but not limited to, each of the following acts or omissions:

    a. Patient 3 had a known history of diabetes, and her blood sugar logs indicated she had poor control over it; however, Licensee made no attempt to adjust her medication;

    b. Licensee failed to document any attempt to educate Patient 3 regarding the risks associated with a poorly controlled blood sugar, including, but not limited to macrosomia and shoulder dystocia;

    c. Licensee failed to monitor the growth of the infant in utero;

    d. Licensee failed to perform appropriate weekly antenatal testing which would be indicated in a poorly controlled diabetic from 32 weeks on;

    e. Licensee failed to appropriately evaluate and treat Patient 3 for preeclampsia in the face of severely elevated blood pressure in a patient with a known history of preeclampsia; and

    f. Patient 3 was administered Methergine, not as a last resort, but as the first medication after oxytocin and before cytotec, putting Patient 3 at risk of a stroke in the postpartum period.

73. Licensee's conduct during the course of treating Patient 3 constitutes acts in violation of the Kansas Healing Arts Acts as follows:

a. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(2), in that Licensee committed repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board;

b. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(3), in that Licensee engaged in a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice the healing arts;

c. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(12), in that Licensee engaged in conduct likely to harm the public;

d. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(24), in that Licensee engaged in repeated failure to practice healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

e. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(25), in that Licensee failed to keep written medical records which accurately describe services rendered to the patient;

f. K.S.A. 65-2836(f), in that Licensee has willfully and/or repeatedly violated the Kansas Healing Arts Act; and

g. K.S.A. 65-2836(k), in that Licensee violated a lawful regulation promulgated by the board, specifically, K.A.R. 100-24-1, by failing to meet the minimum requirements for an adequate patient record.

74. Pursuant to K.S.A. 65-2836, the Board has grounds to revoke, suspend, censure, place on probation, fine, or otherwise limit Licensee's license for violations of the Kansas Healing Arts Act.

COUNT IV

75. Petitioner hereby incorporates herein paragraphs one (1) through seventy-four (74) as if stated fully herein.

76. On or about July 25, 2007, Licensee's insurance companies paid Confidential on behalf of Licensee to settle a lawsuit filed in Wyandotte County District Court. The allegations underlying the lawsuit are that Licensee improperly placed two (2) vacuums during a vaginal delivery causing shoulder dystocia and fetal demise.

77. On or about September 1, 2011, Licensee's insurance companies paid Confidential on behalf of Licensee to settle a lawsuit filed in Wyandotte County District Court. The allegations underlying the lawsuit are that Licensee performed a C-section, and when the patient began to bleed post-operatively, Licensee had to take her back for exploratory surgery twice before finally performing a total hysterectomy.

78. On or about February 11, 2014, Licensee's insurance companies paid Confidential on behalf of Licensee to settle a lawsuit filed in Wyandotte County District Court. The allegations underlying the lawsuit are that Licensee performed a laparoscopic hysterectomy on the patient and following the procedure the patient bled out and died.

79. On or about October 29, 2014, Licensee's insurance companies paid Confidential on behalf of Licensee to settle a lawsuit filed in Wyandotte County District Court. The allegations underlying the lawsuit are that Licensee failed to properly treat a pregnant patient with diabetes, and when the baby was delivered it suffered shoulder dystocia.

80. Licensee's malpractice payouts violate K.S.A. 65-2836(w) in that Licensee has an adverse judgment, award or settlement against him resulting from a medical liability claim related to acts or conduct similar to acts or conduct which would constitute disciplinary action under this section.

81. Pursuant to K.S.A. 65-2836, the Board has grounds to revoke, suspend, censure, place on probation, fine, or otherwise limit Licensee's license for violations of the Kansas Healing Arts Act.

WHEREFORE, Petitioner prays that the Board make findings of fact and conclusions of law that Licensee committed these acts in violation of the Healing Arts Act, that Licensee's license to practice medicine and surgery in the State of Kansas be revoked, suspended, censured, fined or otherwise limited, and that the Board assess such administrative fines and impose such costs against Licensee as it shall deem just and proper and as authorized by law.

WHEREFORE, Petitioner further requests this matter to have a Presiding Officer be appointed and be set for a Formal Hearing pursuant to K.S.A. 77-513.

Respectfully submitted,

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CERTIFICATION OF SERVICE

I, Anne Hall, hereby certify that I caused to be served a true and correct copy of the PETITION by United States mail, postage prepaid, on this 2nd day of July 2015, to the following:

Dennis Miller
21 N. 12th Street #350
Kansas City, Kansas 66102

And the original was hand-delivered for filing with:

Kathleen Selzler Lippert
Executive Director
Kansas Board of Healing Arts
800 SW Jackson
Lower Level, Suite A
Topeka, Kansas 66612