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KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
Victor Hildyard, II, M.D.	)	
	)	
Kansas License No. 04-15836	)	**Docket No. 05-HA-0005**
	)	

FINAL ORDER

NOW ON THIS Eighth Day of April 2006, this matter comes before the Board to review an Initial Order. Respondent Victor H. Hildyard, II, M.D. appears by telephone with Michael R. O'Neal of Gilliland and Hayes, P.A. Diane Bellquist, Litigation Counsel, and David W. Steed, Special Counsel, appear for Petitioner.

The Board hears arguments from counsel and recesses.

THEREUPON, the matter comes before the Board on the Tenth Day of June 2006. Having the agency record before it, the Board makes the following findings of fact, conclusions of law and order:

1. The Board's findings of fact are based exclusively upon the agency record in this matter. Numerous individuals from the community have contacted the agency to express their interest in the outcome of this case. The Board is able to determine the issues in this matter without being influenced by any communication outside of the agency record. No weight is given to the opinions expressed in those communications, and they are not made part of the agency record.

2. At the June 10 meeting, the Board sought to ask questions of Respondent. Through his counsel, Respondent declined to be sworn or to answer the Board's questions, arguing that the evidentiary record had closed. While such a rule would apply in civil actions, the Board finds no rule of law applicable to this proceeding that states the hearing record is closed after the presiding officer issues an initial order. As provided by K.S.A. 77-524(a), the Board is not bound by formal rules of evidence. Additionally, K.S.A. 77-526 states that the agency head, on review of an initial order, may exercise all of the decision-making authority as if it were hearing the matter in the first instance. The Board concludes that it lawfully may ask questions of a party during a review of an initial order. In the present case, no specific question was ever directed to Respondent. Even though the Board might potentially find that a respondent violates the healing arts act by failing or refusing to furnish the Board information that it lawfully seeks, as stated at K.S.A. 65-2836(r), the Board does not make such a finding in this case. The information

that the Board sought might either have mitigated or aggravated Respondent's conduct. Therefore, the Board makes no negative inference from Respondent's refusal to answer questions.

3. The amended petition alleges multiple instances of professional incompetency. K.S.A. 65-2837 states in part,

> "(a) "Professional incompetency" means:
> (1) One or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes gross negligence, as determined by the board.
> (2) Repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board.
> (3) A pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine."

The phrase "gross negligence" refers to willful or wanton conduct.

4. The Board concludes that the phrase "standard of care" refers to the duty to exercise the learning and skill possessed and exercised by prudent members of the profession. The Board concludes that the standard of care is consistent across the state except in those instances where resources are actually unavailable due to the urgency of an individual situation. PIK Civil 3d § 123.01, *Comment.* Respondent does not dispute this conclusion. (Tr. p. 3262.)

5. The term "negligence", as used in the statute and whether ordinary or gross, means the failure to adhere to the standard of care. Negligence is to be determined by the Board. The Board's inquiry is directed at the physician's conduct and professional practice rather than outcomes. The Board need not prove injury or damages. *Fieser v. Kansas State Board of Healing Arts*, 281 Kan. 268, 130 P. 3d 555 (2006).

6. The presiding officer used a "preponderance of the evidence" standard to determine whether the expert testimony had established a failure to practice within the standard of care. He found that all of the expert witnesses were credible. The Board does not make a finding that any of the expert witnesses lack credibility. However, the Board does make determinations of the standard of care in individual instances that differ from the findings of the Presiding Officer. In reaching those different findings, the Board concludes that it may make those findings without relying upon the preponderance of evidence standard. The preponderance of evidence refers to a quantum of evidence. A party who has the burden to prove a matter by a preponderance of the evidence must produce evidence of greater weight. *Ortega v. IBP*, 255 Kan. 513, 874 P. 2d 1188 (1994); *Hoyer v. Cannedy*, 4 Kan. App. 2d 228, 604 P. 2d 27 (1979). A presiding officer who does not possess any special expertise regarding the medical profession might require a party to prove deviations from the standard of care by a preponderance of evidence. The record does not disclose that Presiding Officer Gaschler possesses any special expertise regarding the medical profession, thus it was likely proper for him to

use that evidentiary standard. In comparison, the Board possesses that expertise, and is entitled and expected to rely upon that expertise in determining whether the record establishes practices below the standard of care. *Hart v. Kansas State Board of Healing Arts*, 27 Kan.App.2d 213, 2 P.3d 797, rev. denied 269 Kan. 932 (2000). The Board concludes that in light of the decision in *Hart*, it makes findings based upon the quality of evidence, as judged by the Board's expertise, rather than upon the quantity of evidence offered.

7. The Presiding Officer required a clear and convincing standard of proof. Evidence is clear if it is understandable and unambiguous, and convincing if it is reasonable and persuasive. The evidence upon which the Board makes its findings, as stated in this Final Order, is understandable, unambiguous, reasonable and persuasive, and thus is of a quality to satisfy the clear and convincing standard. In *Lacy v. Kansas Dental Board*, 274 Kan. 1031, 1037, 58 P. 3d 668 (2002), the Court held that the clear and convincing standard was not required in a disciplinary action to revoke a dentist's professional license. The Court only required the violations to be established by evidence that was substantial and competent. Thus, the Presiding Officer in the Initial Order, and the Board in this Final Order, makes findings based upon evidence that is of a greater quality than is minimally necessary.

Count I

Additional Finding of Fact regarding Count I:

8. Patient Number One of is a twenty-two year old female. This patient was in about the 38th week of pregnancy. She was admitted to Citizen's Medical Center hospital at 7:35 in the morning on October 26, 1998. The patient was in labor throughout the day. (Exhibit 1, p. HIL1350.) At 18:25, Respondent artificially ruptured the patient's membrane. Fetal heart tone decelerations were noted at about 18:34. (Exhibit 1, p. HIL1352.) Respondent noted at 18:37 that the umbilical cord was double- looped in the birth canal. (Exhibit 1, p. HIL1489-90.) Labor continued, with the patient giving at least two pushes, one at 18:41, and one at 18:47. (Exhibit 1, p. HIL1490, 1491.) The labor progress chart notes that the patient was too tired and unable to push. (Exhibit 1, p. HIL1352.) Anesthesia was initiated at 18:55, and the patient went to the operating room at 19:00 for an emergency cesarean section. (Exhibit 1, p. HIL1353, 1493.) The baby was delivered stillborn. (Exhibit 1, p. 1349.)

The Board adopts paragraphs one through four of the Initial Order regarding Count I, as follows:

9. Count One of the Board's Petition alleges that Respondent's care and treatment of a 21 year-old pregnant patient deviated from the applicable standard of care. (Initial Order, p. 8, ¶ 1.)

10. Specifically, the Petitioner alleges that Respondent failed to adhere to the applicable standard of care in that he encouraged Patient Number One to continue

pushing in an attempt to deliver the baby; that Respondent delayed the emergency C.-section by refusing to call another physician; and that Respondent failed to appropriately respond to the patient's and baby's condition. (Initial Order, p. 8, ¶ 2.)

11. The Board presented expert testimony from Dr. David Hanson, who is Board Certified by the American Board of Family Practice and the American Board of Medical Examiners. (Initial Order, p. 8, ¶ 3.)

12. Respondent presented testimony of Doctor Michael E. Machen, who practices in Quinter, Kansas and who is also Board Certified in Family Practice. (Initial Order, p. 9, ¶ 4.)

13. The Board does not adopt the findings in paragraphs five and six, or conclusions of law in paragraphs one through four of the Initial Order.

Additional findings of fact and conclusions of law regarding Count I:

14. Respondent testified that the baby's head was either engaged or nearly engaged when he ruptured the membrane. (Tr. p. 3355.) There is no dispute that the risk of a prolapsed cord increases if membranes are ruptured when the baby's head is not engaged. (Tr. p. 1809, 3355.) The term "engaged" means the baby's head is pressed against the pelvic structure.

15. The Board notes that progression of delivery is generally described within the obstetrical profession in terms of "station", among other methods. Zero station (0-STA)is where the presenting part of the baby is at the ischial spine within the pelvis. The ischial spine is the narrowest bone structure within the pelvis. Respondent testified that the baby was at zero station, but later moved down to plus one station (+1STA). (Tr. p. 3354-55.) A station of +1 means the baby has descended one centimeter past the ischial spine. The labor progress record does not document +1STA. The record shows the baby at zero station when the membrane was ruptured, and continued at that station. (Exhibit 1, p. HIL1350-1351.) Because the record shows the baby was at 0-STA, the Board finds that its head was engaged when the membrane was artificially ruptured, and does not suggest that Respondent caused the cord prolapse.

16. The Board finds that once the prolapsed cord is discovered, the standard of care requires that pushing must immediately cease, administration of Pitocin is terminated, the mother is given 100% oxygen, and the pressure that the baby's head is putting on the cord is relieved manually and through gravity. This finding is supported by the testimony of Dr. Hanson. (Tr. p. 1805.) A circumstance that justifies encouraging the mother to push when the cord is prolapsed is when the baby's head is crowning (i.e., visible) and the doctor is confident that the baby can deliver with one push. (Tr. p. 1807.)

17. Dr. Machen's testimony did not dispute that the standard of care generally requires an immediate cessation of pushing when the cord is prolapsed. He also stated that if the baby is high in the pelvis, a C-section is the only treatment, but that if the baby

is crowning or at plus two station the baby should be delivered. (Tr. p. 2276-77.) He was aware of no evidence that the baby was crowning at the time Respondent directed the patient to push. (Tr. p. 2277.) There is no evidence in the record that the baby ever reached +2 station. Dr. Machen did state his belief that the patient should have been able to deliver the baby with two pushes since she had two prior deliveries. (Tr. p. 2280.) Given that the baby's fetal heart tones already showed decelerations, and that the pushes were a few minutes apart, the Board does not agree that the prior deliveries justified deviating from the standard of care.

18. The Board finds that Respondent failed to adhere to the applicable standard of care by directing or encouraging Patient Number One to continue pushing more than one time after discovery of the prolapsed cord. This deviation from the standard of care might have been mitigated had a surgical team for a C-section delivery been in place and ready to begin while the patient pushed. However, the surgical team was not in place, and would not be in place for several minutes.

Count II

19. The Board adopts by reference the findings of fact as stated in the Initial Order regarding Count II.

20. The Board finds and concludes that the facts do not establish professional incompetence as defined at K.S.A. 65-2837(a) with regard to Patient Number Two.

Count III

The Board adopts paragraphs one through six of the Initial Order regarding Count III, as follows:

21. Count III of the Board's petition deals with Respondent's care and treatment of Patient Number Three, a thirty-three year-old pregnant female. (Initial Order, p. 8, ¶ 1.)

22. Patient Number Three was in an automobile accident on July 11, 2002, and thereafter presented to the Citizen's Medical Center in Colby. Following a vaginal exam and some monitoring of fetal heart tones by Respondent, the patient was discharged. (Initial Order, p. 8, ¶ 2.)

23. On July 28, 2002, the patient, who was an employee of Citizen's Medical Center, had complaints of bleeding and pain while at work. (Initial Order, p. 8, ¶ 3.)

24. Following an examination by Respondent, the patient was discharged from Citizen's Medical Center with instructions to go to Hays, Kansas. The patient was transported to Hays, Kansas by private vehicle. Soon upon the patient's arrival at Hays, she was admitted to the hospital and a cesarean section was performed. Marginal abruption was found at the time of the C-Section. (Initial Order, p. 8, ¶ 4.)

25. The Board alleges that Respondent failed to adhere to the applicable standard of care in that he failed to adequately evaluate the patient following the motor vehicle accident; failed to adequately evaluate the patient for potential placenta abruption; and allow the patient to be transported from Colby to Hays by private car. (Initial Order, p. 8, ¶ 5.)

26. In this case, Dr. Hanson provided his expert opinion that the Respondent did not meet the applicable standard of care in the care of Patient Number Three. Conversely, Doctor Machen provided his expert opinion that the Respondent met the applicable standard of care in his treatment of Patient Number Three. (Initial Order, p. 8, ¶ 6.)

27. The Board does not adopt the conclusions of law stated in the Initial Order regarding Count III.

Additional findings of fact and conclusions of law regarding Count III:

28. Based upon its own knowledge, the Board describes placental abruption as the premature separation of the placenta from the location of the uterine wall at which it is implanted. A marginal abruption is separation involving the placental rim. Abruption may be caused by several factors, including trauma. A history of prior abruption is a common predisposing factor, though future abruption is not a certainty.

29. Patient Number Three was not wearing a restraint when she had the accident on July 11. The EMS report describes the patient's condition at the scene of the accident. The patient described abdomen pain at seven on a scale of one to ten, with ten being the worst, and intermittent contractions. She was transported to the hospital by ambulance. (Exhibit 3, p. HIL2063) Patient Number Three arrived at the hospital emergency room at 12:10 p.m. (Exhibit 3, p. HIL2065.) Respondent examined the patient.

30. The emergency nursing record for Patent Number Three notes the chief complaint as low pelvic pain, no contractions, no vaginal bleeding, and records a past history of an abrupted placenta. (Exhibit 3, p. 2066.)

31. Respondent discharged Patient Number Three at 1:10 p.m. (Exhibit 3, p. 2069, 2079.)

32. The standard of care applicable to Patient Number Three's care following the accident is fetal monitoring for at least four hours. (Tr. p. 1832; Exhibit 116, p. HIL0009.) Patient Number Three was discharged one hour after she arrived at the emergency room. During that time, fetal monitoring lasted 40 minutes. (Tr. p. 1832-33.)

33. The Board finds that Respondent deviated from the standard of care with regard to Patient Number Three by failing to monitor the fetus for a minimum of four hours. The agency record does not establish that the motor vehicle accident caused a

placental abruption, or that Patient Number Three was actually injured as a result of Respondent's failure to adhere to the standard of care.

34. Patient Number Three returned to the emergency room on July 28, 2002 at 4:45 p.m. She was then 38 weeks pregnant, and was experiencing bleeding. (Exhibit 3, p. HIL2085-85.) A nurse documented a vaginal assessment. At some point following that assessment, the patient stood up and passed two clots and had a gush of bright red blood. (Exhibit 3, p. HIL2090; Exhibit 3h, p. HIL2058.) Respondent does not dispute that he knew at the time that the patient had passed two clots, and that as a result the patient had blood on her leg and on her shoe. (Tr. p. 3395.)

35. Respondent considered that the patient might have a partial abruption. He obtained an obstetrical consultation, and it was agreed that the patient should have an ultrasound and possible surgery. (Exhibit 3, p. HIL2086.) Those services were not available at the time at Citizen's Medical Center.

36. Patient Number Three was transported to Hays, Kansas by her private vehicle. As previously noted, Patient Number Three then had a cesarean section with a good outcome, and a marginal abruption was discovered.

37. The Board finds that the standard of care when the patient is in labor and potentially has an abrupted placenta with serious, perhaps fatal, vaginal bleeding is to transport by emergency medical services. (Tr. p. 1839-40.)

38. The Board further finds that if a patient refuses to follow the physician's recommendation, the physician has an obligation to advise the patient of the risks, and to document the patient decision in the patient record. (Tr. p. 1840.)

39. Patient Number Three signed a statement that Respondent did not offer an ambulance (Exhibit 3h, p. HIL2058), and the record does not disclose any documentation by Respondent that the patient had refused such transportation. The Board finds that Respondent failed to practice within the standard of care by failing to recommend transportation by ambulance under the circumstances.

Count IV

40. The Board adopts by reference the findings of fact regarding Count IV as stated in the Initial Order.

41. The Board does not adopt the conclusions of law stated in the Initial Order regarding Count IV, as causation and injury are not relevant in determining whether a licensee has practiced below the standard of care. K.S.A. 65-2837(a), *Fieser v. Kansas State Board of Healing Arts*, 281 Kan. 268, 130 P. 3d 555 (2006).

42. The Board finds that the facts do not establish practice below the standard of care with regard to Patient Number Four.

Count V

43. The Board adopts by reference the findings of fact regarding Count V as stated in the Initial Order.

44. The Board finds that the facts do not establish a violation of the healing arts act with regard to Patient Number Five.

Count VI

45. The Board adopts by reference the findings of fact regarding Count VI as stated in the Initial Order.

46. The Board finds that the facts do not establish practice below the standard of care with regard to Patient Number Six.

Count VII

47. The Board adopts by reference the findings of fact regarding Count VII as stated in the Initial Order.

48. The Board finds that the facts do not establish practice below the standard of care with regard to Patient Number Seven.

Count VIII

49. Count VIII of the Amended Petition alleged that Respondent engaged in unprofessional conduct by signing blank progress notes in hospital charts for midlevel practitioners to complete. The Initial Order finds that this occurred on three occasions, and that Respondent did not deny the allegation. Respondent does not seek review of the findings. The Board deems the findings to be undisputed. The Board adopts the finding of fact and the conclusion that this constitutes unprofessional and dishonorable conduct and professional incompetency, and constitutes grounds for disciplinary action as provided by K.S.A. 65-2836(b).

Count IX

50. The Board adopts by reference the Presiding Officer's findings of fact and conclusions of law regarding Count IX, and as Respondent's behavior regarding Patient Number Eight was dishonorable and unprofessional, the Board further concludes that the conduct is grounds for disciplinary action under K.S.A. 65-2836(b).

Count X

51. The Board adopts by reference the findings of fact as stated in the Initial Order regarding Count X.

52. The Board finds that the facts do not establish a willful violation of the healing arts act with regard to Count X.

Count XI

53. The Board adopts the Presiding Officer's findings of fact as stated in the Initial Order regarding Count XI.

54. The Board finds that, as a whole and in light of his response to the petition for review, Respondent does not dispute and does not challenge the Presiding Officer's findings that he used vulgar and inappropriate language, inappropriate sexual gestures, inappropriate touching, sudden and unpredictable outbursts of anger, and abusive and profane language in front of subordinates and patients, on multiple occasions.

55. As a policy matter, the Board determines that this disruptive behavior adversely impacts patient care by affecting other health-care providers, including subordinate staff, their ability to effectively communicate with physicians, and patient's confidence in the health delivery system. The Board further observes that disruptive behavior might be the result of a mental or physical impairment, or might simply be bad conduct. Disruptive behavior resulting from the impairment might be remedied through evaluation and treatment, and the impairment might be a mitigating factor. Respondent did not cooperate in efforts by the board to determine the cause of his disruptive behavior. As a result, the Board is left with the finding that Respondent's conduct was simply unmitigated disruptive, unprofessional, and dishonorable behavior, and is grounds for disciplinary action under K.S.A. 65-2836(b).

Count XII

56. The Board adopts the Presiding Officer's finding of fact number one regarding Count XII. In Count XII, the Board alleged that the Respondent's practice privileges were revoked by Citizen's Medical Center in Colby because the behavior of the Respondent contributed to a hostile work environment and as a result of this finding the Respondent is subject to discipline by the board.

57. The Board bases its decision to revoke Respondent's license upon the violations described in other counts of the petition. The board does not base its decision to revoke Respondent's license upon the violation alleged in Count XII. As a result, the Board does not adopt findings of fact numbers 2 through 8, or conclusions of law numbers 1 through 10, or conclusion of law number 4 located on page 26 of the Initial Order.

Count XIII-XIX

The Board adopts the presiding officer's findings, numbered 1 through 14 and 19 of the Initial Order, but does not adopt findings of fact number 15 through 18, pages 23 and 24, regarding counts XIII through XIX as follows:

58. Count 13 of the Board's petition involves the treatment of Patient Number Twelve. Patient Number Twelve was 73 years old and suffered from asthmatic bronchitis, chronic obstructive pulmonary disease, enlarged prostate, peripheral edema, hypertension, gout, diabetes, and degenerative arthritis. (Initial Order, p. 23, ¶ 1.)

59. From 2000 to 2002, the Respondent administered approximately 43 intramuscular injections of corticosteroids to Patient Number Twelve. (Initial Order, p. 23, ¶ 2.)

60. Count 14 of the Board's petition involves the treatment of Patient Number Thirteen. Patient Number Thirteen was a 62-year-old and was being treated for cervical disease, osteoarthritis of the spine, heart disease, gastritis, colitis, and neurological damage as a result of a stroke. (Initial Order, p. 23, ¶ 3.)

61. From 2000 to 2001, Patient Number Thirteen received approximately 38 intramuscular injections of corticosteroids under the direction of the Respondent. (Initial Order, p. 23, ¶ 4.)

62. Count 15 of the Board's petition involves the treatment of Patient Number Fourteen. Patient Number Fourteen was 80 years old with a history of dermatitis, sinusitis, bronchitis, fatigue, pneumonia, hypertension, osteoarthritis, heart disease, breast cancer, and chronic obstructive pulmonary disease. (Initial Order, p. 23, ¶ 5.)

63. Between 2000 and 2004, Patient Number Fourteen received approximately 30 intramuscular injections of corticosteroids under the respondent's direction. (Initial Order, p. 23, ¶ 6.)

64. Count 16 of the Board's petition involves the treatment of Patient Number Fifteen. Patient Number Fifteen was 55 years old and suffered from mental retardation, cerebral palsy, diverticulosis, hypertension, osteoarthritis, and degenerative back pain, esophagitis, gastritis, cirrhosis, and congestive heart failure. (Initial Order, p. 23, ¶ 7.)

65. 33 injectable corticosteroids were administered to Patient Number 15 by the respondent between 2000 and 2004. (Initial Order, p. 23-24, ¶ 8.)

66. Count 17 of the Board's petition involves the treatment of Patient Number Sixteen. Patient Number Sixteen was a 77 year-old patient who suffered from hypertension, osteoarthritis, diverticulosis, reflux, malabsorbtion, atrial fibrillation, heart disease, hyperlipidemia, and anemia. Patient Number Sixteen also had a history of intestinal bleeding. (Initial Order, p. 24, ¶9.)

67. Patient Number Sixteen received 42 intramuscular injections of corticosteroids between 2000 and 2004. (Initial Order, p. 24, ¶ 10.)

68. Count 18 of the Board's petition involves the treatment of Patient Number 17. Patient Number 17 had a history of chronic lung disease, osteoporosis, and osteoarthritis, depression and various functional gastrointestinal difficulties. (Initial Order, p. 24, ¶ 11.)

69. This 72-year-old patient received approximately 44 intramuscular injections of corticosteroids between 2000 and 2003. Patient Number Seventeen also received narcotic injections from the respondent. (Initial Order, p. 24, ¶ 12.)

70. Count Number 19 of the Board's petition involves the treatment of Patient Number Eighteen. Patient Number Eighteen had asthma, diabetes, obesity, degenerative lumbar disc disease, gastroesophagus reflux disease, irritable bowel syndrome, hyperlipidemia, hyperthyroidism, and retardation. (Initial Order, p. 24, ¶ 13.)

71. Patient Number 18 was 42 years of age and between 2000 and 2004, received approximately 86 intramuscular steroid injections at the direction of the Respondent. (Initial Order, p. 24, ¶ 14.)

72. In the Initial Order, the Presiding Officer noted in finding of fact number 19 that Respondent's expert acknowledged there are side effects and potential harm with injectable corticosteroids. (Initial Order, p. 24-25, ¶ 19.)

Additional findings regarding Counts XIII through XIX:

73. Steroids are natural hormones produced by the adrenal glands. Steroids are used to reduce inflammation. Corticosteroids are a class of steroids.

74. Side effects of steroids include GI bleeding, weakening of bones, cataracts, thinning of skin, and suppression of natural immune systems. This suppression of immunity makes the patient more susceptible to infection. (Tr. p. 1069-70.)

75. The GI bleeding from steroid use is not caused by the effect of the ingested pill in the stomach, but rather is caused by the steroids effect on the stomach's protective system. Thus, intolerance of oral steroids because of GI bleeding is not avoided by use of injectable steroids. (Tr. p. 1082.)

76. Steroids also have a euphoric component. A side effect is steroid dependence. (Tr. p. 1068, 3148.)

77. There is minimal medical literature regarding indications for and quantity of utilization of corticosteroids. (Tr. p. 3132.) Likewise, there is minimal literature regarding the indications for oral versus injectable corticosteroids. (Tr. p. 1066.)

78. Steroids that are injected become effective faster than when taken orally, and are used in acute settings rather than long-term care. (Tr. p. 1066.) Injectable steroids are absorbed into the system in a relatively unpredictable manner. The benefit from the drug when injected will be highest soon after used, and will decline on a daily basis as the drug is metabolized. Oral steroids are more predictably metabolized and thus are easier to adjust so that the patient receives only the amount needed. (Tr. p. 1074-75.)

79. Respondent prescribes or administers injectable corticosteroids that exceed the indications in the drug's package insert. His testimony suggests that this off-label use is supported by anecdotal experience but not by medical literature. (Tr. p. 3134.)

80. As a policy matter, the Board believes that physicians are not bound by a drug's package insert approved by the Food and Drug Administration. A physician does not automatically practice below the standard of care merely by prescribing a drug off-label if the medical literature supports such off-label use. Where the support in medical literature is lacking or limited, off-label use is deemed experimental, requiring adherence to strict standards for engaging in clinical research. In the present case, Respondent does not claim that he engaged in clinical research with these patients. The lack of medical literature to support Respondent's extreme use of injectable steroids, and the lack of institutional controls over this use, results in the Board's finding that Respondent did not exercise the skill prudent members of the profession would ordinarily possess and exercise.

81. The 43 injections that Patient Number 12 received in the three-year period of 2000 to 2002 were not regularly spaced. Nine injections were given in the year 2000, seven in 2001, and 27 in 2002. (Tr. p. 1076.) The Board finds that the standard of care does not limit a practitioner to a specific number of injections in a year. A prudent practitioner should use a guideline of one injection about every three months, though there are exceptions that might result in exceeding that on occasion. (Tr. p. 1077-78.) Respondent's expert, Dr. Machen, stated that the generally accepted practice is to give no more than four to six injections per year. (Tr. p. 2242-43.) Additionally, a prudent practitioner should attempt to manage a patient with long-term oral steroids. In the case of Patient Number 12, the Board is less critical of the injections given in the years 2000 and 2001. However, the Board finds that Respondent practiced below the standard of care in the year 2002 by administering 27 injections of steroids over a one-year period without attempting to manage the disease through the long-term use of oral steroids. Of those 27, four injections were given in an eight-day period. (Exhibit 1E, p. 149-151.)

82. Further, the Board finds that Respondent practiced below the standard of care when he failed to adequately document the side effects Patient Number 12 experienced with oral steroids, which lead to the use of steroid injections. Respondent noted on April 13, 2000 that the patient was intolerant of oral steroids. However, this intolerance was simply described as the patient's GI discomfort the last time they were taken. (Exhibit 1E, p. 135.) The conclusion that the discomfort rises to the level of

intolerance is contradicted by the fact that Respondent ordered a prednisone burst, an oral steroid, on January 10, 2002. The Board does note that Respondent then documented on January 24, 2002 that the patient experienced nervousness when taking the oral prednisone, but that symptom was not known or documented to exist on April 13, 2000, the date that Respondent noted the patient's intolerance to oral steroids. (Exhibit Exhibit 1E, p. 149.) The Board's finding is supported by the testimony of Dr. Simpson, when he stated his opinion that Respondent inadequately documented the necessity for intramuscular rather than oral administration of steroids. (Tr. p. 1081-1082.)

83. Patient Number 13 received 27 injections over a one-year period. The Board finds that these injections were not indicated. The injections were administered in the deltoid muscle for osteoarthritis. (Exhibit 13, p. 643-47.) Intramuscular injections of systematic steroids have no value for the diseases of the joint that Respondent was treating. Rather, the steroids must be placed in an intra-articular manner at the site of the inflammation. (Tr. p. 1084-85.)

84. Respondent did not appropriately manage the steroid use of Patient Number 13. Respondent documented a discussion with the patient on September 25, 2000 regarding the potential complications of continued steroid use. He notes the patient's belief of being bound to a wheelchair without the drugs. (Exhibit 13, p. 649.) The risks are again discussed during a patient encounter on October 23 of that year, on January 15, 2001, and on February 12, 2001. (Exhibit 13, p. 650.) Throughout the period of September 25, 2000 and July 16, 2001, the patient received 20 injections. Respondent did document that he would try to limit the injections to once every three weeks. (Exhibit 13, p. 649-55.) On July 16, 2001, the patient informed Respondent that the injections were not helping. (Exhibit 13, p. 655.) Respondent then discontinued the steroids for Patient Number 13. Discontinuing steroids without gradually reducing the dose places the patient at risk for complications. There is no evidence in the patient record that Respondent tapered off the injections. (Tr. p. 1086-1087.)

85. The Board finds that Respondent practiced below the standard of care with regard to Patient Number 13.

86. Respondent managed allergies of Patient Number 14 using injected steroids. The patient record indicates that, at times, this patient also received bursts of oral steroids. (Tr. p. 1092-93.) While the number of injections given to this patient is not as extreme as with the previous two patients, this patient's tolerance of oral steroids indicates that the injections were not indicated. Other methods that were not used to manage the allergies should have been pursued. (Tr. p. 1096-97.) The Board finds that Respondent practiced below the standard of care with regard to Patient Number 14.

87. Respondent provided IM steroids to Patient Number 15 for low back pain. The number of injections was not extraordinarily high. However, the steroids were not indicated for this patient's ailments. (Tr. p. 1100.) IM steroids have not proven to be effective for the conditions being treated. (Tr. p. 1103-04.) Dr. Machen did testify that the IM steroid serendipitously reduced pain associated with abdominal varicosities, and

that he did not know why that happened. He did not address the concern that this drug was not indicated. (Tr. p. 2205.) The Board finds that Respondent practiced below the standard of care with regard to Patient Number 15.

88. Respondent provided IM steroids to Patient Number 16 to treat numbness, generalized arthritis, irritable bowel syndrome and diverticulosis. (Tr. p. 1106.) These are not indications for using IM steroids. (Tr. p. 1106.) Additionally, the drugs were given in excessive numbers. (Tr. p. 1106-7.) Respondent did discontinue the drugs because of the side effects. (Tr. p. 2210-11.) As Dr. Machen testified, this might indicate Respondent's recognition of when to discontinue giving the drugs (Tr. p. 2211). However, it does not mitigate the finding that Respondent practiced below the standard of care by giving the drug for a non-indicated purpose in the first place. The Board finds that Respondent practiced below the standard of care with regard to Patient Number 16.

89. Patient Number 17 received 43 shots of injectable steroids in a three-year period. Additionally, this patient received several bursts of oral steroids. (Tr. p. 1113.) Dr. Machen based his opinion upon the patient's intolerance to oral steroids. (Tr. p. 2201.) There was little or no documentation that the patient was intolerant of oral steroids. (Tr. p. 1113-14.) Respondent did note on the July 1, 2002 visit that the patient was given IM Depo-Medrol, and that she is unable to tolerate the oral equivalent but without a description of her reaction to the oral drug. (Ex. 17, p. 2787.) A review of the patient record does not disclose when she was given an oral equivalent, or that she reported any ill effects. For example, she received an IM injection, along with an oral steroid on February 14, 2001. She returned to the office on February 22, but there is no note of intolerance to the oral prednisone, only a note that she was to continue the medical regimen. (Ex. 17, p. 2766-67.) The patient returned to the office several times prior to April 2, 2001, at which time she again received the Depo-Medrol and oral prednisone. (Ex. 17, p. 2768.) Respondent's reference to intolerance of oral steroids is in conflict with the fact that Respondent did give the patient oral steroids on occasion, and in the absence of evidence to the contrary, the patient tolerated oral steroids. The Board finds that Respondent practiced below the standard of care with regard to Patient Number 17.

90. Patient Number 18 received an extraordinarily high number of IM injections of steroids. She received 11 in the year 2000, 12 in 2001, 28 in 2002, 22 in 2003, and 13 in 2004. Some of these shots were given for neck pain, sore throat, and low back pain. (Tr. p. 1122.) The drug is not indicated for those conditions. The Board finds that Respondent practiced below the standard of care with regard to Patient Number 18. Additionally, the Board notes that the drug brings on or exacerbates diabetes. This patient had a diagnosis of diabetes. Exacerbating that disease to treat other ailments for which the drug is not indicated aggravates the substandard practice.

Additional Findings of Fact and Conclusions of Law

91. The Board finds as fact that Respondent practiced below the standard of care to a degree constituting ordinary negligence on multiple occasions involving

different professional services, and on repeated instances involving multiple patients. The Board concludes that the multiple and repeated failures to adhere to the standard of care constitute professional incompetency, as that term is defined at K.S.A. 65-2837(a). The Board is authorized to revoke, suspend, or limit a license, or censure or fine a licensee, upon the ground of professional incompetency. K.S.A. 65-2836(b).

92. The Board finds that Respondent failed to keep patient records accurately by pre-signing progress notes for completion by others. Respondent does not dispute this. The Board concludes Respondent engaged in unprofessional conduct, as defined at K.S.A. 65-2837(b)(25).

93. The Board finds as fact that Respondent used derogatory, insulting, and vulgar language with regard to a patient and with regard to other staff. As a policy matter, this conduct casts disrepute on the profession both in the eyes of the public and other professionals, and predictably results in failures in communication. Failures in communication inhibit the reporting of medical observations by nursing and other professional staff, and this directly impacts patient welfare. The Board concludes that Respondent engaged in dishonorable conduct. The Board is authorized to revoke, suspend, or limit a license, or censure or fine a licensee, upon the ground of dishonorable conduct. K.S.A. 65-2836(b).

94. As a policy matter, the Board concludes that a practitioner who is found to be professionally incompetent is a danger to the public heath and safety. In *Kansas State Board of Healing Arts v. Foote*, 200 Kan. 447, 454, 438 P. 2d 828 (1968), the Court held that no conduct or practice could be more devastating to the public health and welfare than professional incompetence. Respondent's professional incompetence is aggravated by his unprofessional conduct and his dishonorable conduct. The Board finds and concludes that Respondent's license should be revoked.

<u>Petitioner's Statement of Costs</u>

95. K.S.A. 65-2846 provides that any assessment of costs shall be included in the Board's final order. Subsection (a) states that if the Board's order is adverse to the licensee, the costs incurred by the board in conducting the proceeding may be assessed in such proportion as the Board may determine. In making any assessment, the Board shall consider the nature of the proceeding and the level of the parties' participation. The Board concludes that the statute does not specify the amount of weight to be given to any particular factor. The Board interprets the statute to direct the board to weigh the relative success on the merits of either party on multiple counts. The Board also interprets the statute to determine whether it was required to expend funds unnecessarily in order to resolve the matter.

96. The Board finds that Respondent actively participated in the proceeding. The factual disputes by the parties appear to have had at least some evidentiary support, even in those instances where the evidence was not persuasive. Both parties prevailed on some of the issues raised by the Petition.

97. The Board finds and concludes that the parties should bear their own costs.

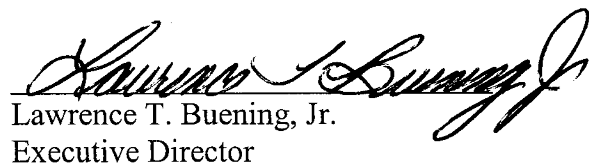
IT IS, THEREFORE, ORDERED that the license of Victor H. Hildyard, II, M.D. is revoked.

IT IS FURTHER ORDERED that the parties shall bear their own costs.

PLEASE TAKE NOTICE that this is a final order. A final order is effective upon service. A party to an agency proceeding may seek judicial review of a final order by filing a petition in the District Court as authorized by K.S.A. 77-601, et seq. Reconsideration of a final order is not a prerequisite to judicial review. A petition for judicial review is not timely unless filed within 30 days following service of the final order. A copy of any petition for judicial review must be served upon the Board's Executive Director at 235 SW. Topeka Blvd., Topeka, KS 66603.

Dated this 14th day of August, 2006.

Kansas State Board of Healing Arts



Lawrence T. Buening, Jr.
Executive Director

Certificate of Service

I certify that a true copy of the foregoing Final Order was served this 14th day of August, 2006, by depositing the same in the United States Mail, first-class postage prepaid, and addressed to:

Victor Hildyard, II, M.D.
175 S Range
Colby, KS 67701

and

Michael O'Neal
Gilliland & Hayes, P.A.
P.O. Box 2977
Hutchinson, KS 67504

And a copy was hand-delivered to the office of

Diane Bellquist
David W. Steed
Kansas State Board of Healing Arts
235 S. Topeka Blvd.
Topeka, KS 66603