

COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO
CIVIL DIVISION

TERMINATION NO. 10
BY 2-4-09

E. ALLAN BREWER, M.D.

:

Appellant,

:

CASE NO. 08CVF-08-12488

-vs-

:

JUDGE DALE A. CRAWFORD
(By Assignment)

STATE MEDICAL BOARD OF OHIO,

:

Appellee.

:

DECISION AND ENTRY AFFIRMING THE AUGUST 13, 2008 ORDER OF THE
STATE MEDICAL BOARD OF OHIO

Rendered this 4 day of February 2009

CRAWFORD, JUDGE,

This matter comes before this Court upon an appeal pursuant to R.C. § 119.12 from
An August 13, 2008 Order of the State Medical Board of Ohio (hereinafter the "Board").
The Board approved the Proposed Order of the Hearing Officer permanently revoking
Appellant's license to practice medicine. See August 13, 2008 Entry of Order. The record
certified by the Board can be summarized as follows:

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FRANKLIN CO., OHIO
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CLERK OF COURTS

In an August 9, 2007 letter, the Board notified appellant that it was taking
disciplinary action against his license to practice medicine in Ohio based on two violations.
See State's Exhibit 1A. The Board's actions pursuant to 4731.22(B)(24) were based on
allegations that the Department of Veterans Affairs had suspended appellant's clinical
privileges to practice medicine at a VA Medical Center in Texas. The record shows that on
April 17, 2003 the Department of Veterans Affairs, West Texas VA Health Care system
summarily suspended Dr. Brewer's clinical privileges. State's Exhibit 2, at 85.

In the same August 9, 2007 citation letter, the Board notified appellant that he was

also being charged with violating R.C. 4731.22(B)(15) since he had violated conditions placed upon him by the Board in a July 10, 1996 Order. Appellant previously was disciplined by the Board and his license to practice medicine in Ohio was indefinitely suspended. He was also subjected to probationary terms based upon his violations of R.C. 4731.22(B)(2) and (B)(6). See State's Exhibit 3.

The Board at that time concluded that appellant failed to employ acceptable scientific methods in the selection of modalities for treatment of disease and that he failed to conform to minimal standards of care with respect to treatment of patients in his urology practice. See State's Exhibit 3. The record shows that appellant completed a fellowship in his specialty and assured the Board that he had been rehabilitated and that there would be no further issues with his charting and patient care procedures. Based on these assurances, on February 12, 2003 the Board granted appellant's request for reinstatement. State's Exhibit 4. In the time between 1996 and 2003, appellant had been practicing at the VA Medical Center in Texas under his California license. State's Exhibit 2, at 84; Tr. 84.

The notification in 2003 that appellant's license has been reinstated in Ohio prompted the VA in Texas to investigate appellant's situation further. Appellant explained that the VA became concerned when it was alerted to the fact that his Ohio license was subject to restrictions, particularly the requirement that if he practiced in Ohio he must have a monitoring physician. See Tr. 71. Likewise, the Medical Board of California became concerned and informed the VA that appellant was placed on a "tolled out-of-state probation status" because he did not reside or practice in that state. Appellant explained at the hearing that the California disciplinary order was prompted by the notification of his 2003 Ohio reinstatement and the 1996 Ohio Order placing restrictions on his license to practice

medicine. See State's Exhibit 3, at 86; Tr. 87.

In the matter now before this court the record shows that on April 17, 2003, the Department of Veterans Affairs, West Texas VA Health Care system, summarily suspended appellant's clinical privileges and placed him on paid administrative leave while the matter was investigated. See State's Exhibit 3, at 85. Upon gathering pertinent information for a period of approximately five months, in September 2003 the VA Medical Center allowed appellant to return to work under an assignment with reduced privileges. The VA Medical Center concluded in January/February 2004 that appellant's reduction in privileges was definite and final and there would be no further review.

Appellant's reduction/restriction of privileges at the VA Medical Center was based upon a peer review conducted by Dr. Saeed Akhter. Dr. Akhter reviewed thirty-two (32) of appellant's urology cases and presented his findings to the VA. The VA found inadequacies and errors reflected in the patients' charts. See State's Exhibit 2, at 41, 61-81.¹ Evidence in the record shows that appellant was informed of his right to review the evidence, respond to the allegations and request a hearing on the matter. See State's Exhibit 2, at 55-56.

Although appellant claims he requested a hearing, there is nothing in the record that substantiates appellant's assertion that he did, in fact, timely request a hearing before the VA Medical Center through his Texas attorney. The court will note that even if appellant requested a hearing through his Texas attorney, there is no evidence or documentation that either appellant or his Texas attorney pursued the matter any further. To the contrary, the record shows that appellant notified the VA Medical Center on June 14, 2004 that he would

¹ A memorandum dated August 4, 2004 shows that Peter R. Auriemma, M.D., Chief of Urology at the Carl T. Hayden Veterans Administration Medical Center in Phoenix, Arizona, completed a case review on appellant and submitted his findings to the Quality Manager at the VAMC Big Spring, Texas. See State's Exhibit 2, at 10-12, 15-18.

not be renewing his clinical privileges (which privileges were already reduced) at the VA Medical Center in Big Spring, Texas when his term expired in August 2004. See State's Exhibit 2, at 19; Tr. 23-25, 32-33. Moreover, it was appellant's responsibility to pursue the matter with the VA further and not leave it unresolved.

In the fall of 2004 appellant moved to Indianapolis, Indiana. Since appellant does not possess a license to practice medicine in Indiana, appellant enrolled in a graduate program. The record demonstrates that while in Indiana, the appellant worked with Clarian Health Partners in an administrative capacity as an educational requirement for a master's of health administration degree. On January 18, 2006 the VA Medical Center notified the State Medical Board of Ohio of its determination regarding appellant. See State's Exhibit 2, at 5-6.

The hearing in the matter now before this court took place before Hearing Examiner Patricia Davidson on March 5, 2008. The Hearing Examiner filed her Report and Recommendation on July 14, 2008. The Hearing Examiner recommended that appellant's license to practice medicine be permanently revoked. The Board reviewed the record and voted 10-0 to approve the Proposed Order as recommended by the Hearing Examiner.² The Board's August 13, 2008 Order permanently revoked appellant's license to practice medicine in the state of Ohio. Appellant filed a timely appeal and the matter is now before this court.

STANDARD OF REVIEW

R.C. § 119.12 sets forth the standard of review a common pleas court must follow when reviewing an administrative appeal. R.C. 119.12 provides in pertinent part:

The court may affirm the order of the agency complained of in the appeal if it

² Two members of the Board abstained from voting.

finds, upon consideration of the entire record and such additional evidence as the court has admitted, that the order is supported by reliable, probative and substantial evidence and is in accordance with law.

In *Our Place* the Ohio Supreme Court provided the following definition of reliable, probative and substantial evidence as:

(1) 'Reliable' evidence is dependable; that is, it can be confidently trusted. In order to be reliable, there must be a reasonable probability that the evidence is true. (2) 'Probative' evidence is evidence that tends to prove the issue in question; it must be relevant in determining the issue. (3) 'Substantial' evidence is evidence with some weight; it must have importance and value.

Our Place, Inc. v. Ohio Liquor Comm. (1992), 63 Ohio St. 3d 570, 571.

Once the common pleas court has determined that the administrative agency's order is supported by reliable, probative and substantial evidence, the court must then determine whether the order is in accordance with law. See R.C. § 119.12. The reviewing court cannot substitute its judgment for the agency's decision where there is some evidence supporting the decision. See *Harris v. Lewis* (1982), 69 Ohio St. 2d 577, 579; see also *University of Cincinnati v. Conrad* (1980), 63 Ohio St. 2d 108.

Moreover, the common pleas court has no authority to modify a penalty that the agency was authorized to, and did impose, on the ground that the agency abused its discretion. When reviewing a Medical Board's order, courts must accord due deference to the Board's interpretation of the technical and ethical requirements of its profession. See *Coniglio v. State Med. Bd. of Ohio*, 2007 Ohio 5018.

LAW AND ARGUMENT

On August 9, 2007 the Board notified appellant that it intended to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate his certificate to practice medicine and surgery, or to reprimand him or place him on probation

for one of the following reasons:

- (1) On or about July 10, 1996, the Board issued an Entry of Order [Ohio Order] that indefinitely suspended your certificate to practice medicine and surgery in Ohio, but not less than three months, and subjected you to certain probationary terms, conditions and limitations, based upon violations of Section 4731.22(B)(2) and (B)(6), Ohio Revised Code. The Ohio Order concluded that you failed to employ acceptable scientific methods in the selection of modalities for treatment of disease, and that you failed to conform to minimal standards of care with respect to treatment of patients in the course of your practice of urology. On or about February 12, 2003, the Board granted your request for reinstatement of your Ohio certificate, subject to the probationary terms, conditions and limitations placed pursuant to the Ohio Order. As of this date, your certificate to practice medicine and surgery in Ohio remains subject to the probationary terms, conditions and limitations of the Ohio Order, a copy of which is attached hereto and incorporated herein.
- (2) Paragraph 3.b of the Ohio Order requires that you appear in person for an interview every three months before the full Board, or its designated representative.

Despite this requirement, since in or about February 2005, you have failed to appear at all scheduled appearances before the board or a designated representative of the Board.

- (3) Paragraph 3.c of the Ohio Order requires that you submit quarterly declarations stating whether there has been compliance with all the conditions found in the Ohio Order.

Despite this requirement, since in or about February 2005, you have failed to submit quarterly declarations of compliance.

- (4) On or about April 17, 2003, the Department of Veterans Affairs, West Texas VA Health System [West Texas VA] summarily suspended your clinical privileges. After reviewing evidence, the West Texas VA subsequently found, *inter alia*, the following in its Determination Letter dated January 12, 2006: failure to properly document examinations, assessments, and treatment of patients; lack of diagnostic or treatment capability; and inability to perform procedures considered basic to the performance of your occupation as a urologist. Further, the West Texas VA found you to have failed to conform to generally accepted standards of clinical practice so as to raise reasonable concern for the safety of patients. Copies of selected portions of the State Licensing Board Reporting File from the West Texas VA are attached hereto and incorporated herein.

See State's Exhibit 1A.

First and foremost, what stands out to this court is the similarity of the reasons regarding appellant's falling below the minimal standards of treatment and patient care set forth in paragraph 1 by the 1996 Ohio Order and the allegations set forth in paragraph 4 by the West Texas VA.³ See State's Exhibit 2, at 7. The court's observation is substantiated in Dr. Powell's May 19, 2003 letter to appellant wherein he informs him that "a majority of the patients undergoing a TURP had the same issues" that had been identified by the Ohio Board. See State's Exhibit 2, at 84. Thus, as a result of a peer review of a sampling of appellant's cases by local VA physicians and Quality Management Nurses, the Professional Standards Board concluded, very much the same as the Ohio Medical Board had concluded years earlier, that appellant had demonstrated a consistent pattern of conduct in failing to meet minimal standards of patient care. See State's Exhibit 2, 41, 84; See also Report and Recommendation, p. 7.

Therefore, this court will address the two separate violations of the Ohio Medical Practices Act that appellant is charged with violating. Specifically, appellant is charged with violating R.C. 4731.22(B)(15) wherein he did not comply with paragraph 3 (c) of the 1996 Ohio Order, and R.C. 4731.22(B)(24) which is based upon the VA's April 2003 action summarily suspending the privileges of appellant to practice in the Texas VA Medical Center.

Appellant's Non-Compliance with the 1996 Ohio Order pursuant to R.C. 4731.22(B)(15).

Paragraph 3 (c) of the 1996 Ohio Order required appellant to submit quarterly

³ Prior to the hearing, the appellee learned that the Board's Compliance Officer, Danielle Bickers, sometime around February 2005, orally informed appellant that he did not need to make in-person appearances before the Board. Appellant, in good faith, relied on her representation. Accordingly, rather than request a continuance so that the Board could dismiss that portion of the notice letter, the parties reached an agreement. They agreed that the appellee would not present any evidence in regard to the allegations set forth in paragraph 2 of the August 9, 2007 notice letter and appellant agreed that he would waive any statutory claim to seek attorney's fees regarding content or allegations of paragraph 2. See Tr. 7-8. Consequently, the allegations set forth in paragraph 2 of state's Exhibit 1A are not at issue in this appeal. See Report and Recommendation, p. 2-3.

declarations stating whether he had complied with all the terms and conditions set forth in the 1996 Order. See State's Exhibit 1A. However, the record shows that after February 2005, appellant admitted that he failed to submit those required quarterly compliance reports. Tr. 19-20. Appellant's explanation to the Hearing Examiner is that he stopped submitting them because he was not sure whether he was required to do so.

The Hearing Officer found that appellant lacked credibility on this point since it was his obligation to clarify his continuing duties under the 1996 Ohio Order and not stop compliance on his own accord. Consequently, the Hearing Officer concluded as a matter of law that appellant had violated "the conditions of limitation placed by the board upon a certificate to practice," pursuant to R.C. 4731.22(B)(15). Accordingly, there is reliable, substantial and probative evidence to conclude from appellant's own admission that he violated the conditions of limitation placed on his certificate to practice medicine in Ohio pursuant to R.C. 4731.22(B)(15). See Tr. 18-23.

The VA's reduction/revocation of appellant's clinical privileges in violation of R.C. 4731.22(B)(24).

The VA's summary suspension of appellant's clinical privileges invested authority in the Board to pursue disciplinary action against his Ohio medical license.

R.C. 4731.22(B)(24) provides as follows:

The board, by an affirmative vote of not fewer than six members, shall, to the extent permitted by law, limit, revoke, or suspend an individual's certificate to practice, refuse to register an individual, refuse to reinstate a certificate, or reprimand or place on probation the holder of a certificate for one or more of the following reasons:

* * *

(24) The revocation, suspension, restriction, reduction, or termination of clinical privileges by the United States department of defense or department of veterans affairs or the termination or suspension of a certificate of registration

to prescribe drugs by the drug enforcement administration of the United States department of justice...

The record demonstrates that appellant was summarily suspended from the Texas VA Health Care System as of April 17, 2003. See State's Exhibit 2, at 82 and 85. He was placed on administrative leave for approximately five months, from April 2003 until September 2003. See Tr. 29-30. Appellant was removed from administrative leave, ordered to report to work, but was given a different assignment with reduced privileges. From September 2003 until the time that appellant resigned in August 2004, he was assigned the task of performing disability examinations. Tr. 30-33. The record shows that this position involved a reduction/revocation of his clinical privileges and his ability to provide independent medical care to patients. Tr. 25-30.

The VA reviewed thirty two (32) of appellant's urology cases (wherein the record illustrates that appellant was the primary attending physician) in which it found inadequacies and errors in the patients' charts. The records from the West Texas VA show that the medical center reviewed the decision to reduce appellant's privileges and concluded in January/February of 2004 that the reduction of appellant's privileges was definite and final. See State's Exhibit 2, at 20, 56.

The evidence demonstrates that appellant was informed that he had a right to review the evidence, respond to the decision, and request a hearing in that matter. See State's Exhibit 3. The record is devoid of any evidence that appellant actually requested and/or was denied a hearing. Appellant asserts that he did ask for a hearing through his Texas attorney, but failed to proffer any evidence to substantiate this claim.

Appellant asserts that the action taken by the West Texas VA, to suspend his clinical privileges, was not a final action and therefore cannot be considered by the Ohio Board. In

essence, appellant is attempting to collaterally attack the West Texas VA action. However, pursuant to the holding in *Coniglio v. State Med. Bd. of Ohio*, the appellant cannot use this action to collaterally attack the VA's decision. See *Coniglio*, 2007 Ohio 5018. Based on the undisputed fact that appellant's clinical privileges were summarily suspended by the VA, there was a sufficient enough basis to trigger the Ohio statute regarding this issue.

R.C. 4731.22(B)(24) gives the Ohio Board the authority to take action against the appellant by virtue of the fact that the VA took action against appellant by suspending his clinical privileges when they placed him on administrative leave in April 2003 and when they reduced his clinical privileges when he returned to work in September 2003. See Tr. 25-30. The record shows that appellant was given the opportunity to challenge the decision of the West Texas VA Medical Center and did not avail himself of that opportunity. See Sstate's Exhibit 2. Moreover, it is not incumbent upon this court to address whether appellant was afforded due process in the West Texas VA action back in 2004. Appellant has admitted on the record that the Texas VA placed him on a five month administrative leave, suspended his clinical privileges and ability to practice medicine, and during that time investigated his patient care, diagnostics, and medical charting among other things. He then was ordered to return to work and was assigned a position that reduced his clinical privileges and ability to provide independent medical care to patients. See Tr. 25-30.

Accordingly, there is reliable, substantial and probative evidence to conclude from appellant's own admission that there was either a revocation, suspension, restriction or termination of his clinical privileges which violated R.C. 4731.22(B)(24). See Tr. 25-30.

APPELLANT'S ARGUMENTS

Although appellant does not set forth specific assignments of error, appellant asserts that the Board's Order is not supported by reliable, probative and substantial evidence and is not in accordance with law. Appellant argues:

It is crucial that the Court understand that there is not a scintilla of non-hearsay evidence in this record which supports an action against Dr. Brewer because of clinical issues. There are no charts in evidence; there is no sworn expert testimony; there are no records of bad or unacceptable outcomes; and, there are no final adverse actions in the record.

It is undeniable that the VA commenced an investigation of Dr. Brewer's clinical care two months after his Ohio medical license was reinstated. However, as detailed in the attached "Objections," this VA investigation never culminated in a final action, supported by competent evidence. For the Ohio Board to then rely on a record wholly deficient of evidence means that the Ohio order itself cannot be found to contain reliable, probative and substantial evidence as required under Ohio law. Ohio law requires that the Medical Board must base its decision upon reliable, probative, and substantial evidence. However, the Board apparently engaged in factual speculation in concluding that Dr. Brewer "must have" been culpable for substandard care at the VA, irregardless (sic) of the lack of a final action by the VA. Speculation has recently been defined as "****theorizing about a matter upon which the evidence is *insufficient* to support a conclusion either way." (Emphasis sic.)

This court has addressed that appellant's admissions in his testimony, in addition to other evidence in the record , provide reliable, probative and substantial evidence to support the August 13, 2007 Order of the Board. However, this court will address appellant's arguments. Upon review, it was permissible for the Board to rely on evidence that may have been based on hearsay. Statements or other evidence that may constitute inadmissible hearsay are permitted in administrative proceedings where the rules of evidence are relaxed. See *Simon v. Lake Geauga Printing Co.*, (1982), 69 Ohio St.2d 41, 44. However, discretion to consider hearsay evidence cannot be exercised in an arbitrary manner. See *Fox v. Parma Community Gen. Hosp.*, 160 Ohio App.3d 409 quoting *Menon v. Stouder Mem. Hosp.* (Feb. 21, 1997), 1997 Ohio LEXIS 567. This court concludes, after a thorough review of the

record, that the Hearing Examiner did not admit hearsay evidence arbitrarily.

Appellant also objected to a portion of appellee's evidence wherein persons making statements in certain documents had not been called as witnesses and thus, were not subject to cross-examination. However, the Hearing Examiner noted that the appellant had the same issue with several of his exhibits, particularly noting the deputy undersecretary for health operations and management in Respondent's Exhibit A, Dr. Tiu in Respondent's Exhibit B, and the writers in Respondent's Exhibits C, D, and E. See Tr. 88-89. After reviewing the record, this court concurs with the Hearing Examiner's evidentiary rulings.

The Board's primary mission is to protect the public. The Board is comprised of twelve members: nine physicians and three non-physician public members. Each board member is appointed by the Governor and serves a five-year term. Thus, a majority of the Board's members are experts in their own right since they are doctors and already possess the specialized knowledge needed to determine the acceptable standard of general medical practice. See *Arlen v. The State Medical Board of Ohio* (1980), 61 Ohio St. 2d 168; see also *In re Williams* (1991), 60 Ohio St. 3d 85, 87.⁴ This court concludes that a majority of the Board members themselves possess the expertise necessary to determine if the appellant fell below the minimum standards of practice and all other matters regarding appellant's conduct that were before the Board. Thus, appellant's argument that there was no sworn expert testimony is not well-taken. Accordingly, this Court concludes that there was reliable, probative and substantial evidence that appellant had a fair and impartial hearing, and that the hearing was conducted in accordance with law.

Appellant also asserts that there are no charts in evidence, no records of bad or

⁴ The Medical Board is comprised of twelve members: nine physicians and three non-physician public members. Each Board member is appointed by the Governor and serves a five-year term.

unacceptable outcomes, and that there is no final adverse action regarding the action taken against appellant by the West Texas VA. As was addressed previously, the holding in the *Coniglio* case is applicable and thus, this court will not allow appellant to collateral attack the action taken against him by the West Texas VA. The Hearing Examiner made a conclusion of law that there was “sufficiently finality of decision-making by the VA, by the end of February 2004 if not before, to warrant disciplinary action by the Board under R.C. 4731.22(B)(24) based on a reduction of clinical privileges by the VA.” See Report and Recommendation, p. 23. The Board agreed with this conclusion of law and, based on the evidence, this court concurs. Even when assuming that appellant or his Texas attorney made a request for a hearing, there is no evidence or other documentation that either the appellant or his attorney pursued the matter. Clearly, it was appellant’s responsibility to follow through with this matter and not leave it unresolved.

In this case, the evidence supports that in 1996 the Board disciplined appellant for conduct that related to the potential for harm to patients:

- (1) failure to use reasonable care/discrimination in the administration of drugs and/or failure to employ acceptable scientific methods in the selection of drugs or other treatment modalities, and
- (2) the departure from, or failure to conform to, minimal standards of patient care.

As noted by the Hearing Examiner, in 1996, the Board was presented with evidence that after having lost his hospital privileges, appellant obtained further training and successfully completed a fellowship in his area of specialty. When appellant appeared before the Board in 1996, he assured the Board that he had improved his charting practices and patient care. He presented to the Board, in essence, that his knowledge and skills had been rehabilitated by the additional training and experience and that he anticipated no

further problems with charting and patient care.

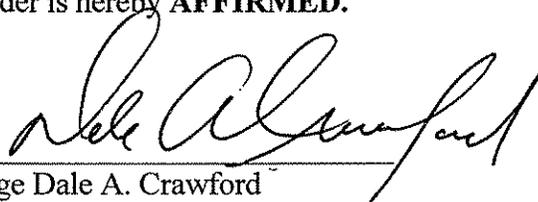
Approximately ten years later, the Board was presented with essentially the same deficiencies, as documented by the VA. See State's Exhibit 3. However, in this instance, the Board was not shown any evidence that appellant had undergone any rehabilitation. Clearly, the additional training appellant received in the 1990s and the 1996 Ohio Board disciplinary action failed to maintain and/or sustain any rehabilitative effect.

Accordingly, this court concludes that the conduct of appellant as set forth in the Hearing Examiner's Findings of Fact and Conclusions of Law and as supported by the record, provide that there is reliable, probative and substantive evidence that appellant violated R.C. 4731.22(B)(15) and (24). Therefore, appellant's arguments are not well-taken and are hereby **OVERRULED**.

DECISION

Based on the foregoing, and upon a review of the record, this court concludes that there is reliable, probative and substantial evidence supporting the August 13, 2008 Order of the State Medical Board of Ohio. Moreover, this court concludes that the Board's Order is in accordance with law. The Board's August 13, 2008 Order is hereby **AFFIRMED**.

It is so ordered.



Judge Dale A. Crawford

Copies to:

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Counsel for Appellee

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO
CIVIL DIVISION

E. Allan Brewer, MD,
8911 Pennwood Court
Indianapolis, Indiana 46240
Appellant,

v.

State Medical Board of Ohio,
30 East Broad Street, 3rd Floor
Columbus, Ohio 43215
Appellee.

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*

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CASE NO. _____

JUDGE _____

FILED
COMMON PLEAS COURT
FRANKLIN CO., OHIO
2008 AUG 29 PM 1:52
CLERK OF COURTS

Appeal from the State Medical Board of Ohio

APPELLANT'S NOTICE OF APPEAL

Pursuant to RC §119.12, notice is hereby given that Appellant, E. Allan Brewer, MD, appeals the order of the State Medical Board dated August 13, 2008, and mailed August 15, 2008, (copy attached as *Exhibit A.*) The Medical Board order is not supported by the necessary quantum of reliable, probative and substantial evidence nor is it in accordance with law.

Respectfully submitted,

KEVIN P. BYERS CO., L.P.A.

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Attorney for E. Allan Brewer, MD

STATE MEDICAL BOARD
OF OHIO
2008 AUG 29 P 1:35

STATE MEDICAL BOARD
2008 SEP -9 P 2:20

Certificate of Service

I certify that the original of the foregoing document was hand-filed this 29th day of August, 2008, at the State Medical Board, 30 East Broad Street, 3rd Floor, Columbus, Ohio 43215 with a copy filed this same date in the Court of Common Pleas of Franklin County in accord with RC §119.12 and Ohio caselaw¹, with a courtesy copy mailed to Assistant Attorney General Kyle C. Wilcox, Health & Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215-3426.

KPB:AS
Kevin P. Byers

STATE MEDICAL BOARD
OF OHIO

2008 AUG 29 P 1:35

STATE MEDICAL BOARD
2008 SEP -8 P 2:20

¹ Stultz v. Oh. Dept. of Admin. Svcs. 10th Dist. No. 04AP-602, 2005-Ohio-200

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



August 13, 2008

Eugene Allan Brewer, M.D.
8911 Pennwood Court
Indianapolis, IN 46240

Dear Doctor Brewer:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Patricia A. Davidson, Esq., Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on August 13, 2008, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

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 setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of an original Notice of Appeal with the State Medical Board of Ohio and a copy of the Notice of Appeal with the Franklin County Court of Common Pleas. 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

A handwritten signature in black ink, appearing to read "Lance A. Talmage M.D.", is written over the typed name.

Lance A. Talmage, M.D.
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3934 3487 3016
RETURN RECEIPT REQUESTED

CC: Kevin P. Byers, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3934 3487 3023
RETURN RECEIPT REQUESTED

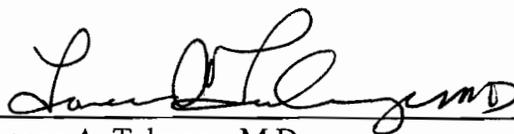
*Remailed 9/15/08 via
Certificate of mailing*

Mailed 8.15.08

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Patricia A. Davidson, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on August 13, 2008, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Eugene Allan Brewer, M.D., 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, M.D.
Secretary

(SEAL)

August 13, 2008

Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

EUGENE ALLAN BREWER, M.D.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on August 13, 2008.

Upon the Report and Recommendation of Patricia A. Davidson, 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 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:

The certificate of Eugene Allan Brewer, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

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

(SEAL)



Lance A. Talmage, M.D.
Secretary

August 13, 2008

Date

2008 JUL 14 P 12: 06

**REPORT AND RECOMMENDATION
IN THE MATTER OF EUGENE ALLAN BREWER, M.D.**

The Matter of Eugene Allan Brewer, M.D., was heard by Patricia A. Davidson, Hearing Examiner for the State Medical Board of Ohio, on March 5, 2008.

INTRODUCTION

Basis for Hearing

By letter dated August 9, 2007, the State Medical Board of Ohio notified Eugene Allan Brewer, M.D., that it intended to determine whether or not to take disciplinary action against his certificate to practice medicine and surgery in Ohio.¹ The Board's proposed action was based on allegations that the Department of Veterans Affairs had taken adverse action with regard to Dr. Brewer's clinical privileges to practice at a VA medical center in Texas. In addition, the Board stated that Dr. Brewer had failed to comply with probationary terms in a Board Order issued in 1996, in that Dr. Brewer had allegedly failed to make quarterly personal appearances and file quarterly declarations as required.

The Board charged that the action by the VA constitutes "[t]he revocation, suspension, restriction, reduction, or termination of clinical privileges by the United States department of defense or department of veterans affairs or the termination or suspension of a certificate of registration to prescribe drugs by the drug enforcement administration of the United States department of justice," as that language is used in Ohio Revised Code Section [R.C.] 4731.22(B)(24). The Board further charged that Dr. Brewer's conduct constituted a "[v]iolation of the conditions of limitation placed by the board upon a certificate to practice," as that language is used in R.C. 4731.22(B)(15).

The Board advised Dr. Brewer of his right to a hearing upon request, and received his request for hearing on September 4, 2007. (St. Ex. 1A, 1B)

Appearances

Nancy H. Rogers, Attorney General, and Kyle C. Wilcox, Assistant Attorney General, for the State.

Kevin P. Byers, Esq., for the Respondent.

EVIDENCE EXAMINED

Testimony Heard

Eugene Allan Brewer, M.D.

¹ This matter does not have a case number because the Notice was issued before October 2007.

Exhibits Examined

- A. State's Exhibit 1: Procedural exhibits (including St. Ex. 1I, admitted July 14, 2008).

State's Exhibit 2: Documents from the VA regarding Dr. Brewer.

State's Exhibit 3: Documents maintained by the Board regarding Dr. Brewer, including the Board's 1996 Order and the 1996 Report and Recommendation.

State's Exhibit 4: Minutes regarding Dr. Brewer from the Board's February 2003 meeting.

State's Exhibit 5: Affidavit of Danielle Bickers, the Board's Compliance Supervisor.

- B. Respondent's Exhibit A: Letter from a VA Deputy Undersecretary in November 2002 including positive commentary on Dr. Brewer's work.

Respondent's Exhibits B through D: Letters from Dr. Brewer's fellow physicians in September 2003, supporting the restoration of his California medical license.

Respondent's Exhibit E: Letter of support in February 2004 from a physician assistant who assisted Dr. Brewer and had also been Dr. Brewer's surgical patient.

Respondent's Exhibits F through H: Three proficiency reports from the VA regarding Dr. Brewer. [The Hearing Examiner redacted Social Security numbers post-hearing.]

Respondent's Exhibit I: A draft report by J. Lance Pickard, M.D., dated April 30, 2004, setting forth opinions regarding the practice of urology and Dr. Brewer's patient records.

**STIPULATION REGARDING PARAGRAPH 2
OF THE NOTICE OF OPPORTUNITY FOR HEARING**

At the beginning of the hearing, the State and the Respondent notified the Hearing Examiner that they had reached agreement regarding the allegations in Paragraph 2 of the notice of opportunity for hearing [Notice], which charged that Dr. Brewer, beginning in about February 2005, had failed to make quarterly appearances as required in the Board's 1996 Order. Assistant Attorney General Wilcox explained that he had learned, upon discussion with Danielle Bickers, the Board's Compliance Supervisor, that the Board's Supervising Member had orally informed Dr. Brewer during a meeting in or about February 2005 that Dr. Brewer "did not need to make the in-person appearances before the Board until the end of his probationary period." Ms. Bickers explained that she had discovered this information upon reviewing her notes regarding Dr. Brewer. (Tr. at 6-7)

Mr. Wilcox further advised that, while the Board has authority to change the frequency of personal appearances, the Board itself had not made any change to Dr. Brewer's required appearances. Nonetheless, the parties stipulated that Dr. Brewer had stopped making personal appearances based on his good-faith reliance on the Supervising Member's statement, and they considered the most

expeditious manner to address this new information. (Tr. at 7) The parties felt that amending the Notice to remove the allegation would cause undue delay. Therefore, they agreed that the State would not present evidence to support the allegation regarding personal appearances, with the expected result of an adjudication that the violation had not been proven. The parties further stipulated that the Board was substantially justified in charging the violation under the circumstances. (St. Ex. 7-8)

SUMMARY OF THE EVIDENCE

All exhibits and transcripts of testimony were reviewed and considered by the Hearing Examiner, although not all items of evidence are included below.

Background

1. In 1995, the Board alleged that Eugene Allan Brewer, M.D., had failed to use reasonable care in the administration of drugs, to employ acceptable scientific methods in selecting drugs or other treatment modalities, and/or failed to conform to minimal standards of care. (St. Ex. 3 at 52-55) Following a hearing, the Hearing Examiner issued a Report and Recommendation providing an extensive review of Dr. Brewer's medical education, training, and employment, including the following information:
 - Dr. Brewer began medical school at the University of Louisville after completing three years of undergraduate school at the University of Kentucky. He received his bachelor's degree after his first year of medical school and received his medical degree in 1978 with honors in general surgery, cardiac physiology and environmental physiology.
 - Dr. Brewer began residency training at the University of Cincinnati Medical Center in general surgery and then interrupted that training in 1979 to complete a service obligation to the Navy, where he served as a General Medical Officer. He resumed his Cincinnati residency in 1980 and completed a four-year program in urology, serving as chief resident during his final year.
 - Dr. Brewer returned to active duty in 1984, serving as a staff urologist at the Bethesda Naval Hospital in Maryland. Following honorable discharge in 1987, Dr. Brewer entered a group practice in Kettering, Ohio, and earned board certification in urology. In 1989, Dr. Brewer opened a solo practice in Middletown, Ohio, where he practiced until April 1993.
 - Dr. Brewer obtained privileges at Middletown Regional Hospital (MRH), the only hospital at which he practiced. In 1992, when renewing his Ohio certificate, Dr. Brewer informed the Board that MRH had suspended his privileges to perform radical prostatectomies.
 - MRH had imposed a summary suspension of Dr. Brewer's privileges, prohibiting his performance of radical prostatectomies and limiting his performance of major, open, intra-abdominal and retroperitoneal procedures, allowing only surgeries performed with the assistance of a board-certified urologist or a board-certified surgeon. Further, MRH allowed

Dr. Brewer to perform transurethral resection of the prostate [TURP] only after obtaining a second opinion from a board-certified urologist and recording the opinion in the patient file. The limitations were based on concerns that the tissue specimens removed were unusually small and may not have constituted adequate surgical resection. Pathologists and surgeons had expressed concern regarding the small amount of tissue produced from Dr. Brewer's TURPs. The hospital subsequently upheld the limitations in March 1993.

- Dr. Brewer resigned his privileges and closed his practice in Middletown. He entered a fellowship program in Kansas City, Missouri, at the Mid-America Urologic Oncology Institute. He testified in 1996 that he had successfully completed the one-year fellowship and had then joined the practice of the institute's director, and had served as an assistant professor in the fellowship program.
- During the 1996 hearing Dr. Brewer stated that he was currently practicing general urology at the Guthrie Clinic in Sayre, Pennsylvania, having left the Kansas City practice because he was not busy enough. Dr. Brewer asserted that he had improved the care he provided to patients and had also improved his charting practices. He further stated that, due to his additional training and experience, he was providing superior care to patients.

(St. Ex. 3 at 17-18, 45)

The Board's 1996 Order

2. In an Order dated July 10, 1996, the Board adopted the following Findings of Fact (paragraph numbers omitted):

Dr. Brewer failed to perform and/or failed to document in his office records the necessary medical evaluation and/or preoperative examination of his patients sufficient to substantiate his diagnosis or support his choice of treatment.

Dr. Brewer failed to obtain and/or document cultures on Patient 8 prior to diagnosing prostatitis and instituting antibiotic therapy.

Dr. Brewer failed to sufficiently evaluate and/or document bladder function prior to performing a transurethral resection of the prostate (TURP) surgical procedure on Patients 5, 8 and 13.

Dr. Brewer failed to take and/or record in his office records and hospital chart a patient history of urinary obstructive signs and/or symptoms sufficient to support the need for surgical intervention prior to performing the TURP procedure in Patients 1, 2, 3, 8, 16, 18 and 19. Furthermore, Dr. Brewer documented a lack of urinary obstructive symptoms prior to surgery in the patient chart for Patients 1, 3 and 8.

In the routine course of his practice, Dr. Brewer frequently failed to attempt appropriate conservative therapy before subjecting his patients to surgery. Instances

of such practice include the care rendered to Patients 2, 3, 5, 6, 8, 13, 14, 16, 17, 18 and 19.

Dr. Brewer demonstrated a lack of knowledge of the healing process of tissue and/or a lack of understanding of the pathophysiology of prostate cancer.

Pathology reports indicate that prostate cancer was found in Patients 3, 10 and 12 incidental to Dr. Brewer's performance of a TURP. Instead of allowing adequate healing of prostate tissue in order to avoid surgical complications associated with additional surgery, or following these patients with repeat prostate biopsies or PSA² values to determine whether or not there was in fact any residual prostate cancer, Dr. Brewer scheduled these patients for radical retropubic prostatectomy (RRP), a complex and extensive operative procedure, within a very short time (less than two months) of the TURP. Patient 3 refused the surgery. Additionally, Patient 10 experienced the surgical complications which would be expected from the RRP so soon after the TURP.

The subsequent laboratory reports and PSA reports indicate that there was residual cancer in both Patient 10 and 12.

Dr. Brewer performed a RRP on Patient 9 despite the fact that he was seventy-six years old with numerous comorbid factors, making RRP inappropriate as treatment for cancer of the prostate. Patient 9 experienced operative and post-operative problems, as would be expected.

Dr. Brewer performed a RRP on Patient 17, a seventy-six year old male, despite the fact that the pathophysiology of prostate cancer in patients of this age group is such that conservative, nonsurgical intervention is the appropriate choice of treatment.

The pathology reports indicate that Dr. Brewer failed to obtain sufficient tissue for diagnostic purposes when doing needle biopsies of the prostate. Instances of such practice include Patients 2, 3, 7, 10 and 16 in which Dr. Brewer obtained single or two core needle biopsies to rule out cancer. The standard of care for needle biopsies of the prostate is for sextant biopsies to be taken. Obtaining a single or two core needle biopsy indicates a lack of knowledge of the pathophysiology of cancer of the prostate.

The State did not prove its allegation that in the routine course of his practice, Dr. Brewer's rectal exam findings frequently did not correlate with the actual size of the prostate as evidenced by a comparison of his clinical notes to his operative notes and surgical pathology reports. * * *

² The test for Prostate Specific Antigen is used to screen for cancer. (*E.g.*, St. Ex. 2 at 61-81)

The State did not prove its allegations regarding Patient 11.

(St. Ex. 3 at 4, 46-47)

3. In addition, the Board set forth two Conclusions of Law. First, the Board concluded that Dr. Brewer's acts, conduct, and/or omissions constituted a "(f)ailure to use reasonable care discrimination in the administration of drugs," and/or "failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as that language is used in R.C. 4731.22(B)(2).

Second, the Board concluded that Dr. Brewer's acts, conduct, and/or omissions constituted 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 language is used in R.C. 4731.22(B)(6). (St. Ex. 3 at 4, 47-48)

4. In its 1996 Order, the Board imposed sanctions including a suspension of Dr. Brewer's certificate to practice medicine and surgery in Ohio for an indefinite period of not less than three months. The Board imposed terms and conditions for reinstatement and also ordered probationary terms, conditions, and limitations for at least three years following reinstatement. (St. Ex. 3 at 3-6) The probationary terms include the following provisions in Paragraphs 3(b) and 3(c):

Dr. Brewer shall appear in person for interviews before the full Board or its designated representative at three (3) month intervals, or as otherwise requested by the Board.

Dr. Brewer shall submit quarterly declarations under the penalty of Board disciplinary action or criminal prosecution, stating whether he has complied with all the terms and conditions of his probation in this State and with all terms, conditions and limitations imposed by any other state medical board.

(St. Ex. 3 at 4)

New Employment in 1996 -- VA Medical Center in Texas

5. In July or August 1996, Dr. Brewer began employment at the VA Medical Center in Big Spring, Texas [the VA Medical Center], which was part of the VA West Texas Health Care System. Dr. Brewer received three proficiency reports for the period from July 1999 to July 2002. In each he was rated "High Satisfactory" in clinical competence. (Resp. Exs. F-H; Tr. at 17, 72)

Licensure Status in Ohio and California – 2003

6. At its meeting in February 2003, the Board voted to reinstate Dr. Brewer's Ohio certificate, subject to the probationary terms, conditions and limitations imposed by the Board in its 1996

Order. At the VA Medical Center, Dr. Brewer had been practicing under his California medical license. (St. Ex. 4; St. Ex. 2 at 84; Tr. at 84)

6. On April 17, 2003, the Medical Board of California informed the VA by facsimile transmission that Dr. Brewer was currently “on a tolled out-of-state probation status” in California because he did not reside and practice in that state. The California Board stated that a “tolled probation” means that “all of the terms and conditions of Dr. Brewer’s Decision Order are held in abeyance until such time he decides to return to [California] and engage in the practice of medicine.” Dr. Brewer explained in 2008 that he never practiced medicine in California and that the disciplinary order in California had resulted from the 1996 Order in Ohio. (St. Ex. 3 at 86; Tr. at 87)

Events at the VA Medical Center in 2003 & 2004

7. Summary suspension of privileges. On April 17, 2003, Cary D. Brown, the Director of the VA Medical Center, informed Dr. Brewer that his clinical privileges were suspended pending further review:

* * * [Y]our privileges at West Texas VA Health Care System are summarily suspended pending the conclusion of the current analysis of your state medical licensure status. As verbally instructed * * * you are temporarily reassigned to non-patient care, administrative activities until further written notice.

(St. Ex. 2 at 85)

8. Administrative leave. On May 19, 2003, Darryl Powell, M.D., the Chief of Staff at the VA Medical Center, advised Dr. Brewer that his clinical privileges were still under review and that he was being placed on administrative leave, with his duty station at home, until the issues were resolved. (St. Ex. 2 at 82-83; Tr. at 25-29) Dr. Brewer noted that he was on paid administrative leave during this time. (Tr. at 28)
9. Initial review of patient records. On May 19, 2003, Dr. Powell informed Dr. Brewer by letter that a review of his TURPs and radical retropubic prostatectomies from January 2001 to the present (May 2003) had been conducted by “local VA physicians and Quality Management Registered Nurses.” Dr. Powell further informed Dr. Brewer that the results of the review had been presented to the Professional Standards Board [PSB] and eventually to the Governing Board. He advised Dr. Brewer that the PSB had found that “a majority of the patients undergoing a TURP had the same issues” that had been identified by the Ohio Board.³ (St. Ex. 2 at 41, 84)

³ It appears that this May 2003 review of Dr. Brewer’s patient records was prompted, at least in part, by the Ohio Board’s reinstatement of his certificate in February 2003. Dr. Brewer testified that, when the Board reinstated his license, it disseminated information that his Ohio license was restored subject to probationary conditions established in a 1996 Order. Dr. Brewer explained that the VA had learned that his Ohio license was subject to restrictions including a requirement that, if he practiced in Ohio, he must have a monitoring physician. He stated that this requirement had raised concern within the VA. (Tr. at 71)

Dr. Powell, as Chief of Staff, further stated:

* * * Based on the standard of care set by the urologist in Ohio, the PSB and Governing Body concluded you do not meet the minimal standard of care in performing a TURP.

The majority of the electronic medical records contained “cut and paste” or “copy and paste” entries. The same entries were found on different patients with respect to certain portions of the history and almost all physical examinations. The medical record contained entries of different patients, often to the degree that the reviewers could not ascertain to which patient data made reference in the electronic medical record. The PSB deliberation concluded this was inappropriate documentation on most patients and falsification of the electronic medical record on other patients.

* * * The Medical Center Director stated the findings in the review of your patients and the PSB recommendations were sufficient to conclude you continue to have the same deficiencies as described in the Ohio and California documents[;] therefore you failed rehabilitation and your California Medical License is restricted.

If the revocation of clinical privileges is upheld, a report will be filed with the National Practitioner Data Bank, with a copy sent to all appropriate State Licensing Boards.

You have the right to be represented by an attorney or other representative of your choice throughout any proceedings.

You have ten (10) working days in which to submit a response to the notice, and granted an additional ten (10) days under extraordinary circumstances.

All information will be forwarded to the Medical Center Director for a decision.

(St. Ex. 2 at 84)

10. Peer review by a urologist. Following this initial review of Dr. Brewer’s patient records in May 2003, the VA Medical Center obtained a peer review by a urologist. On June 21, 2003, Saeed Akhter, M.D., provided a report entitled “Urology Cases Review,” which he signed as “Consultant Urologist.” (St. Ex. 2 at 41, 61)

In his report, Dr. Akhter explained that he had performed a retrospective review of 32 cases at the VA Medical Center between 1998 and 2003. Dr. Akhter stated that the patient care in these cases was “mainly performed” by Dr. Brewer, although some visits and procedures noted in the charts had involved another physician or a physician assistant, and that, in two cases, the other physician had been the primary surgeon. In discussing these cases,

Dr. Akhter noted when a practitioner other than Dr. Brewer had participated in a patient's care. (St. Ex. 2 at 61-81)

In his June 2003 report, Dr. Akhter set forth a detailed case-by-case commentary regarding each patient's records. In addition, he provided an overall assessment of "problems and trends." He discussed these problems and trends in eight categories: Delay in Urological Consultation; Initial Urological Evaluation, History, Physical and Follow-up; Work-up of the Patient; Transrectal Ultrasound and Prostate Needle Biopsy; Pre-operative Note; Operative Note; Postoperative Course; and Final Outcome and Follow-up. (St. Ex. 2 at 61-81) The problems and trends identified by Dr. Akhter included the following:

- that Dr. Brewer's description of initial history and physical examination were too generic;
- that rectal tone was never mentioned with regard to any patient;
- that the weight of prostates on rectal examination showed no correlation to the specimens following radical prostatectomies and that such large discrepancies are "not common";
- that a urinalysis is "an absolute must" before elective open or transurethral surgery on the bladder or prostate due to the risk from active infection, but no urinalysis or culture was done on 8 patients, and that in 13 patients a test showed infection before surgery, but there was no discussion in the chart regarding this infection;
- that staging bone scans and CT scans of the abdomen and pelvis were done when not indicated for a number of patients, and then the results were not reviewed with the patient, and that in one case a significant test result was ignored;
- that certain chart notes were so similar from patient to patient that it was "difficult to believe";
- that the performance of, and/or notes on, transrectal ultrasounds were insufficient;
- that the pre-operative notes were so generic that they did not meet the needs for informed consent;
- and that templates were not appropriately used in creating medical records.⁴

(St. Ex. 2 at 61-63) However, Dr. Akhter also noted positive factors. He stated that Dr. Brewer's work-up "was generally okay" except with respect to certain patients, and that operative notes were "quite satisfactory" describing the details of surgical procedures, with the exception of prostate needle biopsy. He found that Dr. Brewer's postoperative management was generally satisfactory except for lack of discussion with patients about positive surgical margins on the tissue removed and excessive delay in notifying patients about biopsy results, which should be provided within a "few days rather than waiting for 6 weeks." (St. Ex. 2 at 61-63)

⁴ Dr. Akhter's lengthy report is not quoted here in full. However, the content and organization of his report makes clear when subsequent commentators are summarizing or referring to Dr. Akhter's report even when not stating his name.

11. VISN Administrative Board Review. The May 2003 review of Dr. Brewer's records also prompted a review by the "VISN 18 Administrative Board."⁵ In August 2003, this board issued a report regarding the quality of surgical care at the VA Medical Center, describing, among other things, inadequacies and errors reflected in Dr. Brewer's charts. The report is signed by two persons, including the board's chair, James Robbins, M.D., although spaces for two other signatures are blank. (St. Ex. 2 at 41, 56-60)
12. Decision: Reduction of privileges and return to work. On November 18, 2003, the VA Medical Center notified Dr. Brewer that the PSB had recommended, and the Medical Center Director had approved, a reduction/revocation of his privileges. The reduction/revocation of privileges imposed a substantial limitation: Dr. Brewer was prohibited from performing any procedures of urological surgery. Dr. Brewer was instructed to report back to work at the VA Medical Center to perform work within his reduced privileges. (St. Ex. 2 at 41)

Dr. Brewer testified that his new duties consisted of performing disability examinations regarding "compensation and pension," although his recollection was that he had returned to work in September 2003 while the decision on privileges was still being considered. Dr. Brewer acknowledged, however, that Dr. Jamie Robbins, the Chief of Staff at that time, had called him in and asked him to do disability examinations, and had given him written instructions to return to work as a Compensation and Pension Examination Specialist. Dr. Brewer explained that he was happy to return to work and had received some training on how to perform disability examinations. (Tr. at 25, 28-36, 73)
13. Reconsideration decision: No change in reduction of privileges. On January 14, 2004, the PSB reconsidered Dr. Brewer's clinical privileges, according to a letter subsequently sent to Dr. Brewer by Ana Mello, M.D., who was the Interim Chief of Staff at that time. On completing its reconsideration on January 14, 2004, the PSB recommended no change in the reduction of Dr. Brewer's privileges. (St. Ex. 2 at 41)
14. Notice letter regarding the reduction/revocation of privileges, right to respond, and opportunity for hearing. On January 22, 2004, Dr. Mello wrote to Dr. Brewer. First, she reviewed the events that had led to the proposed reduction of his privileges, including the initial review of records in May 2003, which had prompted a "thorough peer review by an Urologist" and a review by the VISN Board. Dr. Mello provided an extensive description of Dr. Akhter's findings, although she did not identify Dr. Akhter by name, and she also summarized the findings of the VISN 18 Board of Investigation. (St. Ex. 2 at 41-56, St. Ex. at 2 at 55, par. 7)
15. Dr. Mello noted that the PSB had recommended, and the Medical Center Director had approved, the "reduction/revocation" of his privileges, and that Dr. Brewer had been notified in writing of that decision on November 18, 2003, and that he had also been notified of the reduction/revocation of his clinical privileges by Dr. Jamie Robbins, who had instructed him on November 18, 2003, to return to duty at the medical center. (St. Ex. 2 at 41)

⁵ The acronym "VISN" apparently refers to Veterans Integrated Service Network.

16. In addition, Dr. Mello recited that, on January 14, 2004, the PSB had reconsidered the matter of Dr. Brewer's clinical privileges. She stated that, upon reconsideration, the PSB had recommended no change in the reduction of his privileges. She further stated this recommendation had been "approved by the Medical Center Director and is the final decision." (St. Ex. 2 at 41)
17. However, Dr. Mello indicated that a further review would be provided by the Medical Center Director. She advised Dr. Brewer of his right to review the evidence, respond to the decision, and request a hearing:

You have the right to review all evidence not restricted by regulation or statute upon which the proposed changes are based. Following that review, you may respond in writing to this written notice of intent. You will be given until the close of business on February 12, 2004, to respond in writing.

All information will be forwarded to the Medical Center Director for decision. The Director will make, and document, a decision based on the record. If you disagree with the facility Director's decision, a hearing may be requested.

You have the right to be represented by an attorney or other representative of your choice throughout the proceedings.

Consistent with the VA Handbook * * * and 38 C.F.R. Part 46, it is the policy of the VA to file a report with the National Practitioner's Data Bank [regarding] adverse clinical privileges taken against physicians that are final and affect privileges for more than 30 days or the restriction of clinical privileges when the action is related to professional competence or professional conduct. A copy will be forwarded to the appropriate State Licensing Board in all states in which you hold a license, and in the state of Texas.

You will be retained in an active duty status during this notice period in the same capacity as present.

If you have any questions you may contact Human Resources Office or me for further information.

(St. Ex. 2 at 55-56) (paragraph numbering omitted)

18. Dr. Brewer has presented no document showing that he requested a hearing. None of the documents from the VA make reference to a hearing request. Dr. Brewer asserted, however, that he had asked his attorney to request a hearing and that the attorney had reported that he had requested a hearing. (Tr. at 73-74)

Further Consideration by the VA: Reporting to State Licensing Boards

19. *February 2004 letter from the VA: Notice of intent to report to state licensing boards.* By letter dated February 27, 2004, William E. Cox, the Interim Director of the VA Medical Center, advised Dr. Brewer that the VA was considering whether to report Dr. Brewer to state licensing boards, based on the review by the urologist peer reviewer. Mr. Cox stated that “it is the policy of the Department of Veterans Affairs (VA) to report to State Licensing Boards (SLB) licensed health care professionals whose clinical practice appears to have so significantly failed to meet generally accepted standards of clinical practice so as to raise reasonable concern for the safety of patients.” (St. Ex. 2 at 20-39)
20. Mr. Cox stated, among other things, that the review of the 32 medical records had shown that Dr. Brewer’s lack of patient-specific documentation was “prevalent” and that he had engaged in “generic template cut/paste.” Mr. Cox stated that several examples of records showed “falsification of the medical record, substandard documentation of patient-specific information, and patient safety concerns.”⁶ (St. Ex. 2 at 20-21)
21. Mr. Cox listed specific patient records where preoperative notes, or history and examination note, were identical from patient to patient, indicating that a template was used as a substitute for patient-specific assessment and documentation, or that Dr. Brewer had copied and pasted from another patient’s medical record. He stated that the use of generic notes and instances of copied notes left doubt as to the actual history, assessment and/or examination of the patients in question. (St. Ex. 2 at 21-22)
22. In addition, Mr. Cox noted the problem, as described by the peer reviewer, regarding the positive surgical margins in cancer surgeries, and he quoted from medical literature on the significance of surgical margins in cancer surgery. He further noted that the concerns identified in Middletown, Ohio, and by the State Medical Board of Ohio, had been noted again with regard to patients treated by Dr. Brewer at the VA Medical Center.
23. Mr. Cox also described additional information that had been obtained after the urologist’s case review. For example, Mr. Cox noted that one patient had been sent to an outside, fee-based urologist for further care after the peer-reviewer urologist had expressed concern for the patient based on his review of Dr. Brewer’s patient records. Mr. Cox stated that the patient had reported that Dr. Brewer had failed to discuss the fact that the in-dwelling stent needed to be removed within 2 months and failed to discuss the positive surgical margins. (St. Ex. 2 at 38)
24. In his letter, Mr. Cox advised Dr. Brewer that, if he had any information that he believed should be considered regarding whether the VA should report these matters to SLBs, he should submit it within 14 calendar days from receipt of the letter. Mr. Cox explained that, if Dr. Brewer did not provide information, the VA would decide based on the information already available. Mr. Cox clarified that a response was not required, and that, if a response

⁶ As set forth more fully below, the VA ultimately determined, on further review, that there was *not* sufficient evidence to show falsification of records by Dr. Brewer. (St. Ex. 2 at 7, 10-12)

were provided, it would be maintained in the VA system and could be available to state licensing boards. (St. Ex. 2 at 20-39)

25. Mr. Cox's letter indicates that Dr. Brewer had provided a written response to a previous notice, because Mr. Cox describes Dr. Brewer's written rebuttal as follows:

Rebuttal from Dr. Brewer regarding the discussion of delay throughout the report notes that Dr. Brewer's productivity has never been questioned in any review. As noted, the Proficiency Report which covered July 28, 1999, to July 28, 2000, described the concern about the volume of patients and consequences of that volume being unable to request surgical procedures in time * * *. Dr. Brewer had been made aware of this problem; he has not found an amicable solution. The rebuttal also noted the "overwhelming majority of the patients seen by Dr. Brewer had very serious concerns," which corresponds to the Urologist Peer Reviewer's comments and concerns voiced. The peer review noted the pattern of serious concerns identified without follow up and treatment in a timely manner. Dr. Brewer was aware of the seriousness and had the authority and responsibility to limit his caseload accordingly to provide safe, quality care to the veterans under his charge. Rather than [being] "shoved aside to make room for others," patients who could not be scheduled could have been referred for fee-basis as was required when the peer reviewer discovered the lapses and oversights.

(St. Ex. 2 at 39)

26. Second case review by a urologist. In May 2004, prior to making a determination as to whether the VA should report Dr. Brewer to state licensing boards, the VA requested further review by another urologist. Specifically, the VA Medical Center where Dr. Brewer was employed in Big Spring, Texas, requested that a urologist at the VA's Medical Center in Phoenix, Arizona, provide a review of Dr. Brewer's patient records. (St. Ex. 2 at 9)

27. Dr. Brewer's letter of resignation. On June 14, 2004, Dr. Brewer notified the VA that he would be leaving:

Please be advised I do not intend to renew my clinical privileges at the VA Medical Center in Big Spring, Texas when my current privileges expire. I will be leaving the Medical Center in order to pursue my career in Urology elsewhere.

(St. Ex. 2 at 19) Dr. Brewer testified that his contract with the VA had ended toward the end of August 2004, about six weeks after his resignation notice. (Tr. at 23-25, 32-33)

28. Case Review by Dr. Auriemma. On August 4, 2004, a report titled "Urology Case Review" was provided by Peter R. Auriemma, M.D., Chief of Urology at the VA Medical Center in Phoenix, Arizona. Dr. Auriemma's curriculum vitae includes the following background: residency programs in general surgery and urology at several hospitals, followed by a fellowship in urologic oncology at the Roswell Park Cancer Institute in Buffalo, New York;

practice experience in adult and pediatric urology at St. Joseph's Hospital in Buckhannon, West Virginia; appointment to the position of Chief of Surgical Services at St. Joseph's Hospital; an assistant professorship in urology at the West Virginia University School of Medicine; employment as a staff urologist at the VA Medical Center in Phoenix; and his current employment (in 2004) as the Chief of the Urology Section, Department of Surgical Services, at the VA Medical Center in Phoenix. (St. Ex. 2 at 10-12, 15-18)

29. In his report, Dr. Auriemma reviewed Dr. Brewer's patient records and addressed the same categories that Dr. Akhter had addressed. Dr. Auriemma reported as follows:

Delay in Urological Consultation

There are many factors that can impact the time frame from when a PCP⁷ generates a Consult and when the patient is actually scheduled and then seen by a specialist. Most of these factors do not involve the specialist. For the most part, physicians within the VA are not even a part of this scheduling process.

Initial Urological Evaluation

One of the most significant problems identified in this review is the documentation by the Urology provider. With rare exception, every DRE done described the prostate as 30 grams without nodularity, induration, or tenderness, and it seems that the description of the DRE is simply cut and pasted and used on multiple patients. For Urologists, the DRE is a very important part of the physical exam. In fact, Urologists should be the experts in examining the prostate and describing as accurately as possible what is found by the DRE. While determining the size of the prostate by DRE is somewhat subjective, one would expect that with this many patients, there should be some variety in the size and description of the prostate noted. One would question if the DRE were even done with the discrepancy in the amount of tissue resected. This may also account for the number of positive margins from radical prostatectomies that were performed. Even when the Pre-Op diagnosis was "abnormal DRE," the description of the prostate exam did not describe this.

AUA symptom score or IPSS should be documented, especially when the patient is undergoing a TURP for LUTS.

⁷ Dr. Auriemma's report included the following additional abbreviations and acronyms: PCP (primary care provider), TRUS (transrectal ultrasound), TRUS-BX (transrectal ultrasound-guided biopsy), AUA (American Urological Association), IPPS (International Prostate Symptom Score), DRE (digital rectal examination), UA (urinalysis), GU (genito-urinary), H&P (history and physical), and LUTS (lower urinary tract symptoms).

Work Up of the Patient

A UA should be done prior to GU instrumentation. Any instrumentation should not be performed on a patient with infected urine unless it is an emergency situation.

While most Urologists agree that a staging CT Scan of the abd/pelvis and a Bone Scan are not required in patients with a PSA < 10 since the yield is low, suspicious clinical findings by the provider may suggest these exams. However, if these studies are ordered, the results need to be reviewed and documented by the ordering physician, along with any other associated abnormal findings.

TRUS-BX

The volume of the prostate should be measured when performing a TRUS; however, a PSA density is not necessarily required for every TRUS. PSA density is usually calculated when the prostate is very large and does not feel abnormal other than the large size. In certain instances, as in the absence of prostate nodularity or induration, the PSA density may demonstrate that a prostate biopsy is not indicated because the total PSA may be elevated because of the volume of prostate tissue present.

Pre-Op Notes should include the indications for the procedure and that the surgeon has discussed the benefits and risks of the procedure with the patient.

Operative Notes from surgery were found to be satisfactory by the initial case review.

Postoperative Course

It is essential that documentation that the Path Report was reviewed with the patient be noted in the patient's record. Furthermore, in the case of a positive surgical margin, the patient has to be made aware of his current status and the stage of his cancer, and he also needs to be informed of any further treatment options available to him. Having 12 cases with positive surgical margins out of 16 reviewed is an inordinately high number. This should prompt a further review of the total number of radical prostatectomies performed, as well as the number of cases with positive margins, for a complete picture of this Urologist's care. However, rather than suggesting poor surgical technique, this most likely represents inadequate pre-operative clinical staging and poor surgical candidate selection, and may reflect the fact that more accurate DREs should have been done. After a TRUS-BX is performed, the patient should be told of his Path results in a timely fashion, usually within a week. A 6-week wait to review the Path Results is inordinately long.

Final Outcome

A positive surgical margin in 12 of 16 radical prostatectomies represents an unusually high occurrence rate. As stated above, perhaps a review of a larger

sample of RRP's or the total number performed by this Urologist may be more representative.

Every effort should be made to remove the seminal vesicles during a radical prostatectomy.

The most striking factor in this review was what appears to be the use of cutting and pasting for the H&P, especially regarding the description of the DRE. The more accurate the description of the DRE, the more accurate pre-op staging is, not only for TURP's, but also, and more importantly, for RRP's. This could also clinically translate into a smaller number of positive surgical margins for RRP's.

(St. Ex. 2 at 10-12)

30. *Determination Letter*. On January 12, 2006, Deborah McCallum, Acting Assistant General Counsel for the VA, issued a memorandum on the subject of "Disclosure to State Licensing Board – Eugene A. Brewer, M.D." (St. Ex. 2 at 1-2, 7-8) Ms. McCallum stated in part:

The Office of the General Counsel has reviewed the request to report Eugene A. Brewer, M.D., to the appropriate State Licensing Board (SLB). The criterion for reporting is whether the professional's actions so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concerns for the safety of patients.

We believe that the documentation in the Evidence File contains substantial evidence meeting the reporting standard for the following charges: failure to properly document examinations, assessments and treatments of patients; lack of diagnostic or treatment capability; and inability to perform procedures considered basic to the performance of his occupation as a urologist.

* * * [T]he file reveals the use of generic templates or cut and past in making notes; poor surgical outcomes and positive surgical margins; significant discrepancies between the volume of tissue described preoperatively and the volume of tissue actually removed; failure to identify conditions that should have been apparent; failure to perform or order appropriate clinical procedures; contraindicated clinical procedures performed or ordered; and poor preoperative, intra-operative, or postoperative workup or course of patients.

With respect to the charges of falsification of medical records and patient abandonment, however, we are unable to conclude that the file contains substantial evidence supporting the charges. * * *

* * * We suggest the following summary statement for disclosure to the SLB:

"Eugene A. Brewer, M.D., so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern

for the safety of patients when, during his clinical performance as a urologist, he made multiple diagnostic and treatment errors.”

(St. Ex. 2 at 7-8) (paragraph numbers omitted) The VA described this memorandum as a “determination letter.” (St. Ex. 2 at 1-2)

31. On January 12, 2006, the Deputy Undersecretary for Health, for Operations and Management, instructed the Director of the VA Medical Center in Big Springs, Texas, to send a report to the appropriate SLBs regarding Dr. Brewer, based on the determination made by the Office of the General Counsel. On January 18, 2006, the VA Medical Center notified the State Medical Board of Ohio of its determination regarding Dr. Brewer. (St. Ex. 2 at 5-6)

Draft Report by Dr. Brewer’s Consultant

32. Dr. Brewer retained a consultant, J. Lance Pickard, M.D., who drafted a letter on his behalf dated April 30, 2004 [Draft Letter].⁸ Dr. Brewer testified that Dr. Pickard is a board-certified urologist practicing in west Texas. He stated that the Draft Letter was prepared with a view toward a hearing, “if and when I had a hearing before the VA on these concerns that were raised.” He acknowledged that the letter is stamped “Draft,” although he does not know why it is captioned as a “Draft.” Dr. Brewer testified that he believes the VA was not provided an opportunity to consider the Draft Letter. (Tr. at 81-82; Resp. Ex. I)
33. The Draft Letter was addressed to Mr. Cox, the Interim Medical Center Director. Dr. Pickard commented on a review done by a person he identified as the “reviewer,” and he criticized “the reviewer’s” opinions. Although the identity of the “reviewer” is not made explicit, Dr. Pickard refers at least twice to a “23-page letter” to which he is responding. On page 6 of the Draft Letter, Dr. Pickard refers to a “23 page letter from Dr. Cox dated April 14, 2004.” (St. Ex. 2, Resp. Ex. I) Thus, the “reviewer” to whom Dr. Pickard may be Mr. Cox. However, the documents submitted by the State and the Respondent do not include an April 2004 letter from Mr. Cox. In any event, in his Draft Letter Dr. Pickard disagreed with many opinions expressed by “the reviewer” and commented that the reviewer lacked “fundamental urological knowledge” and was unaware of matters that “any urologist would know.” Dr. Pickard faulted the observations of the reviewer as “completely unfounded” and “based on a faulty understanding of the anatomy.” (Resp. Ex. I at 2, 6, 18)
34. Dr. Pickard indicated that he has not seen the review prepared by the urologist on whom the VA Medical Center had relied. Dr. Pickard stated: “I wonder where that review is and what it says.” (Resp. Ex. I at 25)
35. Indeed, Dr. Pickard indicated that there were numerous areas on which he needed further information before he could render more definite conclusions. For example, Dr. Pickard

⁸ Dr. Brewer described Dr. Pickard’s report as being 32 pages long, but it has only 29 pages. However, the fax-transmission pagination indicates that page 1 of Dr. Pickard’s letter is page 4 of the fax and that page 29 of his letter is page 32 of the fax, which accounts for the description of Dr. Pickard’s report having 32 pages. (Resp. Ex. I at 1, 29)

agreed that many of Dr. Pickard's templates were not patient-specific, but he thought the problem could be related to the software used. He stated that he was not familiar with the software used by the VA, but perhaps the software used by Dr. Brewer might not have allowed him to "edit back in time" but permitted only contemporary entries. Dr. Pickard acknowledged that he did not know whether the problem was with the software or was "specific to Dr. Brewer." (Resp. Ex. I at 3; Tr. at 81-82)

36. With regard to Dr. Brewer's ordering of tests that were not required and then missing a significant result in one individual's results, Dr. Pickard conceded that this patient record presented "worrisome issues." He speculated, however, that perhaps there was a VA protocol that had forced Dr. Brewer to order the tests. Nonetheless, he agreed that "if you order a test, you should know the results." Dr. Pickard opined that, while Dr. Brewer could do a better job of documenting his care, the problems did not warrant suspension. Dr. Pickard opined that the "cut and paste technique to save time" may have "in this instance * * * failed to carry over the stone event into the post-operative notes." He commented that, while the "cut and paste" method can save time by avoiding repetition of information that does not change from visit to visit, "it is sure to catch up with you eventually as it did on this case, unfortunately for the patient and for Dr. Brewer." (Resp. Ex. I at 3-4, 24-25)
37. Dr. Pickard presented additional arguments in Dr. Brewer's favor on a variety of issues, such as the issue of positive surgical margins and the issue of pre-surgery urinalysis. For example, Dr. Pickard stated that Dr. Brewer routinely treated patients with pre-surgical antibiotics. (Resp. Ex. I at 4, 25-26, 28)
38. In his conclusion, Dr. Pickard stated that it was "unfortunate" that an "apparent non-urologic reviewer" had acted as a "peer" reviewer of Dr. Brewer. Dr. Pickard opined that Dr. Brewer's patient records did not show a poor urologist or poor medical care. Rather, he concluded that, "As with most peer review problems, this case is mostly about poor documentation and how it can get you into trouble, and I think very little of this is poor urological care." (Resp. Ex. I at 29)

Dr. Brewer's Compliance With the Board's 1996 Order

39. As stated above, the probationary terms in the Board's 1996 Order required Dr. Brewer, among other things, to submit quarterly declarations stating whether he was in compliance with all the terms and conditions of his probation. (St. Ex. 3 at 4)
40. In an affidavit dated March 4, 2008, Danielle Bickers, the Board's Compliance Supervisor, stated that she had reviewed Dr. Brewer's probationary compliance file in its entirety. She reported that Dr. Brewer's last quarterly declaration, prior to the Board's issuance of the notice of opportunity for hearing in August 2007, had been received by the Board on January 28, 2005. Ms. Bickers stated that, since January 2005, the Board had not received any quarterly declarations from Dr. Brewer until after the August 2007 notice was issued. (St. Ex. 5)

41. Dr. Brewer acknowledged that his obligation to submit quarterly reports had commenced in 2003 when his Ohio certificate was reinstated. He further acknowledged that, at some point after February 2005, he had stopped submitting his quarterly declarations. (Tr. at 19-20)
42. Dr. Brewer testified that, during the summer or fall of 2005, he had sent an e-mail to Ms. Bickers regarding his failure to submit the quarterly declarations. Dr. Brewer described his communication to her as follows: “ * * * I noted in that e-mail that I had fallen behind with my compliance and I asked for some guidance to get back into compliance.” Dr. Brewer testified that, by the phrase “fallen behind” with compliance, he meant that he had “failed to fill out and mail in the form on at least one occasion in the period after I had seen her last.” (Tr. at 20-24)
43. However, Dr. Brewer also testified that, after he was told by Mr. Albert that quarterly appearances were no longer necessary, he had not understood whether he still needed to submit the written declarations. Dr. Brewer asserted that, when he had sent the e-mail to Ms. Bickers, he had been “unclear” regarding his responsibilities with respect to the quarterly statements. He conceded, however, that he had not asked her about his obligations other than in the single email, which he said constituted an inquiry as to whether he was required to submit the quarterly declarations. (Tr. at 20-24)
44. Dr. Brewer stated that he does not have a copy of the email because he no longer has that e-mail account, which he had maintained as a full-time student working on a master’s degree. He said he did not try to contact Ms. Bickers by telephone because he had not previously had success in reaching her by telephone. With regard to whether he had asked his attorney to try to contact the Board to clarify Dr. Brewer’s obligations, Dr. Brewer stated that he did not recall. He also testified that he does not recall receiving a response to his e-mail. (Tr. at 20-24)

Additional Testimony by Dr. Brewer

45. Dr. Brewer stated that he had been represented by an attorney in Texas regarding the VA matters, but he did not know how often or when his attorney contacted the VA on his behalf, as he did not receive ongoing reports regarding the status of the VA’s review. (Tr. at 35-36)
46. At the hearing in 2008, Dr. Brewer asserted that, although the VA had “conducted a review” of his cases, the “review was not conducted by a urologist.”⁹ (Tr. at 35-36)
47. Dr. Brewer testified that he currently holds licenses to practice medicine in Ohio and California. He further testified that he is not currently employed. Dr. Brewer explained that, after he and his wife had sold their home in Texas, they moved to Indianapolis, where they lived with his wife’s parents. He stated that they still live in Indianapolis but now have their own residence.

⁹ The Hearing Examiner rejects the contention that the VA’s review of Dr. Brewer’s cases was not conducted by a urologist. In June 2003, a detailed case review was performed by a urologist, Dr. Saeed Akhter, and his report formed the central basis for the decision to limit Dr. Brewer’s privileges. Moreover, prior to reaching its determination on whether to report Dr. Brewer to state licensing boards, the VA obtained another review by a different urologist, Dr. Auriemma. At the Board hearing, Dr. Brewer may have been referring to a summation or description provided by Dr. Mello as Interim Chief of Staff or Mr. Cox as Interim Medical Center Director.

Dr. Brewer stated that, as part of a master's program in health administration, he had held a part-time job with Clarion Health Partners, the governing body of numerous medical centers in Indiana. However, Dr. Brewer testified that he was not "acting as a medical doctor." He acknowledged that, "at times," due to his medical training and expertise, he had been asked "to offer opinions that may have overlapped into the area of clinical concern," but he stated that he "wasn't writing orders, writing prescriptions, giving instructions to patients or nurses in how to care for anyone." He stated that he did not have a license to practice medicine in Indiana and provided only "administrative level care." (Tr. at 12, 33-35)

POST-HEARING RULING ON ADMISSION OF EXHIBITS

During the hearing, the Respondent objected to and sought to exclude the January 2004 letter written by Dr. Mello to Dr. Brewer. (St. Ex. 2 at 41 to 56, and St. Ex. 1A) In the alternative, the Respondent argued that, if the Hearing Examiner admitted Dr. Mello's letter, then the draft report from Dr. Brewer's expert consultant should also be admitted into the hearing record. (Tr. at 38-44, 49-50; Resp. Ex. I)

The Respondent argued that Dr. Mello's letter must be excluded from evidence because it constitutes or contains impermissible expert opinion, and/or because her letter was not the final decision by the VA, and that there had never been a final order. Further, the Respondent argued that the VA had based its decision on untested opinions, some of which were unsigned or had unidentified authors. The Hearing Examiner took the matter under advisement for later determination upon review of the documents. (Tr. at 38-44, 49-50, 52, 59-66; Resp. Ex. I) For the reasons set forth below, the Hearing Examiner admits State's Exhibit 2, including Dr. Mello's letter dated January 22, 2004, and also admits Respondent's Exhibit I, the draft letter written by Dr. Lance Pickard, dated April 30, 2004.

First, Dr. Mello's letter does not constitute or contain improper expert opinion that must be excluded from this hearing record. In her letter, Dr. Mello, in her role as the acting Chief of Staff at the VA Medical Center at that time, notified Dr. Brewer of the most recent decision regarding his privileges, and she informed him of certain rights. In the course of providing this notice, Dr. Mello reviewed the decision-making history since May 2003 with respect to the proposed reduction/revocation of Dr. Brewer's privileges, and, in doing so, she summarized Dr. Akhter's report. She did not purport to issue a new or independent opinion regarding Dr. Brewer's practice of urology; rather, she provided a summation of the evidence on which the VA had relied. (Tr. at 35, 39; Resp. Ex. I at 6, 29; St. Ex. 2 at 41) The fact that she summarized the report of a urologist does not mean that she was attempting to render an expert opinion in urology without sufficient expertise in that specialty.¹⁰

Second, Dr. Mello did not purport to render a final decision in her letter but stated that she was notifying Dr. Brewer of a decision recommended by the PSB and approved by the Director, and that she was giving notice of further review available. (St. Ex. 2 at 41) Moreover, the finality of the decision related by Dr. Mello in her January 2004 letter does not determine the letter's admissibility. A non-final determination or a "notice letter" may be admitted as part of the sum of

¹⁰ The record does not state Dr. Mello's area of specialization, and her letter does not state that she herself is a urologist. The Hearing Examiner accepts *arguendo* that she is not a urologist.

evidence showing the decision-making process. Dr. Mello's letter is relevant in several respects regardless of whether it represents an absolutely final decision by the VA Medical Center.

With respect to Dr. Pickard's report, the Hearing Examiner recognizes that it does not represent his final, fully considered opinion. Nonetheless, it is a lengthy and detailed report that presents arguments favorable to Dr. Brewer, and the Hearing Examiner finds no harm in its admission. The State Medical Board of Ohio is comprised largely of licensed physicians, and they have expertise with which they can assess the medical opinions of Dr. Pickard and others, which minimizes any risk of undue prejudice from admitting a draft report.

FINDINGS OF FACT

1. In an Entry of Order dated July 10, 1996, the State Medical Board of Ohio concluded that Eugene Allan Brewer, M.D., had failed "to use reasonable care discrimination in the administration of drugs" and/or had failed "to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as that language is used in Ohio Revised Code Section [R.C.] 4731.22(B)(2). In addition, the Board concluded in its 1996 Order that Dr. Brewer's acts, conduct, and/or omissions constituted 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 language is used in R.C. 4731.22(B)(6). Based on these conclusions, the Board indefinitely suspended Dr. Brewer's certificate to practice medicine and surgery in Ohio for a period of not less than three months. The Board also imposed probationary terms, conditions and limitations for a period of at least three years, which would apply upon reinstatement.
2. On February 12, 2003, the Board granted Dr. Brewer's request for reinstatement of his Ohio certificate, subject to the probationary terms, conditions and limitations in the 1996 Order. To date, Dr. Brewer's Ohio certificate remains subject to the probationary terms, conditions and limitations in the 1996 Order.
 - (a) With regard to quarterly personal appearances, Paragraph 3(b) of the 1996 Order requires Dr. Brewer to appear in person for an interview every three months before the full Board, or its designated representative, during his probationary period. However, the parties did not submit evidence to prove that Dr. Brewer violated the 1996 Order by failing to make personal appearances after February 2005.
 - (b) With regard to quarterly declarations, Paragraph 3(c) of the 1996 Order requires Dr. Brewer to submit quarterly declarations stating whether there has been compliance with all the terms and conditions in the 1996 Order. However, after about February 2005, Dr. Brewer failed to submit quarterly declarations of compliance. Dr. Brewer's explanations with respect to why he ceased submitting the quarterly declarations are found to lack credibility insofar as he testified that he ceased submitting the declarations because he was not sure whether he was required to do so. To the extent that Dr. Brewer may have been confused about his compliance requirements, it was his obligation to clarify his continuing duties under the 1996 Order, not to cease compliance on his own decision.

3. In April 2003, Dr. Brewer was employed by the Department of Veterans Affairs [VA] at the VA Medical Center in Big Spring, Texas [the Medical Center], which is part of the West Texas VA Health Care System. On April 17, 2003, the Director of the Medical Center notified Dr. Brewer that his privileges to practice in the West Texas VA Health Care System were summarily suspended. However, this was only a preliminary, non-final decision pending further review.
4. The Medical Center, after reviewing additional evidence, made a decision to “reduce” Dr. Brewer’s clinical privileges; this reduction of privileges was essentially a partial revocation of his privileges. The Medical Center set forth this decision in a document dated November 18, 2003, and it immediately implemented the decision: pursuant to the November 2003 decision, Dr. Brewer was taken off administrative leave, and he returned to different work within the reduced privileges as determined.

On January 14, 2004, the VA Medical Center afforded reconsideration of the November 2003 decision, through a review by its Professional Standards Board [PSB]. However, the PSB recommended against a modification of the November 2003 decision, and that recommendation was approved by the Medical Center Director. Dr. Brewer was informed of this decision in a letter dated January 22, 2004, from the Interim Chief of Staff.

5. Additional review was provided by the Interim Medical Center Director. The record reflects that, as part of this review process, Dr. Brewer submitted a written statement of his position, and the Interim Medical Center Director considered that statement in making and documenting his conclusions in a letter dated February 27, 2004.

The statements in this February 2004 letter make clear that the reduction of Dr. Brewer’s privileges was definite and final at that time if not before, and that there was no further chance that the reduction of privileges would be modified. Also, the February 2004 letter makes clear that further review would be limited to the issue of whether the VA Medical Center should report its findings regarding Dr. Brewer to state licensing authorities.

6. The VA’s decision to report Dr. Brewer to state licensing authorities was set forth in a letter dated January 12, 2006. In this letter, the VA’s Office of the General Counsel stated that it had determined, based on substantial evidence, that Dr. Brewer had so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concerns for the safety of patients, in these respects: “failure to properly document examinations, assessments and treatments of patients; lack of diagnostic or treatment capability; and inability to perform procedures considered basic to the performance of his occupation as a urologist.”

However, in making this determination in January 2006, the VA did *not* decide whether to impose a revocation, suspension, restriction, reduction, or termination of Dr. Brewer’s clinical privileges. Rather, on January 12, 2006, the VA was simply deciding whether and how to make a report of information.

CONCLUSIONS OF LAW

1. The acts, conduct, and/or omissions of Eugene Allan Brewer, M.D., as set forth above in Finding of Fact 2(b), constitute a “[v]iolation of the conditions of limitation placed by the board upon a certificate to practice,” as that language is used in R.C. 4731.22(B)(15), with respect to the conditions of limitation set forth in the Board’s Order described in Finding of Fact 1.

Based on Finding of Fact 2(a), the Hearing Examiner finds no additional violation of R.C. 4731.22(B)(15). Further, based on the parties’ stipulation, the Hearing Examiner concludes that the Board was substantially justified in making its allegation regarding quarterly appearances.

2. The reduction/revocation of Dr. Brewer’s clinical privileges by the Department of Veterans Affairs [VA] as set forth above in Findings of Fact 4 and 5, individually and/or collectively, constitute the “[t]he revocation, suspension, restriction, reduction, or termination of clinical privileges by the United States department of defense or department of veterans affairs * * *,” as that language is used in R.C. 4731.22(B)(24).

The Hearing Examiner concludes that, under the circumstances presented here, it is not necessary to pinpoint the precise day on which the decision-making process by the VA may be viewed as having reached its absolutely final decision on the issue of Dr. Brewer’s privileges. There was sufficient finality of decision-making by the VA, by the end of February 2004 if not before, to warrant disciplinary action by the Board under R.C. 4731.22(B)(24) based on a reduction of clinical privileges by the VA.

3. The VA decision set forth above in Finding of Fact 6 does not constitute a “revocation, suspension, restriction, reduction, or termination of clinical privileges by the United States * * * department of veterans affairs,” as that language is used in R.C. 4731.22(B)(24). In its determination on January 12, 2006, the VA decided a reporting issue, not a limitation of clinical privileges.

* * * * *

Documents in the record describe Dr. Brewer as a pleasant, well-liked, compassionate physician. Commentators note his excellent bedside manner and admirable demeanor with co-workers. Others mention his enthusiasm for the practice of medicine. During the hearing, the Hearing Examiner’s observations were consistent with these reports.

Nevertheless, the Board’s primary mission is to protect the public. In this case, the evidence establishes that Dr. Brewer had previously been disciplined in 1996 for conduct that was directly related to the potential for patient harm: (1) failure to use reasonable care/discrimination in the administration of drugs and/or failure to employ acceptable scientific methods in the selection of drugs or other treatment modalities, and (2) the departure from, or failure to conform to, minimal standards of patient care.

In 1996, the Board imposed an indefinite suspension of at least three months and probationary terms and restrictions. However, the circumstances presented in 1996 were significantly different from the circumstances presented in 2008. The Board in 1996 was presented with evidence that Dr. Brewer, following a loss of hospital privileges, had obtained further training and had successfully completed a fellowship in his area of specialty. During the 1996 hearing, Dr. Brewer had confidently assured the Board that he had improved his charting practices and care of patients. He argued essentially that his knowledge and skills had been rehabilitated by the additional training and experience, and that any problem with charting or patient care was a thing of the past.

Since that time, however, documentation from the VA has demonstrated that serious and pervasive problems remain. The record includes no evidence to prove a substantial rehabilitation after a loss of clinical privileges. To the contrary, there is evidence that additional training and a Board disciplinary action failed to have a sustained rehabilitative effect. The charting practices described by the VA are not merely a deficiency of paperwork; they pose a substantial risk of harm to patients. Under the circumstances, a new Order imposing more training, more supervision, and/or more evaluation is not likely to provide sufficient assurance of patient safety.

PROPOSED ORDER

It is hereby ORDERED that:

The certificate of Eugene Allan Brewer, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

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


Patricia A. Davidson
Hearing Examiner

State Medical Board of Ohio

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

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EXCERPT FROM THE DRAFT MINUTES OF AUGUST 13, 2008

REPORTS AND RECOMMENDATIONS AND PROPOSED FINDINGS AND PROPOSED ORDERS

Dr. Varyani announced that the Board would now consider the Proposed Findings and Proposed Orders appearing on its agenda. He asked whether each member of the Board had received, read and considered the hearing record; the findings of fact, conclusions and proposed orders; and any objections filed in the matters of: Shelly Bade, M.D.; Eugene Allan Brewer, M.D.; William David Leak, M.D.; Brian Frederic Griffin, M.D.; Kyle Elliott Hoogendoorn, D.P.M.; Parisa Khatibi, M.D.; and William W. Nucklos, M.D.; and the Proposed Findings and Proposed Orders in the matters of John A. Halpin, M.D., and Frank Murray Strasek, D.P.M. A roll call was taken:

| | | |
|------------|----------------|-------|
| ROLL CALL: | Mr. Albert | - aye |
| | Dr. Egner | - aye |
| | Dr. Talmage | - aye |
| | Dr. Suppan | - aye |
| | Dr. Madia | - aye |
| | Mr. Browning | - aye |
| | Mr. Hairston | - aye |
| | Dr. Stephens | - aye |
| | Dr. Mahajan | - aye |
| | Dr. Steinbergh | - aye |
| | Dr. Varyani | - aye |

Dr. Varyani 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: | Mr. Albert | - aye |
| | Dr. Egner | - aye |
| | Dr. Talmage | - aye |
| | Dr. Suppan | - aye |
| | Dr. Madia | - aye |
| | Mr. Browning | - aye |
| | Mr. Hairston | - aye |

| | |
|----------------|-------|
| Dr. Stephens | - aye |
| Dr. Mahajan | - aye |
| Dr. Steinbergh | - aye |
| Dr. Varyani | - aye |

Dr. Varyani noted that, in accordance with the provision in Section 4731.22(F)(2), 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. They may, however, participate in the matter of Dr. Khatibi, as that case is not disciplinary in nature and concerns only the doctors' qualifications for licensure. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member.

The original Proposed Findings and Proposed Orders shall be maintained in the exhibits section of this Journal.

.....

EUGENE ALLAN BREWER, M.D.

.....

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MS. DAVIDSON'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER IN THE MATTER OF EUGENE ALLAN BREWER, M.D. DR. EGNER SECONDED THE MOTION.

.....

A vote was taken on Dr. Steinbergh's motion to approve and confirm:

| | | |
|------------|----------------|-----------|
| ROLL CALL: | Mr. Albert | - abstain |
| | Dr. Egner | - aye |
| | Dr. Talmage | - abstain |
| | Dr. Suppan | - aye |
| | Dr. Madia | - aye |
| | Mr. Browning | - aye |
| | Mr. Hairston | - aye |
| | Dr. Amato | - aye |
| | Dr. Stephens | - aye |
| | Dr. Mahajan | - aye |
| | Dr. Steinbergh | - aye |

EXCERPT FROM THE DRAFT MINUTES OF AUGUST 13, 2008
IN THE MATTER OF EUGENE ALLAN BREWER, M.D.

Page 3

Dr. Varyani - 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



August 9, 2007

Eugene Allan Brewer, M.D.
8911 Pennwood Court
Indianapolis, IN 46240

Dear Doctor Brewer:

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 medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) On or about July 10, 1996, the Board issued an Entry of Order [Ohio Order] that indefinitely suspended your certificate to practice medicine and surgery in Ohio, but not less than three months, and subjected you to certain probationary terms, conditions and limitations, based upon violations of Section 4731.22(B)(2) and (B)(6), Ohio Revised Code. The Ohio Order concluded that you failed to employ acceptable scientific methods in the selection of modalities for treatment of disease, and that you failed to conform to minimal standards of care with respect to treatment of patients in the course of your practice of urology. On or about February 12, 2003, the Board granted your request for reinstatement of your Ohio certificate, subject to the probationary terms, conditions and limitations placed pursuant to the Ohio Order. As of this date, your certificate to practice medicine and surgery in Ohio remains subject to the probationary terms, conditions and limitations of the Ohio Order, a copy of which is attached hereto and incorporated herein.
- (2) Paragraph 3.b. of the Ohio Order requires that you appear in person for an interview every three months before the full Board, or its designated representative.

Despite this requirement, since in or about February 2005, you have failed to appear at all scheduled appearances before the Board or a designated representative of the Board.

Mailed 8-9-07

- (3) Paragraph 3.c. of the Ohio Order requires that you submit quarterly declarations stating whether there has been compliance with all the conditions found in the Ohio Order.

Despite this requirement, since in or about February 2005, you have failed to submit quarterly declarations of compliance.

- (4) On or about April 17, 2003, the Department of Veterans Affairs, West Texas VA Health Care System [West Texas VA] summarily suspended your clinical privileges. After reviewing evidence, the West Texas VA subsequently found, *inter alia*, the following in its Determination Letter dated January 12, 2006: failure to properly document examinations, assessments, and treatment of patients; lack of diagnostic or treatment capability; and inability to perform procedures considered basic to the performance of your occupation as a urologist. Further, the West Texas VA found you to have failed to conform to generally accepted standards of clinical practice so as to raise reasonable concern for the safety of patients. Copies of selected portions of the State Licensing Board Reporting File from the West Texas VA are attached hereto and incorporated herein.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) through (3) above, individually and/or collectively, constitute a “[v]iolation of the conditions of limitation placed by the board upon a certificate to practice,” as that clause is used in Section 4731.22(B)(15), Ohio Revised Code.

Further, the West Texas VA State Licensing Board Reporting File, including the April 17, 2003 summary suspension, as alleged in paragraph (4) above, individually and/or collectively, constitutes “[t]he revocation, suspension, restriction, reduction, or termination of clinical privileges by the United States department of defense or department of veterans affairs or the termination or suspension of a certificate of registration to prescribe drugs by the drug enforcement administration of the United States department of justice,” as that clause is used in Section 4731.22(B)(24), Ohio Revised Code.

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.

Eugene Allan Brewer, M.D.

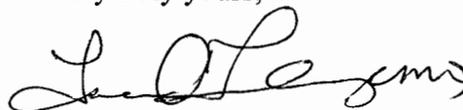
Page 3

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 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,

A handwritten signature in black ink, appearing to read "Lance A. Talmage, M.D.", written in a cursive style.

Lance A. Talmage, M.D.
Secretary

LAT/DSZ/flb
Enclosures

CERTIFIED MAIL #91 7108 2133 3931 8317 6567
RETURN RECEIPT REQUESTED

**Department of
Veterans Affairs****Memorandum**

Date:

JAN 12 2006

From:

Acting Assistant General Counsel (024)

Subj:

Disclosure to State Licensing Board – Eugene A. Brewer, M.D.
(Big Springs, Texas, VAMC)

To:

Deputy Under Secretary for Health for Operations and Management (10NC)

1. The Office of the General Counsel has reviewed the request to report Eugene A. Brewer, M.D., to the appropriate State Licensing Board (SLB). The criterion for reporting is whether the professional's actions so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients.
2. We believe that the documentation in the Evidence File contains substantial evidence meeting the reporting standard for the following charges: failure to properly document examinations, assessments, and treatments of patients; lack of diagnostic or treatment capability; and inability to perform procedures considered basic to the performance of his occupation as a urologist.
3. As detailed in the April 14, 2004, Notice of Intent to Report at Tab ii, the file reveals the use of generic templates or cut and paste in making notes; poor surgical outcomes and positive surgical margins; significant discrepancies between the volume of tissue described preoperatively and the volume of tissue actually removed; failure to identify conditions that should have been apparent; failure to perform or order appropriate clinical procedures; contraindicated clinical procedures performed or ordered; and poor preoperative, intra-operative, or post-operative workup or course of patients.
4. With respect to the charges of falsification of medical records and patient abandonment, however, we are unable to conclude that the file contains substantial evidence supporting the charges. The instances of improper documentation are insufficient to show falsification of medical records. Similarly, the evidence does not support the charge of patient abandonment, in part because not all delays in consultation and treatment could be attributed to Dr. Brewer's actions. Incidentally, the August 4, 2004, Case Review at Tab iii also disagreed with the proposed reporting of this charge.

2.

Deputy Under Secretary for Health for Operations and Management (10NC)

5. The Privacy Act authorizes the Department to provide the SLB with only a summary statement that is sufficient to alert an SLB to the fact that VA has learned of evidence of substandard care by this professional. We suggest the following summary statement for disclosure to the SLB:

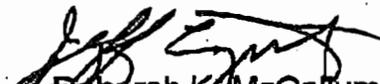
"Eugene A. Brewer, M.D., so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients when, during his clinical performance as a urologist, he made multiple diagnostic and treatment errors."

6. We note that the Evidence File contains information that is visible despite the redactions and must be **completely redacted** before the records are provided to the SLB. VHA Handbook 1100.18, Appendix B, para. 2b(1). Should the SLB properly request additional information, **patient identifiers, such as portions of names and social security numbers, must be completely redacted** before the file is released. VHA Hbk. 1100.18, App. B, para. 2b(1).

7. The Evidence File must consist of information that is relevant and material, that is, evidence that has a significant bearing on the charge of substandard care and is important to the resolution of the issues in dispute. VHA Hbk. 1100.18, App. B, para. 2a(1). With respect to Dr. Brewer, information that is not relevant or material to the specific charges being reported, as discussed in paragraph 2, but related to the charges discussed in paragraphs 4 and 5, should be redacted or removed from the file.

8. The Reporting File may be released, as redacted, to an SLB pursuant to either Dr. Brewer's prior written consent or a qualifying law enforcement written request from the SLB. VHA Hbk. 1100.18, para. 14, 15, App. B, para. 2b(1). Sample letters that meet the requirements for a proper consent or law enforcement request are contained at Appendices H and I of VHA Handbook 1100.18.

9. We recommend that the Director provide Dr. Brewer with a copy of the summary report made to the SLB. Please contact Gi Hyun An, the attorney assigned to this matter, at (202) 273-6371, if there are questions or other concerns.


Deborah K. McCallum

Attachment



DEPARTMENT OF VETERANS AFFAIRS
Medical Center
Big Spring, Texas 79720

January 22, 2004

In Reply Refer To: 519/11

Eugene Allan Brewer, M. D.
701 Caprock
Big Spring, Texas 79720

Subject: Proposed Reduction/Revocation of Privileges

1. The Professional Standards Board has recommended, and the Medical Center Director approved, a reduction/revocation of your privileges prohibiting any procedures under urological surgery. The recommendation was made following completion of a comprehensive review of identified issues resulting in your summary suspension.
2. You were notified of this reduction/revocation through written notice November 18, 2003 from Dr. Jamie Robbins and were instructed to report for duty on November 18, 2003.
3. The Professional Standards Board reconsidered your clinical privileges on January 14, 2004, with no change in the reduced privileges recommended. This recommendation was approved by the Medical Center Director and is the final decision.
4. Based on review of the issues surrounding the revocation of your Ohio State Medical License, the PSB initiated a retrospective review of urological cases with pathology specimens for a two-year period, on May 8, 2003. The results of the retrospective review prompted a VISN 18 Administrative Board Review in addition to a thorough peer review by an Urologist.
5. A total of thirty-two cases were reviewed by the Urologist with common problems and trends noted as follows:
 - a. Initial history and physical examinations were too generic in nature based on some template where the findings were too similar. History for BPH symptoms did not take into account the American Urological Association (AUA) Symptoms and Index and Quality Life Score, also known as the International Prostate Symptoms Score. (IPSS) In the physical examination, rectal tone was never mentioned in any of the patients. Most of the prostates on rectal exam measured 30-40 gm while pathological specimens of radical prostatectomies showed no correlation. The physical examination also followed a generic template as most of prostates were 30-40 gm, smooth glands. In one patient, who had undergone a unilateral orchiectomy, it was described as both testicles were descended. This was corrected in a later addendum.
 - b. There is a consensus of opinions among urologist that active Urinary Tract Infection (UTI) is an absolute contraindication for elective open or transurethral surgery on bladder or prostate. A urinalysis prior to the surgery is an absolute must. Of the 32 cases, there

was no urinalysis or culture ordered before surgery in eight. In nineteen patients, the urine was negative for any infection. In thirteen patients, the urine was infected before surgery. There seems to be no acknowledgement by you to take the infection of urine into account and address it before surgery. In the cases where the urine was infected, surgery was carried out and you failed to recognize that there was active infection. Based on literature, most urologist agree that for people with prostate cancer with PSA less than 10, a staging bone scan and CT scan of the abdomen and pelvis are not indicated. However, this was done on most of the patients but was not reviewed by them. In one patient, a stone with hydronephrosis was missed.

- c. In patients who underwent transrectal ultrasound, there was a very generic note describing the transrectal ultrasound findings. This note was similar in most of the patients, which is difficult to have faith in. It also did not describe the volume of the prostate. The transrectal ultrasound machine has the software program to calculate prostate volume and PSA density and this measurement should have been included in the operative reports. For example, one patient who underwent TURP, the preoperative assessment of the volume was 30 gm while 52 gm were resected, while in another case 2.4 gm of prostate was resected. One other patient who was thought to have a very large prostate underwent open suprapubic prostatectomy, only 10 gm prostate was removed. This open surgery could have been avoided if prostate volume was known in advance.
 - d. The preoperative note was very generic in nature, not describing the specifics of the operation for each individual patient.
 - e. Discussion with the patients about their positive surgical margins is completely absent. For every patient who undergoes a cancer surgery, it becomes the responsibility of the surgeon to describe to the patient that the pathological specimen has a positive margin which in theory leaves a chance of some residual cancer or a recurrence of the cancer. Out of 16 cases of radical prostatectomies that were reviewed, 12 had a positive surgical margin which is a very high number. This is suggestive of poor surgical technique for most T1c cancers. In postoperative notes, this discussion was missing.
 - f. The complication for prostate cancer patients who underwent radical prostatectomy were too high. These include positive surgical margins (12/16), incontinence (10/16) and bladder neck contractures (4/16). In three patients, part of seminal vesicles was left behind indicating poor surgical technique. The tissue resected in TURP was generally small. Some patients were continued on medical treatment of BPH after TURP and some were incontinent. The follow up of BPH patients was not consistent.
6. The specific finding summary for the 32 reviewed cases was as follows:

- a. 62 year-old with PSA of 6.2. His preoperative exam showed a 30-gram, smooth prostate. He underwent prostate needle biopsy on August 12. There is a very generic note on the TRUS prostate needle biopsy, which is a consistent finding in all of the patients without describing the specifics of this gland. On August 22, a letter was sent from Dr. Brewer informing the patient that he has malignancy and he should come for further workup. On December 10, he underwent a radical retropubic prostatectomy, after 4 months from his diagnosis. There was no Neoadjuvant hormonal coverage given to him in the meantime. His rectal examination showed a 30-gram prostate while his surgical specimen showed a 92-gram prostate, which is a significant discrepancy. This discrepancy could have easily been avoided if transrectal ultrasound had measured the volume of the gland. He had positive surgical margins for which he was not counseled. A seminal vesicle was also not removed completely, which is sub optimal surgery. Now his postoperative PSA is slowly increasing from 0.1 in January 2003 to 0.2 in May 2003. This patient may need some adjuvant treatment down the road. He developed episode of urinary retention and bladder

neck contracture in May 2003. He is still using diapers because of urinary incontinence. Most of the management of this patient is Level II, however in postoperative counseling and follow up, I would grade this as Level III.

- b. This 69-year-old had elevated PSA and was seen by Dr. Robert Martinez in January 2002 for a PSA of 5.8 and tender prostate. He was treated for prostatitis and was advised to follow up in 4 weeks. However, the next visit of the patient instead of 4 weeks later was in August 2002, seen by PA Bob Eshleman with increased PSA of 5.9 and abnormal digital rectal exam. In August, he underwent transrectal ultrasound guided prostate needle biopsy. In the physician's pre-op note before the biopsy there was no rectal examination done by the urologist, in October 2002, he underwent radical prostatectomy with positive surgical margins and very scant seminal vesicle, so the specimen was not completely removed. (sub optimal surgery) His urinalysis prior to surgery was grossly infected. It was not treated appropriately and no culture was obtained. It is of note that his pathology showed diffused cancer in both lobes but preoperative biopsy only showed one positive core. In a gland with a diffuse disease, obtaining only one positive core questions the technique of random sampling of the prostate gland. This patient was also not counseled for his positive surgical margins. In the note on February 21, 2003, it says to "continue his therapy as previously indicated" while there was no documentation of any discussion after surgery about future treatment plan. The surgical technique and the management of this patient is Level 11. However, the follow up of the patient is considered as Level II.
- c. This 70-year-old male was referred for elevated PSA of 5.9 on March 6, 2000 and was seen on July 11, 2000. He underwent a biopsy on August 16, 2000, which is a significant delay from initial referral to the first diagnostic step. His staging workup included a bone scan and CT Scan and took 4 months, which was redundant for a PSA of 5.9. In December, he was started on Neoadjuvant Hormonal treatment. He underwent radical retropubic prostatectomy in March 2001, which is 8 months after making the initial diagnosis. His pathology shows Gleason 7 cancer of prostate with positive surgical margins. In his follow up management, positive surgical margins were not discussed with the patient. This patient died of a brain tumor in October 2001. His overall surgical management is Level 1, however his follow up is Level III. The delay of 5 months from initial referral to the prostate biopsy and then the delay from biopsy to the definitive treatment are unacceptable and constitute Level III.
- d. This 69-year-old male was referred because of rise in his PSA from 4.8 to 6.8 and a nodule on rectal examination. Patient was treated with alpha blockade but he continued to have significant residual of 213 cc. The initial note is only by the physician's assistant, Bob Eshleman and no MD note describing his rectal examination. On September 14, 2000, he underwent transrectal ultrasound guided prostate needle biopsy with a generic note of the surgical procedure. It took 3 months for the staging, which was again redundant because of the low PSA. He underwent a radical retropubic prostatectomy on February 12, 2001 about 6 months after the initial diagnosis His surgical pathology showed positive surgical margins that were not discussed with the patient On a follow up examination by Dr. Martinez on January 8, 2002, a right-sided apical nodule was felt but no further workup, follow up or biopsy of this nodule was done. The overall surgical management of this patient is Level 11 but the follow up surgical management is Level III. Patient also has stress urinary incontinence. This patient needs a repeat PSA and a biopsy of that nodule that was described by Dr. Martinez. This patient also waited for a

- long period of time from the initial diagnosis to the final management.
- e. This 64-year-old male was seen on March 8, 2002 in urology because of elevated PSA of 13 and symptoms of prostatism. His initial rectal exam showed a smooth, 30-40 gram gland. He underwent a prostate needle biopsy on July 25, 2002 after 4 months of initial referral, which is an unacceptably long time period of time. In the post op note, Dr. Brewer described that only six cores could be obtained because of the pain and discomfort of this patient. However, there is no description of pain in the operative note of the prostate needle biopsy suggesting that this was dictated based on a standardized template and not describing the actual event in the operating room. His follow up visit in the office for discussion of his prostate biopsy results was on September 7, which is about 6 weeks after the initial biopsy, which is a very long period of time. After a biopsy, patients are usually very anxious to learn about the results of their pathology and be called as soon as the pathology result is available, within the next few days rather than 6 weeks. The decision for radical prostatectomy was made on November 29 after a discussion with the patient, which is again 5 months after his initial diagnosis. On December 2, underwent radical retropubic prostatectomy with positive surgical margins. Patient continues to have stress urinary incontinence and there is no postoperative PSA available in the chart. The concerns about this patient are #1 delay in his definitive treatment, which brings the care to Level I11, no discussion with patient about positive surgical margins and future planning which brings it to Level III, and no follow up PSA or rectal examination since the surgery in December 2002.
- f. 68-year-old male who was initially seen by PA Bob Eshleman on September 1, 2000 with elevated PSA of 6.8 and nodularity of the prostate. After about 3 months on November 30, 2000. Patient underwent a transrectal ultrasound and prostate needle biopsy, a significant delay for the initial diagnostic procedure. Patient underwent a bone scan and a CT Scan for his metastatic workup, which is redundant for a PSA of 6.8. On the CT Scan there was right-sided hydronephrosis with a staghorn stone in the right kidney. Hydronephrosis was also evident on the bone scan. None of these findings was registered in Dr. Brewer's notes in his preoperative evaluation for radical prostatectomy. Patient underwent radical retropubic prostatectomy on April 30, 2001 with positive surgical margins. His follow up clinic visit on May 11 did not mention any stone disease. The first time the stone was ever mentioned was in the past medical history described in Bob Eshleman's note on November 30, 2001, but no treatment planning was done for the stone. In a follow up note by Dr. Brewer on March 26, 2002, the stone was not even mentioned. The first time the stone was ever mentioned by the urologist was in a note on April 23, 2002 and on May 6, 2002 a JJ stent was placed. A letter was sent to him on November 21, 2002 by Dr. Brewer to notify him to come to clinic. This patient has an indwelling stent and as of April 4, 2003, a note by Dr. Meera reflects that nothing has been done for this stone or stent. (A stent should not be left in for more than 3 months) He needs to follow up soon or he may lose a kidney. This patient has multiple quality issues that need to be addressed.
- i. Diagnosis of cancer of prostate was made in November of 2000 and his radical prostatectomy was performed in April of 2001. He was given Neoadjuvant Hormonal treatment on February 28, but there was no notation in the chart of any discussion with the patient. This hormonal treatment should have been started earlier if there was any wait or delay in the definitive treatment.

- ii. There was a gross omission in missing the diagnosis of hydronephrosis and a staghorn stone. A kidney was left obstructed for more than a year, which would lead to a natural deterioration of the renal function. There is no evidence that Dr. Brewer ever registered this from his preoperative surgical workup. It was very evident from bone scan and CT Scan that there was a stone and obstruction of the right kidney. It seems that there was omission on the part of the urologist to review the preoperative workup, even though for his PSA, this was not indicated. However, this was performed and not followed through. There is no evidence that stent has been removed and it may break during removal as it has been left indwelling for more than one year.
- iii. Lack of communication about his surgical specimen finding of positive surgical margins. This makes the overall treatment of this patient Level III.
- g. This 57-year-old male was initially evaluated on September 27, 2002 because of elevated PSA of 4.5 and symptoms of prostatism. In a preoperative note on September 30, Dr. Brewer writes that he could not examine his prostate well because of a thick perineum. However, in all subsequent notes including the operative note of prostate biopsy, he continues to call it "abnormal digital rectal examination" which is not possible. Digital rectal exam cannot be labeled as abnormal until the gland has been examined well. On October 24, patient underwent a prostate needle biopsy with a 3-week gap between referral and the first diagnostic step. The patients' subsequent follow up visit was on December 20, almost 2 months later to discuss the pathology results, which is an unacceptably long period of time. The note on December 30, 2002 seems to be a cut and paste note from the second pre-op note. He underwent a radical retropubic prostatectomy on December 30, 2002. Pathology showed cancer of the prostate with positive surgical margins. This patient developed postop urinary retention on January 17, 2003 and went to the operating room again on March 6 for transurethral incision of the bladder neck and debridement of the eschar. Patient continues to have some incontinence. The overall management of this patient was level 1, however there was a significant delay in his diagnosis and definitive treatment and especially in the period between his biopsy and the post-biopsy discussion of his original disease constituting Level III. There were too many cuts and pastes in this chart.
- h. This is a 59-year-old gentleman who was seen on June 21, 2002 for elevated PSA and symptoms of prostatism. Rectal exam at that time showed a smooth, 30-40 gm gland. On August 8, after 6 weeks, he underwent a transrectal ultrasound guided prostate needle biopsy, which showed adenocarcinoma. There was a significant delay in the discussion between his biopsy results and initiation of workup for his definitive treatment. On November 4, 3 months after his original diagnosis, he underwent radical prostatectomy with positive surgical margins. Subsequently, patient developed bladder neck contracture with symptoms of severe outlet obstruction along with impotence and incontinence. In this patients postoperative management there was no discussion with this patient about this positive surgical margins and there was no follow up PSA. There was too long a delay in between initial urology workup and his final treatment. I would consider the follow up part and the preoperative part as level III treatment for this patient. His outcomes are also less than optimal because of his continued bladder neck contracture and incontinence constituting Level II care.
- i. 62 year-old male was first seen on July 25, 2000 with elevated PSA of 5.1 and minimal

voiding symptoms. He was started on Alpha-blockers. His prostate gland at that time was 30 gm, smooth gland. There was a cut and paste note on October 18, 2000 and he underwent a needle biopsy on October 19, 2000, which is 3 months after the initial consultation. He returned for his follow up appointment on November 21 about 4 weeks after the biopsy to the diagnosis and treatment options. He was given a choice to return back in 4 months to make up his mind. Customarily, after the diagnosis is made, a decision is usually made early in game whether a patient is going to be observed or undergo definitive treatment. In the time his decision is being made, patients are covered with Neoadjuvant hormonal treatment so the prostate cancer does not spread. His radical prostatectomy was performed on February 5, 2001, which is about 6 months after his initial visit and about 4 months after the diagnosis was made. This patient also has positive surgical margins. He also has significant stress urinary incontinence, post surgery. The overall care of this patient with the delay in treatment and lack of follow up on the surgical pathology and incontinence is Level 11, however, the postoperative and preoperative care is Level III.

- j. This 68-year-old male was seen by urology PA for his initial urological evaluation on December 4, 2001 with a PSA of 6.8. According to the rectal exam by the PA, the prostate was smooth, 30 gram. On December 17, the patient underwent a transrectal ultrasound guided prostate needle biopsy without rectal examination by the urologist. The first consultation done by the urologist was after the prostate biopsy on March 5. There was a cut and paste note by the PA on April 2. There was pre-op note from the urologist on May 24, which was a cut and paste copy with minor changes from the PA's note. Failure of urologist to examine him before prostate biopsy with a very generic pre-op note constitutes Level 111 care. Patient underwent a radical prostatectomy with positive surgical margins. There was no follow up discussion about the positive surgical margins of this patient. Patient continues to have significant stress urinary incontinence as late as February 18, 2003. Follow up PSA's have been 0. Overall workup of this patient was Level 11, however, there was less input by the MD and there are a lot of cut and paste notes. There was Level 111 care in terms of pre-op workup and postoperative management and discussion of positive surgical margins.
- k. This is an 83-year-old gentleman whose initial urology consultation was requested in January 2001 for elevated PSA of 5.0. Patient was seen after delay of 4 months on May 18, 2001. Patient at this time had minimal voiding symptoms with 30-40 gm, smooth prostate with no masses. Biopsy was suggested which in my judgment for a man of 83 years is not indicated. Most of the urologists would not workup for cancer of prostate with patients above 75 years and some even above 70 years because of biological behavior of this slow growing cancer and would only treat the symptoms. There was a cut and paste note on June 3, 2001. A prostate needle biopsy was done on June 4, 2001, which showed a Gleason 7 prostate cancer in left lobe. The follow up visit of this patient to discuss his positive biopsy for malignancy was on July 17, which is again 6 weeks later. Patient was treated with Zoladex and various treatment options were given to him. His radical prostatectomy was planned for September 10, 2001. His pathology showed Gleason 7 adenocarcinoma with positive surgical margins. Patient had significant incontinence of urine post surgery and he also developed bladder neck contracture for which he underwent direct visual internal urethrotomy on July 2002. Patient's postoperative PSA started to rise, which was never discussed with the patient. This

patient in my judgment did not require a prostate needle biopsy and radical prostatectomy and should have only been treated for symptoms of his BPH and not treated for his cancer. Once he was treated for his cancer, he should have been counseled for positive surgical margins. There was a significant delay from the initial consultation from January to when the patient was first seen in May of 2001 His overall outcome is also very poor, as he had developed the contracture and he had to undergo a second surgery for that. So, the overall treatment of this patient would be regarded as level 11 care while in reference to his postoperative counseling for his positive surgical margins this case should be regarded as level III.

- l. This 61-year-old male was seen on July 17, 2001 for elevated PSA of 9.8 with a 30-40 gm, smooth prostate. He underwent TRUS prostate needle biopsy on August 6, 2001 with a very generic note for the TRUS prostate needle biopsy. His pathology showed Gleason 7 carcinoma of the prostate. His follow up note after his prostate needle biopsy was on the October 23, almost 10 weeks after his initial procedure for discussion of pathology, which is too long a period of time translating into poor quality of care. There is a typographical error that Mr. Lincoln returned for his follow up visit, which is the wrong patient. Patient also underwent a CT Scan of the abdomen and pelvis but in the subsequent follow up notes, there seems to be no mention of any discussion of his radiological examination with the patient. After a delay of 5 months, in March 2002, the patient underwent a total androgen blockade and then a radical retropubic prostatectomy in May 2002, which is a significant delay in the treatment from the initial diagnosis to the final treatment. Surgical margins were negative. This patient developed postoperative Foley catheter obstruction that was treated at University Medical Center, which cleared up. On a visit in November 2002. He had significant stress urinary incontinence. The overall quality of care of this patient was level I with two exceptions.
 - i. There was a significant delay from July 2001, the time of referral to the time of the biopsy in August 2001 and definitive treatment in May of 2002, almost 8 months after his initial diagnosis.
 - ii. There were significant typographical errors and cut and paste notes in the chart of this patient.
- m. 63-year-old male after urological consultation in March 2001 for elevated PSA, was first in urology clinic in August 2001. Initial urological evaluation showed PSA of 6.0 in February 2001 and 10 in July 2001 with a "prostate gland of 30-40 gm with right-sided asymmetry." Patient underwent a prostate needle biopsy in August 2001 with a generic preoperative note. The follow up pathology discussion was on September 7 after 5 weeks from initial biopsy result. In October, patient came in for a follow up and had a second discussion about his pathology result with treatment options. Here the patient is described as Mr. Lincoln rather than Mr. T. Zoladex injection was started. (Neoadjuvant Hormonal therapy) Dr. Brewer's note on March 29 did not describe any discussion with patient about Zoladex injection, its indication, contraindication, and side effects. A note in March 2002 suggested normal digital rectal examination. (Preop exam had right-sided asymmetry) This is a very , generic sort of note and OR was planned for May of 2002. Patient underwent a radical retropubic prostatectomy which was uneventful with negative pathological surgical margins 'with good surgical results in terms of cancer cure and patient outcome with no incontinence The overall management of this patient was level I. However, there was a significant delay between the initial consultation in March to the

first evaluation by the urologist in August of 2001. There was a significant delay from initial diagnosis to the definitive treatment in May of 2002. These two aspects should be regarded as level III.

- n. 63-year-old with initial urological consultation requested on July 15, 2002 for abnormal digital rectal examination with a normal PSA of 2.7. His initial evaluation was performed by urologist on August 20 about 5 weeks after the initial request. In a note by the urologist on August 20, 2002, there was a gross discrepancy in the history and physical examination. In the history part, it stated that patient came for abnormal DRE and in the physical exam part it is stated that the "digital rectal exam shows a prostate 30-40 gm with no nodules". However, the final impression says prostatic nodularity. There are gross misstatements in this chart suggestive of a cut and paste type of notes throughout the entire chart. If the digital rectal examination is to be believed, it is unclear why this patient underwent a prostate needle biopsy for PSA of 2.7. (Prostate biopsy is not indicated for PSA of 2.7 in a 63-year-old male if digital rectal exam is normal) There was gross error on his prostate needle biopsy note on September 5, 2002 where it says "elevated PSA" and abnormal digital rectal examination on the indication for the biopsy where the PSA was only 2.7. Patient was notified by a letter about his prostate cancer on September 13, which was very appropriate. He had a bone scan, CT Scan, and chest x-ray which was not indicated because of the low PSA. On September 9, with a very generic preoperative note, he underwent radical prostatectomy with positive surgical margins, which were not discussed with the patient. In a note by the urologist, it says that the patient has no incontinence on February 18, 2003. On a follow up with Dr. Koko on March 14, 2003. He was prescribed diapers. In this chart, even though the final outcome of the patient is okay, except some degree of incontinence which may improve with the passage of time there was no postoperative discussion for follow up for positive surgical margins, There were also a lot of misstatements in this note about elevated PSA as well as a lot of cut and paste notes. Overall surgical care was level I other than the fact that there was a delay in his initial diagnosis from the consultation to the initial diagnosis for 5 weeks and initial diagnosis to the final radical prostatectomy of 4 months.
- o. 70-year-old: the initial urological consultation was requested in March 99 for elevated PSA of 6.5. The first urological visit was in April 99 where the prostate was estimated to be a 30 gm smooth gland. Patient had mild urinary symptoms for which he was prescribed Hytrin. On April 15, he underwent a TRUS guided prostate needle biopsy. There is no follow up note on pathology discussion with patient. Biopsy came back negative for malignancy. The note on August 99 describes a 35-gram gland without any nodularity. Patient underwent a re-biopsy in September 99 because of elevated PSA and "abnormal DRE." His gland on all previous rectal examinations was labeled as a normal, smooth gland. So the diagnosis of DRE being abnormal cannot be explained. Prostate volume of 33 cc was calculated by the transrectal ultrasound machine and incorporated into the note, which is very comparable to his postoperative gland weight after radical prostatectomy. (This is the only patient where prostate volume was calculated by TRUS machine) The prostate biopsy showed a Gleason 6 adenocarcinoma in the right lobe. The follow up discussion on biopsy results was on October 30, 6 weeks after biopsy which is quite late. This patient was interested in radiation therapy instead of surgery so he was referred to Dallas on October 29, 1999: The chart does not reflect what happened in the meantime but a note on June 26, 2000 suggests that he became interested in surgery and

did not go through radiation treatment. Patient was not covered with Neoadjuvant hormonal treatment in the meantime. In June of 2000, he underwent radical prostatectomy with negative surgical margins. There was no follow up pathology discussion documented in the chart. The follow up notes on October 29, 2000, May 1, 2001, September 7, 2001, March 8, 2002, September 6, 2002 are all cut and paste notes. The overall surgical outcome of this patient met level 1 care. However, the time lapse between diagnosis in October 99 and final treatment in June 2000 was very significant even though patient is partly responsible for it.

- p. This initial urological consultation for this 68-year-old male was made on June 17, 1999 for symptoms of BPH with a PSA rise from 4.9 to 6.4. There was a delay of 2 months before he was seen by the urologist on August 13, 1999. At that time, his rectal examination showed a prostate of 30 gm with nodularity on the left side. On August 19, with a generic preop note, patient underwent a prostate needle biopsy. There was no discussion on pathology until September 17 when Dr. Yazdani e-mailed Dr. Brewer to follow up on pathology. On November 9, the nurse notes that a CT Scan was done. On November 16, Zoladex was given by the nurse without any discussion from the urologist. On February 7, 2000, he underwent radical retropubic prostatectomy with Gleason score 7. The tumor was close to the surgical margin but not through the margins. There was no pathology discussion with the patient. He developed urinary retention because of a bladder neck contracture on March 20 He underwent a transurethral incision of the bladder neck which failed and he underwent a second operation. Subsequently, the PSA started to rise, from 0.4 to 2.7 recently. This patient has a PSA failure but there was no discussion about his PSA failure. Patient also has significant incontinence of urine. The overall management of this patient was poor, and because of delay in communication about prostate biopsy results, failure to talk to the patient about his pathology results after the radical retropubic prostatectomy, failure of surgical results leading to incontinence, bladder neck contracture, recurrent surgeries, and no treatment offered for the PSA failure, the overall care was level III.
- q. This 69-year-old male was seen in the urology clinic on February 12, 2002 for gross hematuria. An IVP and cystoscopy were planned. However, a cystoscopy and bilateral Retrograde ureteropyelogram were done under local anesthesia on March 7, about 5 weeks after the initial urological evaluation. For a patient with gross hematuria, this is too long a waiting period between presentation and the first diagnostic procedure. During the cystoscopy a bladder tumor was identified. Patient underwent transurethral resection of the bladder tumor (TURBT) on March 25, (significant delay). Pathology results showed Grade III transitional cell carcinoma of bladder involving lamina propria (G3 T1) and carcinoma in situ (CIS) The catheter was discontinued on April 2 and, a BCG treatment was scheduled for April 19. However, on April 19, patient was found to have a UTI which was treated with Levaquin. Patient subsequently followed up on May 3 for BCG treatment but catheterization caused hematuria and BCG could not be instilled. Patient never received a BCG treatment after his initial diagnosis of CIS and T1 G3 transitional cell carcinoma. On June 20, he underwent a second transurethral resection of the bladder tumor which showed Grade III, transitional cell carcinoma of the bladder. There was no muscularis propria seen. It is unclear to me, why a cystectomy was planned for this tumor with no definite evidence of muscle invasive disease. A cystectomy is not the indicated procedure. However, it is my impression that because the CT Scan suggested extra

vesicle disease, a cystectomy was planned. On July 15, patient underwent radical cystectomy which showed positive lymph nodes, T3b, G3 transitional cell carcinoma of the bladder. The preliminary pathology report was given on the July 15 and was sent for a second opinion from AF1P which came 28 days later on August 13, confirming the pathological disease of the patient. Such a delay in the final diagnosis of patient can seriously compromise his final outcome. The subsequent follow up by urologist and follow up treatment plan for his non-organ confined disease was not documented in the chart. It seemed that patient went to Allison Cancer Center and underwent radiation treatment with chemotherapy. On April 4, 2003, the wife called and stated that the patient was admitted to Midland Memorial Hospital where he died on April 23, 2003. There are quite a few concerns and problems in the management of this patient which will be elaborated as follows.

- i. There was a significant delay after initial consultation on February 12 through his first diagnostic Cystoscopy on March 7.
 - ii. There was significant delay in his transurethral resection of the bladder tumor from diagnosis on March 7 through TURBT on March 25.
 - iii. This patient should have received immediate intravesical BCG within 2 weeks after his TURBT. It was planned for April 19 which was delayed because of urinary tract infection. However, if this was planned properly and the urine was checked on April 11, and the infection was treated by the April, 19 this could have been avoided. Patient subsequently was not followed up on a weekly basis. The patient underwent a second TURBT and the surgical pathology results were sub optimal because no muscularis propria was seen. This patient should have undergone a second restaging TURBT to get to deeper muscles from the muscularis propria which was not done. Clinical diagnosis of muscle invasive TCC was made and cystectomy was performed. However, during the cystectomy, left-sided pelvic lymph nodes were not dissected just because they were not visible.
 - iv. The pathological specimen showed a positive lymph node and positive surgical margins but there is no discussion with the patient on the follow up of surgical pathology, it is not clear how this patient got connected with the Allison Cancer Center but the chart does not reflect that this attempt was made by the urologist. Even though given the aggressive nature of the disease of this patient, his final outcome may have not been different, no matter how he was treated, however, the quality of care provided to him was substandard and meets Level III. This patient also had infected urine when he underwent his surgery which was not recognized and was not treated.
- r. An 86-year-old male was initially seen in the urology clinic in June 2000 for hématuria along with elevated PSA. He underwent a prostate needle biopsy which for his age of 86 was a redundant procedure. This biopsy showed a Gleason Grade 8, carcinoma of the prostate. Because of the symptoms, he underwent cysto TURP in September 2000. During the cystoscopy, it is mentioned that there was one diverticulum on the right side of the bladder but a diverticulum on the left side which later on developed a bladder tumor was not mentioned by Dr. Brewer in his operative note. In December 2001, Dr. Martinez found the bleeding from the left-sided diverticulum which had a tumor. In January 2002, patient underwent a transurethral resection of the bladder tumor with TI,

G3 disease. No intravesical BCG was given for T1 G3 bladder tumor. In May, a second resection of bladder tumor after recurrence was done which showed T2, G3 disease. This patient subsequently died in December 2002. The concerns are as follows:

- i. A missed bladder tumor in left-sided bladder diverticulum by Dr. Brewer on September 18, 2000 where he did mention the right-sided bladder diverticulum but did not describe any left-sided diverticulum. Diverticulae like these do not develop in a very short span of time. It is more likely that a bladder diverticulum with a tumor causing hematuria was missed. The overall care of this patient is Level III.
- s. This 81-year-old male was evaluated on February 29, 2000 for urinary retention. This patient also had gross hematuria. On May 4, 2000, he underwent transurethral resection of prostate. (TURP) Preoperative diagnosis on rectal exam suggested 30 gm prostate and only 5.7 gm of tissue was resected. There was no upper tract evaluation done on this patient for hematuria workup. A non-contrast CT Scan of the abdomen showed a left adrenal mass that was not followed up. On June 20, patient developed urinary retention again which suggests poor surgical outcome after transurethral resection of prostate gland. There is no follow up note on this patient since June 2000. We do not even know if the patient is alive now or not. This patient needs to be followed up if he is alive. The overall quality of care is Level III.
- t. This 65-year-old male was initially seen by urology on April 2000. His PSA at that time was 7. He was treated with medical treatment for BPH (Alpha blockade) with no significant results. He underwent a prostate needle biopsy because of elevated PSA in November which showed no malignancy. His rectal exam suggested a prostate size of 30-40 gm. He had elevated PSA of 27.3 with infected urine in June 2001 which was unrecognized by the urologist. He underwent TURP in July 2001 with active urine infection. Patient postoperatively became hypotensive and developed leukocytosis with a white cell count of 31,000 and severe hyponatremia. Patient was treated in ICU. A culture prior to the surgery in May had shown enterococcus but it was not treated appropriately. Prior to the surgery even though the urine had shown more than 45 WBC's, a culture was not done. Hyponatremia was treated appropriately. Following his surgery, he developed severe urinary incontinence, wearing diapers with significant skin excoriation as evident on a note from January 2002. The areas of concern in this patient are as follows.
 - i. He underwent a transurethral resection of prostate with significant infection which should have been an absolute contraindication for the surgery. He underwent a very aggressive resection and on a 30-40 gm gland assessed by rectal exam, 52 gm tissue was resected. He developed significant hyponatremia and sepsis which may have precipitated hypotension and MI. Patient also had a pre-surgery PSA of 27.3 which now seems to be from his infection. However, this should have been addressed and recognized by the physician prior to the TURP. All of these findings including a preoperative poor workup, poor intra-operative course, poor postoperative course, and poor outcome make the overall care of this patient Level III.
- u. 78-year-old seen in urology for urinary retention and voiding symptoms in October 1999. He was started on Alpha blockade. In January 2000, he underwent laser treatment of the prostate which did not resolve his symptoms. He underwent TURP on May 22, 2000

where 38.9 gm of prostate tissue was removed from a 45 gm gland as documented by digital rectal exam. After the surgery, patient continues to dribble, has the symptoms of BPH, and still requires alpha blockade and Proscar. The overall treatment for this patient is Level II. He needs flexible or rigid cystoscopy to rule out bladder neck contracture or stricture as well as urodynamics to explain the cause of dribbling and persistent voiding symptoms. A bladder neck contracture or residual prostatic tissue has to be ruled out before Alpha blockade is restarted.

- v. This 67-year-old male was seen in urology in January 2001 with elevated PSA, abnormal digital rectal examination, and urinary retention. His PSA in January was 5. He received medical treatment for prostatic symptoms. In March 2001, he was brought to the operating room for transurethral ultrasound guided prostate needle biopsy because of his elevated PSA. There was no urinalysis done before this procedure, in the operating room, it was noted that his bladder was distended so the transrectal ultrasound guided prostate needle biopsy was cancelled. It is not clear to me, why the patient was not catheterized and underwent a TRUS guided prostate needle biopsy in the first visit to OR as a distended bladder is not a contraindication for prostate biopsy. Patient was started on Alpha-blockers, he was brought back to the operating room on September 13, 2001 for TRUS prostate needle biopsy. In October 2001 after biopsy came back negative, he underwent a TURP. His prostate size was estimated to be 30-40 gm on rectal examination. A total of 30.8 gm BPH tissue was resected. The final outcome of this patient was good. He should have undergone a TRUS calculated prostate volume for better staging of his prostate size. The overall care of this patient is Level 1, except for the redundant trip to the OR.
- w. This 68-year-old male was seen in the urology clinic with voiding symptoms in October 1998. Patient received medical treatment for his BPH symptoms. In July 2000, he was treated for a urinary tract infection with pseudomonas by Dr. Finn. In the same month, he underwent a TURP without appropriate eradication of his urinary tract infection. It seems from the notes that Dr. Brewer failed to recognize that this patient ever had a urinary tract infection. A total of 9.9 gm of tissue was removed from a 30 gm prostate gland. The area of concern is that his TURP should have been done after complete eradication of the urinary tract infection as a UTI is an absolute contraindication for the surgery. There is no pre-op note and there is no follow up on the patient. The overall quality of care in terms of his preoperative evaluation and management was Level III while the surgical results cannot be graded as there is no follow up on this patient. The amount of tissue resected for a 30 gm gland is somewhat small.
- x. This 85-year-old male was evaluated in the urology clinic in December 1999 because of his significant voiding symptoms. He was treated with Alpha-blockers which did not improve his symptoms. Proscar was added to the treatment. On December 11, 2001, his urinalysis showed positive leukocyte esterase with 36 WBC's and positive fungus. On December 12, 2001, he underwent a TURP where 17 gm tissue was resected. In this patient, the overall outcome is Level I. however, failure to recognize and treat a urinary tract infection before surgery makes that part of the pre-op workup as Level III. There are a lot of cut and paste notes on this patient.
- y. An 89-year-old male was seen in urology clinic in May 1998 for his voiding symptoms and hematuria. His PSA's were high but appropriate for his age. They were not worked up which is okay. In December 1998, he underwent cysto with indigo laser ablation of

prostate but his symptoms persisted and patient was unable to void properly with high residuals. On his rectal exam, prostate was noted to be 30 gm and smooth. Proscar was added at that point. Patient continued to be on medication with high residual urine. His symptoms persisted so TURP was performed on March 12, 2001. The preoperative note suggested 30-40 gm, smooth Prostate and TURP chips volume was 15.1 gm BPH. There was also a question of diverticulum in bladder. Patient did not do well after the TURP and continued to have obstructive symptoms with large residual urines. A cystoscopy was done to rule out bladder outlet obstruction and none was found. Because of this high residual volume and inability to void, he had cystometrogram which showed atonic bladder. He was started on self-catheterization but now has an indwelling catheter. A rectal tone assessment pre-op could have helped in making the diagnosis of neurogenic bladder and could have avoided the TURP. A cystogram is indicated to rule out a bladder diverticulum. The overall level of care is Level II. There are a lot of cuts and pastes in this chart.

- z. A 66-year-old male seen in urology clinic for symptoms of BPH in February 99 was started on Hytrin. A bladder ultrasound showed a post-void residual of 130 cc. Patient continued on Hytrin but did not improve significantly. In August 99, Proscar was added and residual urine decreased. No International Prostate Symptoms Score (IPSS) was ever described in the follow up of this patient. Patient continued to hold high residual urine so it was decided to perform a TURP on this patient after failed medical treatment which is an appropriate decision. On February 26, he underwent a TURP. Gland size by digital rectal examination was 30-40 gm. The total tissue removed was 9.6 gm. Patient died postoperatively from either an MI or pulmonary embolism. The urological concern about this patient was a small resection volume compared to the size of the gland. Overall care of this patient was Level 1.
- aa. 81-year-old male was seen in urology clinic on January 15, 1999 because of significant voiding symptoms including nocturia x 5 with urinary incontinence and urgency. Patient was started on 2 mg of Hytrin. Prostate on rectal examination was 40 grams and 400 cc of post void residual urine was noted on the ultrasound. The Hytrin was increased to 5 mg and the catheter was left indwelling. PSA at that time was 1.1. Patient could not void after catheter was removed. Catheter was re-inserted and patient was given another trial of void, which he failed again. In March 1999, he underwent indigo laser ablation of the prostate. He continued to have voiding symptoms and developed acute urinary retention in May 1999. Patient's Hytrin was discontinued and he was started on Flomax 0.4mg qd which was increased to 0.8 mg and his Foley catheter was removed. He again went into urinary retention, so the Foley catheter was replaced. In August 1999, he underwent a TURP after failed medical treatment. At that time, rectal examination revealed 40 gm prostate. (A very generic note) He continued to have his voiding symptoms after TURP so he was started back on Flomax. Patient had high residual urine and he was started on self-catheterization. At this point in time, cysto and CMG was performed. CMG did not show any neurogenic component so it was thought that the patient had regrowth of the prostatic tissue or residual tissue. At this time, rectal exam again revealed a prostate of 40 gram (again a generic note) with 400 cc of residual urine. In August 2000, he underwent a second TURP. He had significant stress incontinence after his second TURP. Diagnosis of bladder neck contracture was made. He underwent cystoscopy and incision for bladder neck contracture. He did not do well even after this 3rd surgery. He was

started on self-catheterization. A diagnosis of urethral stricture was made. He was continued on urethral dilatations. Because of his significant leakage, patient was given the option of artificial urinary sphincter in August 2001, but he declined the surgery. Because of high residuals, the patient continued to have enterococcus in his urine but no treatment was given before his TURP. His overall surgical outcome was very poor. In the first TURP, 9.9 grams of tissue was resected while in the second TURP, 11.1 grain of tissue was resected and sphincter damage was also done. Overall quality of care is Level 1 11. An active urinary tract infection was ignored before the TURP.

- bb. A 76-year-old male visited the urology clinic in October 1999 with hematuria, urinary hesitancy, and nocturia. The prostatic examination showed 30 gm, smooth prostate on the rectal exam. IVP and urine cytologies were done. The IVP showed a large bladder stone with normal upper tracts. Cystoscopy done by Dr. Brewer suggested a large volume gland. This patient underwent an open prostatectomy with the bladder stone removal in August 2000. On the final pathology, the open prostatectomy specimen weighed only 10.9 gm. This patient did not need open prostate and bladder stone surgery. A TURP instead could have been performed if proper volume of the prostate was measured ahead of time and his bladder stone could have been broken by electrohydrolic lithotripsy. The second concern is that the patient got a lot of run around between October 99 and August 2000. His overall surgical results are satisfactory so from surgical perspective his level of care is Level 1. However, his open surgery could have been avoided if proper estimation of the prostate size was done by the transrectal ultrasound.
- cc. A 75-year-old male was seen in urology in March 1999 for symptoms of bladder outlet obstruction. Patient also had a history of recurrent urinary tract infections. He was started on Proscar and Flomax. His rectal exam suggested a prostate of 30 gm. He underwent a TURP in July 2000 where 2.4 gm tissue from prostate was resected. This patient had recurrent urinary tract infections with pseudomonas in March, May, June, and September 2000 which were not treated appropriately. There is also a discrepancy in the nurses and the MD's note on December 21, 2001 where the MD's note suggests that the patient is doing well, while the nurse suggests that the patient is having nocturia every hour. Patient subsequently improved. This patient with a resection volume of 2.4 gm probably did not require surgery if his pseudomonas infections had been treated appropriately in the first place. It is very important to recognize that active urinary tract infection is an absolute contraindication for surgery. Considering his poor preoperative workup and small amount of tissue resected, his level of care is III.
- dd. A 65-year-old male with a history of micro hematuria and BPH symptoms was seen in May 1999. Patient underwent cystoscopy in June 1999 and was started on Flomax and Proscar. An IVP showed a bladder diverticulum. In December 1 999, patient underwent Indigo Laser Ablation of the prostate which failed. Patient subsequently underwent a TURP in March 2000. His preoperative prostate size was 30 gm while only 9.5 grams of tissue was resected. Patient continued to have high residuals of 199 cc as documented in August 2000 and prostate size of 30-40 gm as documented in May 2001. He continues to require Flomax for his treatment. Following are the concerns in the quality of care of this patient. As part of the hematuria workup, urine cytologies should have been done. He underwent indigo Laser Ablation which failed. Post TURP, his prostatic symptoms have not improved. According to one of the nurse's notes, he started to dribble while his obstructive symptoms have not resolved. This is not documented by the MD. There are

lots of cuts and pastes notes in this chart. Overall care of this patient is Level 11. Patient needs a cystogram for better evaluation of bladder diverticulum, which may be the cause of his persistent symptoms.

- ee. This patient was seen in February 2001 for elevated PSA. After a lapse of 4 months, a transrectal ultrasound guided prostate needle biopsy was scheduled for the June 21, 2001. A TRUS was done but the prostate needle biopsy was not done because of the large post void residual urine. Patient was started on Alpha Blockers. Patient was brought back to the operating room on June 28 and a TRUS was done which suggested that his prostate gland was big enough to explain his high PSA. However, the actual volume of the prostate gland and PSA density was not measured. His rectal exam suggested a 30-40 gill smooth prostate. On July 18, he underwent a TURP and 16.8 gm tissue was removed. Patient subsequently did well. There are some concerns in this chart.
- i. Significant delay between the diagnosis of elevated PSA to the first trip to the operating room for TRUS prostate needle biopsy. There was a delay about 4 months.
 - ii. He was brought into the operating room and biopsy was not done.
 - iii. When the TRUS was done the actual size of the prostate and PSA density was not measured. Patient was started on Alpha Blockers on June 21, and brought back for the same procedure on June 28. Alpha Blockers do not give any significant relief of symptoms of prostatism in one week. The first trip to the operating room on the June 21 was redundant. The overall care of this patient is Level I with the exception of these findings.

7. The findings from the VISN 18 Board of Investigation noted the following:

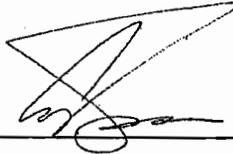
- a. Adequate documentation of physical preoperative evaluation was not evident in two cases.
 - b. Dr. Brewer engages in improper documentation practices which result in significant errors and confusion in the medical record and which in some cases constitute de facto falsification. Templates that are already completed prior to insertion in the medical record are used and are not modified appropriately based on the patient encounter. Documentation on some patients is completed an entire day prior to the patient encounter. Finally, the evidence strongly suggests overt cut and paste activity, despite Dr. Brewer's denial.
 - c. Proper procedures for handling and disposal of radioactive materials may not have been adhered to in the course of one TURP procedure.
 - d. Dr. Brewer is not performing radical prostatectomies appropriately. Furthermore, inadequate resection of the prostate during radical prostatectomy has already resulted in an action against his privileges in the past.
8. You have the right to review all evidence not restricted by regulation or statute upon which the proposed changes are based. Following that review, you may respond in writing to this written notice of intent. You will be given until close of business on February 12, 2004 to respond in writing.
9. All information will be forwarded to the Medical Center Director for decision. The Director will

make this document, a decision based on the record. If you disagree with the facility Director's decision, a hearing may be requested. You must submit the request for a hearing within five (5) workdays after receipt of decision.

10. You have the right to be represented by an attorney or other representative of your choice throughout the proceedings.
11. Consistent with VHA Handbook 1100.19, VHA Handbook 1100.17, and 38 CFR Part 46, it is the policy of the VA to file a report with the National Practitioner's Data Bank adverse clinical privileges actions taken against physicians that are final and affect privileges for more than 30 days or the restriction of clinical privileges when the action is related to professional competence or professional conduct. A copy will be forwarded to the appropriate State Licensing Board in all states in which you hold a license, and in the state of Texas.
12. You will be retained in an active duty status during this notice period in the same capacity as present.
13. If you have any questions you may contact Human Resources Office or me for further information.


ANA MELLO, M. D.
Interim Chief of Staff

Receipt acknowledged by



Date: 2 Feb 04

**DEPARTMENT OF
VETERANS AFFAIRS**

MEMORANDUM

Date: May 19, 2003

From: Chief of Staff (11)

Subj: Clinical Privileges

To: E. Allan Brewer, M.D.

1. The documents on your status of clinical privileges are under review by the Medical Center Director.
2. Effective immediately you are granted administrative absence with your duty station at home under the issues are resolved.



DARRYL POWELL, MD

Cc: Chief, Human Resources Service (05)
Chief, Quality Management Section (11A)



DEPARTMENT OF VETERANS AFFAIRS
West Texas VA Health Care System
Big Spring, Texas 79720

In Reply Refer To: 519/11

May 19, 2003

E. Allan Brewer, M.D.
C/O West Texas VA Health Care System
300 Veterans Boulevard
Big Spring, Texas 79720

Re: Revocation of Clinical Privileges

Dear Dr. Brewer,

A review of the Transurethral Prostatectomies (TURP) and Radical Retropubic Prostatectomies (RRP) performed by you from January 1, 2001 until the present was conducted by local VA physicians and Quality Management Registered Nurses. The results of this review were presented to the Professional Standards Board (PSB) that recommendations made to the Medical Center Director (Governing Board). The PSB found a majority of the patients undergoing a TURP had the same issues on which your Ohio Medical License was suspended, i.e., the estimated weight of the prostate gland by digital rectal examination (DRE) versus the amount of tissue removed by TURP was significantly less than the prostate gland size by DRE. Based on the standard of care set by the urologist in Ohio the PSB and Governing Body concluded you do not meet the minimal standard of care in performing a TURP.

The majority of the electronic medical records contained "cut and paste" or "copy and paste" entries. The same entries were found on different patients with respect to the certain portions of the history and almost all physical examinations. The medical record contained entries of different patients, often to the degree that the reviewers could not ascertain to which patient data made reference in the electronic medical record. The PSB deliberation concluded this was inappropriate documentation on most patients and falsification of the electronic medical record on other patients.

The Medical Center Director noted the California Medical License under which you are credentialed and privileged at this VAMC had the appearance of being unrestricted, but with conditions. The Medical Center Director stated the findings in the review of your patients and the PSB recommendations were sufficient to conclude you continue to have the same deficiencies as described in the Ohio and California documents, therefore you failed rehabilitation and your California Medical License is restricted.

If the revocation of clinical privileges is upheld, a report will be filed with the National Practitioner Data Bank, with a copy sent to all appropriate State Licensing Boards.

You have right to be represented by an attorney or other representative of your choice throughout any proceedings.

You have ten (10) working days in which to submit a response to this notice, and granted an additional ten (10) days under extraordinary circumstances.

All information will be forwarded to the Medical Center Director for a decision.

DARRYL POWELL, M.D.

Cc: Chief, Quality Management Section (11A)
Chief, Human Resources Management Service (05)

Reference: VHA Handbook 1100.19 dated March 6, 2001
Bylaws and Rules of the Medical Staff dated May 2002

Receiver Acknowledged

Date

**DEPARTMENT OF
VETERANS AFFAIRS**

Memorandum

Date: April 17, 2003

From: Medical Center Director (00)

Subj: Summary Suspension

To: Allan Brewer, M. D.

1. Based on the recommendation of the Chief Medical Officer and in accordance with the Bylaws and Rules of the Medical Staff, (Article Six {VI}, Section Two {2}, paragraph c), and VHA Handbook 1100.19, your privileges at West Texas VA Health Care System are summarily suspended pending the conclusion of the current analysis of your state medical licensure status. As verbally instructed April 16, 2003, by Dr. Darryl Powell and me, you are temporarily reassigned to non-patient care, administrative activities until further written notice.
2. If you have any questions regarding this issue, you may direct them to the Chief of Staff or me.


CARY D. BROWN
Medical Center Director

CC: Professional Standards Board
Chief of Staff
Quality Management, Credential & Privileging File

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO
CIVIL DIVISION

EUGENE A. BREWER, M.D.
Appellant,
vs.
THE STATE MEDICAL BOARD OF
OHIO,
Appellee.

CASE NO. 96CVF03-5471
JUDGE CAIN

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STATE MEDICAL BOARD

**JUDGMENT ENTRY
AFFIRMING THE JULY 10, 1996
ORDER OF THE STATE MEDICAL BOARD**

FILED
COMMON PLEAS COURT
FRANKLIN COUNTY
97 NOV 19 11 31 AM '97
CLERK OF COURTS

This case is before the Court upon the appeal, pursuant to R.C. 119.12, of the July 10, 1996 order of the State Medical Board of Ohio. For the reasons stated in the decision of this Court filed on October 22, 1997, which decision is incorporated by reference as if fully rewritten herein, it is hereby

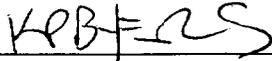
ORDERED, ADJUDGED AND DECREED that judgment is hereby entered in favor of Appellee, State Medical Board of Ohio, and the July 10, 1996 order of the State Medical Board in the matter of Eugene A. Brewer, M.D., is hereby AFFIRMED. Costs to Appellant.

IT IS SO ORDERED.

DATE

DAVID E. CAIN, JUDGE

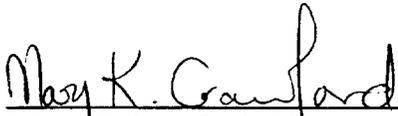
APPROVED:



Kevin P. Byers (0040253)
KEVIN P. BYERS CO., L.P.A.
10 West Board Street
Suite 260
Columbus, Ohio 43215

Attorney for Appellant, Eugene A. Brewer, M.D.

ATTORNEY GENERAL
BETTY D. MONTGOMERY (0007102)



Mary K. Crawford (0021451)
Assistant Attorney General
Health & Human Services Section
30 East Broad Street, 26th floor
Columbus, Ohio 43215-3428
(614) 466-8600

Attorneys for Appellee, the State Medical Board of Ohio

brewer.ent

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO
CIVIL DIVISION

E. Allan Brewer, MD,
P.O. Box 236
Sayre, Pennsylvania 18840
Appellant,

v.

State Medical Board of Ohio
77 South High St., 17th Floor
Columbus, Ohio 43266-0315
Appellee.

*

*

*

CASE NO. _____

JUDGE _____

Appeal from the State Medical Board of Ohio

APPELLANT'S NOTICE OF APPEAL

Pursuant to RC 119.12, notice is hereby given that Appellant, E. Allan Brewer, MD, appeals the decision and order of the State Medical Board dated July 10, 1996, mailed July 11, 1996, and received by Appellant's counsel on July 15, 1996, (copy attached as Exhibit A.) The Medical Board order is not supported by the necessary quantum of reliable, probative and substantial evidence nor is it in accordance with law.

Respectfully submitted,

KEVIN P. BYERS CO., L.P.A.

KPB/ES

Kevin P. Byers 0040253
One Columbus
10 West Broad Street, Suite 260
Columbus, Ohio 43215
614.228.6283 Fax 228.6425

Attorney for E. Allan Brewer, MD

SMB original

Certificate of Service

I certify that an original of the foregoing document was hand
delivered this ^{23rd} 16th day of July, 1996, to the Clerk of the Common
Pleas Court of Franklin County, 369 South High Street, 3rd Floor,
Columbus, Ohio 43215 and also a copy was placed in first class U.S.
Mail addressed to Assistant Attorney General Lawrence D. Pratt,
Health & Human Services Section, 30 East Broad Street, 26th Floor,
Columbus, Ohio 43215-3428.

K. BYERS
Kevin P. Byers



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

July 10, 1996

Eugene Allan Brewer, M.D.
4320 Wornell Road, Suite 444
Kansas City, Missouri 64111

Dear Doctor Brewer:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Suzanne E. Kelly, 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 July 10, 1996, including Motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

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

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of a Notice of Appeal with the State Medical Board of Ohio, and a copy of that Notice of Appeal with the Franklin County Court of Common Pleas within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12 of the Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

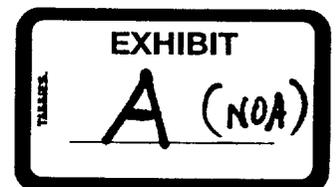
Thomas E. Gretter, M.D.
Secretary

TEG:em
Enclosures

CERTIFIED MAIL RECEIPT NO. P 152 983 593
RETURN RECEIPT REQUESTED

cc: Kevin P. Byers, Esq.

CERTIFIED MAIL RECEIPT NO. P 152 983 594
RETURN RECEIPT REQUESTED



Mailed 7-11-96



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; attached copy of the Report and Recommendation of Suzanne E. Kelly, Esq., Attorney Hearing Examiner, State Medical Board; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on July 10, 1996, including Motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the Matter of Eugene Allan Brewer, M.D., 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.

Thomas E. Gretter, M.D.
Secretary

(SEAL)

7/10/96

Date



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

EUGENE A. BREWER, M.D.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on the 10th day of July, 1996.

Upon the Report and Recommendation of Suzanne E. Kelly, Hearing Examiner, Medical Board, in this matter designated pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the 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.

1. It is hereby ORDERED that: the certificate of Eugene A. Brewer, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than three (3) months.
2. The State Medical Board shall not consider reinstatement of Dr. Brewer's certificate to practice unless and until all of the following minimum requirements are met:
 - a. Dr. Brewer shall submit an application for reinstatement, accompanied by appropriate fees. Dr. Brewer shall not make such application for at least three (3) months from the effective date of this Order.
 - b. Within thirty (30) days of the effective date of this Order, Dr. Brewer shall provide a copy of this Order by certified mail, return receipt requested, to the proper licensing authority of any state or jurisdiction in which he currently holds a license to practice. Further Dr. Brewer shall provide this Board with a copy of the return receipt as proof of notification within thirty (30) days of receiving that return receipt. The return receipt should be submitted to the Compliance Officer of the Board.
3. Upon reinstatement, Dr. Brewer's certificate to practice medicine and surgery in this state will be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three (3) years.
 - a. Dr. Brewer shall obey all federal, state, and local laws, and all rules governing the practice of medicine in the state in which he is practicing.
 - b. Dr. Brewer shall appear in person for interviews before the full Board or its designated representative at three (3) month intervals, or as otherwise requested by the Board.
 - c. Dr. Brewer shall submit quarterly declarations under the penalty of Board disciplinary action or criminal prosecution, stating whether he has complied with all the terms and conditions of his

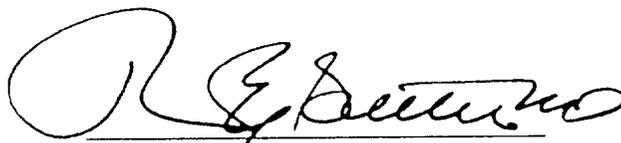
probation in this State and with all terms, conditions, or limitations imposed by any other state medical board.

- d. Dr. Brewer shall notify the Board in writing of any action in any state initiated against a certificate to practice medicine held by Dr. Brewer in that state. Moreover, Dr. Brewer shall provide acceptable documentation verifying same within thirty days of his receipt to the of the Board.
- e. Dr. Brewer shall immediately notify the Board in writing should he fail to comply with any term, condition, or limitation of his probation or with any term, condition, or limitation imposed by any other state medical board.
- f. Upon submitting renewal applications for each Ohio biennial registration period occurring during the period of probation, Dr. Brewer shall also submit acceptable documentation of Category I Continuing Medical Education credits completed. At least twenty (20) hours of such Continuing Medical Education for each registration period, to be approved in advance by the Board or its designee, shall relate to the violations found in this matter. These hours shall be in addition to the Continuing Medical Education requirements for relicensure. This documentation is to be submitted to the Compliance Officer of the Board, separately from the renewal application.
- g. Dr. Brewer shall provide a copy of this Order by certified mail, return receipt requested, at the time of application to the proper licensing authority of any state in which he applies for licensure or reinstatement of licensure. Further, Dr. Brewer shall provide this Board with a copy of the return receipt as proof of notification within thirty (30) days of receiving that return receipt.
- h. Dr. Brewer shall provide a copy of this Order to all employers and the Chief of Staff at each hospital where he has, applies for, or obtains privileges.
- i. Dr. Brewer will not request modification of these terms of probation for at least nine (9) months after probation begins.
- j. Dr. Brewer shall refrain from commencing practice in Ohio without prior written Board approval. Moreover, should he commence practice in Ohio, the Board may place Dr. Brewer's certificate under additional terms, conditions, or limitations, including the following:
 - i. Dr. Brewer shall obey all federal, state, and local laws, and all rules governing the practice of medicine in Ohio.
 - ii. Dr. Brewer shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution stating whether he has complied with all the provisions of probation.
 - iii. Dr. Brewer shall appear in person for interviews before the full Board or its designated representative at three (3) month intervals, or as otherwise requested by the Board.
 - iv. Dr. Brewer shall submit to the Board and receive its approval for a plan of practice in Ohio which, unless and until otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. Brewer's activities will be directly supervised and overseen by another physician approved by the Board.
 - v. Within thirty days of commencement of practice in Ohio, Dr. Brewer shall submit for the Board's prior approval the name of a monitoring physician, who shall review Dr. Brewer's patient charts and shall submit a written report of such review to the Board on a quarterly

basis. Such chart review may be done on a random basis, with the number of charts reviewed to be determined by the Board. It shall be Dr. Brewer's responsibility to ensure that the monitoring physician's quarterly reports are submitted to the Board on a timely basis. If the approved monitoring physician becomes unable or unwilling to serve, Dr. Brewer shall immediately notify the Board in writing and shall arrange another monitoring physician as soon as practicable.

- vi. Dr. Brewer shall provide a copy of this Order to all employers and the Chief of Staff at each hospital where he has, applies for, or obtains privileges.
 - vii. In the event that Dr. Brewer has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to commencement of practice in Ohio, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of Dr. Brewer's fitness to resume practice.
 - viii. If Dr. Brewer violates probation in any respect, the Board, after giving Dr. Brewer notice and the opportunity to be heard, may set aside the stay order and impose the permanent revocation of Dr. Brewer's certificate to practice.
 - ix. Dr. Brewer will not request modification of these terms of probation for at least nine (9) months after he begins practicing in Ohio.
4. Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Brewer's certificate will be fully restored.

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



Thomas E. Gretter, M.D.
Secretary

(SEAL)

7/10/96

Date



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

July 10, 1996

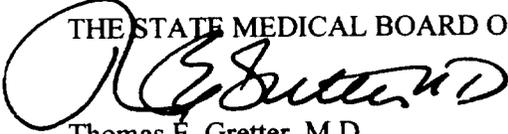
Eugene Allan Brewer, M.D.
4320 Wornell Road, Suite 444
Kansas City, Missouri 64111

Dear Doctor Brewer:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Suzanne E. Kelly, 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 July 10, 1996, including Motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

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

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THE STATE MEDICAL BOARD OF OHIO

Thomas E. Gretter, M.D.
Secretary

TEG:em
Enclosures

CERTIFIED MAIL RECEIPT NO. P 152 983 593
RETURN RECEIPT REQUESTED

cc: Kevin P. Byers, Esq.

CERTIFIED MAIL RECEIPT NO. P 152 983 594
RETURN RECEIPT REQUESTED

Mailed 7-11-96



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; attached copy of the Report and Recommendation of Suzanne E. Kelly, Esq., Attorney Hearing Examiner, State Medical Board; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on July 10, 1996, including Motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the Matter of Eugene Allan Brewer, M.D., 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.

A handwritten signature in black ink, appearing to read "T. E. Gretter, M.D.", written over a horizontal line.

Thomas E. Gretter, M.D.
Secretary

(SEAL)

A handwritten date "7/10/96" written in black ink above a horizontal line.

Date



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

EUGENE A. BREWER, M.D.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on the 10th day of July, 1996.

Upon the Report and Recommendation of Suzanne E. Kelly, Hearing Examiner, Medical Board, in this matter designated pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the 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.

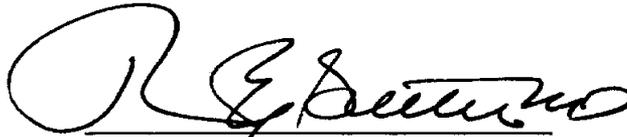
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- probation in this State and with all terms, conditions, or limitations imposed by any other state medical board.
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4. Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Brewer's certificate will be fully restored.

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



Thomas E. Gretter, M.D.
Secretary

(SEAL)

7/10/96

Date

96 MAY 31 PM 12:52

**REPORT AND RECOMMENDATION
IN THE MATTER OF EUGENE A. BREWER, M.D.**

The Matter of Eugene A. Brewer, M.D., came on for hearing before Suzanne E. Kelly, Attorney Hearing Examiner for the State Medical Board of Ohio on March 18, 19 and 20, 1996.

INTRODUCTION

I. Basis for Hearing

- A. By letter dated April 12, 1995 (State's Exhibit 1), the State Medical Board of Ohio (Board) notified Eugene A. Brewer, M.D., that the Board intended to determine whether to discipline his certificate to practice medicine and surgery for one or more of the following reasons:
- 1) The Board alleged that in the routine course of Dr. Brewer's practice, he failed to perform and/or failed to document in his office records the necessary medical evaluation and/or preoperative examination of his patients sufficient to substantiate his diagnosis or support his choice of treatment.
 - 2) In the routine course of his practice, Dr. Brewer frequently failed to attempt appropriate conservative therapy before subjecting his patients to surgery. Instances of such practice include, but are not limited to, the care rendered to Patients 1, 2, 3, 5, 6, 8, 11, 13, 14, 16, 17, 18 and 19. Furthermore, the Board alleged that such practice may have resulted in unnecessary surgery.
 - 3) In the routine course of his practice, Dr. Brewer's rectal exam findings frequently did not correlate with the actual size of the prostate as evidenced by a comparison of his clinical notes to his operative notes and surgical pathology reports. Instances of such discrepancies are illustrated in the medical records of Patients 1, 3, 4, 13, 15 and 18. Additionally, Dr. Brewer routinely noted in the operative report that he resected down to the prostatic capsule in these "markedly enlarged" prostates, indicating complete resection of the obstructing tissue. However, the pathology reports from the surgeries routinely revealed that very little tissue was removed, indicating a much smaller prostate than Dr. Brewer had documented.

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Additionally, on or about February 13, 1991, as noted in Dr. Brewer's records, he performed a rectal exam on Patient 15, palpating a "smooth without nodule, 30 gram mass" prostate. The x-ray report of the CT Scan of Patient 15's abdomen and pelvis, dated February 20, 1991, indicated that this patient had an enlarged prostate with "evidence of extra-capsular extension. Infiltration of the periprostatic fat (was) noted. A nodular soft tissue density (was) noted located between the seminal vesicle and rectum on the left side....(Also) about 1.5 cm. in diameter nodular soft tissue density suggestive of adenopathy (was) also seen in the perirectal area on the left side below the sciatic foramen." Dr. Brewer's rectal exam findings were not consistent with this very abnormal CT scan.

- (4) The Board alleged that in the routine course of Dr. Brewer's practice, he demonstrated a lack of knowledge of the healing process of tissue and/or a lack of understanding of the pathophysiology of prostate cancer.

The Board alleged that these acts, conduct, and/or omissions listed in above paragraphs, individually and/or collectively, constituted "(f)ailure to use reasonable care discrimination in the administration of drugs," and/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.

The Board further alleged that Dr. Brewer's acts, conduct, and/or omissions constituted "(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.

The Board advised Dr. Brewer of his right to request a hearing in this Matter.

- B. On May 12, 1995, Kevin P. Byers, Esq., submitted a written hearing request on behalf of Dr. Brewer. (State's Exhibit 2) (5 pp.)

STATE MEDICAL BOARD
OF OHIO
95 MAY 31 PM 12:52

II. Appearances

- A. On behalf of the State of Ohio: Betty D. Montgomery, Attorney General, by Lawrence D. Pratt and Mary K. Crawford, Assistant Attorneys General.
- B. On behalf of the Respondent: Kevin P. Byers, Esq.

EVIDENCE EXAMINED

I. Testimony Heard

- A. Presented by the State
 - 1. Henry Wise, II, M.D.
 - 2. Eugene Allan Brewer, M.D., as if upon cross-examination.
- B. Presented by the Respondent
 - 1. Eugene Allan Brewer, M.D.

II. Exhibits Examined

In addition to State's Exhibits 1, *1A and 2, the following exhibits were identified and admitted into evidence:

- A. Presented by the State
 - 1. State's Exhibit 3: May 16, 1995, letter to Kevin P. Byers, Esq., from the Board advising that a hearing had been set for May 26, 1995, and further advising that the hearing had been postponed pursuant to Section 119.09, Ohio Revised Code.
 - 2. State's Exhibit 4: May 17, 1995, letter to Attorney Byers from the Board scheduling the hearing for August 14 through August 18, 1995. (2 pp.)
 - 3. State's Exhibit 5: Respondent's July 18, 1995, Motion for Continuance. (2 pp.)

96 MAY 31 PM 12: 52

4. State's Exhibit 6: July 31, 1995, Entry granting Respondent's Motion for Continuance and rescheduling the hearing for the week of October 30 through November 3, 1995.
5. State's Exhibit 7: Curriculum vitae of Henry A. Wise, II, M.D. (23 pp.)
6. State's Exhibit 8: Certified copy of Dr. Brewer's 1992 renewal application and his attached explanation answer to question No. 4. (3 pp.)
7. State's Exhibit 9: Certified copies of Adverse Action Reports received from Middletown Regional Hospital as they appear in the records of the State Medical Board of Ohio in the matter of Eugene Allan Brewer, M.D. (9 pp.)
- *8. State's Exhibit 10: Dr. Brewer's office and hospital records for Patient 1. (Office records 70 pp. - Hospital records 39 pp.)
- *9. State's Exhibit 11: Dr. Brewer's office and hospital records for Patient 2. (Office records 31 pp. - Hospital records 65 pp.)
- *10. State's Exhibit 12: Dr. Brewer's office and hospital records for Patient 3. (Office records 37 pp. - Hospital records 57 pp.)
- *11. State's Exhibit 13: Dr. Brewer's office and hospital records for Patient 4. (Office records 35 pp. - Hospital records 47 pp.)
- *12. State's Exhibit 14: Dr. Brewer's office and hospital records for Patient 5. (Office records 4 pp. - Hospital records 248 pp.)
- *13. State's Exhibit 15: Dr. Brewer's office and hospital records for Patient 6. (Office records 33 pp. - Hospital records 160 pp.)
- *14. State's Exhibit 16: Dr. Brewer's office and hospital records for Patient 7. (Office records 31 pp. - Hospital records 73 pp.)
- *15. State's Exhibit 17: Dr. Brewer's office and hospital records for Patient 8. (Office records 28 pp. - Hospital records 58 pp.; second set Hospital records 303 pp. - third set Hospital records 279 pp.)

96 MAY 31 PM 12: 52

- *16. State's Exhibit 18: Dr. Brewer's office and hospital records for Patient 9. (Office records none - Hospital records 157 pp.)
- *17. State's Exhibit 19: Dr. Brewer's office and hospital records for Patient 10. (Office records 92 pp. - Hospital records 87 pp.)
- *18. State's Exhibit 20: Dr. Brewer's office and hospital records for Patient 11. (Office records 60 pp. - Hospital records 68 pp.)
- *19. State's Exhibit 21: Dr. Brewer's office and hospital records for Patient 12. (Office records 68 pp. - Hospital records 78 pp.)
- *20. State's Exhibit 22: Dr. Brewer's office and hospital records for Patient 13. (Office records 19 pp. - Hospital records 107 pp.)
- *21. State's Exhibit 23: Dr. Brewer's office and hospital records for Patient 14. (Office records 21 pp. - Hospital records 69 pp.)
- *22. State's Exhibit 24: Dr. Brewer's office and hospital records for Patient 15. (Office records 43 pp. - Hospital records 72 pp.)
- *23. State's Exhibit 25: Dr. Brewer's office and hospital records for Patient 16. (Office records 33 pp. - Hospital records 56 pp.)
- *24. State's Exhibit 26: Dr. Brewer's office and hospital records for Patient 17. (Office records 84 pp. - Hospital records 80 pp.)
- *25. State's Exhibit 27: Dr. Brewer's office and hospital records for Patient 18. (Office records 61 pp. - Hospital records 208 pp.)
- *26. State's Exhibit 28: Dr. Brewer's office and hospital records for Patient 19. (Office records 25 pp. - Hospital records 64 pp.)
- 27. State's Exhibit 29: November 22, 1995, Entry rescheduling the hearing for March 18 through 22 and April 2, 1996.
- 28. State's Exhibit 30: February 13, 1996, Entry reassigning this matter, which was previously to be heard by Sharon W. Murphy, Esq., to Suzanne E. Kelly, Esq.

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29. State's Exhibit 31: Copy of diagram of male reproductive organs, pelvic organs; sagittal view; normal; Plate 1, from the *Attorney's Medical Atlas*.
30. State's Exhibit 32: Copy of diagram of male reproductive organs, prostate; sagittal view; normal; Plate 6, from the *Attorney's Medical Atlas*.
31. State's Exhibit 33: Copy of diagram of male reproductive organs, transurethral prostate resection; sagittal view; treatment; Plate 7, from the *Attorney's Medical Atlas*.
32. State's Exhibit 34: Copy of diagram of male reproductive system -- surgical removal of the prostate (transurethral prostatectomy) -- sagittal, Figure 16-2 from *Geriatrics*.
33. State's Exhibit 35: Excerpts from the Sixth Edition of the *Campbell's Urology*, including three separate articles: 1) Chapter 78 - Radical Retropubic Prostatectomy; 2) Chapter 79 - Perineal Prostatectomy; and 3) Chapter 80 - Transurethral Surgery; Edited by Patrick C. Walsh, M.D., Alan B. Retik, M.D., Thomas A. Stamey, M.D., and E. Darracott Vaughan, Jr., M.D. (31 pp.)
34. State's Exhibit 36: Excerpts from the Sixth Edition of the *Campbell's Urology*: Chapter 29 - Adenocarcinoma of the Prostate. (33 pp.)
35. State's Exhibit 37: Excerpt on prostatosis from *Taber's Cyclopedic Medical Dictionary*, 13th Edition, P-148. (2 pp.)
36. State's Exhibit 38: Excerpt on Ascendin from *Physicians' Desk Reference*, 49th Edition, 1995. (4 pp.)
37. State's Exhibit 39: Excerpt on Deltasone from *Physicians' Desk Reference*, 49th Edition, 1995. (4 pp.)

B. Presented by the Respondent

1. Respondent's Exhibit A: Curriculum vitae of Eugene Allan Brewer, M.D. (8 pp.)
2. Respondent's Exhibit B: Copy of certificate from Saint Luke's Hospital of Kansas City, Missouri, certifying that Dr. Brewer served

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as Urologic/Oncology Fellow from July 1, 1993, through June 30, 1994.

3. Respondent's Exhibit C: November 11, 1994, letter to Dr. Brewer from James J. Mongan, M.D., Dean, University of Missouri-Kansas City.
4. Respondent's Exhibit D-1: Copy of credit certification from the University of Colorado School of Medicine, Office of Continuing Medical Education issued to Dr. Brewer, for his attendance to the Fourth International Prostate Cancer Update.
5. Respondent's Exhibit D-2: Copy of Certificate of Completion for program on "Injectable Therapy for Urinary Incontinence" from the American Urological Association, Inc., [AUA] Bellaire, Texas.
6. Respondent's Exhibit D-3: Copy of Certificate of Completion for program on "Annual Mtg-New York Section" from the AUA.
7. Respondent's Exhibit D-4: Copy of seminar meeting on Prostate Cancer of the Mid-America Urologic Oncology Institute.
8. Respondent's Exhibit D-5: Copy of Certificate of Completion for program on "95 Sect: South Central Seminar" from the AUA.
9. Respondent's Exhibit E-2: Application for submission of papers to the 1995 annual meeting of the South Central Section of the AUA.
10. Respondent's Exhibit E-3: Abstract on paper, *The Role of Laparoscopic Pelvic Lymphadenectomy in the Staging of Prostate Cancer*, by E. Allan Brewer, M.D.
11. Respondent's Exhibit E-4: Abstract Form for Housestaff Research Projects to be Presented June 20, 1994.
12. Respondent's Exhibit E-5: Abstract Form for Housestaff Research Projects to be Presented June 20, 1994.
13. Respondent's Exhibit E-6: July 7, 1994, letter to Dr. Brewer from The New York Section of the AUA.

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14. Respondent's Exhibit E-7: Abstract Form for the New York Section of AUA for the 1994 meeting in London, England.
15. Respondent's Exhibit E-8: July 7, 1994, letter to Dr. Brewer from The New York Section of the AUA.
16. Respondent's Exhibit E-9: Abstract Form for the New York Section of AUA for the 1994 meeting in London, England.
17. Respondent's Exhibit F: Description of Urologic Oncology Fellowship Program from Saint Luke's Hospital of Kansas City, Department of Medical Education listing the curriculum of program and other information regarding urology. (5 pp.)
18. Respondent's Exhibit G: Undated letter to Dr. Brewer from James Buchanan Brady Urological Institute, The Johns Hopkins Hospital, Baltimore, Maryland, welcoming Dr. Brewer in the near future to observe a radical retropubic prostatectomy. Attached to this letter are Dr. Brewer's notes from the observation. (15 pp.)
19. Respondent's Exhibit H: Paper entitled *Laparoscopic Pelvic Lymphadenectomy, It's Role In The Present Treatment Of Localized Adenocarcinoma Of The Prostate*, by Bernardo L. Gonzalez, M.D., E. Allan Brewer, M.D., James C. West, Jr., M.D., and Linza T. Killion, M.D. (16 pp.)
20. Respondent's Exhibit I: Paper entitled *PSA and PSA Density Increasing The Probability Of Prostate Cancer In Patients With Negative Initial Biopsy*, by E. Allan Brewer, M.D., Linza T. Killion, M.D., James C. West, Jr., M.D., and Paul G. Cuddy, Pharm. D. (23 pp.)
- *21. Respondent's Exhibit J: St. Luke's Hospital of Kansas City, Urologic Oncology Fellowship Program, Case Log of Eugene A. Brewer, M.D. (54 pp.)
22. Respondent's Exhibit O: Booklet from the South Central Section Seminar, March 3 - 5, 1995, Saint Louis, Missouri. (34 pp.)
23. Respondent's Exhibit P: Paper entitled *The Morbidity of Radical Prostatectomy For Multifocal Stage 1 Prostatic Adenocarcinoma*. (2 pp.)

24. Respondent's Exhibit Q: Paper entitled *Radical Retropubic Prostatectomy After Transurethral Prostatic Resection*. (3 pp.)
25. Respondent's Exhibit R: Paper entitled *Risk Of Urinary Incontinence Following Radical Prostatectomy*. (2 pp.)
26. Respondent's Exhibit S: Excerpt from the Sixth Edition of *Campbell's Urology*, Chapter 25 Benign Prostatic Hyperplasia. (21 pp.).
27. Respondent's Exhibit T: Abstract titled: The Distribution Of Residual Cancer in Radical Prostatectomy Specimens In Stage A Prostate Cancer. (6 pp.)
28. Respondent's Exhibit U: Paper marked "Accepted" regarding material on Prostatic Carcinoma.
29. Respondent's Exhibit V: Paper entitled *Transrectal Ultrasonography*. (3 pp.)
30. Respondent's Exhibit W: Paper entitled Transrectal Biopsy of the Prostate Guided with Transrectal US: Longitudinal and Multiplanar Scanning. (5 pp.)
31. Respondent's Exhibit X: Excerpt from the Sixth Edition of *Campbell's Urology*, Chapter 9, Urologic Ultrasonography. (54 pp.)
32. Respondent's Exhibit Y: Paper entitled: *Ultrasonically Guided Precise Needle Placement In The Prostate And The Seminal Vesicles*. (3 pp.)
- *33. Respondent's Exhibit Z: Patient Key.
34. Respondent's Exhibit BB: Excerpt from *Method of Urology*, Chapter 16, Disorders of Prostate. (14 pp.)
35. Respondent's Exhibit CC: Paper entitled: *Blood Transfusion and Anesthetic Practices in Radical Retropubic Prostatectomy*. (3 pp.)
36. Respondent's Exhibit DD: Paper entitled: *Efficacy of Radical Prostatectomy for Stage A2 Carcinoma of the Prostate*. (4 pp.)

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37. Respondent's Exhibit EE: Paper entitled: *The Use of Transrectal Prostatic Ultrasonography in the Evaluation of Patients With Prostatic Carcinoma*. (6 pp.)
38. Respondent's Exhibit FF: Copy of an application for a license to practice medicine without restriction in Pennsylvania. (2 pp.)
39. Respondent's Exhibit GG: April 8, 1996, letter to the Board from Attorney Byers regarding AUA fellowships. Attached are relevant excerpts from the AUA's listing of fellowships. (3 pp.)

C. Joint Exhibits

1. Joint Exhibit 1: U.S. Department of Health, Benign Prostatic Hyperplasia (BPH) Patient Guide. (12 pp.)
2. Joint Exhibit 2: U.S. Department of Health, BPH Clinical Practice Guideline pamphlet. (10 pp.)
3. Joint Exhibit 3: U.S. Department of Health, BPH Clinical Practice Guideline Book. (122 pp.)

III. Post Hearing Admissions to the Record

- *1. Board Exhibit 1: Subpoena Duces Tecum with attached request and patient description. (3 pp.)
- *2. Board Exhibit 2: Middletown Regional Hospital response to subpoena for specific medical records for Patient 2.
- *3. Board Exhibit 3: Middletown Regional Hospital response to subpoena for specific medical records for Patient 14. (4 pp.)
- *4. Board Exhibit 4: Middletown Regional Hospital response to subpoena for specific medical records for Patient 18. (8 pp.)
5. Board Exhibit 5: Respondent's Written Summation. (11 pp.)
6. Board Exhibit 6: Closing Argument of the State Medical Board of Ohio. (10 pp.)

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NOTE: ALL EXHIBITS MARKED WITH AN ASTERISK (*) HAVE BEEN SEALED TO PROTECT PATIENT CONFIDENTIALITY.

PROCEDURAL MATTERS

1. Several exhibits were withdrawn by the Respondent: Respondent's Exhibits E1, K-N, and Respondent's Exhibit AA.
2. By agreement of the parties, Respondent requested subpoenas for additional medical records for Patients 2, 14, and 18. The subpoenas were issued. Documents were obtained for Patients 14 and 18. The Middletown Regional Hospital wrote a letter stating that no records as described existed for Patient 2. These items were identified as Board Exhibits.
3. The records requested from the Middletown Regional Hospital and the closing arguments from both parties were received on April 8, 1996, The record closed on that date.

SUMMARY OF THE EVIDENCE

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

Eugene A. Brewer, M.D.

1. Eugene A. Brewer, M.D., attended the University of Kentucky for three years. In his third year, the University of Louisville accepted him for medical school. Dr. Brewer received his bachelor's degree from the University of Kentucky after his first year of medical school. Dr. Brewer earned his medical degree in 1978. He graduated with honors grades in general surgery, cardiac physiology and environmental physiology. Dr. Brewer's post-graduate training began at the University of Cincinnati Medical Center in general surgery. He then completed his obligation to the Navy by serving as a General Medical Officer from 1979 to 1980. At Dr. Brewer's request, the Navy allowed him to scrub on surgery as part of his duties. Dr. Brewer separated from the Navy to complete his urology training at the University of Cincinnati where he participated in a four year residency. During his last year, he served as chief resident. Upon his return to active duty with the Navy in 1984, he served as staff urologist at the Bethesda Naval Hospital in Bethesda Maryland. Following his honorable discharge from the Navy in 1987, Dr. Brewer entered private practice in

Kettering Ohio, with a group, and earned board certification in urology. In 1989, Dr. Brewer opened his solo practice in general urology in Middletown, Ohio, and established 4,500 patient practice. Dr. Brewer practiced in Middletown until April 1993. (Respondent's Exhibit [Res. Ex.] A; Transcript [Tr.] 578-592)

2. When Dr. Brewer opened his solo practice in 1989, he obtained privileges at Middletown Regional Hospital (MRH). This is the only hospital at which he practiced. In May 1992, Dr. Brewer renewed his State of Ohio medical license. He informed the Board that MRH had suspended his privileges to perform radical prostatectomies. Subsequent correspondence with MRH revealed that the hospital suspended his privileges due to concerns by the Tissue/Transfusion Committee that the specimens were unusually small and may not have constituted adequate surgical resection. On June 5, 1992, the MRH Medical Executive Committee imposed a summary suspension on Dr. Brewer. The suspension prohibited his performance of radical prostatectomies; limited performance of major open, intra-abdominal and retro-peritoneal procedures to those performed with assistance of a board certified urologist or a board certified surgeon; and allowed exercise of Transurethral Resection of the Prostate privileges only after obtaining a second opinion from a board certified urologist and recording that opinion on the medical record. MRH upheld this suspension in March 1993. MRH based its action on patient records. Specifically, MRH pathologists and surgeons expressed concern regarding the small amount of tissue produced from Dr. Brewer's performance of Transurethral Resections of the Prostate. Dr. Brewer resigned his privileges and closed his Middletown practice prior to the final order in March 1993. (State's Exhibit [St. Ex.] 8 & 9; Tr. 40-45, 73-74)

State's Expert

1. Henry Wise, II, M.D., graduated from the University of Virginia. Dr. Wise trained in surgery at Vanderbilt University and urology at Johns Hopkins Hospital in Baltimore, Maryland. Dr. Wise became head of the Urology Department at Ohio State University in 1978. Although he stepped down as department head for a period of time, Dr. Wise remained a full professor. He returned to the position of department head which is his present position. Dr. Wise also maintains a private practice at Riverside Hospital. Dr. Wise is board certified in urology and pathology. (St. Ex. 7; Tr. 302-303, 428-431)

Background

The patients involved in this action suffered from various urologic complaints. Prior to addressing the care of patients 1-19, common terms and procedures will be defined.

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Benign Prostate Hyperplasia (BPH)

Benign prostatic hyperplasia (BPH) is a noncancerous enlargement of the prostate gland. It arises as spherical masses of epithelial and stromal elements from the glands lining the proximal prostatic urethra. As these masses enlarge, they form lobes of varying configuration. Four conditions are interrelated with the disease process of BPH: 1) anatomic prostatic hyperplasia, 2) the presence of symptoms commonly referred to as prostatism, 3) the urodynamic presence of obstruction, and 4) the response of the bladder (detrusor) muscle to obstruction. Symptoms of prostatism include decreased urinary stream, straining to void, hesitancy, intermittency, bladder emptying, stress incontinence or post-void dribbling, urgency, frequency, and nocturia. BPH is the most common benign neoplasm in the aging human male. Recommended treatments range from "watchful waiting" to surgical intervention. (Res. Ex. S; Joint Exhibits 1-3; Tr. 24-25, 306-307)

Transurethral Resection of the Prostate (TURP)

1. Transurethral Resection of the Prostate (TURP) is one of the most common operations performed. The patient receives a general anesthetic or epidural or subdural spinal block. The surgeon makes a preliminary cystoscopic examination of the bladder, evaluates the extent of the obstruction, and estimates the size of the prostate. The surgeon uses a resectoscope to remove the adenoma which is obstructing the bladder neck. The bladder is filled with approximately 150 ml. of a nonhemolytic irrigation solution. The surgeon then resects the fibers at the bladder neck and immediately adjacent prostatic adenoma. The second stage of the resection begins at the mid-fossa starting at the 12 o'clock position and resecting the lateral lobes so that they drop down to the floor of the prostatic fossa. The final stage requires resecting the prostatic apex. The resection is done to the capsule of the prostate. The adenoma is removed by cutting it into small fragments which are removed through the scope. The portion that is left behind represents the compressed, normal prostate tissue which has been pushed to the periphery by the adenoma. The operation has been compared to removing the meat from an orange and leaving the rind or capsule. (St. Exs. 31-33; St. Ex. 35 at 2900-2919; Tr. 23, 40-58)
2. Complications from the TURP procedure include short- and long-term problems. TUR syndrome occurs when the irrigant is absorbed by the patient causing an electrolyte imbalance. Infection and bleeding are two other short-term complications. Long-term complications are primarily those that relate to recurrence of obstruction, impotency, and incontinence. Impotency occurs in five to ten out of 100 men undergoing the TURP procedure. (Joint Exhibits 1-3; Tr. 42-58, 339)

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Radical Retropubic Prostatectomy (RRP)

1. Radical Retropubic Prostatectomy is a surgical method to treat localized prostate cancer. The primary goal of surgery is to remove all tumor. It consists of two procedures. During the first, the surgeon dissects the bilateral pelvic lymph nodes to determine whether the cancer has spread. The second removes the prostate with the seminal vesicles which are attached to it. This extends from the neck of the bladder where the prostate begins to its most distal portion where the apex of the prostate ends just short of the sphincter muscle. Some complications of RRP include hemorrhage, thromboembolism, bladder neck contracture, incontinence, and impotence. (St. Exs. 31-33; St. Ex. 35 at 2865-2882; Joint Exhibit 1-3; Tr. 67-69, 310-312)

Gleason Scores

1. Dr. Wise and Dr. Brewer discussed a pathology grading technique known as a Gleason score. D.F. Gleason, M.D., a pathologist with the Veterans Administration in the 1960's, developed a method to determine the course of prostate cancer. Dr. Gleason examined the gross microscopic appearance of prostate cancer cells. He found five distinct microscopic patterns and assigned each a number. Dr. Gleason examined and graded each slide twice. Dr. Gleason added these grades together to determine the Gleason score. Since 1975, Gleason scores have been accepted by the urological community as a valid indicator of the course of prostate cancer. (St. Ex. 36 at 1172-1178; Tr. 118-120, 345-346)

Prostatic-Specific Antigen (PSA)

1. Prostatic Specific Antigen (PSA) is the "most unique marker in cancer biology. It is the first and only organ specific cancer marker with the possible exception of thyroglobulin." PSA is an enzyme that is elaborated by the prostate as part of its normal function. It is elaborated in greater quantity, or possibly leaks from the cells in greater amounts, in patients that have inflammation of the prostate and cancer of the prostate. BPH can cause elevations of PSA in the range of 0 to 4 without the presence of either carcinoma or prostatitis. Higher scores indicate abnormalities. PSA levels are proportional to the volume of intracapsular cancer. (St. Ex. 36 at 1186-1190; Tr. 61-62)

Intravenous Pyelogram [IVP]

1. The Intravenous Pyelogram [IVP] or Intravenous Urography [IVU] provides a picture of the kidneys, the bladder, and the tubes between the ureter. The tester injects iodine dye into the patient's bloodstream through the arm. The dye is filtered and excreted by the kidneys. An X-ray is taken. The IVP is an indirect indicator of the size of the prostate because the prostate can be seen as

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a filling defect. When pre- and post-void pictures are taken, the IVP provides information on the patient's ability to void. The IVP's voiding results are affected by the patient's ability to comply with the technician's instructions. (Joint Exhibit 3 at 57-66; Tr. 100-101, 305-306; 371-372, 477-478)

Patient 1

1. On August 31, 1989, Aimee M. Richmond, M.D., referred Patient 1 to Dr. Brewer with a question mark by her diagnosis of prostatitis. Dr. Richmond had started Patient 1 on Cipro 500. Dr. Brewer examined Patient 1, a 51 year old male, who complained of fever, chills and decreased urinary stream. Patient 1 also complained of severe dysuria and lower back pain extending to the sides as well as testicular pain. Dr. Brewer's examination revealed a tender, enlarged, boggy prostate. Dr. Brewer admitted Patient 1 to the hospital for rehydration and antibiotics, IVP and observation of voiding. The IVP was unremarkable. At that time, Dr. Brewer's impression was prostatitis. On September 5, 1989, Dr. Brewer performed a cystoscopy. He found that there was not gross obstruction from the prostate and the bladder had only very fine trabeculation. Dr. Brewer discharged Patient 1 on September 5, 1989. (St. Ex. 10 at Office Records [O]2-O14, O68-O70)

At a follow-up office visit on October 3, 1989, Dr. Brewer determined that Patient 1's prostate was 30 grams. During the next year, Patient 1 received treatments for prostatitis, including hospitalization for antibiotic therapy and rehydration. In March 1991, Dr. Brewer treated Patient 1 as an outpatient for prostatitis. In June 1991, Dr. Brewer admitted Patient 1 to the hospital for treatment of acute prostatitis, impending urosepsis, and urinary frequency. Patient 1 complained of dysuria and diminished urinary stream. The urinalysis indicated elevated white cells. Dr. Brewer described Patient 1's prostate as markedly tender and enlarged, with boggy throughout. Dr. Brewer administered intravenous fluid hydration, and antibiotics. (St. Ex. 10 at O15-O31)

The June 6, 1991, IVP indicated evidence of prostatic enlargement, but was otherwise negative. A urine culture revealed *Escherichia Coli* bacteria. Dr. Brewer discharged Patient 1 on June 8, 1991. (St. Ex. 10 at O42, O48)

Dr. Brewer performed a cystoscopic examination and ordered x-ray studies of Patient 1. These studies showed a markedly enlarged prostate with significant prostatic obstruction warranting further treatment. On June 25, 1991, Dr. Brewer admitted Patient 1 for a TURP. Dr. Brewer's operative note indicates that he resected the prostate down to the prostatic capsule. Dr. Brewer submitted 6.9 grams of prostatic chips. The pathology report noted

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"focal acute prostatitis superimposed on chronic prostatitis with small areas of infarction." (St. Ex. 10 at O54-O60, O64)

2. Dr. Wise testified that chronic prostatitis can only be diagnosed over time and with evidence of urine cultures that show bacteria. Dr. Wise explained that "itis" means inflammation and infection. Without repeated urine cultures which contained bacteria, a diagnosis of chronic prostatitis cannot be made. Additionally, the prostate must be massaged to obtain an appropriate sample. There was no evidence in the record that Dr. Brewer massaged the prostate. While Dr. Wise acknowledged that the June 3, 1991, admission was an episode of acute prostatitis, he stated that there was no evidence in the record of repeated episodes. Dr. Wise admitted that a short course of antibiotics could affect the ability to find the bacteria in cultures. (Tr. 355-359, 454-456)

Dr. Wise also expressed concern that Dr. Brewer described the prostate as "markedly enlarged," yet the tissue sent to the pathology laboratory weighed only 6.9 grams. The operative report indicated that Dr. Brewer aggressively resected the prostate to the prostatic capsule. This should have resulted in more tissue, if the prostate was enlarged. Dr. Wise testified that Dr. Brewer did not accurately evaluate the patient's prostate. (Tr. 353-354)

Dr. Wise testified that the more vigorous the resection, the greater likelihood that impotence will result from the TURP. This coupled with Patient 1's young age did not support Dr. Brewer's operative technique. Moreover, Dr. Wise felt that Dr. Brewer had not appropriately documented the need for surgery in this patient. Patients with prostatitis, acute or chronic, do not necessarily require surgical intervention because they respond to medical treatment. The patient must demonstrate symptoms that require surgery. Patient 1 did not. Dr. Brewer's physical examination was contradicted by pathological findings. Dr. Wise testified that Dr. Brewer failed to conform to the minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease. (Tr. 352, 355, 358-361, 510-511)

3. Dr. Brewer explained that the diagnosis of prostatitis can be made from the clinical presentation. Patient 1 presented with classic symptoms. Dr. Brewer treated those symptoms medically for approximately two years. Dr. Brewer testified that due to the difficulty of obtaining meaningful cultures from the prostate, diagnosing prostatitis from symptoms is acceptable. Further, Dr. Brewer testified that he performed the TURP to obviate the signs and symptoms of bladder outlet obstruction, not to correct prostatitis. Regarding his estimation of the size of the prostate, Dr. Brewer testified that the digital

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rectal examination can be affected by the conditions of the examination which are frequently out of the control of the physician. (Tr. 78-95, 637-642, 715-717)

Patient 2

1. On October 10, 1991, Patient 2, a 69 year old male, presented to Dr. Brewer as a referral from Dr. Sharma who noted a prostate nodule. Dr. Brewer's office record notes, "Asymptomatic except swelling. Large Grand. Gland 50 grams. Smooth. TURP." This is the earliest notation in either the hospital or office records. Dr. Brewer ordered an IVP which indicated an enlarged prostate. The IVP did not include an evaluation of urine retention. Patient 2's PSA was 11.9. (St. Ex. 11 at O19, O24, O29; Bd. Ex. 2; Tr. 99)

Dr. Brewer's history and physical form noted that Patient 2's referral was for prostatic enlargement only. No nodularity or induration was noted in his digital rectal examination. A Complete Blood Count [CBC] and Survey Seven Levels were normal, including a normal BUN and creatinine. Dr. Brewer's plan was for an outpatient cystoscopy and possible TURP on October 21, 1991. During the cystoscopy, Dr. Brewer found 2-3+ cellular formation with trabeculation in the bladder. Dr. Brewer described the prostate as markedly enlarged. Dr. Brewer elected to proceed with the TURP. He reported resecting the prostate down to the prostatic capsule on all four quadrants. Following the TURP, Dr. Brewer obtained a single digitally guided needle biopsy. (St. Ex. 11 at Hospital Records [H]3-H10, H57)

The pathology laboratory received 13 grams of prostate gland curettements and a single needle biopsy. The prostate gland curettements showed "adenomatous hyperplasia, patchy chronic prostatitis, occasional small focus of mildly atypical adenomatous hyperplasia." The needle biopsy did not identify carcinoma. On subsequent office visits, Patient 2 complained of decreased urinary stream and spraying. (St. Ex. 11 at O13-O14, H10)

2. Dr. Wise testified that Dr. Brewer inadequately attempted to diagnose and stage cancer in Patient 2. Patient 2 had a significantly elevated PSA. Dr. Brewer did not adequately biopsy the prostate. The use of a single digitally guided needle biopsy shows a deficit in knowledge regarding cancer. The appropriate procedure would be to do sextant needle biopsies. To avoid surgery or multiple surgeries, cancer must be thoroughly diagnosed before proceeding. Further, Dr. Wise testified that it was absolutely beyond the standard of care to operate on a patient who exhibited no symptoms except for an enlarged prostate. Dr. Brewer did not document any support for his plan of treatment-surgery. Dr. Wise testified that Dr. Brewer failed to conform to the

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minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease. (Tr. 362-369, 456-460)

3. Dr. Brewer testified that Patient 2 suffered from "silent" prostatism. Patients who have anatomic hyperplasia and urodynamic evidence of obstruction without symptoms of prostatism have "silent" prostatism. Dr. Brewer insisted that Patient 2 must have had urinary retention with elevated creatinines, or he would not have recommended a TURP. Evidence of this did not appear in the records. Dr. Brewer testified that MRH did not have a transrectal ultrasound. There was an individual who operated a mobile ultrasound unit that was available for use at his office. He did not utilize this mobile unit on this patient. Further, Dr. Brewer obtained only a single digitally guided needle biopsy because he did not want to over-diagnose clinically unimportant prostate cancer and because the digitally guided method is recommended for palpable lesions. Dr. Brewer testified that he could palpate Patient 2's nodule. Dr. Brewer stressed that the ultrasound is not infallible. (Res. Ex. S at 1018; Joint Exhibit 3 at 1, 8, 21, 29; Tr. 95-111, 642-652)

Patient 3

1. On October 10, 1991, Patient 3, a 63 year old man, presented to Dr. Brewer as a referral from Bernard H. Roberts, M.D. Dr. Roberts told Dr. Brewer that Patient 3 had a PSA of 5.1. Patient 3 exhibited no hesitancy, urgency, nocturia or hematuria. Dr. Brewer's digital rectal examination revealed a smooth prostate gland, approximately 30 grams. Dr. Brewer performed a cystoscopy and a prostate needle biopsies on October 17, 1991. The cystoscopy revealed a markedly enlarged prostate with secondary trabeculation and cellule formation of the bladder. The pathology laboratory found a needle core biopsy with two cores that contained "atypical prostatic hyperplasia, fragmented prostatic needle biopsy." The pathologist recommended additional biopsies from this area. An IVP showed an elevation of the floor of the urinary bladder, perhaps due to prostatic hypertrophy. (St. Ex. 12 at O1-O5, O15, O19, O37, H2)

Dr. Brewer wrote a history and physical form that included a diagnosis of bladder outlet obstruction and BPH. Dr. Brewer admitted Patient 3 for a TURP on October 28, 1991. Dr. Brewer resected the prostate to the capsule. He submitted eleven grams of prostatic tissue to pathology for examination. A diagnosis of the tissue revealed infiltrating adenocarcinoma of the prostate, moderately well-differentiated, mucin producing. The pathologist scored the tissue as Gleason's II+III=V. (St. Ex. 12 at O16-O17, O22, O25, H6-H7)

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Dr. Brewer ordered a bone scan and CT of the pelvis. These tests found no previously unidentified abnormalities. Dr. Brewer scheduled a RRP and bilateral pelvic lymph node dissection for November 25, 1991. Patient 3 canceled the operation to obtain a second opinion. (St. Ex. 12 at O23)

2. Dr. Wise testified that Dr. Brewer's treatment of Patient 3 fell below the standard of care because he failed to do a proper evaluation of Patient 3. Dr. Brewer did not appropriately document the symptomatology that would justify doing a TURP. Further, Dr. Brewer did not need to do the RRP. In a 63 year old patient with prostate cancer, other medical treatments would have obviated the need for an RRP. Dr. Wise testified that Dr. Brewer failed to conform to the minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease. (Tr. 371-377, 461-464)
3. Dr. Brewer testified that he performed a TURP on Patient 3 based on the cystoscopic findings of trabeculation and cellule formations in the bladder. These are indicative of bladder obstruction. Additionally, Dr. Brewer found a markedly enlarged prostate. The carcinoma found in Patient 3 was incidental to the TURP, which occurs in about 10 percent of patients. Patient 3 obtained a second opinion regarding the RRP. In December 1991, Patient 3 underwent an RRP with another physician. (Tr. 111-124, 657-658)

Patient 4

1. Patient 4, a 70 year old man, presented to Dr. Brewer on November 8, 1990, with complaints of severe pain, decreased stream, nocturia (4-5 times per night), and post-void dribbling. Dr. Brewer's digital rectal examination revealed a 30 gram prostate. Dr. Brewer's impression was "BPH/Hematuria." Dr. Brewer ordered an IVP, cystoscopy, and blood work. The IVP showed a significant residual of opacified urine in the urinary bladder. It also revealed a filling defect at the base of the bladder consistent with an enlarged prostate. Patient 4 had a PSA of 9.8. The cystoscopy revealed 2-3+ trabeculation of the bladder without evidence of diverticulum, stone, or bladder tumor. Following the cystoscopy on November 16, 1990, Dr. Brewer prescribed Cipro. Dr. Brewer noted that if the antibiotic therapy was unsuccessful, he would schedule a TURP. (St. Ex. 13 at O2, O6, O8-O10, O12-O13)

On November 20, 1991, Dr. Brewer admitted Patient 4 to MRH. Dr. Brewer noted that the antibiotics did not resolve Patient 4's symptoms. Dr. Brewer described the prostate gland as markedly enlarged with some fullness obliterating the midline sulcus of the gland. Dr. Brewer resected the gland to the level of the prostatic capsule. Dr. Brewer submitted 8 grams of prostate

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tissue to the pathology laboratory. The pathologist diagnosed the tissue as "widespread patchy chronic prostatitis and glandular and fibromuscular hyperplasia. Rare areas of atypical hyperplasia and acute inflammation." (St. Ex. 13 at O18-O19, O22-O24, H2-H7)

2. Dr. Wise testified that Dr. Brewer failed to properly document his physical findings that supported his decision to operate on Patient 4. Dr. Brewer's physical examination that described a thirty gram prostate gland is contradicted by the pathological findings. Only 8 grams of tissue were submitted to pathology even though Dr. Brewer's operative note indicated that he resected the gland to the capsule. Dr. Wise questioned Dr. Brewer's diagnostic abilities. Further, Dr. Brewer allowed only four days between beginning medical treatment and abandoning it. Conservative treatment could have avoided surgery if the symptoms arose from an infection. Dr. Wise testified that Dr. Brewer failed to conform to the minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease. (Tr. 377-380, 464-465)

Patient 5

1. On May 5, 1991, Jeffrey Jarrett, M.D., admitted Patient 5, an 81 year old male, to MRH. Patient 5 had been exhibiting confusion and severe constipation. He came to the emergency room complaining that he could not urinate, a problem he had never previously experienced. He was able to void at the emergency room; however he had residual urine of over 150 ccs. Initial rectal examination revealed no mass or tenderness. The prostate was firm and slightly enlarged. Dr. Jarrett requested a consultation by Dr. Brewer. (St. Ex. 14 at H9-H11, H14-H17)

Dr. Brewer saw Patient 5 on May 6, 1991. Dr. Brewer's digital rectal examination revealed a 40 gram prostate. Dr. Brewer recorded Patient 5's history as acute urinary retention, urinary hesitancy, nocturia (1 time per night), decreased stream and stress incontinence over an indeterminate period of time. Dr. Brewer's impression was BPH. He planned to rule out prostate cancer and ordered a PSA test, IVP, and a cystoscopy with possible TURP. The PSA was 31.2. The IVP showed "evidence of prostatic enlargement. Probable couple of small bladder diverticulum. Otherwise unremarkable IVP." On May 7 he tentatively scheduled Patient 5 for a TURP. (St. Ex. 14 at H18-H20, H32-H41, H51-H53, H55-H58, H62-H63, H65, H225, H244)

On May 9, 1991, Dr. Brewer performed a cystoscopy and TURP. Dr. Brewer resected the prostate down to the capsule. Dr. Brewer submitted 12.5 grams of tissue to pathology for evaluation. The pathologist report indicated

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"hyperplasia, multinodular. Foci of chronic and acute inflammation. Focus of prostatic intraepithelial neoplasia (PIN, Mild)." (St. Ex. 14 at H18-20)

2. Dr. Wise testified that Patient 5 should have been treated conservatively. Alternative medical treatments could have alleviated his urinary symptoms without surgery. First, Patient 5 was severely constipated. Constipation can cause urinary retention. Patient 5's urinary symptoms were of recent onset. However, Dr. Brewer did not address the possible role of constipation in the urinary symptoms. Second, Patient 5 suffered from confusion and dementia. These symptoms make urinary retention almost impossible to diagnose. The patient cannot follow commands, may spontaneously urinate, and cannot self-report symptoms. To accurately diagnose urinary problems in such a patient requires time. Dr. Brewer did not allow sufficient time prior to selecting surgery as the modality to treat Patient 5. Dr. Wise testified that an 81 year old patient should be spared the complications of surgery if conservative therapies would alleviate the symptoms. Dr. Wise testified that Dr. Brewer failed to conform to the minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease. (Tr. 381-382, 464-467)

Patient 6

1. Patient 6, a 72 year old male came to the emergency room of MRH complaining of left sided acute renal colic. Patient 6 had microhematuria. Emergency room personnel obtained an IVP. The IVP showed an obstruction to the left renal collecting system, most likely secondary to the small calculus in the proximal left ureter. The urinary bladder filled without defect. Dr. Brewer admitted Patient 6 to the hospital for evaluation, fluid resuscitation with narcotic pain control and observation for passage of the stone with possible surgical manipulation if the stone failed to pass or progress spontaneously. Subsequent films show that the stone did not progress. (St. Ex. 15 at O2-O33, H3-H4, H6-H10, H12)

On September 9, 1991, Dr. Brewer performed cystoscopy, ureteroscopy, stone manipulation, and insertion of ureteral stent to remove the left ureteral calculus. During the procedure, Dr. Brewer noted an enlarged prostate, trilobar prostatic hypertrophy and 2+ cellule formation and trabeculation of the bladder. Following the stone surgery, Patient 6 attempted to void regularly. However, on September 10, 1991, a Foley catheter had to be inserted. The Foley catheter removed 1250 ccs. of residual urine. The catheter remained in place until September 12, 1991, when Dr. Brewer ordered another voiding trial. Patient 6 was unable to void. The Foley was reinserted and 600

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ccs. of urine returned. Following the second failed voiding trial, Dr. Brewer scheduled a TURP. (St. Ex. 15 at H12, H31-H48, H100).

On September 16, 1991, Dr. Brewer performed a cystoscopy, TURP, and removed the stent placed during the stone manipulation. He resected the prostate down to the prostatic capsule. Dr. Brewer submitted 20 grams of tissue to pathology for review. The pathology report found "multicentric, atypical prostatic hyperplasia (P.I.N. I-III), prostatic tissue." Following the TURP, Patient 6 attempted to void on September 19. This was unsuccessful, and the catheter was replaced with a return of 300 ccs. On September 21, Patient 6 voided successfully and was discharged. At subsequent office visits, he voiced no complaints. (St. Ex. 15 at H20-H21, H128-H131)

2. Dr. Wise testified that Dr. Brewer did not allow an adequate trial of conservative measures to determine if the TURP procedure was necessary. The endoscopic procedure to remove the calcification can cause irritation, swelling and urinary retention. Additionally, the procedure can cause changes in the trigone of the bladder which triggers the urge to urinate. Dr. Wise expressed concern that Patient 6 voided well prior to the stone manipulation. Patient 6's inability to void following the procedure was not uncommon. Dr. Wise testified that healing from such a procedure takes from four to six weeks. The conservative course of action would be to attempt an intermittent catheter program or leave a catheter in for a period of time. The conservative course could have eliminated the need for surgery. Dr. Wise also testified that the stent could have caused irritation and frequency. Dr. Wise testified that in his opinion, Dr. Brewer operated precipitously. Dr. Wise testified that Dr. Brewer failed to conform to the minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease. (Tr. 382-386, 467-469)

Patient 7

1. On October 31, 1991, Dr. Brewer saw Patient 7, a 78 year old man, as a referral from a Dr. Scott. Patient 7 had a PSA of 4.0. Dr. Scott identified a high riding left testicle, an enlarged prostate and a 10 mm. prostate nodule as identified on an ultrasound examination. Dr. Brewer's examination revealed a forty gram prostate, and lower urinary tract voiding symptoms. Dr. Brewer scheduled Patient 7 for a PSA, cystoscopy and prostate needle biopsy for November 6, 1991. The PSA was 8.0. During the cystoscopy, Dr. Brewer noted a markedly enlarged prostate with trilobar hypertrophy and secondary bladder cellule formation with a large anterior bladder diverticulum present. The needle biopsy revealed borderline hyperplasia and mild chronic inflammation. (St. Ex. 16 at O1, O3-O7, O9, O16, O18-O27)

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On November 8, 1991, Dr. Brewer performed a TURP on Patient 7. Dr. Brewer resected the prostate down to the capsule. He submitted 14 grams of tissue to the pathology laboratory for examination. The pathologist diagnosed the tissue as "nodular prostatic hyperplasia, acute and chronic prostatitis, extensive multicentric atypical prostatic hyperplasia, moderate." (St. Ex. 16 at O1, O3-O7, O9, O16, O18-O27)

2. Dr. Wise did not object to the performance of the TURP. This procedure was appropriate. However, Dr. Wise testified that taking a single needle biopsy to diagnose prostate cancer is useless. The standard of care requires multiple site needle biopsies. Further, Dr. Wise testified that taking a single needle biopsy to diagnose prostate cancer shows no understanding of the pathogenesis of cancer. Dr. Wise testified that Dr. Brewer failed to conform to the minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease. (Tr. 386-393, 469-474)

Patient 8

1. Patient 8, a 56 year old man, presented to Dr. Brewer on May 16, 1989. Patient 8 complained of urgency, frequency and nocturia (x2). Patient 8 denied hematuria and had a good stream. In Dr. Brewer's history and physical form, he reported that Patient 8 had exhibited these symptoms for the past two years. Dr. Brewer's digital rectal examination revealed a 40 gram smooth prostate gland. Dr. Brewer did not order a PSA. Dr. Brewer's impression was chronic prostatitis and BPH. Dr. Brewer prescribed Septra-D.S., increased fluids, and vitamin C. On June 15, 1989, Patient 8 still complained of urgency and frequency. A single urinalysis is contained in the office records. It was clear. No urine culture is contained in the hospital or office records. Dr. Brewer estimated Patient 8's prostate to be 40 grams. (St. Ex. 17 at O18, O22-O23, O27, H1-H58)

On June 26, 1989, Dr. Brewer performed a cystoscopy and TURP. His discharge diagnosis was BPH and chronic prostatitis. Dr. Brewer submitted 12 grams of prostate tissue to the pathology laboratory for analysis. The pathologist's diagnosis was "hypertrophy-hyperplasia with foci of chronic inflammation." Patient 8 returned to Dr. Brewer on July 20, 1989, with complaints of insomnia, constipation, bladder spasms, and urinary frequency. The urinalysis revealed a trace of blood. Dr. Brewer estimated that Patient 8's prostate was 30 grams. Dr. Brewer's impression on that visit was recurring frequency and chronic prostatitis/BPH/ constipation. Dr. Brewer prescribed Septra, and milk of magnesia. He noted the possibility of a dilation of the urethra in the future. Patient 8 returned on August 3, 1989, with continued

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symptoms. Dr. Brewer's impression was post-TURP syndrome. (St. Ex. 17 at O18, O13-O16, H3-H9)

Patient 8 continue to return to Dr. Brewer with complaints of urinary frequency and nocturia. On February 17, 1992, Dr. Brewer performed a cystoscopy and urethral dilation on Patient 8. On February 24, 1992, Patient 8 reported that he could not void. Dr. Brewer scheduled Patient 8 for a Re-TURP. (St. Ex. 17 at O4-O12)

2. Dr. Wise testified that Patient 8's age required that his symptoms be thoroughly evaluated prior to proceeding to surgery. Diagnostic measures such as cultures, IVP, kidney x-rays, and urodynamic studies should have been taken prior to suggesting surgery. Dr. Wise testified that the standard of care required a PSA level to be obtained. None of these efforts were undertaken. Additionally, Dr. Wise was not surprised that Patient 8's problems continued after the June 1989 TURP because the source of the problems was never identified. Dr. Wise dismissed Dr. Brewer's explanation of post-TURP syndrome. Hypertrophy of muscles because of bladder obstruction should not affect voiding after the obstruction is removed. Continued urinary tract difficulties two and one-half years after the first TURP cannot be explained by hypertrophy of the bladder. Dr. Wise testified that Dr. Brewer failed to conform to the minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease. (Tr. 396-400, 474-476)

Patient 9

1. On December 19, 1989, Patient 9, a 74 year old man confined to a nursing home, presented to Dr. Brewer with a history of neurogenic bladder, seizure disorder, prostate problems, and pedal edema. On two prior occasions Patient 9 had prostatectomies. Patient 9 complained of dysuria, incontinence, and dribbling after voiding. The urinalysis was clear. The physical examination revealed a small and soft 10 gram prostate gland. Dr. Brewer prescribed antibiotics. Two weeks later, Patient 9 presented with hematuria and urinary tract infection. Dr. Brewer ordered a cystoscopy, IVP, and PSA. (St. Ex. 18 at O143-O150)

The cystoscopy revealed no evidence of continued prostatic obstruction. Adjacent to the right ureteral orifice there was a patch of cystitis and erythema of the overlying mucosa without evidence of gross bladder tumor. The IVP was unremarkable. Patient 9's PSA was 6.3. Over the next two years, Dr. Brewer treated Patient 9's continued urinary tract infections and symptoms. In July 1991, Dr. Brewer admitted Patient 9 to MRH for a bladder

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biopsy. Pathology found "acute and chronic inflammatory exudative material and squamous metaplasia, carcinoma cannot be diagnosed on this material." Dr. Brewer continued to follow Patient 9's PSA level. In October 1991, Patient 9's PSA level was 8.9. Dr. Brewer admitted Patient 9 to evaluate his known squamous metaplasia of the bladder, rule out neoplastic transformation, and for urine cystologies, and prostate needle biopsy for evaluation of his prostatic digital examination. Dr. Brewer obtained a single digitally guided needle biopsy. The pathology results showed "infiltrating adenocarcinoma of prostate, poorly differentiated, probably Gleason IV+V=IX." Dr. Brewer evaluated Patient 9 through bone scans and CT for metastases which were clear. Dr. Brewer counseled Patient 9 and his son regarding treatment. Patient 9 elected to have an RRP. (St. Ex. 18 at O115-O116, O18-O21, O23, O138-O141; Tr. 172-174)

On November 22, 1991, Dr. Brewer attempted to perform the RRP on Patient 9. Previous scarring and continued difficult dissection prohibited continuing safely. Dr. Brewer biopsied the partially exposed prostate and then closed the patient. The pathology report found "infiltrating adenocarcinoma of prostate, moderately to poorly differentiated, probably Gleason's V-VI, involving prostatic tissue and extending into surgical margins." No cancer was found in the right or left pelvic lymph nodes. Patient 9, however, did not recuperate well from his surgery. Patient 9 developed congestive heart failure and cardiac arrhythmia. He then developed respiratory difficulties. In addition, Patient 9's surgical wound partially dehisced and after suturing, healed slowly. Patient 9 was finally released on January 3, 1992. (St. Ex. 18 at O24-O26, H3-H8; Tr. 174-179)

2. Dr. Wise testified that performing a RRP on Patient 9, given his age and physical condition, was "an unbelievably dramatic example of a total lack of understanding of prostate cancer." Dr. Wise stated that to perform or even suggest RRP to this patient, ignores the fact that prostate cancer rarely kills in five years. Life expectancy is the same for radiation treatment, hormonal treatment or surgery. Therefore, there was no reason to attempt surgery on this patient. Dr. Wise testified that Dr. Brewer failed to conform to the minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease. (Tr. 400-403, 476-477)

Patient 10

1. Patient 10, a 66 year old man, presented to Dr. Brewer on July 31, 1990. Patient 10 complained of a urinary tract infection and dysuria. The referring physician had prescribed antibiotics that did not resolve the infection. Patient 10's medical history was remarkable for rheumatoid arthritis.

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Patient 10 took Prednisone and gold injections to treat his arthritis. Dr. Brewer's digital rectal examination found a smooth, firm prostate gland, 25 to 30 grams in weight. Dr. Brewer ordered an IVP, cystoscopy, urine culture and sensitivity/PSA/acid phosphatase. Dr. Brewer's impression was "urinary tract infection/chronic prostatitis/BPH/rule out cancer/dysuria/frequency." The IVP revealed some trabeculation of the bladder, otherwise normal results. The urine culture was clean. Patient 10's PSA level was 14.1. Dr. Brewer suspected a stricture and performed a cystoscopy on Patient 10. Patient 10 did have a stricture which was dilated. During the procedure, Dr. Brewer also observed that Patient 10's prostate was markedly enlarged and 2-3+ trabeculation of the bladder. Dr. Brewer scheduled a prostate needle biopsy with ultrasound. He took a single needle biopsy. The pathologist reported hyperplasia with focal glandular atypia, mild. Patient 10's symptoms improved. (St. Ex. 19 at O30-O33, O69, O78-O83, O91-92; Tr. 276-281)

On October 11, 1991, Patient 10 presented to Dr. Brewer with a recurrent urinary tract infection. Dr. Brewer's office notes state "need to proceed [with] TURP/DVIV 10/21." Patient 10's PSA level on October 15, 1991, was 19.0. On October 21, 1991, Dr. Brewer performed the surgery. He submitted 16 grams of prostatic tissue to the pathology laboratory for analysis. The pathologist's report found a single chip showing changes consistent with well differentiated adenocarcinoma. The pathologist graded the chip as Gleason's I+II=III. Subsequent examination by pathologists at the Mayo clinic graded the cancer as Stage A1. (St. Ex. 19 at O58, O69, O73, H76; Tr. 281-283)

On November 20, 1991, after counseling Patient 10 on his options-radiation or surgery-to treat his cancer, Dr. Brewer performed a radical retropubic prostatectomy and bilateral lymph node resection. Both nodes were negative for cancer. Because of the inflammation from the previous procedure, the remaining prostate had to be removed piecemeal. One month after surgery, Patient 10's PSA level was 10. This indicated that there was prostatic tissue remaining within Patient 10. As a result, Patient 10 underwent radiation treatment at higher than normal levels. In October 1992, Patient 10's PSA level was 1.32. (St. Ex. 19 at O9-O27, O51, O54; Tr. 283-294)

2. Dr. Wise testified that Patient 10's treatment demonstrated a complete lack of understanding of the disease of and the appropriate approach to prostate cancer. From the single needle biopsy taken to the brief interval between the TURP and RRP, Dr. Wise testified that Dr. Brewer failed to meet the minimal standards of care. Dr. Wise testified that Patient 10 will die from cancer instead of survive, due to Dr. Brewer's treatment. Dr. Wise testified that the appropriate standard of care for Patient 10 would have been to reevaluate the

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patient three to six months after the TURP with sextant or greater biopsies of the prostate. The biopsies should have been taken transuretherally and transrectally. While Dr. Wise agreed with Dr. Brewer's assessment that a PSA of 14 indicated more extensive cancer than that found in the TURP, Dr. Wise disagreed with Dr. Brewer's plan of treatment. Dr. Brewer should have performed more biopsies and determined the extent of the cancer prior to proceeding with the RRP. The appropriate interval would have been to wait eight to twelve weeks between TURP and RRP. Patient 10's healing time could have been affected by his treatment with Prednisone. Rushing to surgery before complete healing resulted in edematous tissue with adhesions. These significantly diminish the surgeon's ability to remove the prostate intact. Patient 10's prostate had to be removed piecemeal, which resulted in cancer being left in the body, as evidenced by the continued PSA activity. Dr. Wise stated that the PSA level increase noted between the TURP and the RRP could have been caused by the inflammation from the TURP. More time should have elapsed before a legitimate PSA level could be obtained after a TURP. The patient's selection of an RRP to treat the suspected cancer was legitimate. However, as the surgeon, Dr. Brewer should have dictated an appropriate interval between operations so that the outcome would be beneficial to the patient. Dr. Wise testified that Dr. Brewer failed to conform to the minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease. (St. Ex. 39; Tr. 403-419, 501-509, 516-517, 537-541, 564-567)

Patient 11

1. Patient 11, a 58 year old man, presented for the first time to Dr. Brewer on May 2, 1989. He complained of pain and dysuria. Dr. Brewer's digital rectal exam revealed a smooth, tender 30 gram prostate. Dr. Brewer's impression was chronic prostatitis. Dr. Brewer prescribed Septra DS, instructed the patient to discontinue caffeine, to take vitamin C, and to increase fluids. Over the next twenty months, Dr. Brewer examined Patient 11 on six different occasions. He prescribed drugs to treat symptoms, and monitored his PSA levels. Throughout these visits Patient 11's complaints included nocturia, difficulty urinating in a sitting position, testicular pain, urinary hesitancy, perineal aching pain. On January 11, 1991, Dr. Brewer performed a flexible cystoscopy to rule out obstruction or other cause of Patient 11's chronic refractory epididymitis and testalgia. Dr. Brewer found:

modest prostatic hypertrophy with a great deal of erythema and induration of the prostatic urethral mucosa....The remainder of the bladder examination showed some very fine trabeculation with no evidence of cellular formation or diverticulum. The

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bladder was relatively clear with no evidence of bladder tumor or stone scope.

Dr. Brewer's impression was chronic prostatitis and chronic epididymitis. In January and October 1991, Dr. Brewer ordered Patient 11's PSA levels which were 3.1 and 3.5 respectively. On March 26, 1991, Dr. Brewer scheduled TURP surgery to alleviate the continued urinary difficulties. This surgery was canceled due to Patient 11 developing superficial and deep thrombophlebitis. On October 10, 1991, Dr. Kreider performed an IVP. On October 14, 1991, Dr. Brewer rescheduled and performed the TURP and a circumcision to treat BPH and Phimosis. Dr. Brewer sent 15.5 grams of prostatic chips were sent to pathology for review. The pathologist found "nodular glandular hyperplasia with two foci of mild to moderate glandular atypia." (St. Ex. 20 at O27-O31, O47, O60, H63; Tr. 180-187)

Following the TURP and circumcision procedures, Dr. Brewer continued to treat Patient 11 for sporadic impotence and urethral strictures. (St. Ex. 20)

2. Dr. Wise questioned whether Patient 11 had retention of urine and whether he needed a surgical procedure. One of the reasons for doing a TURP is to reduce the retention of urine. The kidney x-ray and IVP reports showed that Patient 11 had virtually minimal or no retention of urine. However, Dr. Wise testified that the IVP does not tell you anything about prostate and urinary retention unless it shows no residual urine. Current guidelines do not recommend IVPs for prostatic hypertrophy. Dr. Wise testified that unless Patient 11 experienced infection, retention, or stone disease, immediate surgery was not medically indicated. Dr. Wise testified that the use of surgery demonstrated a failure to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease. (St. Ex. 20; Joint Exhibits 1-3; Tr. 304-307, 419-420, 477-479)

Patient 12

1. Patient 12, a 69 year old man, complained of urinary hesitancy and stranguary with nocturia (x3-4), and diminished urinary stream. Dr. Brewer's digital rectal examination indicated that Patient 12's prostate was markedly enlarged of approximately 40 grams mass without significant nodularity. On June 13, 1991, Dr. Brewer admitted Patient 12 to the hospital and ordered a neurologic work-up which included an IVP, a chest x-ray and renal ultrasound, and cystoscopic examination with a probable TURP. Patient 12's PSA was 5.4 on June 13, 1991. The IVP and kidney ultrasound indicated a 7 cm. area of density that could represent a cystic or solid lesion, an elevation of the floor of the urinary bladder suggestive of prostatic enlargement, and a large cyst

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measuring nearly 8 cm. along the inferior aspect of the right kidney. (St. Ex. 21 at O8, O11-O16; Tr. 187-193)

On June 17, 1991, Dr. Brewer performed a TURP on Patient 12. Dr. Brewer submitted 13 grams of focally nodular, pink to gray-white prostate gland type curettements to pathology. The pathologist found five chips with foci of well differentiated adenocarcinoma. The pathologist graded the foci as Gleason's II+III=V. Upon discharge from the hospital, Dr. Brewer directed Patient 12 to return to his office in three weeks for continuing evaluation and staging work-up for his cancer of the prostate. (St. Ex. 21 at O15-O16; Tr. 194-195)

On July 10, 1991, Dr. Brewer dictated a History and Physical report for Patient 12 in anticipation of a July 31, 1991, admission to the hospital. Dr. Brewer reported that Patient 12 was advised that he had Gleason V adenocarcinoma of the prostate. Dr. Brewer recommended that Patient 12 undergo a radical prostatectomy with bilateral lymph node dissection to complete his staging work-up and for treatment of his disease. On July 24, 1991, Patient 12 had a PSA level of 3.0. Many white blood cells were present in a clean catch urine specimen. Patient 12's pelvic CT was essentially negative with prostatic enlargement noted. The July 25, 1991, bone scan was normal. (St. Ex. 21 at O17-O20; Tr. 195-197)

On July 31, 1991, six weeks after his TURP, Dr. Brewer performed a bilateral pelvic lymph node dissection and RRP on Patient 12. The Middletown Regional Hospital Pathology Laboratory reviewed tissue samples and found no evidence of carcinoma. Samples were forwarded to Russell L. Malcolm, Jr., M.D., a pathologist at the Mercy Medical Center, Baltimore, Maryland. Dr. Malcolm found multiple microscopic foci of adenocarcinoma. He gave a Gleason Grade of II+II=IV. He noted that there was no evidence of perineural or lymphatic invasion by the small foci of adenocarcinoma. (St. Ex. 21 at O4-O7, O21-O26; Tr. 197-198)

2. Dr. Wise testified that Patient 12 was a Stage A1 cancer patient. He testified that the current research indicates that the proper course of medical treatment for such a patient is to restage the patient, do biopsies to evaluate for residual cancer, and watchful waiting. Should a RRP become necessary, a physician should wait at least eight to twelve weeks between the procedures. The TURP causes the tissue planes to be distorted until healing is complete. Operating too soon results in a higher chance of incontinence and rectal injury. In this case, Dr. Wise testified that Dr. Brewer was "lucky" that Patient 12 had cancer. Dr. Brewer operated too precipitously. Dr. Brewer failed to conform to the minimal standards of care, and failed to use reasonable care

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discrimination in the selection of modalities for the treatment of disease.
(Tr. 307-314, 479-481)

Patient 13

1. Patient 13 entered the hospital on January 9, 1991, with a diagnosis of urosepsis. Patient 13 had a history of stroke and diabetes mellitus. Dr. Brewer received a request for consultation on January 10, 1991. Dr. Brewer ordered an IVP, a PSA and an acid phosphates test. Patient 13 reported trouble voiding, nocturia (x1-2), temperature of 101 and chills. Dr. Brewer determined Patient 13's prostate gland weighed 45 grams. Dr. Brewer's impression was BPH, urinary track infection, and sepsis. Patient 13 had a PSA of 30.2, and an acid phosphate of 0.9 on January 11, 1991. His IVP was normal. Dr. Brewer recommended a TURP because Patient 13 had a residual urine of approximately 300 ccs. Dr. Brewer testified that the urinary tract infection caused the diabetes to go out of control. The prostate caused the residual urine which resulted in a urine infection. (St. Ex. 22 at H1-H3, H6, H10-H11, H23- H29, H31-H37, H91, H101-102, O2; Tr. 198-208)

On January 14, 1991, Dr. Brewer performed a cystoscopy, TURP and two prostate needle biopsies on Patient 13. Dr. Brewer sent nine point five grams of prostate tissue to the pathology laboratory. No evidence of cancer was found. (St. Ex. 22 at H13-H16, O2; Tr. 205-206, 208-211)

2. Dr. Wise testified that Dr. Brewer rushed Patient 13 to surgery without considering that conservative antibiotic therapies could clear the infection, reduce the swelling of the prostate, and alleviate symptoms without surgery. Dr. Wise testified that performing a procedure while the patient still fought an infection increased the possibility of infection. The four day course of antibiotic treatment was a good start, but in light of Patient 13's diabetes, a longer course of treatment was appropriate. Further, Dr. Wise found no evidence of a trial of voiding. Dr. Wise questioned Dr. Brewer's estimation of the size of the prostate because the amount of tissue removed was so small, even by teaching hospital standards. Dr. Wise found no work-up to determine whether any of Patient 13's other conditions-diabetes or stroke-contributed to his symptoms. The standard of care for Patient 13 would have been to continue antibiotic treatment and wait for resolution of symptoms. Dr. Wise testified that Dr. Brewer failed to conform to the minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease. (Tr. 314-322, 481-484, 514-515, 553-554)

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Patient 14

1. On January 8, 1991, Patient 14, an 82 year old man, was admitted to the Middletown Regional Hospital, Mental Health Unit. He complained that he had bladder problems, stomach problems, and arthritis. Patient 14 also suffered from diabetes. Martin A. Rush, M.D., diagnosed Patient 14 with depression. Dr. Rush prescribed Ascendin and the patient seemed to respond. Patient 14 then developed a urinary obstruction and hematuria. Dr. Rush did not think that Ascendin was the causative agent. At some point, Dr. Rush discontinued the Ascendin, and requested a consultation from Dr. Brewer. (St. Ex. 23 at H3, H15, H21, H28, H64-65; Tr. 211-212)

On January 11, 1991, Dr. Brewer examined Patient 14 and described him as exhibiting acute urinary retention. Upon digital rectal examination, Dr. Brewer estimated the size of the prostate to be 40 grams without nodules. Dr. Brewer ordered an IVP, blood work, and urine studies. On January 14, 1991, Dr. Brewer recorded that the IVP demonstrated prostatic enlargement and trabeculation of the bladder. The January 12, 1991, IVP report does not note prostatic enlargement. The PSA was 23.2./ml. Dr. Brewer recommended a TURP to relieve the prostatic obstruction. On January 16, 1991, Dr. Brewer performed a cystoscopy and TURP. The pathology report indicated that 12.5 grams of prostatic tissue was removed. The pathology report stated that the specimen contained "hyperplasia with foci of interstitial chronic inflammation and focal mild glandular atypia." No malignancy was identified. Following surgery, Patient 14 continued to have retention difficulties. (St. Ex. 23 at O1-09, O16-18, O20, H5-H7; Bd. Ex. 3 at 2; Tr. 212-220)

2. Dr. Wise testified that Patient 14 epitomized the precipitous nature of Dr. Brewer's treatment of urinary retention. Dr. Wise pointed out that chronic constipation can cause urinary retention. However references to constipation appeared in the record after the TURP, not before. Additionally, Patient 14 took Ascendin, a drug that can cause urinary retention. Rather than proceeding with surgery, the standard of care required that a more conservative course of treatment should have been tried first. Dr. Wise testified that Dr. Brewer failed to conform to the minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease. (St. Ex. 23, 38; Tr. 322-326, 484-487, 514-515, 533-534, 553-554)

Patient 15

1. On February 13, 1991, Dr. Brewer examined Patient 15, a 62 year old man, pursuant to a referral for acute urinary retention and admitted to MRH. Dr. Brewer ordered an IVP, blood work and performed a physical examination.

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Dr. Brewer recorded the results of the IVP as showing evidence of prostatic enlargement. The IVP report stated that it was an unremarkable IVP. The Prostatic Acid Phosphatase (PAP) test was elevated. The PSA was 103.0. Dr. Brewer's digital rectal examination revealed a 30 gram prostate, smooth without nodule to palpitation. On February 15, 1991, Dr. Brewer performed a cystoscopy and TURP to alleviate symptoms. The operative report indicated that Dr. Brewer resected down to the level of the prostatic capsule. Dr. Brewer submitted 12.2 grams of prostatic chips. The pathology report revealed that Patient 15 had widespread, poorly differentiated adenocarcinoma. His Gleason Patterns were IV+V=IX. On February 20, 1991, Patient 15 subsequently underwent a CAT scan which showed metastatic disease to his bones, and an enlarged prostate with extracapsular extension. The report continued:

Infiltration of the perioprostatic fat noted. A nodular soft tissue density noted located between the seminal vesicle and rectum on the left side....about 1.5 cm. in diameter nodular soft tissue density suggestive of adenopathy also seen in the perirectal area on the left side below the sciatic foramen.

Subsequently, Dr. Brewer performed Patient 15's volatile orchidectomy to effect immediate hormonal treatment of his condition. Patient 15 underwent radiation treatments as well. (St. Ex. 24 at O1, O7-O14, O17-O18, H1-H8, H16, H20-H22, H69-71; Tr. 220-228)

2. Dr. Wise testified that it was hard to believe that Dr. Brewer did not detect any abnormalities on the digital rectal examination of Patient 15. With such an advanced stage of cancer, Dr. Wise expected Dr. Brewer to find a prostatic abnormality such as a hard texture or undifferentiated borders. The post-operative abnormal CAT scan contradicted Dr. Brewer's digital rectal examination. Additionally, Dr. Brewer should have considered the possibility of cancer prior to performing the TURP based on Patient 15's elevated PAP test. Dr. Wise testified that Dr. Brewer did not obtain a preoperative PSA for Patient 15. However, the PSA report indicates that it was obtained on February 13, 1991. Dr. Wise testified that Dr. Brewer failed to conform to the minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease. (St. Ex. 24 at H8; Tr. 326-329, 487-491)
3. Dr. Brewer testified that the CAT scan was taken five days after the TURP procedure. Accordingly the results of the CAT scan are due to the reaction of

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the tissue to the TURP. The prostate swelled and absorbed irrigant which caused extracapsular extension. (Tr. 224-228)

Patient 16

1. On July 19, 1991, Patient 16, a 56 year old man, presented to Dr. Brewer. The only note in Dr. Brewer's office records states: "BPH, Cysto PSA 7/26." There is no listing of symptoms or patient medical history. Patient 16's PSA was 5.7 on July 25, 1991. The IVP found suggestion of an enlarged prostate; however, there was no evidence of ureteral obstruction. On July 26, 1991, Dr. Brewer performed a cystoscopy and prostate biopsy. Dr. Brewer found a markedly enlarged prostate gland and two plus two trabeculation of the bladder and cellular formation. Dr. Brewer took two needle core biopsies. The pathology report found borderline glandular hyperplasia. The August 2, 1991, office records state only: "TURP 9/8/91." (St. Ex. 25 at O5, O8-O9, O12-O13, O21-23, O25-O29, O32; Tr. 228-235)

The history and physical form completed by Dr. Brewer on August 14, 1991, described Patient 16's symptoms as dysuria and lower urinary tract voiding symptoms. Dr. Brewer described the prostate as markedly enlarged without nodularity. On September 9, 1991, Dr. Brewer performed a TURP. He reported that he resected the prostate to the level of the prostatic capsule in the anterior, posterior, and lateral lobes. Dr. Brewer submitted 14.4 grams of prostatic chips to pathology for review. Pathology reported, "Multiple foci of chronic prostatitis with focal infarction and necrosis. Minimal patchy acute inflammation. Widespread glandular hyperplasia with rare focus of atypical glandular hyperplasia." (St. Ex. 25 at H1-H8)

2. Dr. Wise testified that with a 56 year old patient, conservative measures could have been taken and surgery avoided. Further, the two needle biopsies taken were inadequate to diagnose cancer. With such a young patient, the prostate cancer, if there, would be very small. Therefore, the standard of care requires at least sextant biopsies. The lack of ultrasound guided multiple biopsies necessitated additional biopsies to assure valid results. Dr. Wise testified that Dr. Brewer failed to conform to the minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease. (Tr. 331-335, 420, 492-494)

Patient 17

1. On October 1, 1991, Dr. Brewer saw Patient 17, a 76 year old man, who was seen at a prostate screening. The screener noted an indurated left lateral lobe of the prostate gland and swelling in Patient 17's left testicle. Dr. Brewer found a thirty gram prostate gland with an indurated left lateral lobe when he

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performed a digital rectal examination. Dr. Brewer planned a cystoscopy, PSA test, and an IVP for October 11, 1991.

On October 10, 1991, Dr. Brewer dictated a history and physical form for Patient 17 which stated that he presented for evaluation of lower urinary tract voiding symptoms. This form noted that the cystoscopic evaluation showed an enlarged prostate. However, the form did not note the indurated left lateral lobe or the swelling of the left testicle. Dr. Brewer's plan was to perform a TURP on October 21, 1991. (St. Ex. 26 at O72; Tr. 236-238)

On October 11, 1991, the cystoscopy procedure revealed 1 to 2+ trabeculation of the bladder without stone or cellulite formation. Patient 17 showed modest BPH with trilobar hypertrophy as well. Dr. Brewer took a single core biopsy of the prostate for interpretation. He did not use an ultrasound to guide him. The pathology report stated, "Infiltrating adenocarcinoma of prostate, moderately well-differentiated." The pathologist scored the sample as Gleason II+II=IV. Patient 17's PSA score was 16.7. The IVP revealed a pressure defect on the inferior aspect of the bladder, consistent with prostatic enlargement. (St. Ex. 26 at O1, O5, O12, O21, O71, O82; Tr. 238-242)

No evidence of metastases was found on Patient 17's pelvic CAT scan or bone scan. Dr. Brewer counseled Patient 17 on his options for treating his cancer. The patient chose a radical retropubic prostatectomy and bilateral pelvic lymph node dissection. (St. Ex. 26 at O19-O20, O69; Tr. 242-245)

On October 30, 1991, Dr. Brewer performed a radical retropubic prostatectomy and bilateral pelvic lymph node dissection. The pathologist's review of the fibroadipose tissue of the right and left lymph nodes revealed no evidence of carcinoma. The pathologist did find "[m]ulticentric adenocarcinoma of the prostate, moderately well-differentiated, Gleason's [V], diameter of largest carcinoma .8 CM; total approximate volume of carcinoma equals .8 cm³; surgical margins and right seminal vesicle involved with carcinoma." Following surgery, Patient 17 underwent radiation treatments. (St. Ex 26 at O2-O3, O6-O10, O13-O19, H3-H9; Tr. 245-249)

2. Dr. Wise testified that Dr. Brewer failed to meet the minimal standards of care by performing a radical retropubic prostatectomy on a 76 year old man. With a PSA of 16.7 and a Gleason score of V, watchful waiting would have been the appropriate course of action. More conservative alternatives to RRP would have been radiation treatment or hormonal therapy. Dr. Wise stated that given Patient 17's life expectancy and the slow progression of prostate cancer, radical surgery was not indicated. Dr. Wise testified that Dr. Brewer failed to

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conform to the minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease.
(Tr. 336-344, 346, 361-362, 494-496)

Patient 18

1. Patient 18, a 68 year old male, entered Middletown Regional Hospital with symptoms of upper quadrant abdominal pain and an ultrasound which showed several gallstones. After a laparoscopic cholecystectomy on February 8, 1991, Patient 18 had urinary retention. Dr. Brewer provide a consultation and placed a Foley catheter. His consultation note stated "would like to see [patient after discharge] to schedule cysto/possible TURP." On February 10, Dr. Brewer noted that Patient 18 exhibited an elevated temperature, "[reduced] stream + nocturia + frequency - will proceed [with patient work up] during this hospitalization unless [high] temperature precludes same." Dr. Brewer ordered an IVP which indicated moderate post-void residual. On February 11, 1991, Dr. Brewer performed a cystoscopy. This procedure showed "markedly enlarged prostate with narrowing of the prostatic fossa and elevation of the bladder neck....The remainder of the bladder examination showed some fine trabeculation without cellule formation." Dr. Brewer diagnosed Patient 18 with BPH. (St. Ex. 27 at O52-O53; Bd. Ex. 4 at 1-8; Tr. 249-253)

Following Patient 18's discharge, Dr. Brewer saw him on February 26, 1991, and noted: "Needs TURP...." The next notation in Dr. Brewer's records is the March 15, 1991, history and physical prepared in anticipation of surgery on April 12, 1991. This examination records a prostate gland size of 40 grams. The April 5, 1991, PSA level was 4.5. (St. Ex. 27 at O46-O48, O51; Tr. 253-260)

On April 12, 1991, Patient 18 underwent a cystoscopy and TURP. Dr. Brewer submitted 5.8 grams of prostatic tissue to pathology for diagnosis. The pathology report stated, "Hyperplasia with foci of moderate chronic inflammation, nonspecific." On the day of his surgery, Patient 18 experienced post-operative bleeding from his resection site. Dr. Brewer returned him to surgery for a cystoscopy and fulguration of bleeders. Patient 18 absorbed a large amount of irrigating material due to venous plexus absorption during his fulguration. Patient 18's abdomen became quite distended. He became disoriented and confused. Dr. Brewer opened the lower abdomen and placed a suprapubic tube and Penrose drains for drainage of the extravasation. The patient's post-operative course was prolonged with mobilization of the fluid and systemic edema post-operatively with evidence of congestive heart fluid and pulmonary edema. Dr. Brewer treated the patient with diuretics. This

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problem resolved as did his systemic edema. At the time of his discharge, Dr. Brewer removed Patient 18's Foley and suprapubic catheters and Penrose drains. Patient 19 voided satisfactorily. (St. Ex. 27 at O24, O30-O32, O36-O38; Tr. 260-264)

2. Dr. Wise testified that Patient 18 exhibited only mild urinary symptoms. This combined with the relatively small amount of prostatic tissue removed, 5.8 grams, indicated that surgery was not indicated. Dr. Brewer did not consider any conservative measures. Dr. Wise testified that Patient 18 could have avoided the complications of surgery, through the use of conservative measures. Additionally, Dr. Brewer's description of a markedly enlarged prostate should have indicated at least a 60 gram prostate. However, only 5.8 grams of tissue were removed. This discrepancy means that Dr. Brewer overestimated the size of the prostate. Dr. Wise testified that Dr. Brewer failed to conform to the minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease. (Tr. 346-349, 497-500)

Patient 19

1. On July 11, 1991, Patient 19, a 73 year old male, presented to Dr. Brewer. The entirety of the office notation is "TURP." The history and physical form filled out in anticipation of surgery states that Patient 19 presented with symptoms of "lower urinary tract voiding symptoms, including urinary hesitancy, stranguary and nocturia." On July 16, 1991, Patient 19's PSA was 0.5. During routine pre-admission testing, Dr. Brewer discovered that Patient 19 had an elevated blood sugar. Dr. Brewer referred Patient 19 to Maurice Swanson, M.D. for a consultation. Dr. Brewer performed the TURP on July 22, 1991. On July 23, 1991, Dr. Swanson examined Patient 19 and diagnosed him as suffering from out-of-control diabetes mellitus. (St. Ex. 28 at O5-O6, H4-H12, H58; Tr. 264-272)

During the cystoscopy prior to the TURP procedure, Dr. Brewer discovered a small bladder polyp. Accordingly, Dr. Brewer performed transurethral resection of the bladder tumor as well as a TURP. In Dr. Brewer's operative report he estimated that he removed approximately 25 grams of tissue from the prostate during his resection. He sent the entire sample to the pathology laboratory. The pathology report stated that it received 13.5 grams of prostatic tissue. The pathology report found glandular and stromal hyperplasia with foci of mild chronic inflammation. The bladder polyp did not show significant atypia or malignancy. (St. Ex. 28 at O8-O9, O11-O12, H13; Tr. 272-294)

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2. Dr. Wise testified that Patient 19's out of control diabetes could cause the urinary symptoms. The standard of care requires that the diabetes be brought under control and the symptoms watched before surgery attempted. Controlling the diabetes could have resolved the urinary tract symptoms. Dr. Wise further testified that Patient 19 could have been suffering from a neurogenic bladder secondary to diabetes. Dr. Brewer operated too precipitously. Dr. Wise testified that Dr. Brewer failed to conform to the minimal standards of care, and failed to use reasonable care discrimination in the selection of modalities for the treatment of disease. (Tr. 349-352, 500-501, 514-515, 553-554)

Pattern identified by Dr. Wise

1. Dr. Wise testified that Dr. Brewer established a pattern with the nineteen patients reviewed. Dr. Brewer did not document supporting facts for the surgeries. Dr. Brewer rushed into surgery, when there was no medical need to do so. Dr. Brewer did not attempt conservative treatments prior to surgeries. Additionally, Dr. Wise testified that these patients revealed Dr. Brewer's lack of understanding of the basic pathophysiology of prostate cancer. Dr. Wise opined that Dr. Brewer needed to train under another urologist for a year or two to learn the cancer and disease processes. Dr. Wise testified that a surgeon must be judged both on the quality of the medicine practiced and the results obtained. (Tr. 421-424, 532-533)

Dr. Brewer's Defense

Dr. Brewer did not address each individual patient. Rather he presented a defense to the pattern of practice through the presentation of articles and description of his fellowship experiences.

1. Dr. Brewer testified that MRH did not have a transrectal or transurethral ultrasound machine. There was a mobile ultrasound unit available to him for use in his office. Accordingly, Dr. Brewer often biopsied the prostate using a digitally guided needle. Dr. Wise testified that needle biopsies in the hospital operating room without an ultrasound are acceptable, because many hospitals do not have the appropriate equipment. Dr. Brewer testified that single core digitally guided biopsies are sufficient when the nodule is palpable. However, with this method, the standard of care requires multiple needle biopsies for the results to be meaningful. Digitally guided needle biopsies of palpable nodules are acceptable. However, more than one biopsy must be taken to assure that the nodule is biopsied. Needle biopsies done in the office should utilize an ultrasound, if available. The standard of care requires physicians to obtain multiple biopsies to diagnose cancer, whether the method used is ultrasound or

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digital guidance. (St. Ex. 36 at 1194, 1197-1198; Res. Ex. X at 361-363; Res. Ex. Y, Res. Ex. EE; Tr. 151-159, 234, 240, 279-281, 535-537, 647-656, 673-682)

2. Dr. Brewer asserted that he waited the appropriate amount of time between performing a TURP and an RRP. Dr. Wise testified and presented documentary evidence indicating that the appropriate amount of time to wait between TURP and RRP is eight to twelve weeks. "These delays enable inflammatory adhesions and hematoma to resolve so that anatomic relationships between the prostate and surrounding structures are returned to more normal state." Dr. Brewer presented a study that found of seven patients who underwent an RRP less than four weeks after a TURP, none suffered incontinence. Only twenty patients were involved in the entire study. Dr. Brewer also presented evidence that, in 1989, an article by Dr. Walsh recommended waiting six to eight weeks between a needle biopsy and an RRP. There was no mention of the appropriate interval between a TURP and an RRP in this article. Dr. Brewer admitted that the TURP was a more invasive procedure than the biopsy. He also admitted that logic would dictate that a surgeon should wait at least the same recommended interval between a TURP and an RRP as that between a needle biopsy and RRP. Two other articles presented by Dr. Brewer indicated that the appropriate intervals between a TURP and RRP were at least six weeks or eight weeks. (St. Ex. 35 at 2869; St. Ex. 36 at 1197; Res. Exs. O, P, R, Q, CC, DD; Tr. 525-528, 659-665, 695-706, 725-728, 732-733, 747-749)
3. Dr. Brewer, Dr. Wise, and submitted literature agreed that the "gold standard treatment for BPH is TURP surgery." However, Dr. Wise cautioned that this does not mean that it is the first treatment selected. The physician must make an exact diagnosis for the treatment to be effective. An obstruction must be objectively documented. Additionally, many patients do well with only watchful waiting. (Res. Ex. O; Joint Exhibits 1-3; Tr. 28, 306-307, 473-474 534-535, 659-661,)
4. Both Dr. Brewer and Dr. Wise testified that urologists tend to overestimate the size of the prostate on the digital rectal examination and under-resect during the TURP. Digital rectal examinations are fair predictors of cancer, but probably not a good predictor of size. However, Dr. Wise testified that his concern about the discrepancies between estimated prostate size and the weight of tissue resected, related to the need for the surgery. Additional evidence revealed that the size of the prostate does not indicate the need for surgery. A small prostate can obstruct and a large prostate can cause no problems. (Res. Ex. S at 1012; Tr. 440-441, 448-449, 563, 644-647)

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5. Following the MRH summary suspension of his privileges, Dr. Brewer closed his solo practice in April 1993 and resigned his privileges at MRH. Dr. Brewer explained why he closed his practice and sought a fellowship in urology.

After years of having been extraordinarily successful in my practice, the setback that I encountered in Middletown was of such concern to me that I wanted to go to a training institute and find out whether or not my training was as deficient as I had been told, or if there was some other reason that I might have experienced difficulties in Middletown.

Prior to his fellowship, Dr. Brewer observed Patrick Walsh, M.D., perform a radical retropubic nerve sparing prostatectomy in the spring of 1992. Dr. Brewer obtained a roster of fellowship programs from the American Urological Association (AUA). He entered a fellowship program in Kansas City Missouri directed by Linza T. Killion, M.D., Director of Urologic Oncology. The fellowship lasted a year. It focused on the latest advances in diagnosis, staging, treatment, pain control, and full rehabilitation. (St. Ex. 9; Res. Exs. B, D1-D5, F, G, J, GG; Tr. 591-594, 617-621, 728-729)

6. Following his fellowship, Dr. Brewer joined the practice of Dr. Killion and acted as an assistant professor in the fellowship program at Mid-America Urologic Oncology Institute. During his time in Kansas City, Dr. Brewer conducted studies that he presented at various conferences and in urologic presentations. Dr. Brewer testified that his fellowship experience gave him superior skills and he benefited greatly. Dr. Brewer left the Mid America practice because he was not busy enough. During that time, he continued to log his surgeries to support his board recertification. Dr. Brewer submitted records of his attendance at several continuing medical education seminars. (Res. Exs. D-4, E1-E9, H, I; Tr. 578-580, 594-617, 714-715, 736-737, 741-743)
7. Dr. Brewer currently practices in general urology at the Guthrie Clinic in Sayre, Pennsylvania. He is one of three urologists. The clinic practice has 250 physicians. The clinic conducts chart reviews. Dr. Brewer dictates all of his office notes for transcription. Dr. Brewer testified that he now allows a greater interval between the TURP and RRP. He described his care of the 19 patients at issue in this action as average. However, he described his current level of care as far superior to average because of his additional education and experience. (Tr. 631-633, 741-750)

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FINDINGS OF FACT

1. Dr. Brewer failed to perform and/or failed to document in his office records the necessary medical evaluation and/or preoperative examination of his patients sufficient to substantiate his diagnosis or support his choice of treatment.
2. Dr. Brewer failed to obtain and/or document cultures on Patient 8 prior to diagnosing prostatitis and instituting antibiotic therapy.
3. Dr. Brewer failed to sufficiently evaluate and/or document bladder function prior to performing a transurethral resection of the prostate (TURP) surgical procedure on Patients 5, 8 and 13.
4. Dr. Brewer failed to take and/or record in his office records and hospital chart a patient history of urinary obstructive signs and/or symptoms sufficient to support the need for surgical intervention prior to performing the TURP procedure in Patients 1, 2, 3, 8, 16, 18 and 19. Furthermore, Dr. Brewer documented a lack of urinary obstructive symptoms prior to surgery in the patient chart for Patients 1, 3 and 8.
5. In the routine course of his practice, Dr. Brewer frequently failed to attempt appropriate conservative therapy before subjecting his patients to surgery. Instances of such practice include the care rendered to Patients 2, 3, 5, 6, 8, 13, 14, 16, 17, 18 and 19.
6. Dr. Brewer demonstrated a lack of knowledge of the healing process of tissue and/or a lack of understanding of the pathophysiology of prostate cancer.
7. Pathology reports indicate that prostate cancer was found in Patients 3, 10 and 12 incidental to Dr. Brewer's performance of a TURP. Instead of allowing adequate healing of prostate tissue in order to avoid surgical complications associated with additional surgery, or following these patients with repeat prostate biopsies or PSA values to determine whether or not there was in fact any residual prostate cancer, Dr. Brewer scheduled these patients for radical retropubic prostatectomy (RRP), a complex and extensive operative procedure, within a very short time (less than two months) of the TURP. Patient 3 refused the surgery. Additionally, Patient 10 experienced the surgical complications which would be expected from the RRP so soon after the TURP.
8. The subsequent laboratory reports and PSA reports indicate that there was residual cancer in both Patient 10 and 12.

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9. Dr. Brewer performed a RRP on Patient 9 despite the fact that he was seventy-six years old with numerous comorbid factors, making RRP inappropriate as treatment for cancer of the prostate. Patient 9 experienced operative and post-operative problems, as would be expected.
10. Dr. Brewer performed a RRP on Patient 17, a seventy-six year old male, despite the fact that the pathophysiology of prostate cancer in patients of this age group is such that conservative, nonsurgical intervention is the appropriate choice of treatment.
11. The pathology reports indicate that Dr. Brewer failed to obtain sufficient tissue for diagnostic purposes when doing needle biopsies of the prostate. Instances of such practice include, Patients 2, 3, 7, 10 and 16 in which Dr. Brewer obtained single or two core needle biopsies to rule out cancer. The standard of care for needle biopsies of the prostate is for sextant biopsies to be taken. Obtaining a single or two core needle biopsy indicates a lack of knowledge of the pathophysiology of cancer of the prostate.
12. The State did not prove its allegation that in the routine course of his practice, Dr. Brewer's rectal exam findings frequently did not correlate with the actual size of the prostate as evidenced by a comparison of his clinical notes to his operative notes and surgical pathology reports. The State alleged that the examinations and pathology reports of Patients 1, 3, 4, 13, 15 and 18 supported this claim.
13. The State did not prove its allegations regarding Patient 11.

CONCLUSIONS

1. Findings of Fact 1-11 support a conclusion that Dr. Brewer's acts, conduct, and/or omissions listed in above paragraphs, individually and/or collectively, constituted "(f)ailure to use reasonable care discrimination in the administration of drugs," and/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.
2. Findings of Fact 1-11 support a conclusion that Dr. Brewer's acts, conduct, and/or omissions constituted "(a) departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar

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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.

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Testimony presented indicated that prostate cancer does not require precipitous decisions. Dr. Brewer, however, in several instances performed operations without sufficient interval to allow healing. The dire outcome with Patient 10 occurred due to Dr. Brewer's failure to wait before surgery. With other patients, Dr. Brewer selected surgery as a treatment before ruling out other causes for the symptoms and without attempting conservative therapy. Dr. Brewer's inadequate use of needle biopsies ignored the pathophysiology of prostate cancer and endangered his patients. In mitigation, upon receiving his suspension of surgical privileges from MRH, Dr. Brewer decided to seek out additional training. He closed his private practice. He moved to Kansas City, Missouri, where he spent one year in an urology fellowship and an additional year in practice. Dr. Brewer's current practice is a clinic setting where his practice is overseen. Dr. Brewer's sincere efforts to improve his professional skills indicate that he is amenable to retraining.

Proposed Order

1. It is hereby ORDERED that: the certificate of Eugene A. Brewer, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than three (3) months.
2. The State Medical Board shall not consider reinstatement of Dr. Brewer's certificate to practice unless and until all of the following minimum requirements are met:
 - a. Dr. Brewer shall submit an application for reinstatement, accompanied by appropriate fees. Dr. Brewer shall not make such application for at least three (3) months from the effective date of this Order.
 - b. Within thirty (30) days of the effective date of this Order, Dr. Brewer shall provide a copy of this Order by certified mail, return receipt requested, to the proper licensing authority of any state or jurisdiction in which he currently holds a license to practice. Further Dr. Brewer shall provide this Board with a copy of the return receipt as proof of notification within thirty (30) days of receiving that return receipt. The return receipt should be submitted to the Compliance Officer of the Board.

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3. Upon reinstatement, Dr. Brewer's certificate to practice medicine and surgery in this state will be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three (3) years.
 - a. Dr. Brewer shall obey all federal, state, and local laws, and all rules governing the practice of medicine in the state in which he is practicing.
 - b. Dr. Brewer shall appear in person for interviews before the full Board or its designated representative at three (3) month intervals, or as otherwise requested by the Board.
 - c. Dr. Brewer shall submit quarterly declarations under the penalty of Board disciplinary action or criminal prosecution, stating whether he has complied with all the terms and conditions of his probation in this State and with all terms, conditions, or limitations imposed by any other state medical board.
 - d. Dr. Brewer shall notify the Board in writing of any action in any state initiated against a certificate to practice medicine held by Dr. Brewer in that state. Moreover, Dr. Brewer shall provide acceptable documentation verifying same within thirty days of his receipt to the of the Board.
 - e. Dr. Brewer shall immediately notify the Board in writing should he fail to comply with any term, condition, or limitation of his probation or with any term, condition, or limitation imposed by any other state medical board.
 - f. Upon submitting renewal applications for each Ohio biennial registration period occurring during the period of probation, Dr. Brewer shall also submit acceptable documentation of Category I Continuing Medical Education credits completed. At least twenty (20) hours of such Continuing Medical Education for each registration period, to be approved in advance by the Board or its designee, shall relate to the violations found in this matter. These hours shall be in addition to the Continuing Medical Education requirements for relicensure. This documentation is to be submitted to the Compliance Officer of the Board, separately from the renewal application.
 - g. Dr. Brewer shall provide a copy of this Order by certified mail, return receipt requested, at the time of application to the proper licensing authority of any state in which he applies for licensure or reinstatement

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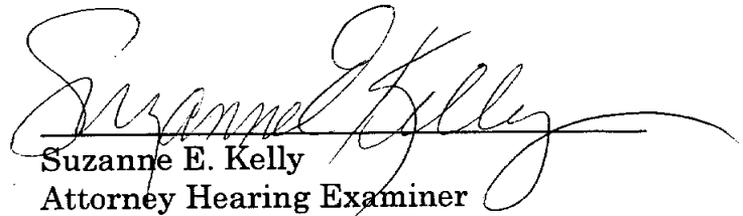
- of licensure. Further, Dr. Brewer shall provide this Board with a copy of the return receipt as proof of notification within thirty (30) days of receiving that return receipt.
- h. Dr. Brewer shall provide a copy of this Order to all employers and the Chief of Staff at each hospital where he has, applies for, or obtains privileges.
 - i. Dr. Brewer will not request modification of these terms of probation for at least nine (9) months after probation begins.
 - j. Dr. Brewer shall refrain from commencing practice in Ohio without prior written Board approval. Moreover, should he commence practice in Ohio, the Board may place Dr. Brewer's certificate under additional terms, conditions, or limitations, including the following:
 - i. Dr. Brewer shall obey all federal, state, and local laws, and all rules governing the practice of medicine in Ohio.
 - ii. Dr. Brewer shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution stating whether he has complied with all the provisions of probation.
 - iii. Dr. Brewer shall appear in person for interviews before the full Board or its designated representative at three (3) month intervals, or as otherwise requested by the Board.
 - iv. Dr. Brewer shall submit to the Board and receive its approval for a plan of practice in Ohio which, unless and until otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. Brewer's activities will be directly supervised and overseen by another physician approved by the Board.
 - v. Within thirty days of commencement of practice in Ohio, Dr. Brewer shall submit for the Board's prior approval the name of a monitoring physician, who shall review Dr. Brewer's patient charts and shall submit a written report of such review to the Board on a quarterly basis. Such chart review may be done on a random basis, with the number of charts reviewed to be determined by the Board. It shall be Dr. Brewer's responsibility to ensure that the monitoring physician's quarterly reports are submitted to the Board on a timely

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basis. If the approved monitoring physician becomes unable or unwilling to serve, Dr. Brewer shall immediately notify the Board in writing and shall arrange another monitoring physician as soon as practicable.

- vi. Dr. Brewer shall provide a copy of this Order to all employers and the Chief of Staff at each hospital where he has, applies for, or obtains privileges.
 - vii. In the event that Dr. Brewer has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to commencement of practice in Ohio, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of Dr. Brewer's fitness to resume practice.
 - viii. If Dr. Brewer violates probation in any respect, the Board, after giving Dr. Brewer notice and the opportunity to be heard, may set aside the stay order and impose the permanent revocation of Dr. Brewer's certificate to practice.
 - ix. Dr. Brewer will not request modification of these terms of probation for at least nine (9) months after he begins practicing in Ohio.
4. Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Brewer's certificate will be fully restored.

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


Suzanne E. Kelly
Attorney Hearing Examiner



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

April 12, 1995

Eugene A. Brewer, M.D.
4320 Wornell Road
Suite 444
Kansas City, MO 64111

Dear Doctor Brewer:

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

- (1) In the routine course of your practice, you frequently failed to perform and/or failed to document in your office records the necessary medical evaluation and/or preoperative examination of your patients sufficient to substantiate your diagnosis or support your choice of treatment. Instances of such practice include, but are not limited to:
 - a) Your failure to obtain and/or document cultures on Patients 1 and 8 (patients are identified on the attached Patient Key - the Key is confidential and is to be withheld from public disclosure) prior to diagnosing prostatitis and instituting antibiotic therapy;
 - b) Your failure to sufficiently evaluate and/or document bladder function prior to performing a transurethral resection of the prostate (TURP) surgical procedure on Patients 5, 8 and 13;
 - c) Your failure to take and/or record in your office records and hospital chart a patient history of urinary obstructive signs and/or symptoms sufficient to support the need for surgical intervention prior to performing the TURP procedure in Patients 1, 2, 3, 8, 16, 18 and 19. Furthermore, in Patients 1, 3 and 8, you documented in the patient chart a lack of urinary obstructive symptoms prior to surgery.

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- (2) In the routine course of your practice, you frequently failed to attempt appropriate conservative therapy before subjecting your patients to surgery.

Instances of such practice include, but are not limited to, the care rendered to Patients 1, 2, 3, 5, 6, 8, 11, 13, 14, 16, 17, 18 and 19.

Furthermore, such practice may have resulted in unnecessary surgery.

- (3) In the routine course of your practice, your rectal exam findings frequently did not correlate with the actual size of the prostate as evidenced by a comparison of your clinical notes to your operative notes and surgical pathology reports. Instances of such discrepancies are illustrated in the medical records of Patients 1, 3, 4, 13, 15 and 18. You routinely recorded, in your clinical notes, prostate sizes ranging from 25 to 45 grams based upon your rectal exams of these patients. Additionally, you routinely noted in the operative report that you resected down to the prostatic capsule in these "markedly enlarged" prostates, indicating complete resection of the obstructing tissue. However, the pathology reports from the surgeries routinely revealed that very little tissue was removed, indicating a much smaller prostate than you had documented.

Additionally, on or about February 13, 1991, as noted in your records, you performed a rectal exam on Patient 15, palpating a "smooth without nodule, 30 gram mass" prostate. The x-ray report of the CT Scan of Patient 15's abdomen and pelvis, dated February 20, 1991, indicated that this patient had an enlarged prostate with "evidence of extra-capsular extension. Infiltration of the perioprostatic fat (was) noted. A nodular soft tissue density (was) noted located between the seminal vesicle and rectum on the left side. . . . (Also) about 1.5 cm. in diameter nodular soft tissue density suggestive of adenopathy (was) also seen in the perirectal area on the left side below the sciatic foramen." Your rectal exam findings were not consistent with this very abnormal CT scan.

- (4) In the routine course of your practice, you demonstrated a lack of knowledge of the healing process of tissue and/or a lack of understanding of the pathophysiology of prostate cancer. Instances of such knowledge deficiencies include, but are not limited to, the following:

- a) Pathology reports indicate that Prostate cancer was found in Patients 3, 10 and 12 incidental to your performance of a TURP.

Instead of allowing adequate healing of prostate tissue in order to avoid surgical complications associated with additional surgery, or following these patients with repeat prostate biopsies or PSA values to determine whether or not there was in fact any residual prostate cancer, you scheduled these patients for radical retropubic prostatectomy (RRP), a complex and extensive operative procedure, within a very short time (less than two months) of the TURP. Patient 3 refused the surgery. The subsequent pathology reports of the RRP's from the local hospital indicate that there was, in fact, no residual cancer in either Patient 10 or 12. Additionally, Patient 10 experienced the surgical complications which would be expected from performing the RRP so soon after the TURP.

- b) You performed a RRP on Patient 9 despite the fact that he was seventy-six years old with numerous comorbid factors, making RRP inappropriate as treatment for cancer of the prostate. Patient 9 experienced operative and postoperative problems, as would be expected.

Additionally, you performed a RRP on Patient 17, a seventy-six year old male, despite the fact that the pathophysiology of prostate cancer in patients of this age group is such that conservative, non-surgical intervention is the appropriate choice of treatment.

- c) The pathology reports indicate that you failed to obtain sufficient tissue for diagnostic purposes when doing needle biopsies of the prostate.

Instances of such practice include, but are not limited to, Patients 2, 3, 7, 10 and 16 in which you obtained single or two core needle biopsies to rule out cancer. The chances of a single needle biopsy or even two core needle biopsies of the prostate yielding a diagnosis of cancer of the prostate is extremely small. The standard of care for needle biopsies of the prostate is for quadrant biopsies to be taken. Obtaining a single or two core needle biopsy indicates a lack of knowledge of the pathophysiology of cancer of the prostate.

Your acts, conduct, and/or omissions as alleged in paragraphs (1), (2) and (4) above, individually and/or collectively, constitute "(f)ailure to use reasonable care discrimination in the administration of drugs," and/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.

April 12, 1995

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) through (4) 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.

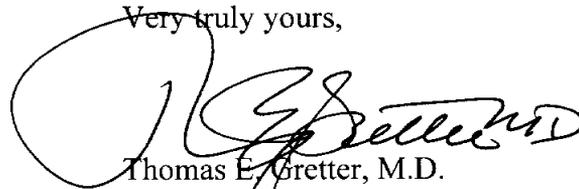
Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty (30) days of the time of mailing of this notice.

You are further advised that 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 (30) 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, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand or place you on probation.

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Thomas E. Gretter, M.D.
Secretary

TEG/bjm
Enclosure

CERTIFIED MAIL # P 348 888 213
RETURN RECEIPT REQUESTED