E-3781

IN THE MATTER OF	)(	BEFORE THE
	)(	
THE LICENSE OF	)(	TEXAS STATE BOARD
	)(	
TOMMY ERNEST SWATE, M.D.	)(	OF MEDICAL EXAMINERS

ORDER

On this the 24th day of January, 1992, came on to be heard before the Texas State Board of Medical Examiners ("the Board"), duly in session the matter of the license of Tommy Ernest Swate, M.D. ("the Respondent"). On November 21, 1989, Respondent appeared in person without representation at an Informal Settlement Conference at the offices of the Board in response to the Board's letter of invitation dated October 31, 1989.

The Texas State Board of Medical Examiners was represented at the Informal Settlement Conference on November 21, 1989, by Robert L.M. Hilliard, M.D., a member of the Board, and Jerome L. Armbruster, D.O., a District Review Committee member. The Board hereby makes the Findings of Fact and Conclusions of Law below, which Respondent agrees not to contest for the purposes of this proceeding; and enters the Order below with Respondent's consent.

FINDINGS OF FACT

1. Tommy Ernest Swate, M.D., holds Texas medical license E-3781.

2. The Respondent received notice as required by law and by the rules of the Board. The parties agree that all jurisdictional requirements have been satisfied.

3. Respondent failed to timely notify C.B. that he was closing his practice in that he failed to advise her until her 7 1/2-8 month of pregnancy at which time it was difficult for her to find a physician to deliver the baby. Respondent also failed to treat C.B. for infection as reflected by an out-of-range white blood cell count contained in a lab report dated June 2, 1987.

4. Respondent failed to complete abortions performed on one or more of the following patients, to maintain proper medical records and/or to appropriately document procedures therein; and/or failed to

repair lacerations which occurred during the procedures and/or attempted procedures:

a. Respondent performed a suction curettage on E.B. on or about August 13, 1986. A repeat pregnancy test on or about August 27, 1986 was positive. On or about September 17, 1986 retained products of conception were noted when E.B. underwent a diagnostic laparoscopy and D & C.

b. Respondent failed to treat D.J. for a perforated uterus which occurred while he was attempting to perform a suction curettage on or about January 5, 1986, which had to be discontinued prior to completion because D.J. was unable to tolerate the pain. Respondent further failed to provide appropriate post-operative care to D.J., which resulted in D.J. being admitted to a hospital with a diagnosis of acute shock, secondary to blood loss, disseminating intravascular coagulapathy (DIC) and retained products of conception.

c. During attempted abortions, which were discontinued because E.S. could not tolerate the pain, on or about May 22, 1986, and/or June 4, 1986, on E.S., Respondent perforated a portion of E.S.'s small bowel, which aspirated into the uterus, and failed to provide treatment therefore, which resulted in E.S. being hospitalized on or about June 6, 1986 and undergoing an exploratory laparotomy during which a 1 1/2 cm perforation in the anterior surface of the uterine was noted. Respondent also failed to provide appropriate post-operative care to E.S.

d. During a dilation and evacuation performed on L.C. on or about September 25, 1987, Respondent lacerated L.C.'s cervix and uterus and failed to treat the lacerations which caused L.C. to experience profuse vaginal bleeding and a drop in her hemoglobin and hematocrit and subsequent hospitalization.

e. Respondent failed to complete a suction curettage on D.R. on or about December 30, 1986 which resulted in her hospitalization on or about January 4, 1987 and a D & C on or about January 5, 1987 wherein retained products of conception in the tissue was removed.

f. Respondent failed to provide appropriate post operative care to C.U. after discontinuing at C.U.'s request, the abortion he

was performing on her on or about January 8, 1985; which resulted in C.U.'s subsequent hospitalization and a D & C which reflected retained products of conception.

g. Respondent failed to complete the abortion performed on D.E. on or about January 8, 1983, which resulted in a subsequent hospitalization on January 9, 1983 for incomplete abortion and discovery of retained products of conception when a D & C was performed on January 10, 1983.

h. Respondent failed to provide proper post operative care to S.P. after advising her on or about August 15, 1983 that some products of conception might remain after the abortion he performed on her on that date. S.P. was hospitalized three days later where she passed portions of the product and other portions was removed during a D & C.

i. Respondent failed to provide proper post-operative care to B.M. after advising her on or about May 12, 1984 that some products of conception might remain after the attempted abortion, which was discontinued due to B.M.'s request, on the above date. On or about May 14, 1984, after passing a small fetus, B.M. was hospitalized. A D & C was performed and additional tissue removed.

j. Respondent failed to provide proper post operative care to D.B. after advising her on or about April 30, 1982 that some products of conception might remain after the attempted abortion which was discontinued because D.B. became violent on the above date. Respondent also failed to appropriately treat D.B. when x-rays reflectd a perforated bowel with peritonitis.

k. Respondent failed to timely advise M. Moore to return to his office for follow-up care after an incomplete abortion was performed on or about September 24, 1983, which resulted in M. Moore experiencing abdominal pain, nausea, and vomiting during the two week interval Respondent advised M. Moore to return.

l. Respondent failed to provide appropriate follow-up care to R.W. on whom he had performed an incomplete abortion on or about July 15, 1988. When her urinary pregnancy test was positive a follow-up examination, Respondent took no action other than to prescribe oral contraceptives. On or about August 20, 1988 R.W. was

hospitalized complaining of lower abdominal cramping and vaginal bleeding with expulsion of clots. A D & C was performed by another doctor and products of conception were removed.

m. Respondent failed to provide appropriate post operative care for M.F. when she developed complications on or about March 7, 1988 after an attempted abortion on or about March 5, 1988 was discontinued due to a vasomotor reaction. When medication prescribed by Respondent was not responsive, Respondent advised M.F. to contact her Ob/Gyn physician rather than provide additional treatment, including but not limited to an immediate D & C and removal of the products of conception.

n. Respondent failed to completely remove all products of conception from M. Mount when performing an abortion on her on or about June 16, 1988 and during subsequent follow-up visits, which resulted in M. Mount's hospitalization on or about July 26, 1988 with complaints of heavy vaginal bleeding and abdominal cramping and a D & C by another physician to remove the tissue found within the uterine cavity.

o. As relates to C.T., R.W., M. Mount, S.P., D.B., B.M., D.E., M. Moore, M.F., E.B., D.J., E.S., L.C., and/or D.R., Respondent failed to perform one or more of the following, or in the alternative to document the patients' medical records accordingly:

(1) Pre-operative and/or post-operative vital signs;

(2) Pre-operative lab studies, including but not limited to hemoglobin, hematocrit, and urinalysis;

(3) Anesthetic agent used in performing the procedures;

(4) Estimated blood loss;

(5) Provide medication post-operative;

(6) Reflect size of cannula used to perform the aspiration;

(7) Reflect type and amount of and rate and time of administration of liquid given in the IV's;

(8) Determine and/or document patients' RH factor;

(9) Reflect whether abortions were completed;

(10) Describe tissue removed; and

(11) Curettement to insure removal of all products of conception.

4. Respondent has sold his abortion clinics and has advised the Board he does not intend to perform abortions in the State of Texas.

5. Six health-care liability claims were filed against Respondent regarding inadequate health care rendered to C.U., M.M., D.E., S.P., B.M. and D.B., during the period 1983-1985. The specifics of each case is set out above.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over the Respondent and the subject matter.

2. The care rendered by Respondent did not meet the acceptable standard of care for abortions. Therefore Respondent violated Sections 3.08(18) of the Medical Practice Act which is defined as professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

3. The health-care liability claims filed against Respondent, which are the subject of this Order, are meritorious and evidence professional incompetence which injured the patients involved. Therefore, Respondent violated Section 3.08(20) of the Medical Practice Act which is defined as repeated or recurring meritorious health-care liability claims that in the opinion of the board evidence professional incompetence likely to injure the public.

4. Respondent is subject to discipline pursuant to Section 4.12 of the Medical Practice Act.

5. Pursuant to Section 4.04(b) of the Medical Practice Act the Board may dispose of this matter by stipulation, agreed settlement, or consent order.

ORDER

IT IS ORDERED, ADJUDGED AND DECREED that:

1. The Respondent's license to practice medicine in the State of Texas shall be suspended, suspension stayed, and placed on probation for a period of five years.

2. The Respondent shall refrain from performing abortions of any type.

3. The Respondent shall appear before the Board or a committee of the Board twice a year during each year of probation to report on the Respondent's compliance with this Order and the Medical Practice Act.

4. The Respondent shall give a copy of this Order to all Hospitals and Health Care Entities where he has privileges.

5. The Respondent shall cooperate with the Board, its attorneys, investigators, compliance officers, and other employees and agents, to verify that Respondent has complied and is in compliance with this Board Order.

6. The Respondent shall advise the Board of any change of address, mailing or office, within (10) days of such occurrence.

7. The time period during which the restrictions, limitations, or conditions are herein assessed shall not include any periods of time during which Respondent either resides or practices medicine outside the state of Texas. If Respondent leaves Texas to live or practice medicine elsewhere, the Respondent shall immediately notify the Board of the dates of the Respondent's departure from and subsequent return to Texas. Upon Respondent's return to Texas, the time period tolled by his departure shall continue until its expiration or termination by the Board.

8. The Respondent shall comply with all the provisions of Article 4495b, Texas Revised Civil Statutes Annotated, and other statutes regulating the practice of medicine, as is required by law for physicians licensed by the Board.

9. The Respondent shall not petition the Board for modification or termination of this Order for a period of at least one

year from the date of this Order. The grant or denial of any relief requested is discretionary with the Board. Such requests may be filed only once a year.

Any violation of the terms, conditions and requirements of this Order shall constitute conclusive evidence of unprofessional or dishonorable conduct that is likely to deceive, defraud, or injure the public within Section 3.08(4) of the Act, and may result in disciplinary action pursuant to Section 4.01(a) of the Act.

In regard to all terms and conditions of this Agreed Board Order, Respondent waives any further hearings or appeal to the Board or to any court regarding this Order and the terms thereunder. Nothing in this paragraph shall be deemed a waiver of Respondent's rights under rule, statute or the United States or Texas Constitutions to appeal any decision or action which may later be taken by the Board subsequent to this Order, except as the Respondent may have agreed herein. Respondent agrees that this Order is a final Order.

THIS ORDER IS A PUBLIC RECORD.

I, TOMMY ERNEST SWATE, M.D., HAVE READ AND UNDERSTAND THE FOREGOING AGREED BOARD ORDER. I UNDERSTAND THAT BY SIGNING, I WAIVE CERTAIN RIGHTS. I SIGN IT VOLUNTARILY. I UNDERSTAND THIS AGREED BOARD ORDER CONTAINS THE ENTIRE AGREEMENT AND THERE IS NO OTHER AGREEMENT OF ANY KIND, VERBAL, WRITTEN OR OTHERWISE.

DATED: Jn- 20, 1992

Tommy Ernest Swate, M.D.
Respondent

STATE OF TEXAS)(
)(
COUNTY OF Harris)(

BEFORE ME, this 20th day of January, 1992, personally appeared Tommy Ernest Swate, M.D. known to me, who, first, being duly sworn, signed the foregoing Agreed Board Order in my presence.

Notary Public, in and for the State of Texas

YOLANDA CAVAZOS
Notary Public
State of Texas
Comm. Expires 2-29-92

Yolanda Cavazos
Printed Name of Notary Public

2-29-92
My Commission Expires

SIGNED AND ENTERED this 24th day of January, 1992.

President, Texas State Board of Medical Examiners

(Bd.or.ll - 8.3/SF)