State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

September 8, 2010

Douglas A. Bruns, D.O.
44 W. Lakeside Avenue
Lakeside Park, KY 41017

RE: Case No. 09-CRF-166

Dear Doctor Bruns:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Gretchen L. Petrucci, Esq., Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on September 8, 2010, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal must be commenced by the filing of a Notice of Appeal with the State Medical Board and the Franklin County Court of Common Pleas. The Notice of Appeal must set forth the Order appealed from and state that the State Medical Board's Order is not supported by reliable, probative, and substantive evidence and is not in accordance with law. The Notice of Appeal may, but is not required to, set forth the specific grounds of the appeal. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

Lance A. Talmage MD

Lance A. Talmage, M.D. RW
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3936 3072 2033
RETURN RECEIPT REQUESTED

Cc: Eric J. Plinke , Esq.
CERTIFIED MAIL NO. 91 7108 2133 3936 3072 2040
RETURN RECEIPT REQUESTED

Mailed 10-5-10

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Gretchen L. Petrucci, Esq., State Medical Board Attorney Hearing Examiner; and excerpt of the Minutes of the State Medical Board, meeting in regular session on September 8, 2010, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Douglas A. Bruns, D.O., Case No. 09-CRF-166, as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.

Lance A. Talmage MD

Lance A. Talmage, M.D. RW
Secretary

(SEAL)

September 8, 2010
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	*	
	*	CASE NO. 09-CRF-166
DOUGLAS A. BRUNS, D.O.	*	

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on September 8, 2010.

Upon the Report and Recommendation of Gretchen L. Petrucci, Esq., State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the modification, approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED that:

A. **SUSPENSION OF CERTIFICATE, STAYED; PROBATION**: The certificate of Douglas A. Bruns, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of at least 180 days. Such suspension is STAYED, subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least two years:

1. **Obey the Law**: Dr. Bruns shall obey all federal, state, and local laws, and all rules governing the practice of osteopathic medicine and surgery in the state in which he is practicing.

2. **Declarations of Compliance**: Dr. Bruns shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which this Order becomes effective. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances**: Dr. Bruns shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which this Order becomes effective, or as otherwise directed by the Board. Dr. Bruns shall also appear in person upon his request for termination of the probationary period, and/or as otherwise directed by the Board.

4. **Patient Safety System Course(s)**: Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Bruns shall submit acceptable documentation of successful completion of a course or courses dealing with patient safety systems, such as Crew Resource Management. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

   In addition, at the time Dr. Bruns submits the documentation of successful completion of the course(s) dealing with the patient safety systems, such as Crew Resource Management, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

5. **Monitoring Physician**: Prior to the commencement of practice in Ohio, or as otherwise determined by the Board, Dr. Bruns shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Bruns and who is engaged in the same or similar practice specialty.

   The monitoring physician shall monitor Dr. Bruns and his medical practice, and shall review Dr. Bruns' patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

   Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Bruns and his medical practice, and on the review of Dr. Bruns' patient charts. Dr. Bruns shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Bruns' declarations of compliance.

   In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Bruns shall immediately so notify the Board in writing. In addition, Dr. Bruns shall make arrangements acceptable to the Board for another monitoring physician within 30 days

after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Bruns shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Bruns' monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Bruns' monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

6. **Required Reporting of Change of Address**: Dr. Bruns shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

7. **Tolling of Probationary Period While Out of Compliance**: In the event Dr. Bruns is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

B. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Bruns' certificate will be fully restored.

C. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Bruns shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training, and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Bruns shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments.

In the event that Dr. Bruns provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, he shall provide a copy of this Order

to the Ohio Department of Public Safety, Division of Emergency Medical Services.

This requirement shall continue until Dr. Bruns receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other State Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Bruns shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any professional license or certificate. Also, Dr. Bruns shall provide a copy of this Order at the time of application to the proper licensing authority of any state or jurisdiction in which he applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. Bruns receives from the Board written notification of the successful completion of his probation.

3. **Required Documentation of the Reporting Required by Paragraph C**: Dr. Bruns shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (a) the return receipt of certified mail within 30 days of receiving that return receipt, (b) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order was hand delivered, (c) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (d) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

Lance A. Talmage, M.D.
Secretary

(SEAL)

September 8, 2010
Date

STATE MEDICAL BOARD
OF OHIO

2010 JUL 30 AM 10: 51

BEFORE THE STATE MEDICAL BOARD OF OHIO

In the Matter of	*	
		Case No. 09-CRF-166
Douglas A. Bruns, D.O.,	*	
		Hearing Examiner Petrucci
Respondent.	*	

REPORT AND RECOMMENDATION

Basis for Hearing

By letter dated December 9, 2009, the State Medical Board of Ohio [Board] notified Douglas A. Bruns, D.O., that it intended to determine whether to take disciplinary action against his certificate to practice osteopathic medicine and surgery in Ohio. The Board based its proposed action on an allegation that, while performing a lumbar myelogram in October 2004, Dr. Bruns had injected a contrast intrathecally that had not been approved for intrathecal injection. Further, the Board stated that Dr. Bruns' acts, conduct, and/or omissions constitute:

- A "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as set forth in Section 4731.22(B)(2), Ohio Revised Code; and/or

- "A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as set forth in Section 4731.22(B)(6), Ohio Revised Code.

Accordingly, the Board advised Dr. Bruns of his right to request a hearing in this matter. (State's Exhibit [St. Ex.] 1A) On January 5, 2010, Dr. Bruns requested a hearing. (St. Ex. 1B)

Appearances at the Hearing

Richard Cordray, Attorney General, by Melinda Ryans Snyder, Assistant Attorney General, on behalf of the State of Ohio. Eric J. Plinke, Esq., on behalf of Dr. Bruns.

Hearing Dates: June 14 and 16, 2010

SUMMARY OF THE EVIDENCE

All exhibits and the transcript, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

Background

1. Douglas A. Bruns, D.O., earned his medical degree in 1994 from the Ohio University College of Osteopathic Medicine. Between 1994 and 1999, he completed a one-year general internship at Grandview Hospital in Dayton, Ohio, and he completed a four-year diagnostic radiology residency at Doctors Hospital in Columbus, Ohio. Next, Dr. Bruns completed a one-year fellowship in neuroradiology at the Ohio State University Medical Center. (Respondent's Exhibit [Resp. Ex.] A; Hearing Transcript [Tr.] at 171-172; St. Ex. 3 at 10, 12, 27)

2. Between 2000 and 2004, Dr. Bruns worked at two hospitals within the Mercy Hospital system in the Cincinnati, Ohio, area through two private radiology practice groups. From April 2004 to mid-2007, he worked primarily at Bethesda North Hospital in Montgomery, Ohio, while employed at Northeast Radiology Incorporated. Since mid-2007, Dr. Bruns has worked exclusively at Margaret Mary Community Hospital in Batesville, Indiana, while employed at Insight Radiology [Insight].[1] Dr. Bruns testified that he practices general radiology, and performs plain film imaging, MRIs, CT imaging, biopsies and myelograms. (Tr. at 14-16, 18, 189; St. Ex. 3 at 12, 13, 18-28)

3. Dr. Bruns holds active medical licenses in Indiana and Ohio. Dr. Bruns became board-certified in radiology in 2000. (Resp. Ex. A; Tr. at 14-15; St. Ex. 3 at 12-13)

The Lumbar Myelogram Procedure

4. A lumbar myelogram is an outpatient, diagnostic test to visualize the condition of the lower back's nerve roots in the spine. A contrast, or dye, is injected into the thecal sac surrounding the nerve roots and the spinal cord. Dr. Bruns explained that the contrast used for a myelogram is Isovue, which is a non-ionic dye approved for intrathecal administration. Real-time x-ray equipment, a fluoroscope, is used to view the lower back. Dr. Bruns noted that, with myelography, the physician varies the position of the patient and physically sees how the nerve roots are impinged. The myelogram procedure typically lasts 10 to 30 minutes, and is followed by a four-hour observation period. (St. Ex. 3 at 30-31, 33, 57, 64, 68; Tr. at 19-23, 35)

5. Dr. Bruns explained that, typically, there is an assistant, called a technologist, present during the myelogram procedure. The technologist is responsible for assembling all of the necessary materials before the procedure, and for giving any non-sterile materials to the physician during the procedure. (Tr. at 23-24)

6. Isovue is used for myelograms, but other contrasts are used for other fluoroscopic procedures. Conray, an ionic contrast, is used for arthograms, which evaluate the joints (i.e., shoulder, knee, or hip). Dr. Bruns testified that the Conray label includes a warning indicating that Conray is not for intrathecal use. Dr. Bruns noted that Conray is not appropriate for myelograms because Conray travels from the thecal sac to the area around the brain and crosses "the

[1]Dr. Bruns' partners referred to the company as Insight Diagnostic Imaging. (Resp. Ex. C at 1, 3) The difference in the company name is inconsequential in this matter.

blood-brain barrier." Conray can cause reactions such as seizures, pain, diaphoresis and death. (Tr. at 18-19, 29-30, 32-33, 36, 96; St. Ex. 3 at 58-59, 114, 122, 126)

7. To ensure that the proper contrast is given to a patient during a myelogram, there are basic procedures to verify the substance. The physician personally identifies the desired substance. Additionally, the technologist verifies the substance, and holds it for the physician to view. The physician then orally consents to the substance. Dr. Bruns stated that this verification procedure typically occurs after the injection site has been designated and the anesthetic has been "drawn up." (Tr. at 37-38, 91-92; St. Ex. 3 at 124)

8. Dr. Bruns further stated that, after the myelogram is complete, the technologist cleans up the patient, places a bandage on the injection site, places the patient on a stretcher, transports the patient to another location, and cleans up the room, including putting the contrast bottle in a disposal container. (Tr. at 93; St. Ex. 3 at 67)

Patient 1

9. Patient 1 was a 55-year-old male in 2004. Patient 1 had experienced back pain since 1990. He had had back surgery, but continued to suffer from back pain. Patient 1 was referred by his orthopedic surgeon, Dr. Stambough, for a myelogram. (Tr. at 47, 104-105, 125; St. Ex. 2 at 12, 19, 20, 24; St. Ex. 3 at 83-84)

Stipulations of the Parties

10. The parties stipulated to the significant facts and legal conclusions alleged in the Notice of Opportunity for Hearing in this matter. The stipulations include the following:

    [a.] On or about October 11, 2004, Dr. Bruns performed a lumbar myelogram on Patient 1. During the lumbar myelogram, Dr. Bruns failed to verify the contrast being intrathecally injected into Patient 1. Although Dr. Bruns intended to inject a non-ionic contrast iopamidol [Isovue 200®], he instead injected an ionic contrast Iothalamate megulmine [Conray®] into Patient 1.

    [b.] Iothalmate megulmine [Conray®] is not approved for intrathecal injection. The intrathecal injection of Iothalamate megulmine [Conray®] into Patient 1 caused generalized muscle spasms associated with myoclonic movements. Due to complications the patient developed from the injection of Iothalamate megulmine [Conray®], Patient 1 died on or about October 11, 2004.

    [c.] Dr. Bruns holds ultimate responsibility for the selection, dosing, and administration of all pharmaceuticals as the operating radiologist. The presence or absence of errors by radiology or hospital support staff is irrelevant to a doctor's responsibility for the selection, dosing and administration of all pharmaceuticals as the operating radiologist. Dr. Bruns' failure to verify the intrathecal contrast material prior to administering it to Patient 1 on or about

October 11, 2004, was a failure to maintain minimal standards of care applicable to the selection and administration of drugs for the treatment of disease.

[d.] Dr. Bruns' acts, conduct, and/or omissions as alleged in paragraphs [a] through [c] above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.

Further, Dr. Bruns' acts, conduct, and/or omissions as alleged in paragraphs [a] through [c] above, individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

(Joint Exhibit AA)

Patient 1's Myelogram

11. At the time of Patient 1's myelogram, a pre-packaged "tray" was provided by the Bethesda North Hospital. The tray included most of the needed materials for the procedure. The tray did not include the contrast. Dr. Bruns testified that the technologist was responsible for obtaining the necessary materials, including the contrast. (Tr. at 25, 81; St. Ex. 3 at 135, 137)

12. Two technologists were present for Patient 1's myelogram. One technologist was a "veteran" with whom Dr. Bruns had worked, and the other was a student. Dr. Bruns testified that he had not met the student technologist beforehand, and did not know, at the time, that she was a student. (Tr. at 38, 82, 89; St. Ex. 3 at 36-37, 50-51, 125)

13. Patient 1 arrived early in the morning on October 11, 2004, in the Radiology Department for the myelogram. He was prepared for the procedure, and the tray and a contrast were laid out for use. Dr. Bruns recalled that, upon entering the fluoroscopy room, he saw the tray and a glass bottle, but he did not look at the glass bottle. Both technologists were present in the room. The veteran technologist left the room before Dr. Bruns began the myelogram. She was gone for approximately five minutes. Dr. Bruns elected to proceed with the myelogram while the veteran technologist was gone. (Tr. at 39-40, 82-83; St. Ex. 3 at 40-41, 46, 49, 51)

14. The following exchange describes the events between Dr. Bruns and the student technologist (also referred to as a "tech"):

    Q. [Ms. Snyder:] And during that procedure, you had the student tech in the room with you. And I think in your deposition you testified that you

felt like she did things a little bit differently. Could you describe that for us?

A. [Dr. Bruns:] From what I remember, you know, I had to tell her, "Okay, can you grab the contrast, the bottle on the thing?" And she grabbed it. And she pretty much, if I do it with my cup, she pretty much – and it's obviously a small bottle.

* * *

It's a lot smaller. She kind of grabbed it like this (demonstrating). And so she picked it up and kind of pointed it at me or directed it towards me.

* * *

Q. Let me just – Before you continue, let me just clean up for the record.

You were demonstrating with your cup. And it looked like you wrapped you entire hand around the cup.

A. Correct.

Q. So I assume if the cup were the bottle, she would have wrapped her entire hand round the label, essentially?

* * *

A. Correct. Most of the label. Obviously, the expiration date was on the label that I could see.

* * *

Q. * * * And when you had the student assist you, you didn't follow your normal procedure about verification --

A. Correct.

Q. * * * So you didn't have her read out the name to you?

A. No.

Q. You thought to check the expiration; you didn't think to check the substance?

A. Correct. Unfortunately, yes.

(Tr. at 41-44; See, also, St. Ex. 3 at 45-48, 52-54) Dr. Bruns acknowledges that the verbal confirmation of the type of contrast was omitted. (Tr. at 93)

15. At the time that Dr. Bruns injected the contrast into Patient 1, he thought he was injecting Isovue. He did not intend to inject Conray into Patient 1. (Tr. at 27-28, 196; St. Ex. 3 at 56, 57, 105)

Later, testing confirmed that Patient 1 had been injected with Conray. (Tr. at 28, 197; St. Ex. 5 at 5; St. Ex. 6)

16. The myelogram ended at 10:20 a.m. Dr. Bruns testified that Patient 1's myelogram procedure lasted for 15 to 20 minutes, and went well. Dr. Bruns saw the contrast, and it looked normal. (St. Ex. 2 at 13; Tr. at 40; St. Ex. 3 at 62-63) Moreover, Dr. Bruns' written notes, written at 10:20 a.m., reflect similar thoughts:

> Lumbar myelogram performed
> 14 cc Isovue 200 given intrathecally
> Ø immediate complications were seen
> Pt. tolerated procedure well.

(St. Ex. 2 at 17; St. Ex. 3 at 105)

17. After the procedure, the contrast bottle and needle were placed in a disposal container called a "Sharps" container. (Tr. at 25)

Post-Procedure Events While Patient 1 was in the Recovery Unit

18. Following the myelogram, Patient 1 had a CAT scan. Then, he was moved from the Radiology Department to the recovery unit, which was referred to as "Same Day Surgery" at Bethesda North Hospital. (Tr. at 21; St. Ex. 3 at 66, 79)

19. The nurses' notes from the recovery unit include the following:

> 10:50 Returned to [Same Day Surgery] from Radiology, [Alert and Oriented,] denies pain, N/V, hand grasps & pedal pushes equal, lumbar puncture site WNL.
>
> 11:50 [Vital signs stable.] c/o jerky spasm-like movements of whole body. Pt. states he feels originates from legs. Has had 4-5 in the last 5 min. Short duration. ↑ pain lower back [with] episode level 7-8. Otherwise when not moving pain level 3. Moves all extremities well. PERSL -- called Radiology. Dr. Bruns spoken to regarding jerky/spasm movements. Referred me to call Dr. Stambough.

12:10 Darvocet 1 PO for pain. Call placed to Dr. Stambough, Rose spoken to info/status given to inform MD.

12:30 Perspiring, lips pale. Pulled pt. up in bed – c/o back spasms.

12:40 Warm diaphoretic, sweating [illegible], pale, lips cyanotic O_2 2 [liters per minute via nasal cannula.] * * * Spasms of entire body [with] arching back + stiffened extremities. Refuses to void to empty bladder[.] moves all ext well. PERRL Called Dr. Brun[s] informed of status above + not heard back from Dr. Stambough's office yet. * * * Refuses to turn over to observe back puncture site. Prior observation at 1150 speck of blood only area unremarkable.

12:55 Dr. Bruns to see pt. Hospitalist called. Msg left to see pt.

13:00 Morphine 2mg IVP as ordered. Another strong muscle spasm that causes him to cry out in pain.

13:05 Transport to [emergency room] ER per stretcher as directed per Hospitalist. Report given. Pt. cont. whole body spasm like intermit. [with] crying out in pain. Diaphoretic, warm, O_2 cont. 2 [liters per minute at nasal cannula.]

(St. Ex. 2 at 21; See, also, St. Ex. 2 at 14)

20. Dr. Bruns testified that he was first contacted about Patient 1 at 11:50. He stated that, at that time, the recovery unit nurse did not inform him of "whole body" spasm movements. He recalled that she had described leg twitching. Additionally, Dr. Bruns explained that he had asked the nurse to contact Dr. Stambough because he was Patient 1's referring physician and he would have better knowledge of this patient's history, including then-current medications. (Tr. at 46-48, 164; St. Ex. 3 at 76-78, 83)

21. Dr. Bruns further testified that, at the conclusion of the myelogram, he had prescribed Darvocet for pain because it is a fairly common post-procedure complaint. Dr. Bruns stated that, when the Same Day Surgery nurse first contacted him at 11:50 and stated that Patient 1 was in pain, he directed the nurse to provide the Darvocet. He further stated that, at that point, he did not have significant concerns. (Tr. at 164; St. Ex. 3 at 72, 83; St. Ex. 2 at 13)

22. Dr. Bruns stated that, after the second call from the nurse, he went "right away" to see Patient 1. He stated that he did not read the nurses' notes; instead, he spoke with the nurse.[2] He stated that the nurse did not mention "whole body" spasms at that time, either. Instead, she

[2]During his investigatory deposition, Dr. Bruns stated that he had reviewed notes before entering Patient 1's room, but did not review Patient 1's vital signs because the nurse had those with her in Patient 1's room. At the hearing, he stated that his testimony is consistent because he had reviewed patient-history notes maintained at the nurses' station before entering Patient 1's room, and did not review the nurse's notes. (St. Ex. 3 at 86-87; Tr. at 49-53)

showed him and he observed the twitching in one of Patient 1's leg. Dr. Bruns stated that he observed Patient 1. Dr. Bruns testified that he was in Patient 1's recovery room for two or three minutes. (Tr. at 49-50, 54, 90, 165, 166; St. Ex. 3 at 85-89)

23. Dr. Bruns testified about his thoughts at that time:

> * * * I saw a pale man that was sweating, that had a cardiovascular history that I knew of from the history sheet that I read prior to the procedure, where he had – I believe he had bypass surgery, I can't recall for sure, but I know he had a cardiovascular history.
>
> So I was thinking, honestly, at that time, he was having a heart attack, because that would – that would have been the most common thing that would have happened in a patient, you know, [in] my experience.

(Tr. at 56-57; See, also, Tr. at 187 and St. Ex. 3 at 90, 129) Dr. Bruns further noted that at that point, he still thought that he had injected Isovue. (Tr. at 57)

24. Dr. Bruns remained in the recovery unit and spoke with the hospitalist. Dr. Bruns informed the hospitalist of Patient 1's pain, but does not recall whether he informed the hospitalist of the twitching. They jointly decided that, "due to the symptoms and * * * it was over my head as a radiologist, that we thought it was best that he would go to the ER to get evaluated." (Tr. at 59, 90-91; St. Ex. 3 at 91-92)

25. Dr. Bruns testified that he personally transported Patient 1 to the ER, along with someone else from the recovery unit. (Tr. at 60, 64, 167; St. Ex. 3 at 93)

26. Dr. Bruns' written notes from 1:00 p.m. stated:

> Called by Pt's nurse in same day surgery. Pt. c/o intense back pain – won't move. Was given Darvocet earlier for pain – no relief. Also having muscle spasms in legs. Nurse states became somewhat cyanotic & diaphoretic. Requires more pain meds. Given 2mg morphine initially. Will transfer to ER for further evaluation.
>
> VS stable please see nursing notes
> Pt. does appear diaphoretic
> Will not allow us to move him

(St. Ex. 2 at 17; St. Ex. 3 at 105-106)

Post-Procedure Events while Patient 1 was in the Emergency Room

27. Dr. Bruns stated that he spoke directly with the physician in the emergency room. Dr. Bruns was not certain that he had described the spasms to the ER doctor, but if he had, the spasms

were "lower down on the list of things that I wanted him to know about." Then, Dr. Bruns returned to the Radiology Department. (Tr. at 63-64; St. Ex. 3 at 94)

28. At 2:14 p.m., Dr. Bruns dictated his report regarding Patient 1's myelogram. (Tr. at 21, 68; St. Ex. 3 at 108) His report includes the following:

> The patient was prepped and draped in a sterile fashion. The skin and subcutaneous tissues were anesthetized utilizing 2% Lidocaine. A 22 gauge spinal needle was inserted into the thecal sac behind the L3 vertebral body. Approximately 14cc of Isoview 200 was injected intrathecally. No extravasation of contrast was seen. The contrast was seen to be within the thecal sac. The needle was removed and pressure was applied until hemostasis was achieved. At this point, the patient was stood up and imaging of the lumbar spine was performed * * *. The patient tolerated the procedure well. No immediate complications were encountered.

(St. Ex. 2 at 55)

29. Dr. Bruns stated that he had tried to conduct other work, but he had been troubled by Patient 1's condition. Dr. Bruns stated that he went to the fluroscopy room to reenact the events, in the hopes of determining what may be causing Patient 1's problems. He also spoke with the manager of the fluoroscopy unit, who is a radiology technologist. The manager of the fluoroscopy unit suggested that, perhaps, Conray had been injected into Patient 1. They opened the Sharps container and attempted to determine what was last placed in the container.[3] Dr. Bruns remembered seeing no bottles of contrast on the top of the items in the container. Three bottles of contrast were extracted from the Sharps container – two bottles of Isovue and one bottle of Conray.[4] (Tr. at 70-77; St. Ex. 3 at 98-102, 109)

30. Dr. Bruns testified that, during this time, he also spoke with the veteran technologist, who had laid out all the necessary materials, including the contrast. Dr. Bruns asked her what contrast she put out before Patient 1's myelogram. Dr. Bruns testified that she responded "Isovue," and as a result he believed that was the case. Dr. Bruns never communicated to the ER that Patient 1 might have received Conray. (Tr. at 78-80, 192; St. Ex. 3 at 102, 114-115, 130)

31. Dr. Bruns recalled that the fluoroscopy unit manager stated that he would "look up something on the computer" about Conray. Dr. Bruns retrieved one of the package inserts for Isovue, and it was taken to ER. (Tr. at 69, 187-188; St. Ex. 3 at 93, 102-104, 131-132)

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[3]Dr. Bruns testified that it is difficult to open a Sharps container, and the container was jostled during the process. The contents of the container could have been mixed up, and the items on top would not necessarily have been the last items placed in the container. (Tr. at 73)

[4]Dr. Bruns stated that the labels for Isovue and Conray were not significantly different in 2004. Moreover, there is no visible difference in the two contrasts when viewed through the imaging equipment. (Tr. at 191, 196-197)

32. Dr. Bruns also went to the CAT scan department and discussed additional scans of Patient 1 that had been ordered by the ER. (St. Ex. 3 at 116)

33. Patient 1 died at 4:33 p.m. The coroner concluded that the injection of Conray ultimately lead to Patient 1's death. (St. Ex. 2 at 77-79; St. Ex. 6; St. Ex. 7 at 2)

Dr. Bruns' Testimony Regarding His Knowledge in 2004 of Intrathecal Injection of Conray

34. In the following exchange at the hearing, Dr. Bruns explained his knowledge in 2004 of the intrathecal injection of Conray:

> Q. [Mr. Plinke:] * * * And going back to 2004, can you tell me, tell the Board, what did you know at that point in time about misadministration of Conray?
>
> * * *
>
> A. [Dr. Bruns:] Not very much. I had never run into that situation before. I hadn't read anything about that in particular. I have read about general misadministration of different kind[s] of contrasts or things that you inject either in the blood or elsewhere. And you know how you treat certain things because most of the time when we deal with stuff like this, it's from an allergic reaction to IV contrast for a CAT scan or something. So – but in particular Conray, nothing more than any other just sort of general things. Nothing specific about Conray.
>
> Q. Okay. Were you aware of any literature at the time on that subject?
>
> A. Specifically about intrathecal injection of Conray, no, I had not run into anything on that.
>
> Q. Okay. What about since then?
>
> A. Yes. Since then, obviously, as part of this whole ordeal, we have run – other lawyers and things in my own investigation have run across a few articles that have stated that there has been – what happens with misadministration of the contrast and subsequent how they treated things.

(Tr. at 162-163; See, also, Tr. at 184-185 and St. Ex. 3 at 113-114)

35. Dr. Bruns also stated that he had been aware in 2004 that seizures and death were complications from Conray. (St. Ex. 3 at 113-114, 123)

Events after Patient 1's Death

36. Dr. Bruns testified that there was an internal review of the matter at Bethesda North Hospital. Dr. Bruns participated in that internal review. He explained that, following the internal review, Bethesda North Hospital eliminated Conray (and all ionic contrasts), and educated the technologists about the proper procedures with the radiologists. Additionally, all the radiologists were reminded of the procedures. (Tr. at 163, 192-193; St. Ex. 3 at 15)

37. Additionally, Dr. Bruns self-reported the incident with Patient 1 to the Board in July 2006. He participated in an interview with a Board investigator and an investigatory deposition in January 2008. Dr. Bruns told the Board that he had deviated from the minimal standard of care because he did not confirm the substance and did not confirm that it was the substance that he wanted to inject prior to injecting it into Patient 1. (Tr. at 173-175; Resp. Ex. B; St. Ex. 3)

38. Dr. Bruns continued to work for nearly three more years (until July 2007) with the same radiology group after the incident with Patient 1.[5] (Tr. at 170-171)

39. Dr. Bruns pointed out that, when he sought a medical license in Indiana, he notified that state board about the incident with Patient 1. Similarly, he notified Margaret Mary Community Hospital when he applied for privileges there. (Tr. at 171, 173)

40. Dr. Bruns stated that, as a result of the incident with Patient 1, he has become more vigilant with medications and procedures. He makes sure that he looks at the substance and looks at the expiration dates beforehand. He stated that he has researched actions to take upon intrathecal injection of contrast, and has taken an Advanced Cardiac Life Support course. (Tr. at 169, 194)

Report of Stephen W. Sabo, D.O.

41. The State presented the expert report of Stephen W. Sabo, D.O., and Dr. Bruns did not object to its admission. Dr. Sabo did not testify at the hearing, in light of the stipulations reached. (St. Ex. 4B; Joint Exhibit AA)

42. Among other things, Dr. Sabo stated the following in his report:

> Both the toxicology and coroner's reports are strikingly unambiguous. A high concentration of hypertonic contrast material (Conray™, iothalamate meglumine) is indentified in the decedent's cerebrospinal fluid; the patterns of injury present at autopsy correlate with reported complications of intrathecal iothalamate meglumine administration.

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[5]Dr. Bruns explained that his employment contract was a "three years to partnership" contract. He stated that his employment contract was renewed each year, but at the end of the third year, he was told that he would not become a partner at Northeast Radiology. Dr. Bruns stated that he began looking for other employment opportunities so that he could obtain a partnership position and the associated benefits. (Tr. at 183; St. Ex. 3 at 17-18)

> The presence or absence of errors by radiology or hospital support staff is irrelevant to the present investigation. Dr. Bruns holds ultimate responsibility for the selection, dosing, and administration of all pharmaceuticals as the operating neuroradiologist. In this case, the error chain of "wrong drug" injected into a sensitive anatomic space (the thecal sac) is exceedingly short and fatal to Patient 1. The failure to verify the intrathecal contrast material, prior to administration, represents violation of statutory standards set forth in Sections 4731.22(B)(2) and (6), Ohio Revised Code.
>
> It is my opinion that, to a reasonable degree of osteopathic radiological medical certainty, Dr. Bruns failed to maintain minimal standards applicable to the selection and administration of drugs for the treatment of disease when he provided care and treatment to Patient 1 on or about October 11, 2004. This is in violation of Section 4731.22(B)(2) of the Ohio revised code. And, to a reasonable degree of osteopathic radiological medical certainty, Dr. Bruns departed from and failed to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, when he provided care and treatment to Patient 1 on or about October 11, 2004, which is in violation of Section 4731.22(B)(6) of the Ohio revised code.

(St. Ex. 4B)

Testimony of Patient 1's Wife

43. Patient 1's wife testified with great emotion regarding the impact of this event upon her and her family. She stated that she and her children have struggled since her husband's death. She described her husband as a very kind person and a very good father. She stated that the family was a very close family. (Tr. at 100-104, 119-120)

44. Patient 1's wife stated that Patient 1 had agreed to the myleogram because he "wanted to try one more time to see if he could get some help and relief" from the pain. (Tr. at 104)

45. Patient 1's wife recounted the events from that day. Patient 1's wife stated that, shortly after the myelogram, Patient 1 appeared to be fine. However, after a period of time, Patient 1's leg began to jerk. Then, he began to sweat. Patient 1's wife remembered that the nurse decided to contact Dr. Bruns. Patient 1's wife testified that Patient 1 was given Darvocet, but it did not work. She stated that, then, Patient 1 was given morphine, which also did not help him. She stated that the jerking became more frequent, and her husband "just kept jerking and screaming." (Tr. at 107-112, 127)

46. Patient 1's wife recalled that someone who she believes was Dr. Bruns visited her husband, and he "just shook his head and then he left." She stated that, later, it was decided that Patient 1 would be moved to the ER and that an orderly took him to the ER. She does not believe that Dr. Bruns accompanied Patient 1 to the ER. Additionally, she stated that Patient

1 was in so much pain that he was screaming and asked that they stop moving him to the ER. (Tr. at 113-115, 123-124)

47. Patient 1's wife stated that, in the ER, Patient 1 continued jerking and screaming, which made it difficult to conduct tests. She stated that Patient 1 was put into a "semi-coma," so that tests could be conducted. (Tr. at 116-118)

Dr. Browne's Testimony and Letter of Support

48. Jim Browne, M.D., is a radiologist and one of Dr. Bruns' partners at Insight. Dr. Browne has known Dr. Bruns for approximately three years, since Dr. Bruns joined that practice. (Tr. at 147-149; Resp. Ex. C at 1)

49. Dr. Browne explained that he has constant contact with Dr. Bruns, and that they work side by side on a daily basis. Dr. Browne stated that he is knowledgeable of Dr. Bruns' abilities, and he has reviewed his cases. Dr. Browne explained his opinion of Dr. Bruns: "I have complete confidence in him and – and have been very happy and pleased with the work that he's performed for our group. And that's why we decided to make him partner." (Tr. at 151)

50. Dr. Browne further stated that Dr. Bruns has good visual acuity and communication skills. He noted that Dr. Bruns' work is trusted. Dr. Brown added that Dr. Bruns informed him of the incident at Bethesda North Hospital before being offered the position at Insight. Dr. Browne believes that Dr. Bruns is extremely careful and diligent, and noted that no similar incident has occurred in Indiana. He stated that the incident with Patient 1 was an aberration. (Tr. at 152-154, 156, 159; Resp. Ex. C at 1)

Other Letters of Support

51. Dr. Bruns presented five other letters of support. The letters were authored by his other practice partner, the President of Margaret Mary Community Hospital, the Radiology Manager at Margaret Mary Community Hospital, the President of his radiology group at Bethesda North Hospital, and the chair of his radiology residency at Doctors Hospital. (Resp. Ex. C at 2-6; Tr. at 175-177) The State did not have the opportunity to cross-examine the authors.

    Among other things, the authors stated that Dr. Bruns is professional, attentive and dedicated. Also, they stated that he is approachable, caring, and competent. Furthermore, it was reported that Dr. Bruns has a strong moral character, and he has offered guidance and learning opportunities for the radiology technologists. (Resp. Ex. C at 2-6)

Dr. Bruns' Additional Testimony

52. Dr. Bruns stated that, in addition to his other testimony, he wanted the Board to know that he will be vigilant with the administration of intrathecal contrast and will try to do his best. He expressed great remorse for his actions. Additionally, Dr. Bruns stated an apology to Patient 1's family and asked for forgiveness. (Tr. at 180-181)

FINDING OF FACT

On October 11, 2004, Douglas A. Bruns, D.O., performed a lumbar myelogram on Patient 1. During the lumbar myelogram, Dr. Bruns injected a contrast intrathecally into Patient 1. While Dr. Bruns intended to inject a non-ionic contrast iopamidol (Isovue 200®), Dr. Bruns did not verify the substance before he injected it, and instead he injected an ionic contrast Iothalmate meglumine (Conray®) into Patient 1. Iothalmate meglumine (Conray®) is not approved for intrathecal injection. The patient developed complications from the injection of Iothalmate meglumine (Conray®) and died on October 11, 2004.

CONCLUSIONS OF LAW

1. Dr. Bruns' acts, conduct, and/or omissions as set forth in the Finding of Fact constitute a "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as set forth in Section 4731.22(B)(2), Ohio Revised Code.

2. Dr. Bruns' acts, conduct, and/or omissions as set forth in the Finding of Fact constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as set forth in Section 4731.22(B)(6), Ohio Revised Code.

Rationale for the Proposed Order

Dr. Bruns made a significant error on October 11, 2004, and his error had tragic consequences. The medical evidence demonstrates that, before his death, Patient 1 suffered. Moreover, Patient 1's family has suffered from Dr. Bruns' error. Those are aggravating factors in this matter.

The State argues as an additional aggravating factor that Dr. Bruns was reckless. "Reckless" behavior is that which is careless, heedless, without regard to the consequences, and rash.[6] The evidence demonstrates that Dr. Bruns omitted part of the contrast verification process and injected Conray, which certainly was an error. Nevertheless, the Hearing Examiner does not believe that Dr. Bruns' behavior was reckless.[7]

A number of mitigating factors exist. First, this is an isolated incident involving a single patient, and it occurred nearly six years ago. Moreover, Dr. Bruns has no prior disciplinary action, and he was honest about his conduct. He acknowledged the error and has cooperated with the Board. Additionally, the

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[6]Webster's New World Dictionary of American English, Third College Edition. Cleveland & New York: Simon & Schuster, Inc., 1988.

[7]The State also argued that Dr. Bruns was reckless in his follow-up care, for which disciplinary action should be imposed. The Notice of Opportunity for Hearing addressed only Dr. Bruns' injection of Conray, not follow-up care. Therefore, that portion of the State's closing argument is disregarded.

error did not occur because Dr. Bruns lacked medical knowledge, lacked appropriate judgment or lacked a skill. He made a human error, and sadly the then-existing protocols did not correct the error. Finally, Dr. Bruns was genuine and sincere at the hearing. He is clearly remorseful and deeply regretful of the error he made. Dr. Bruns' mistake is very unlikely to recur.

The tragic outcome in this matter is significant. Also, the mitigating factors are sizeable in this matter. It is recommended that Dr. Bruns be reprimanded for his error and that his certificate be placed on probation for one year.

PROPOSED ORDER

It is hereby ORDERED that:

A. **REPRIMAND**: Douglas A. Bruns, D.O., is REPRIMANDED.

B. **PROBATION**: The certificate of Dr. Bruns to practice osteopathic medicine and surgery in the State of Ohio shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of one year:

1. **Obey the Law**: Dr. Bruns shall obey all federal, state, and local laws, and all rules governing the practice of osteopathic medicine and surgery in the state in which he is practicing.

2. **Declarations of Compliance**: Dr. Bruns shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which this Order becomes effective. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances**: Dr. Bruns shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which this Order becomes effective, or as otherwise directed by the Board. Dr. Bruns shall also appear in person upon his request for termination of the probationary period, and/or as otherwise directed by the Board.

4. **Tolling of Probationary Period While Out of Compliance**: In the event Dr. Bruns is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

5. **Required Reporting of Change of Address**: Dr. Bruns shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

C. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Bruns' certificate will be fully restored.

D. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Bruns shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training, and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Bruns shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments.

   In the event that Dr. Bruns provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, he shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services.

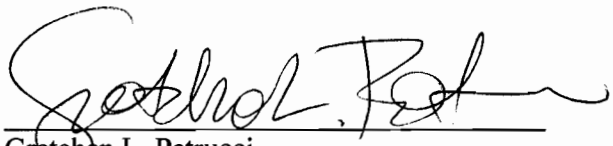
   This requirement shall continue until Dr. Bruns receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other State Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Bruns shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any professional license or certificate. Also, Dr. Bruns shall provide a copy of this Order at the time of application to the proper licensing authority of any state or jurisdiction in which he applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. Bruns receives from the Board written notification of the successful completion of his probation.

3. **Required Documentation of the Reporting Required by Paragraph (D)**: Dr. Bruns shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (a) the return receipt of certified mail within 30 days of receiving that return receipt, (b) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order

was hand delivered, (c) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (d) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.



Gretchen L. Petrucci
Hearing Examiner

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

EXCERPT FROM THE DRAFT MINUTES OF SEPTEMBER 8, 2010

REPORTS AND RECOMMENDATIONS AND PROPOSED FINDINGS AND PROPOSED ORDERS

Dr. Amato announced that the Board would now consider the Reports and Recommendations, and the Proposed Findings and Proposed Order appearing on its agenda.

Dr. Amato asked whether each member of the Board had received, read and considered the hearing records; the Findings of Fact, Conclusions of Law, Proposed Orders, and any objections filed in the matters of: Douglas A. Bruns, D.O.; Kimberly Jo Cull, M.D.; Thomas E. Dunaway, M.D.; William Arthur Garringer, M.D.; Tonya R. Rutledge, M.D.; Shannon Dimetra Weikert; and Roy Whitman, M.D. A roll call was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Amato	- aye
	Mr. Albert	- aye
	Dr. Madia	- aye
	Dr. Talmage	- aye
	Dr. Suppan	- aye
	Mr. Morris	- aye
	Dr. Ramprasad	- aye

Dr. Amato asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Amato	- aye
	Mr. Albert	- aye
	Dr. Madia	- aye
	Dr. Talmage	- aye
	Dr. Suppan	- aye
	Mr. Morris	- aye
	Dr. Ramprasad	- aye

Dr. Amato noted that, in accordance with the provision in section 4731.22(F)(2), Ohio Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member. However, Dr. Talmage and Mr. Albert may vote on the matter of Roy Whitman, M.D., as that case is not disciplinary in nature and only involves the respondent's qualifications for licensure.

Dr. Amato reminded all parties that no oral motions may be made during these proceedings.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

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DOUGLAS A. BRUNS, D.O.

Dr. Amato directed the Board's attention to the matter of Douglas A. Bruns, D.O. He advised that objections were filed to Hearing Examiner Petrucci's Report and Recommendation and were previously distributed to the Board members.

Dr. Amato continued that a request to address the Board has been timely filed on behalf of Dr. Bruns. Five minutes would be allowed for that address.

Dr. Bruns was accompanied by his attorney, Eric Plinke.

Mr. Plinke stated that this is a tragic case of a medical error committed by Dr. Bruns which was clearly preventable and cost a patient his life. After Dr. Bruns reported this incident to the Medical Board many years ago, he was interviewed by an investigator and was later deposed. Mr. Plinke stated that Dr. Bruns cooperated fully with this investigation and provided complete information about his error.

Mr. Plinke stated that, while Dr. Bruns committed a tragic mistake, it is an isolated incident in regard to his practice. Mr. Plinke objected to the State's contention regarding adding discipline for Dr. Bruns' allegedly reckless behavior following the incident in question. Mr. Plinke opined that this is not a fair or valid argument, stating that complete information was provided to the Board. Mr. Plinke stated that at Dr. Bruns' hearing, the State could have called their expert, Stephen Sabo, D.O., to the stand to answer many of the questions the State claimed to have. However, the State failed to call Dr. Sabo to the stand. As a consequence, Mr. Plinke stated, there essentially was not a hearing about Dr. Bruns' actions following his error and whether or not they constituted a reckless deviation from the standard of care. Mr. Plinke agreed with the hearing examiner, Ms. Petrucci, that it would be inappropriate to consider Dr. Bruns' actions following his error.

Mr. Plinke stated that discipline should be imposed in this case and opined that Ms. Petrucci's proposed

order is reasonable under these circumstances.

Dr. Bruns stated that he is a radiologist and lives with his wife and four daughters. Dr. Bruns currently works at Margaret Mary Community Hospital in Batesville, Indiana. Dr. Bruns applied for and was granted a medical license by the state of Indiana in 2004, after full disclosure of the event in question. Dr. Bruns stated that he also fully disclosed the incident to his partners and to Margaret Mary Community Hospital.

Dr. Bruns explained that in October 2004, he made a grave mistake while performing a lumbar myelogram on a patient. Dr. Bruns checked the expiration date on the bottle of contrast, but failed to identify the name of the contrast on the bottle. In the following days and weeks, Dr. Bruns learned that he had injected the contrast Conray, not Isovue as he had initially thought. Dr. Bruns stated that Conray is contraindicated in a lumbar myelogram.

Dr. Talmage exited the meeting at this time.

Dr. Bruns continued that he has openly acknowledged his responsibility for this mistake. Dr. Bruns stated that he turned himself in to the State Medical Board of Ohio and has fully cooperated with all investigations into this incident. Dr. Bruns stated that he is personally distraught over what happened that day, because his failure to identify the contrast cost a man his life and is a temendous loss to his family.

Dr. Bruns contended that he used his best efforts to find out what was wrong with his patient, despite skepticism raised at his hearing regarding his actions that day. Dr. Bruns stated that he thinks about this event everyday. Dr. Bruns stated that, as a practicing Catholic, he has asked forgiveness from God. Dr. Bruns stated that physicians accept the ultimate responsibility for the actions they take in caring for their patients. Dr. Bruns stated that he committed a simple and avoidable mistake which cost a man his life, an error he has not made again and has vowed to never make again.

Dr. Bruns offered his heartfelt condolences to the patient's family. Dr. Bruns stated that, although he cannot reverse his past actions, he can continue to work hard and be aware of the ramifications of his actions. Dr. Bruns hoped that the Board would allow him to continue to practice medicine, which he enjoys very much and which gives him the satisfaction of helping others.

Dr. Amato asked if the Assistant Attorney General would like to respond. Ms. Snyder stated that she would like to respond.

Ms. Snyder stated that this is a tragic case for Dr. Bruns, the patient, and the patient's family who continues to suffer six years later. Ms. Snyder stated that the hearing examiner correctly noted that there are mitigating factors in this case, notably that the Board is unaware of any other problems that have occurred in Dr. Bruns' practice in the six years since this incident. However, Ms. Snyder stated that there are also aggrevating factors which the Board can and should consider.

Ms. Snyder reminded the Board that in the case of Leonid Macheret, M.D., the Tenth District Court of Appeals held that the Board can consider uncharged conduct when determining the appropriateness of sanctions for a licensee. In Dr. Bruns' case, Ms. Snyder stated that the State is not asking the Board to discipline Dr. Bruns for his recklessness, nor is the State attempting to add to the allegations of the Notice of Opportunity for Hearing. However, the State is asking that the Board consider circumstances that surround the conduct for which Dr. Bruns was charged because Dr. Bruns has admitted to falling below the minimum standards of care while performing this lumbar myelogram procedure.

Ms. Snyder continued that a series of very dangerous errors led to the patient's death. First, Dr. Bruns went forward with the procedure with only a student technologist in the room. Dr. Bruns has testified that he knew this person was inexperienced because of the way she held the contrast bottle. An experienced technician was supposed to have been in the room as well, but she stepped out of the room for reasons unknown and Dr. Bruns chose to go forward with the student technologist. Dr. Bruns also failed to follow hospital protocol to verify the substance. Specifically, Dr. Bruns failed to ask the student technologist to read back to him the substance listed on the bottle's label.

Ms. Snyder asked the Board to consider Dr. Bruns' actions following the procedure. Ms. Snyder stated that, as a radiologist, Dr. Bruns had a duty to know what happens when you inject Conray into the interthecal space and was the only physician present who could have diagnosed the patient's symptoms. However, Dr. Bruns failed to make this diagnosis, even after a radiology technologist suggested the he may have injected Conray instead of Isovue. Dr. Bruns and the radiology technologist found an empty Conray bottle inside a sharps container, along with two empty Isovue bottles. Ms. Snyder argued that at that moment, Dr. Bruns should have recognized the possibility that he had mistakenly injected Conray into the patient and notified the emergency department accordingly.

Ms. Snyder asked the Board to consider the agony the patient endured during the five hours that his spine was literally breaking from the muscle contractions caused by the Conray. Ms. Snyder also asked the Board to consider the impact of this incident on the patient's wife, who still suffers emotionally six years later. In addition, Ms. Snyder stated that Dr. Brun's actions violated the minimum standards of care.

In light of the aformentioned aggrevating factors, which the hearing examiner did not consider when she recommended a reprimand and one-year probation, Ms. Snyder asked the Board to consider a permanent revocation, stayed, with a one-year probation. Ms. Snyder stated that Dr. Bruns committed an extremely careless act which had an horrible outcome. Ms. Snyder stated that a stayed permanent revocation would indicate that the Board takes this case very seriously, but also recognize that there are mitigating factors, such as Dr. Bruns' clean record in the intervening six years.

Dr. Madia moved to approve and confirm Ms. Petrucci's Findings of Fact, Conclusions of Law, and Proposed Order in the matter of Douglas A. Bruns, D.O. Mr. Hairston seconded the motion.

Dr. Amato stated that he would now entertain discussion in the above matter.

Dr. Steinbergh stated that this is a very tragic case of a patient who died due to a medical error. Dr. Steinbergh stated that the thousands of medical errors that occur annually are a concern to everyone.

Dr. Steinbergh opined that this is not a simple case of one event, Dr. Bruns' injection of Conray, leading directly to the patient's death. Instead, several red flags were apparent at different times. First, Dr. Bruns violated his own procedure and policy in not identifying the contrast material he was about to inject. Second, Dr. Bruns proceeded with the procedure without having the appropriate support in the room, depending on an inexperienced student technologist instead of an experienced technologist. Although Dr. Bruns had verbal assurance from the student technologist that she had placed Isovue on the tray, Dr. Bruns violated his own policy by not looking at the material himself.

Dr. Steinbergh noted that Dr. Bruns' behavior after the patient began experiencing side-effects has been characterized as reckless. Dr. Steinbergh opined that Dr. Bruns' behavior was not reckless, but he did make errors in decision-making. Dr. Steinbergh opined that once Dr. Bruns saw the pain and spasms the patient was experiencing, he should have realized as a well-trained neuroradiologist that these symptoms could have been a response to any contrast, including Isovue. Dr. Steinbergh faulted Dr. Bruns for not recognizing this possibility and communicating it to the emergency department.

Dr. Steinbergh stated that another red flag was the tremendous confusion among the physicians, nurses, and everyone involved as to what exactly had happened. Dr. Steinbergh stated that when Dr. Bruns discovered an empty Conray bottle and two Isovue bottles in the sharps container, he should have communicated to the emergency department the possibility that he may have inadvertently injected Conray instead of Isovue. Dr. Steinbergh did not know if this patient could have been saved regardless of the situation, and therefore could not say that the patient's life would have been saved if Dr. Bruns had communicated appropriately.

Dr. Steinbergh noted that many families who lose a loved one through a medical error get involved in support systems and patient safety acts that allow them to make a difference. Dr. Steinbergh encouraged the patient's family in this case to look into organizations like the Empowered Patient Coalition, which teaches what types of systems are in hospitals and how they can help relatives or those they care for if they think a medical error has occurred. In this way, the family can empower themselves and teach others to do the same in case of a potential medical error.

Dr. Steinbergh offered an alternative order which would suspend Dr. Bruns' medical license indefinitely, but not less than 180 days. Dr. Steinbergh's alternative order also calls for a probationary period of two years, during which Dr. Bruns would have a monitoring physician who would provide reports to the Board. The alternative order requires Dr. Bruns to complete a patient safety system course before the end of the first year of probation.

Dr. Steinbergh moved to amend the Proposed Order to reflect the Alternative Order she has presented to the Board. Mr. Hairston seconded the motion.

Dr. Amato stated that he would now entertain discussion on the proposed amendment.

Dr. Mahajan noted that Dr. Bruns' continues to feel remorseful, Dr. Bruns has not hurt any other patients in six years, and Dr. Bruns has been accepted by the group which employs him. Dr. Mahajan does not feel that taking Dr. Bruns out of practice would serve any purpose and opined that Dr. Bruns' suspension could be stayed. Dr. Mahajan agreed with Dr. Steinbergh's proposal of a required course in patient safety systems.

Dr. Stephens agreed with Dr. Mahajan and stated that, although certain errors should not be made, medicine is practiced by humans and humans make errors. Dr. Stephens opined that it is unrealistic and unfair to think that medicine can be practiced with perfection on a daily basis. Dr. Stephens related a recent incident in her practice which was very similar to that of Dr. Bruns'; when a patient complained of headache following a myelogram, Dr. Stephens was called instead of the radiologist. Dr. Stephens stated that in many hospitals, and perhaps all hospitals, radiologists are not trained to address patient complications following a myelogram and are not part of that process. Dr. Stephens stated that Dr. Bruns' reaction to his patient's complication was probably very common for a radiologist.

Dr. Stephens opined that Dr. Bruns has learned from this one mistake. Dr. Stephens also opined that revocation of Dr. Bruns' medical license is not warranted, even in light of the patient's pain and suffering and the suffering of his family. Dr. Stephens stated that physicians who perform a procedure should be able to handle the complications of that procedure. Dr. Mahajan agreed with Dr. Stephens that radiologists rarely deal with convulsions or complications of that nature; rather, attending physicians usually address such things. Dr. Steinbergh agreed that a radiologist will not provide ongoing care following a complication. Dr. Steinbergh stated that her primary concern is that Dr. Bruns failed to communicate the possibility that he may have injected the incorrect contrast, not that he did not treat the patient.

Dr. Suppan stated that, as a senior vice-president of medical affairs at a hospital, she works a great deal in the area of risk management. Dr. Suppan opined that this incident resulted from a system problem. Dr. Suppan felt that a chain of events occurred, beginning with how the bottle of contrast was originally engineered and labeled, and each event garnered more momentum towards the critical mistake. Dr. Suppan acknowledged that Dr. Bruns was responsible for what happened, but saw this as a broader issue of system failure. Dr. Suppan supported a stay of Dr. Bruns' proposed suspension.

Dr. Amato stated that he agreed with Dr. Stephens and Dr. Suppan. Dr. Amato stated that the role of the State Medical Board is to protect the citizens of Ohio. Dr. Amato opined that the Board did not need to fear for the safety of the citizens from Dr. Bruns.

Dr. Steinbergh stated that she would not oppose a stay of Dr. Bruns' suspension. Dr. Stephens opined that Dr. Bruns' probationary period should be less than two years. Dr. Suppan suggested the Board accept documentation that Dr. Bruns has already completed a patient safety systems course, if he has done so.

Ms. Debolt suggested, in light of the numerous changes being offered by Board members to the proposed

alternative order, that the alternative order be withdrawn so that the staff can draft a new alternative order containing all of the desired changes.

Dr. Steinbergh withdrew her motion to amend. Mr. Hairston agreed.

Dr. Madia moved to table this discussion. Dr. Steinbergh seconded the motion. A vote was taken:

ROLL CALL:		
	Dr. Strafford	- nay
	Mr. Hairston	- aye
	Dr. Stephens	- nay
	Dr. Mahajan	- aye
	Dr. Steinbergh	- nay
	Dr. Amato	- aye
	Mr. Albert	- abstain
	Dr. Madia	- aye
	Dr. Suppan	- aye
	Mr. Morris	- nay
	Dr. Ramprasad	- abstain

The motion to table carried.

.....

Dr. Talmage returned to the meeting before resumption of this discussion.

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Dr. Steinbergh moved to remove the topic of Douglas A. Bruns, D.O., from the table for further discussion. Dr. Strafford seconded the motion. All members voted aye. The motion carried.

Dr. Steinbergh moved to amend the Proposed Order as follows:

It is hereby ORDERED that:

A. **SUSPENSION OF CERTIFICATE, STAYED; PROBATION**: The certificate of Douglas A. Bruns, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of at least 180 days. Such suspension is STAYED, subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least two years:

1. **Obey the Law**: Dr. Bruns shall obey all federal, state, and local laws, and all rules governing the practice of osteopathic medicine and surgery in the state in

which he is practicing.

2. **Declarations of Compliance**: Dr. Bruns shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which this Order becomes effective. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances**: Dr. Bruns shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which this Order becomes effective, or as otherwise directed by the Board. Dr. Bruns shall also appear in person upon his request for termination of the probationary period, and/or as otherwise directed by the Board.

4. **Patient Safety System Course(s)**: Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Bruns shall submit acceptable documentation of successful completion of a course or courses dealing with patient safety systems, such as Crew Resource Management. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

   In addition, at the time Dr. Bruns submits the documentation of successful completion of the course(s) dealing with the patient safety systems, such as Crew Resource Management, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

5. **Monitoring Physician**: Prior to Dr. Bruns commencing practice in Ohio, or as otherwise determined by the Board, Dr. Bruns shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Bruns and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Bruns and his medical practice, and shall review Dr. Bruns' patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Bruns and his medical practice, and on the review of Dr. Bruns' patient charts. Dr. Bruns shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Bruns' declarations of compliance.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Bruns shall immediately so notify the Board in writing. In addition, Dr. Bruns shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Bruns shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Bruns' monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Bruns' monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

6. **Required Reporting of Change of Address**: Dr. Bruns shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

7. **Tolling of Probationary Period While Out of Compliance**: In the event Dr. Bruns is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

B. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Bruns' certificate will be fully restored.

C. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Bruns shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training, and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Bruns shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments.

   In the event that Dr. Bruns provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, he shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services.

   This requirement shall continue until Dr. Bruns receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other State Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Bruns shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any professional license or certificate. Also, Dr. Bruns shall provide a copy of this Order at the time of application to the proper licensing authority of any state or jurisdiction in which he applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. Bruns receives from the Board written notification of the successful completion of his probation.

3. **Required Documentation of the Reporting Required by Paragraph C**: Dr. Bruns shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (a) the return receipt of certified mail within 30 days of receiving that return receipt, (b) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order was hand delivered,

(c) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (d) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

Dr. Mahajan seconded the motion.

Dr. Amato stated that he would now entertain discussion of the above proposed amendment.

Dr. Strafford opined that something positive should result from this tragedy and suggested that Dr. Bruns be asked to construct a narrative or a protocol which would be useful for others who find themselves in a similar situation. Dr. Strafford stated that this incident is an indictment of the process.

Dr. Talmage exited the meeting at this time.

Dr. Steinbergh opined that the error in this case is a physician error, not a system error. Dr. Steinbergh noted that Dr. Bruns himself agrees that he made an error. Dr. Steinbegh also reiterated her concern about Dr. Bruns' decision-making process following the onset of the patient's symptoms and his failure to notify the emergency department the an error had potentially been made.

Dr. Steinbergh stated that the report Dr. Bruns will be required to produce on the patient safety systems course will not only stimulate his thoughts on this issue, but will also teach others. Dr. Steinbergh believed that Dr. Bruns will never make this same mistake again, but wants him to be aware that there are other mistakes that can be made. If patient safety systems are followed, then the possibilities of such errors can be reduced.

Mr. Morris stated that this case is not simply about punishment, but also about accountability. Mr. Morris stated that he is troubled that an argument for a system error may be used as a rationale for not imposing a particular penalty on Dr. Bruns. Mr. Morris stated that he supported a real suspension of Dr. Bruns' license without a stay.

Dr. Amato opined that, although Dr. Bruns did make an error, there is a system problem in this case. Dr. Amato noted that Dr. Bruns was not on the faculty of the institution teaching the student technologist. Dr Amato questioned where the institution was in this case where one of their students was allowed in the room without her instructor. Dr. Amato also noted that there were at least three empty bottles in the sharps container and stated that if there had been only one empty container, there would have been no question what contrast was injected. Dr. Amato questioned why the hospital had not totally cleaned the room.

Dr. Amato opined that the role of the Medical Board should be protection, not punishment. Dr. Amato further opined that Dr. Bruns has already punished himself. Dr. Amato supported the stayed suspension and noted that this punishment is more than what was recommended by the hearing examiner.

A vote was taken on Dr. Steinbergh's motion to amend:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- nay
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Amato	- aye
	Mr. Albert	- abstain
	Dr. Madia	- aye
	Dr. Suppan	- aye
	Mr. Morris	- nay
	Dr. Ramprasad	- aye

The amendment carried.

Dr. Steinbergh moved to approve and confirm Ms. Petrucci's Findings of Fact, Conclusions of Law, and Proposed Order, as amended, in the matter of Douglas A. Bruns, D.O. Dr. Mahajan seconded the motion. A vote was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Amato	- aye
	Mr. Albert	- abstain
	Dr. Madia	- aye
	Dr. Suppan	- aye
	Mr. Morris	- aye
	Dr. Ramprasad	- aye

The motion carried.

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

December 9, 2009

Case number: 09-CRF- 166

Douglas A. Bruns, D.O.
44 West Lakeside Avenue
Lakeside Park, Kentucky 41017

Dear Doctor Bruns:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

(1) On or about October 11, 2004, you performed a lumbar myelogram on Patient 1. (Patient 1 is identified on the attached Patient Key. **The Patient Key is confidential and not subject to public disclosure**). During the lumbar myelogram, you injected a contrast intrathecally into Patient 1. While you intended to inject a non-ionic contrast iopamidol [Isovue 200®], you did not verify the substance before you injected it, and instead injected an ionic contrast Iothalamate meglumine [Conray®] into Patient 1. Iothalamate meglumine [Conray®] is not approved for intrathecal injection. The patient developed complications from the injection of Iothalamate meglumine [Conray®] and died on or about October 11, 2004.

Your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Mailed 12-10-09

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

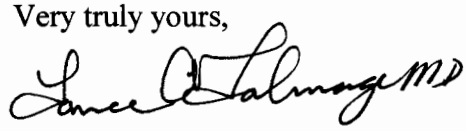
You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.
Secretary

LAT/CDP/flb
Enclosures

CERTIFIED MAIL #91 7108 2133 3936 3070 8914
RETURN RECEIPT REQUESTED

cc: Eric J. Plinke, Esq., Dinsmore & Shohl, LLP, 191 West Nationwide Blvd., Suite 300, Columbus, Ohio 43215-2568

CERTIFIED MAIL #91 7108 2133 3936 3070 8907
RETURN RECEIPT REQUESTED

IN THE MATTER OF
DOUGLAS A. BRUNS, D.O.

09-CRF-166

DECEMBER 9, 2009 NOTICE OF OPPORTUNITY FOR HEARING PATIENT KEY

SEALED TO PROTECT PATIENT CONFIDENTIALITY AND MAINTAINED IN CASE RECORD FILE.