STATE MEDICAL BOARD OF OHIO
77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614)466-3934

November 12, 1997

Brent E. Woodfield, M.D.
85 Arbutus Trail
Chatham, MA 02633

Dear Doctor Woodfield:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of R. Gregory Porter, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on November 12, 1997, 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 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, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

Thomas E. Gretter, M.D.
Secretary

TEG:jam
Enclosures

CERTIFIED MAIL RECEIPT NO. Z 395 591 397
RETURN RECEIPT REQUESTED

Mailed 11/20/97

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on November 12, 1997, 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 Brent E. Woodfield, 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)

11/12/97
Date

## BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF *

*

BRENT E. WOODFIELD, M.D. *

## ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on November 12, 1997.

Upon the Report and Recommendation of R. Gregory Porter, 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.

## PROPOSED ORDER

It is hereby ORDERED that:

1. Nothing herein shall be deemed to limit the discretion or authority of this Board concerning any reinstatement or restoration application that this Board may receive from Brent E. Woodfield, M.D.

2. The certificate of Dr. Woodfield to practice medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than two years. Because Dr. Woodfield's certificate expired on September 30, 1994, due to non-renewal, and is currently lapsed and inactive, such suspension shall become effective immediately if the Board grants or approves the restoration of Dr. Woodfield's Ohio certificate.

3. Following restoration of Dr. Woodfield's certificate, and the subsequent indefinite suspension of his certificate as described in paragraph 2, above, the Board shall not consider reinstatement of Dr. Woodfield's

certificate to practice unless all of the following minimum requirements have been met:

a. Dr. Woodfield shall submit an application for reinstatement, accompanied by appropriate fees. Dr. Woodfield shall not make such application for at least two years from the effective date of an Order from this Board granting the restoration of Dr. Woodfield's certificate as described in paragraph 2, above.

b. Dr. Woodfield shall provide documentation of successful completion of a course or courses dealing with professional ethics. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the biennial registration period(s) in which they are completed.

c. Dr. Woodfield shall provide acceptable documentation of satisfactory completion of a clinical education program, to be approved in advance by the Board or its designee, related to laparoscopic surgery. The exact number of hours and the specific content of the program shall be determined by the Board or its designee. The Board may require Dr. Woodfield to pass an examination related to the content of the program. This program shall be in addition to the Continuing Medical Education requirements for relicensure.

d. Dr. Woodfield shall notify the Board of any action in any state taken against a certificate to practice medicine held by Dr. Woodfield in that state. In addition, Dr. Woodfield shall immediately notify the Board in writing of any modification or change to any term, condition, or limitation imposed by any other state medical board. Moreover, Dr. Woodfield shall provide acceptable documentation verifying the other state boards' actions.

e. Within thirty (30) days of the restoration of Dr. Woodfield's certificate as described in paragraph 2, above, Dr. Woodfield 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. Dr. Woodfield further agrees to 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. Woodfield shall provide this Board with a copy of the return receipt as proof of notification within thirty (30) days of receiving that return receipt.

f. In the event that Dr. Woodfield has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of his fitness to resume practice.

4. Upon reinstatement, Dr. Woodfield's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least five years:

a. Dr. Woodfield shall not request modification of the terms, conditions, or limitations of probation for at least one year after imposition of these probationary terms, conditions, and limitations.

b. Dr. Woodfield shall obey all federal, state, and local laws, and all rules governing the practice of medicine in the state in which he is practicing.

c. Dr. Woodfield shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of probation. The first quarterly declaration must be received in the Board's offices on the first day of the third month following the month in which the probation becomes effective, provided that if the effective date is on or after the 16th day of the month, the first quarterly declaration must be received in the Board's offices on the first day of the fourth month following. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

d. Dr. Woodfield shall immediately notify the Board in writing of any modification or change to any term, condition, or limitation imposed by any other state medical board.

e. Dr. Woodfield shall appear in person for interviews before the full Board or its designated representative within three months of the reinstatement of his certificate, at three month intervals thereafter, and upon his request for termination of the probationary period, or as otherwise requested by the Board.

If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled. Although the Board will normally give him written notification of scheduled appearances, it is Dr. Woodfield's responsibility to know when personal appearances will occur. If he does not receive written notification from the Board by the end of the month in which the appearance should have occurred, Dr. Woodfield shall immediately submit to the Board a written request to be notified of his next scheduled appearance.

f. Dr. Woodfield shall refrain from commencing practice in Ohio without prior written Board approval. Moreover, should he commence practice in Ohio, the Board may place Dr. Woodfield's certificate under additional terms, conditions, or limitations, including the following:

i. Prior to commencement of practice in Ohio, Dr. Woodfield shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan, unless otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. Woodfield's activities will be directly supervised and overseen by a monitoring physician approved by the Board. The monitoring physician shall monitor Dr. Woodfield and provide the Board with reports on Dr. Woodfield's progress and status on a quarterly basis. All monitoring physician reports required under this paragraph must be received in the Board's offices no later than the due date for Dr. Woodfield's quarterly declaration. It is Dr. Woodfield's responsibility to ensure that the reports are timely submitted.

In the event that the approved monitoring physician becomes unable or unwilling to serve, Dr. Woodfield shall immediately notify the Board in writing and shall make arrangements for another monitoring physician as soon as practicable.

Dr. Woodfield shall refrain from practicing until such supervision is in place, unless otherwise determined by the Board. Dr. Woodfield shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

ii. Dr. Woodfield shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order. In the event that Dr. Woodfield's supervising physician under this practice plan becomes unable or unwilling to so serve, Dr. Woodfield shall immediately notify the Board in writing, and make arrangements acceptable to the Board for another supervising physician as soon as practicable. Dr. Woodfield shall refrain from practicing unless and until such supervision is in place, unless otherwise determined by the Board.

iii. Dr. Woodfield shall obey all federal, state, and local laws, and all rules governing the practice of medicine in Ohio.

iv. Dr. Woodfield shall appear in person for quarterly interviews before the full Board or its designated representative, or as otherwise directed by the Board.

If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled. Although the Board will normally give him written notification of scheduled appearances, it is Dr. Woodfield's responsibility to know when personal appearances will occur. If he does not receive written notification from the Board by the end of the month in which the appearance should have occurred, Dr. Woodfield shall immediately submit to the Board a written request to be notified of his next scheduled appearance.

g. Within thirty (30) days of the reinstatement of Dr. Woodfield's certificate as described in paragraph 3, above, Dr. Woodfield shall provide a copy of this Order to all employers or entities with which he is under contract to provide physician services or is receiving training, and the Chief of Staff at each hospital where Dr. Woodfield has privileges or appointments. Further,

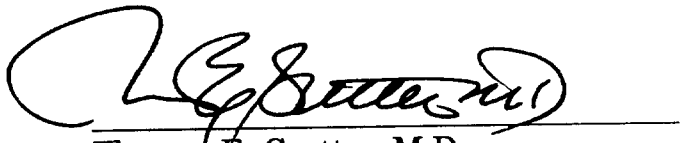
Dr. Woodfield shall provide a copy of this Order to all employers or entities with which he contracts to provide physician services, or applies for or receives training, and the Chief of Staff at each hospital where Dr. Woodfield applies for or obtains privileges or appointments.

h. If Dr. Woodfield violates probation in any respect, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period.

i. If Dr. Woodfield violates probation in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of Dr. Woodfield's certificate.

5. Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Woodfield's certificate will be fully restored.

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



Thomas E. Gretter, M.D.
Secretary

(SEAL)

11/12/97
Date

# REPORT AND RECOMMENDATION UPON REMAND FROM THE STATE MEDICAL BOARD OF OHIO IN THE MATTER OF BRENT E. WOODFIELD, M.D.

The Matter of Brent E. Woodfield, M.D., came on for hearing before me, R. Gregory Porter, Esq., Attorney Hearing Examiner for the State Medical Board of Ohio, on July 21, 1997, pursuant to the Board's Remand Order of May 12, 1995.

## INTRODUCTION

### I. Procedural History

By letter dated March 9, 1994 (State's Exhibit 1), the State Medical Board notified Brent E. Woodfield, M.D., that it proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board based its action on the revocation of Dr. Woodfield's Idaho license by the Board of Professional Discipline of the Idaho State Board of Medicine [Idaho Board] on or about July 16, 1993, and the facts upon which that revocation was based. The Board alleged that such acts, conduct, and/or omissions, individually and/or collectively, constituted: "'the limitation, revocation or suspension by another state of a license or certificate to practice issued by the proper licensing authority of that state, the refusal to license, register, or reinstate an applicant by that authority, or the imposition of probation by that authority for an action that would also have been a violation of this chapter, except for nonpayment of fees,' as that clause was used in Section 4731.22(B)(22), Ohio Revised Code, in effect at that time, to wit: Sections 4731.22(B)(5), (B)(6)(a), and (B)(18), Ohio Revised Code to wit: Principals I, II, IV, and VII of the American Medical Association Principles of Medical Ethics."

On November 15, 1994, a hearing was held before Attorney Hearing Examiner Porter. Evidence produced at this hearing revealed that the Idaho Board had revoked Dr. Woodfield's certificate to practice medicine in that State. Dr. Woodfield appealed the Idaho Board's action. On May 5, 1994, the Ada County (Idaho) District Court vacated the decision and order of the Idaho Board, and remanded the case to the Idaho Board for further proceedings. (Respondent's Exhibit [Resp. Ex.] A) On or about June 7, 1994, the Idaho Board appealed the court's decision. The Idaho Board also renewed Dr. Woodfield's license pending the outcome of the appeal. (Resp. Exs. B and D)

Based on that evidence, on April 6, 1995, Attorney Hearing Examiner Porter issued a Report and Recommendation. On May 12, 1995, the Board issued an Order remanding the matter to the Hearing Examiner. (State's Exhibit [St. Ex.] 9)

On April 28, 1997, the State's representative filed a Notice of Submission of State's Exhibits on Remand and advised that the Idaho matters had come to fruition. On April 30, 1997, the Attorney Hearing Examiner issued an Entry giving Dr. Woodfield an opportunity to respond to the State's Notice of Submission of State's Exhibits on Remand. (St. Ex. 15) Dr. Woodfield requested additional hearing time in which to do so. This additional day of hearing took place on July 21, 1997.

II. Appearances on July 21, 1997

A. On behalf of the State of Ohio: Betty D. Montgomery, Attorney General, by Anne B. Strait, Assistant Attorney General.

B. On behalf of Respondent: Dr. Woodfield, having been apprised of his right to counsel, appeared on his own behalf.

## ADDITIONAL EVIDENCE TAKEN ON JULY 21, 1997

I. Testimony Heard

Presented by the Respondent

1. Lisa W. Woodfield

2. Brent E. Woodfield, M.D.

II. Exhibits Examined

The following additional exhibits were identified and admitted into evidence:

A. Presented by the State:

1. State's Exhibit 9: Copy of the May 12, 1995, letter to Brent E. Woodfield, M.D., from the Board, apprising Dr. Woodfield of his right to appeal, and attaching copies of the following documents: May 12, 1995, Certification; May 12, 1995, Entry of Order; April 6,

1995, Report and Recommendation; and except of minutes of the Board's May 10, 1995, meeting concerning Dr. Woodfield. (12 pp.)

2. State's Exhibit 10: Copy of a November 1, 1996, Entry, indicating that the Attorney Hearing Examiner was apprised that the Idaho matter had been concluded, and ordering the State's representative to submit the relevant documents.

3. State's Exhibit 11: Copy of an April 25, 1997, Notice of Appearance of Counsel for the State.

4. State's Exhibit 12: Certified copy of the November 1, 1995, Opinion of the Idaho Court of Appeals in *Brent E. Woodfield, M.D. vs. Board of Professional Discipline of the Idaho State Board of Medicine.* (28 pp.)

5. State's Exhibit 13: Certified copy of the March 11, 1996, Findings of Fact, Conclusions of Law, and Final Decision and Order of the Board of Professional Discipline of the Idaho State Board of Medicine in the matter of Brent E. Woodfield, M.D. (12 pp.)

6. State's Exhibit 14: Certified copy of a March 20, 1997, Order of the Fourth Judicial District Court, Ada County, Idaho, in *Woodfield vs. Idaho State Board of Medicine,* dismissing with prejudice Dr. Woodfield's appeal of the Idaho Board's action. (3 pp.)

7. State's Exhibit 15: Copy of an April 30, 1997, Entry granting Dr. Woodfield an opportunity to respond to the State's Notice of Submission of State's Exhibit's on Remand.

8. State's Exhibit 16: Copy of the May 14, 1997. Notice of Withdrawal of Kevin P. Byers, Esq., as Dr. Woodfield's representative.

9. State's Exhibit 17: Copy of a May 13, 1997, Entry scheduling an additional day of hearing for July 21, 1997, and noting that the parties had agreed to exchange hearing exhibits.

B. Presented by the Respondent

Respondent's Exhibit G-1 through G-3: Collection of documents, which originally were marked and admitted to the record as Respondent's Exhibit G. To allay confusion, however, the Hearing Examiner separated and re-marked this exhibit as follows: Respondent's Exhibit G-1 consists

of a July 15, 1997, letter to the Attorney Hearing Examiner from Dr. Woodfield, containing some of Dr. Woodfield's arguments and contentions concerning his case; Respondent's Exhibit G-2 consists of supporting documentation for Dr. Woodfield's July 15, 1997, letter; and Respondent's Exhibit G-3 consists of a draft of Dr. Woodfield's Memorandum in Support of Petition for Review, which was to have been submitted to the Ada County [Idaho] District Court.

III. Post-Hearing Exhibits

On the Hearing Examiner's own motion, the following additional exhibits are admitted to the record:

1. Board Exhibit B: Copy of the State's April 28, 1997, Notice of Submission of State's Exhibits on Remand. (4 pp.)

2. Board Exhibit C: Copy of the State's August 13, 1997, Motion to Reopen Hearing Record. (3 pp.)

3. Board Exhibit D: August 14, 1997, Entry granting the State's Motion to Reopen Hearing Record, and holding the hearing record open until September 15, 1997.

4. Board Exhibit E: Copy of the State's September 15, 1997, Memorandum Concerning Jurisdictional Issue. (3 pp.)

5. Board Exhibit F: Letter faxed to the Attorney Hearing Examiner on September 15, 1997, from Lisa W. Woodfield, Dr. Woodfield's wife; a September 11, 1997, letter sent to a New York State official concerning a pending action against Dr. Woodfield's license in that state was included. (24 pp.)

6. Board Exhibit G: American Medical Association Principles of Medical Ethics, published by the Council on Ethical and Judicial Affairs in its 1996-1997 edition, and title page. (2 pp.)

7. Board Exhibit H: September 30, 1997, Entry, requesting further information concerning Dr. Woodfield's current licensure status.

8. Board Exhibit I: October 2, 1997, Affidavit of Debra L. Jones, concerning Dr. Woodfield's current licensure status. (2 pp.)

## COMPLETE RECORD

The record in this matter includes the evidence taken on November 15, 1994, as well as that taken on July 21, 1997.

## SUMMARY OF THE EVIDENCE

All transcripts of testimony and exhibits, whether or not specifically referred to hereinafter, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

**Note:** All references to transcripts refer to the transcript of the July 21, 1997, hearing. No testimony was taken at the November 15, 1994, hearing.

### Background Information

1. Dr. Woodfield testified that he had obtained his Doctor of Medicine degree in 1977 from the medical school in Guadalajara, Mexico. He then completed a fifth-pathway program at Maryland General Hospital in Baltimore, Maryland in 1979. Dr. Woodfield did a residency in obstetrics and gynecology at Creighton University in Omaha, Nebraska. Following his residency, Dr. Woodfield worked for a short time in Hamilton, Ohio, then went into private practice in Ontario, Oregon. (Transcript at page(s) [Tr.] 45-56)

   Dr. Woodfield stated that he had taken and passed "with a solid score" his written Ob/Gyn Boards shortly after his residency. He further stated, however, that he had been unable to pass the oral portion of the exam. Dr. Woodfield attributed his inability to pass the oral Boards to his Attention Deficit Disorder [ADD], which was diagnosed at a later time. (Respondent's Exhibit [Resp. Ex.] G-3, p. 5; Tr. 46-47)

2. Dr. Woodfield testified that he had practiced in Ontario, Oregon for about four years. He further testified that during this period he had become tired and irritable, and had gotten into arguments with others at the hospital over "silly issues." As a result, Dr. Woodfield testified, officials at the hospital had wanted Dr. Woodfield to be evaluated for drug and alcohol abuse because they had believed Dr. Woodfield was "being abusive and disruptive." Dr. Woodfield testified that he then "took three or four random urine drug tests which were negative." Dr. Woodfield testified that he did not have a substance abuse problem. (Tr. 47-48)

Dr. Woodfield testified that the hospital had insisted that he "be evaluated for this disruptiveness." This evaluation took place at the Springbrook Institute in Newberg, Oregon, in January 1990. Dr. Woodfield testified that he underwent "an extensive battery of psychological testing." One neurologist believed that Dr. Woodfield had "organic brain syndrome, etiology unknown." Another neurologist rejected that diagnosis and instead diagnosed Dr. Woodfield with "organic dementia." Dr. Woodfield stated that he had been advised that such a diagnosis would require him to cease medical practice. Dr. Woodfield did so, and took a disability retirement. (Resp. Ex. G-3, pp. 6-7; Tr. 49-50)

Dr. Woodfield testified that, following his diagnosis of organic dementia and going on disability, he had moved to Salt Lake City. He further testified that he went to Western Rehabilitation Institute. There, he was tested by a consulting psychologist, and was told that he did not have organic dementia, but possibly "some kind of dyslexia or undiagnosed ADD." Dr. Woodfield testified that ADD was confirmed by a neurologist and by a psychiatrist, and he was placed on treatment for that condition. (Tr. 52-53)

3. Dr. Woodfield advised that after he had been diagnosed with ADD he "came to realize that [his] disability 'retirement,' which lasted 22 months, had been wholly unwarranted." Dr. Woodfield further noted that his physician had told him that a diagnosis of ADD should not prevent Dr. Woodfield from practicing medicine, and had encouraged Dr. Woodfield to return to practice.

   Dr. Woodfield indicated that a friend from medical school then invited him to join his practice in Rexburg, Idaho. Dr. Woodfield applied for temporary privileges at Madison Memorial Hospital. In his application, Dr. Woodfield informed the hospital administrator of his 22 month absence from practice and his diagnosis of ADD. The hospital granted him privileges(Resp. Ex. G-3, pp. 7-8)

   Dr. Woodfield stated that, during his first week of practice in Rexburg, he had been contacted by the Executive Director of the Idaho Board, who, Dr. Woodfield wrote, had "expressed a great deal of hostility regarding [Dr. Woodfield's] 'medical condition' and resumption of practice." Dr. Woodfield further stated that "[t]his was spawned by communications from the Ontario, Oregon physicians who'd arranged for [Dr. Woodfield's] outrageous misdiagnosis and resultant 'disability retirement.'" (Resp. Ex. G-3, p. 8)

4. Dr. Woodfield stated that approximately one month after he had resumed practice in Rexburg he was informed that his surgical procedures would be

proctored by two other local ob/gyn practitioners. Dr. Woodfield further stated that he had readily agreed, and had "never expected it to be anything other than an honest, objective process[.]" In addition, Dr. Woodfield stated that he had been under the impression that the proctoring program was established to assist him in resuming practice after an absence of 22 months. (Resp. Ex. G-1, p. 4) (Resp. Ex. G-3, p. 8)

5. *Whether that proctoring program was intended to simply observe and assess Dr. Woodfield's surgical skills, or whether it was also to provide some instruction to Dr. Woodfield, is unclear from the record.* The Hearing Officer for the Idaho Board [IHO] found that it had a teaching aspect. (State's Exhibit 7, p. 4) The Idaho Board disagreed, finding that "[t]he proctors were not intended to be teachers, but rather were merely to observe and critique Dr. Woodfield's skills and his ability to practice with reasonable skill and safety to patients." (State's Exhibit 8, p. 2) In vacating the decision and order of the Idaho Board, the Idaho District Court stated that the proctors acted as mentors and teachers, as well as observers. (Respondent's Exhibit A, pp. 22-24)*

   The Idaho Court of Appeals ruled that the proctoring program was originally established to have the proctors merely observe Dr. Woodfield's performance. The court further ruled, however, that, in practice, the proctors had provided mentoring and assistance to Dr. Woodfield. The proctoring program had therefore differed in practice from its original concept. The Idaho Court of Appeals determined that the IHO had understood the proctoring program, and that the Idaho Board could not disregard the IHO's findings "merely by saying that he did not understand." Nevertheless, the Idaho Court of Appeals ruled that the Idaho Board would be free to use the evidence derived from the proctoring program in making its own findings. (St. Ex. 12, pp. 10-12)

6. Dr. Woodfield advised that, although the original Ohio Report and Recommendation indicated that he had been out of practice for eighteen months, the actual time that he had been out of practice was a little over 22 months. (Resp. Ex. G-1, p. 3)

7. Dr. Woodfield argued that the information derived from the proctoring program should never have been reported to the Idaho Board because no negative action had been taken against Dr. Woodfield by Madison Memorial Hospital. (Resp. Ex. G-1, pp. 15-17)

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* Excerpts from the April 6, 1995, Report and Recommendation, admitted to the record as State's Exhibit 9, are quoted herein in italics.

**General Information Concerning the Idaho Board Action**

1. In its statement of the facts of the Idaho case, the Idaho Court of Appeals stated that, in March 1992, a former patient of Dr. Woodfield's had filed a complaint with the Idaho Board which spawned an investigation. This led to a 12 count complaint against Dr. Woodfield alleging a breach of the standard of care concerning his treatment of 12 patients, and unethical conduct involving sexual improprieties with one of those patients. (St. Ex. 12, p. 2)

2. *On or about November 9, 1992, the Board of Professional Discipline of the Idaho State Board of Medicine (Idaho Board) issued a Complaint against Brent E. Woodfield, M.D. The complaint alleged 12 counts of misconduct. Most of these counts alleged minimal standards problems. Count Ten also alleged an ethical violation arising from sexual improprieties between Dr. Woodfield and a patient. The minimal standards allegations related primarily to Dr. Woodfield's diagnostic and surgical skills in gynecology. (State's Exhibit 8, pp. 8-17) Count 3 of the Complaint was withdrawn by the Idaho Board during the hearing. (State's Exhibit 7, p. 9)*

   *The remaining eleven counts against Dr. Woodfield were heard in February 1993. The IHO issued his Disciplinary Findings on June 11, 1993. He found that Dr. Woodfield had violated three of those counts, specifically, minimal standards as alleged in Counts One and Nine, and the ethical violation alleged in Count Ten. (State's Exhibit 7)*

   *The IHO recommended that Dr. Woodfield be required to seek further skill training, and that "[s]urgical suspension or limitation upon Respondent's license would seem to be in order until further training or retraining has been obtained." (State's Exhibit 7, p. 29) He also recommended that Dr. Woodfield be reprimanded and required to attend counseling, along with possible license suspension, for the ethical violation. (State's Exhibit 7, p. 29)*

3. *On July 16, 1993, the Idaho Board issued its Findings of Fact, Conclusions of Law and Final Order. The Board took issue with the Disciplinary Findings of the IHO. In addition to the violations found by the IHO, the Idaho Board found that Dr. Woodfield's conduct fell below the community standard of care as alleged in Counts Two, Four, Six, Seven, Eight, and Twelve. (State's Exhibit 8) The Idaho Board also found that Dr. Woodfield's treatment of the patient in Count Ten "failed to meet the community standard of care," in addition to the ethical violation found by the IHO. (State's Exhibit 8, p. 6)*

*On the basis of its findings and conclusions, the Idaho Board revoked the license of Dr. Woodfield to practice medicine and surgery in that state. (State's Exhibit 8, p. 7)*

4. *Following the Idaho Board's revocation of his license, Dr. Woodfield appealed. On May 5, 1994, the Ada County District Court filed a lengthy Memorandum Decision. The Court vacated the decision and order of the Idaho Board, and remanded the case to the [Idaho] Board for further proceedings. (Respondent's Exhibit A) The Court determined that the Idaho Board had "erred in several significant aspects." (Respondent's Exhibit A, pp. 2-3) These errors, as articulated by the court, center on the Idaho Board's relying on inadmissible evidence, and on its failure to state the bases from the record for its findings. (Respondent's Exhibit A, pp. 3-8) The Court was also concerned that the [Idaho] Board had reached certain conclusions regarding the standard of care without offering any explanation. The [Idaho] Board had apparently defined a standard of care that was at odds with the standards explained by the witnesses. The Court thought that the Idaho Board was sanctioning Dr. Woodfield "for the violation of a standard which it [was] creating or defining for the first time within the context of the present disciplinary proceedings ... ." (Respondent's Exhibit A, pp. 24-28)*

   *The Court remanded the matter to the Idaho Board for further proceedings on the following issues:*

   a. *Dr. Woodfield's truthfulness concerning his previous exposure to video laparoscopy. (Respondent's Exhibit A, pp. 29-30)*

   b. *"[A] reexamination of the record and the preparation of additional findings and conclusions on all of those counts where the [Idaho] Board has departed from the hearing officer's recommendations." (Respondent's Exhibit A, pp. 30-31)*

   c. *The Court did not disturb the findings in Counts One and Nine, or the ethical violation found in Count Ten. Nevertheless, the Court remanded the matter to the [Idaho] Board for further proceedings to reconsider the sanction to be imposed. (Respondent's Exhibit A, p. 29)*

5. *On or about June 7, 1994, the Idaho Board Appealed the District Court's decision. (Respondent's Exhibit D) Oral argument before the Idaho Court of Appeals was requested by Dr. Woodfield's Idaho counsel on November 8, 1994. (Respondent's Exhibit F) The Idaho Board renewed and extended*

STATE MEDICAL BOARD OF OHIO
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*Dr. Woodfield's license pending the outcome of the appeal. (Respondent's Exhibits B and D)*

6. The Idaho Court of Appeals, in an opinion filed on November 1, 1995, affirmed the Idaho Board's conclusion that Dr. Woodfield had breached the standard of care with regard to Counts 1, 7, and 12. In addition, with regard to Counts 2, 6, and 9, the Idaho Court of Appeals agreed that Dr. Woodfield had breached the standard of care, but not for all of the bases found by the Idaho Board. Further, with regard to Counts 2, 4, 9, and 10, the Idaho Court of Appeals left it to the discretion of the Idaho Board to make additional findings and conclusions which would be consistent with the Idaho Court of Appeals' decision. Specifically with regard to Count 10, the Idaho Court of Appeals stated that the Idaho Board would not be precluded from finding that Dr. Woodfield's conduct had violated the standard of care, as well as having exploited the patient. Finally, with regard to Count 8, the Idaho Court of Appeals reversed the Idaho Board's findings and conclusion that Dr. Woodfield had breached the standard of care, and precluded the Idaho Board from making such findings and conclusions in the future with regard to that count. (St. Ex. 12, p. 27)

   Additionally, the Idaho Court of Appeals remanded the matter to the Idaho Board for the Idaho Board to reconsider its decision in light of the court's decision. (St. Ex. 12, p. 28)

7. The Idaho Board, in Findings of Fact, Conclusions of Law, and Final Decision and Order dated March 11, 1996, made additional findings, and, based upon those findings, concluded that Dr. Woodfield had breached the standard of care with regard to Counts 1, 2, 4, 6, 7, 9, 10, and 12. The Idaho Board further concluded, with regard to Count 10, that Dr. Woodfield's conduct toward that patient had been exploitative and abusive. Based on these conclusions, the Idaho Board revoked Dr. Woodfield's license. (St. Ex. 13)

8. Dr. Woodfield appealed the Idaho Board's 1996 action to the Idaho District Court. However, by order filed on March 20, 1997, Dr. Woodfield's appeal was dismissed with prejudice by that court. (St. Ex. 14)

   Dr. Woodfield stated that the appeal was dismissed because he had failed to file a brief. He indicated that the reason he had not filed a brief was that he had not been given access to his medical records, which had been in the possession of both the Idaho Board and Madison Memorial Hospital. Dr. Woodfield believed that, as a result, he had been placed at an unfair disadvantage and had thus been unable to prepare his brief. (Resp. Ex. G-1, pp. 3, 16-17)

9. During the Idaho Board hearing, Dr. Woodfield denied that he had been trained in video laparoscopy or the "double puncture" approach. Dr. Woodfield testified that his experience in the area of laparoscopic procedures had been limited to "lysing adhesions, visualizing the pelvis, taking biopsies in the pelvis and performing tubal ligations," as summarized by the Idaho Court of Appeals. (St. Ex. 12, p.6)

   The Idaho Board called a witness, Dr. Sigurdson, to rebut Dr. Woodfield's testimony concerning his experience with video laparoscopy. However, Dr. Sigurdson had no personal knowledge of Dr. Woodfield's experience. Dr. Sigurdson's testimony was based instead upon a review of hospital logs from Ontario, Oregon, that indicated times when Dr. Woodfield had checked out laparoscopic equipment. The Idaho Board relied on this testimony to determine that Dr. Woodfield had lied about his experience with laparoscopy. (St. Ex. 12, p. 6)

   The Idaho Court of Appeals noted that the District Court had found that the Idaho Board's finding had not been supported by substantial evidence, and had further held "that the Board's finding unfairly injected into the proceedings the question of whether Dr. Woodfield had misrepresented his experience with the laparoscope to the doctors who were proctoring his surgical skills, an allegation which had not been charged in the complaint and against which Dr. Woodfield had not defended." The Idaho Court of Appeals agreed, and ruled that Dr. Sigurdson's testimony had been speculative and constituted hearsay. It had therefore been error for the Idaho Board to have found, based upon Dr. Sigurdson's testimony, "that Dr. Woodfield's testimony was not to be believed, which finding contributed to the [Idaho] Board's ultimate decision to revoke Dr. Woodfield's license." (St. Ex. 12, pp. 6-8)

   Dr. Woodfield wrote in his July 15, 1997, letter that "[i]t would have been unethical if I had represented that I was appropriately trained and experienced [in operative camera laparoscopy] and just went ahead and did indirect laparoscopic dissection and in doing so had caused harm to a patient." Dr. Woodfield further wrote that he had informed his proctors that he had not been trained in that procedure. Dr. Woodfield also wrote that he had not applied for operative camera laparoscopy privileges at Madison Memorial Hospital. Additionally, Dr. Woodfield wrote that only 20 percent of ob/gyn residency programs in 1991 taught their residents indirect laparoscopic dissection. Moreover, Dr. Woodfield wrote that only 70 percent of such programs do so today because of a lack of qualified instructors. Finally, Dr. Woodfield wrote that, to date, the Residency Review Committee, which

establishes requirements for residency training programs, does not require graduating ob/gyn resident to have been trained in indirect laparoscopic dissection. (Resp. Ex. G-1, p. 4-5)

**Count One**

1. *Regarding Count One, the IHO found that Dr. Woodfield performed a conization of the cervix and a D&C on Patient S.H. based on an improper diagnosis. Dr. Woodfield diagnosed cervical dysplasia on the results of a single PAP test. "Rather than invasive surgical approach, the accepted standard of care indicates an additional PAP smear." Dr. Woodfield "failed to meet the standards of his profession when reaching the conclusion that surgical examination was needed." (State's Exhibit 7, pp. 6-7)*

2. The findings of the IHO with regard to Count One were adopted by the Idaho Board. (St. Ex. 8, pp. 2-3; St. Ex. 12, p. 13)

3. Both the Idaho District Court and the Idaho Court of Appeals upheld the Findings and Conclusions of the Idaho Board concerning Count One. In upholding the Idaho Board's decision, the Idaho Court of Appeals noted the following:

> Dr. Woodfield undertook an "invasive surgical approach" which was not warranted under the "presenting circumstances." The [IHO] and the [Idaho] Board made separate findings showing that Dr. Woodfield's own office records did not support his diagnosis and his testimony. The [Idaho] Board, particularly, focused on these discrepancies to conclude that Dr. Woodfield was not honest and had attempted to improperly justify the surgery when his own charts belied his version of the facts. The [Idaho] Board also concluded that "his failure to do an appropriate workup demonstrates a lack of understanding of the basic principles of the practice of medicine." The composite findings of the [Idaho] Board on this point are supported by substantial competent evidence. While the fact-finding process involved a question of Dr. Woodfield's credibility, that question was resolved by the fact finders on the basis of the doctor's own records, and [the Idaho Court of Appeals has been] shown no reason to disturb any of the [Idaho] Board's findings in this case.

(St. Ex. 12, pp. 13-14)

4. Upon remand, the Idaho Board found with regard to Count One that Dr. Woodfield had performed unnecessary surgery on this patient, namely a D&C and conization. The Idaho Board further found that such surgery had been based upon a PAP smear showing "very few squamous cells of a benign nature" that Dr. Woodfield had "improperly elevated * * * to a dysplasia diagnosis[.]" In addition, the Idaho Board found that Dr. Woodfield had taken "an invasive surgical approach which was not warranted under the circumstances," and that Dr. Woodfield should have taken an additional PAP smear. Moreover, the Idaho Board found that Dr. Woodfield should have taken a biopsy when the colposcopy was done. Finally, the Idaho Board found that Dr. Woodfield's "failure to do an appropriate workup demonstrates a lack of understanding of the basic principles of the practice of medicine in a case of this nature." (St. Ex. 13, p. 2)

5. In his July 15, 1997, letter and accompanying attachments, Dr. Woodfield wrote that the lab results had been interpreted by the Idaho Board as a normal PAP smear result, when in fact

> it was actually evaluated using the newly instituted Bethesda System, and was an ASCUS result—favoring a dysplasia finding. The subsequent pathology report on the tissue from the cone biopsy could not rule out the possibility of cancer because the cells had been somewhat damaged by the biopsy process and the pathologist did not have the cervical cytology for comparison.

(Resp. Ex. G-1, pp. 7-8; Resp. Ex. G-2, pp. 2-26, and 29) Dr. Woodfield further wrote that "[u]tilization of the new Bethesda System had barely begun by the larger labs around the country before the [Idaho] hearing." (Resp. Ex. G-1, p. 8)

In his draft memorandum, Dr. Woodfield provided a detailed discussion of his position concerning Count One. Among other things, Dr. Woodfield disputed the Idaho Board's finding that he had failed to perform an adequate work-up of the subject patient prior to performing a conization and D&C. (Resp. Ex. G-3, pp. 12-29)

## Count Two

1. *Regarding Count Two, the Idaho Board found that Dr. Woodfield inserted a scalpel too deeply, and failed to recognize the sacral promontory. His surgical skill was inadequate. (State's Exhibit 8, p. 3)*

2. The Idaho Court of Appeals ruled that the Idaho Board's finding concerning the insertion of a scalpel too deeply had not been supported by the evidence. Nevertheless, the Idaho Court of Appeals upheld the Idaho Board's finding that Dr. Woodfield's misidentification of the sacral promontory during diagnostic laparoscopy had violated the standard of care, stating:

> Dr. Crouch [one of Dr. Woodfield's proctors] testified that he had been recalled into surgery when Dr. Woodfield was unable to identify a "bony mass" which [Dr. Woodfield] determined should be biopsied by means of a laparotomy. Dr. Crouch testified that he recognized and identified the bony mass as the "sacral promontory," dispelling any need for a biopsy, but that Dr. Woodfield remained unpersuaded. Dr. Crouch also testified that the sacral promontory is generally obscured by the bowel and that Dr. Woodfield may not previously have seen one so obvious as the one in this thin patient. Dr. Cook, the attending anesthesiologist, confirmed that Dr. Woodfield continued to doubt the identification of the bony mass. After consulting with another doctor, Dr. Gerrie, Dr. Woodfield scheduled a CT scan to conduct further tests instead of proceeding with a laparotomy.

(St. Ex. 12, pp. 14-15) The Idaho Court of Appeals further noted that other experts who had testified at the Idaho Board hearing had indicated that it would have been a standard of care violation had Dr. Woodfield proceeded with a laparotomy, and that Dr. Woodfield's decision to conduct further tests had been appropriate and within the standard of care. The Idaho Board nevertheless found that Dr. Woodfield had violated the standard of care, and the Idaho Court of Appeals ruled that there was sufficient evidence in the record for the Idaho Board to have done so. The Idaho Court of Appeals stated that "[s]uch a finding is one which falls well within the expertise possessed by the [Idaho] Board. From the testimony of the various doctors who testified about this incident, the [Idaho] Board could infer that under the circumstances presented a proper identification should have been made." (St. Ex. 12, p. 15)

3. Upon remand, the Idaho Board found, with regard to Count Two, that the proctor had been there merely to observe Dr. Woodfield's performance. The proctor had observed that Dr. Woodfield initially inserted the scalpel into the patient at an angle perpendicular to the patient's skin. The patient was very thin, and the Idaho Board found that this act endangered the patient's internal organs and exposed her to surgical risk. (St. Ex. 13, pp. 2-3) It should be noted, however, that the Idaho Court of Appeals had previously overturned

this finding as not being supported by the evidence contained in the Idaho hearing record. (St. Ex. 12, pp. 14-15)

The Idaho Board further found that Dr. Woodfield had failed to properly identify the patient's sacral promontory, that Dr. Woodfield had thought it was a pathological "bony mass," and that Dr. Woodfield had considered performing a biopsy on this structure before it was identified by other physician's as a normal anatomical structure. Finally, the Idaho Board found that "Dr. Woodfield's confusion in recognizing the sacral promontory, which represents an inability to recognize normal anatomic structures, constitutes a violation of the community standard of care." (St. Ex. 13, pp. 2-3)

Finally, the Idaho Board found that "Dr. Woodfield's own office records did not support his diagnosis and his testimony." (St. Ex. 13, p. 2)

4. Dr. Woodfield indicated that this Count involved direct laparoscopy. (Tr. 43)

In his July 15, 1997, letter, Dr. Woodfield stated that the proctor had pronounced a quick conclusion and had "abruptly left the [operating room] without further discussion. The general surgeon [he] consulted agreed that it looked 'odd' and suggested a CT scan, which was done rather than any further surgical procedure." Dr. Woodfield further stated that the issue of the scalpel insertion had been improperly considered by the Idaho Board upon remand, because the Idaho Board's previous determination on this issue had been overruled by the District Court or the Idaho Court of Appeals. (Resp. Ex. G-1, p. 8; Resp. Ex. G-2, pp. 34-38)

In his draft memorandum, Dr. Woodfield provided a detailed discussion of his position with regard to Count Two. Dr. Woodfield argued that the Idaho Board had not properly considered all of the expert testimony before it, including that of Dr. McGowan. Dr. Woodfield argued that Dr. McGowan had testified that it would have been conceivable that a physician would not have immediately identified the sacral promontory during laparoscopy, because it is usually obscured by bowel. Dr. Woodfield further argued that Dr. McGowan had testified that it would have been appropriate for a physician under such circumstances to have sought the opinion of others in the operating room. In addition, Dr. Woodfield argued that the Idaho Board had ignored substantial evidence in his favor. Moreover, Dr. Woodfield argued that one of the proctors had jumped to unwarranted conclusions and had acted upon those conclusions without any investigation. (Resp. Ex. G-3, pp. 29-39)

**Count Three**

1. Count Three was withdrawn by the Idaho Board during its hearing on this matter. (St. Ex. 7, p. 9)

**Count Four**

1. *Regarding Count Four, the Idaho Board found that Dr. Woodfield failed to discuss goals and surgical options with the patient prior to surgery, and failed to insure that enough blood was available prior to surgery. The Idaho Board found that Dr. Woodfield was evasive in his trial testimony. It found that he did not understand coagulation studies. He misstated the amount of the patient's blood loss. (State's Exhibit 8, pp. 3-4)*

2. The Idaho Court of Appeals noted that the District Court had overturned the Idaho Board's conclusion that Dr. Woodfield's conduct breached the standard of care. The Idaho Court of Appeals upheld the majority of the District Court's ruling. Nevertheless, the Idaho Court of Appeals, having found that the patient's original doctor—who brought Dr. Woodfield into the case—had ordered four units of blood before turning the matter over to Dr. Woodfield, ruled that the evidence was sufficient to support a conclusion that Dr. Woodfield either had failed to order sufficient blood product to sustain the patient during surgery; or, alternatively, had failed to properly assess the amount of blood product needed to sustain the patient during surgery. The Idaho Court of Appeals further supported the Idaho Board's finding that Dr. Woodfield had misstated the amount of the patient's blood loss in his written report of the surgery. However, the Idaho Court of Appeals left it to the Idaho Board to determine, on remand, whether such findings would constitute a failure to meet the standard of care. (St. Ex. 12, pp. 15-17)

3. Upon remand, the Idaho Board found that the surgery involved a patient who had delivered a baby and had experienced post-partum hemorrhaging. The Idaho Board further found that Dr. Woodfield had "failed to insure adequate blood products were available or ordered prior to surgery, nor did he demonstrate an awareness of the patient's blood status and the need for blood products at the time he proceeded with the surgery, placing the patient at jeopardy." In addition, the Idaho Board found that Dr. Woodfield had relegated to the assisting surgeon the responsibility of managing and ordering blood products. Finally, the Idaho Board found that Dr. Woodfield misstated the total blood loss amount in his written summary of the surgery. (St. Ex. 13, pp. 3-4)

4. Dr. Woodfield testified that he "went in on the consult from one of the practitioners on an individual who was bleeding after delivering a baby. When [he] got this she was in shock, receiving blood." Dr. Woodfield testified that the patient was bleeding to death, "which was substantiated by the fact that in the last 10 or 15 minutes of the procedure she had problems which could lead to cardiac arrest and the whole ball of wax. But the main issue was over what procedures should have been performed. The practitioner felt that she should have received an artery ligation, I felt she should have received a hysterectomy. Subsequently it became obvious that she needed a hysterectomy to save her life." (Tr. 29)

   Dr. Woodfield also stated that there was also a question concerning the amount of packed cells that had been ordered—whether it was six units or eight units. Dr. Woodfield stated that eight units were ordered by the consult and were given. (Resp. Ex. G-3, pp. 41-44; Tr. 29-30)

   In his draft memorandum, Dr. Woodfield discussed his position in detail concerning Count Four. Among other things, Dr. Woodfield alleged bias on the part of the proctor. Further, Dr. Woodfield stated that he had not misrepresented the amount of the patient's blood loss. Dr. Woodfield indicated that the amount of blood loss that he had recorded for the surgery was accurate, but that the patient had lost a significant amount of blood prior to the surgery. Finally, Dr. Woodfield stated that the subject patient had a condition called "placenta accreta," which, Dr. Woodfield stated, had necessitated a hysterectomy. (Resp. Ex. G-3, pp. 41-52)

**Count Five**

1. The Idaho Board found that no violation occurred concerning Count Five. (St. Ex. 13, p. 4)

**Count Six**

1. *Regarding Count Six, the Idaho Board found that Dr. Woodfield failed to perform an adequate pre-surgical workup on the patient. He performed a hysterectomy without performing a biopsy to rule out cervical carcinoma. He did not understand antibiotic therapy. "Dr. Woodfield's approach was awkward, indecisive and represented poor surgical technique." (State's Exhibit 8, pp. 4-5)*

2. The Idaho Court of Appeals rejected some of the findings of the Idaho Board concerning Count 6, but upheld the Idaho Board's findings and conclusions that

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Dr. Woodfield's surgical technique had been poor, indecisive, and awkward; and that he had not been prepared to perform the surgery via the intrafascial method. The Idaho Court of Appeals ruled that these findings were supported by the evidence, and further found that "[t]he evidence does not suggest that this was a pre-arranged training session for Dr. Woodfield, rather, that he undertook a surgery that he was unprepared to handle in a manner that would meet the community standard of care." (St. Ex. 12, pp. 17-19)

In making its determination, the Idaho Court of Appeals had found that the surgery took place on December 7, 1991, which would have been approximately three weeks since Dr. Woodfield's proctoring program began. (St. Ex. 12, p. 19)

3. Upon remand, the Idaho Board found that Dr. Woodfield had not been prepared to perform a hysterectomy via the intrafascial method, and that such conduct violated the community standard of care. The Idaho Board further found that Dr. Woodfield's surgical technique had been "awkward and indecisive," and that this violated the community standard of care. The Idaho Board noted that such was true even though the surgery had been successful. (St. Ex. 13, pp. 4-5)

4. Dr. Woodfield testified that he had been accused of not having shown good surgical technique in performing an intrafascial hysterectomy. Dr. Woodfield testified that this was merely a question of technique, and that "technique legally is not something that you can go after." Dr. Woodfield testified that, for every surgeon, there is a different way of doing something. (Tr. 30-31)

   In his draft memorandum, Dr. Woodfield denied that he had been unable to perform the hysterectomy via the intrafascial method. Dr. Woodfield acknowledged that, had he not been prodded by the proctor, he would have performed the procedure via the extrafascial method. Dr. Woodfield quoted from a textbook on gynecology that stated that the extrafascial method is faster and usually results in less blood loss; and further stated that the authors of that textbook prefer the extrafascial method. In addition, Dr. Woodfield testified that, given the proctor's and the Idaho Board's concerns about malignancy, it would have been preferable to remove the fascia for testing, as would have been done via the extrafascial method. (Resp. Ex. G-3, pp. 53-58)

**Count Seven**

1. *In discussing Count Seven, the Idaho Board stated that Dr. Woodfield lied when he testified that he had not used indirect video laparoscopy. "His inability*

*to use the laparoscopic approach [to lyse adhesions] fell below the community standard of care."* (State's Exhibit 8, *p. 5)*

2. The Idaho Court of Appeals rejected the Idaho Board's finding that Dr. Woodfield had lied concerning his experience with laparoscopy; nevertheless, the court ruled that such finding was not necessary to support the ultimate determination—that Dr. Woodfield's inability to use a laparoscopic approach to lyse adhesions fell below the community standard of care—and upheld the Idaho Board's conclusion. (St. Ex. 12, pp. 20-21)

   In reaching this determination, the Idaho Court of Appeals stated that, following diagnostic laparoscopy, "Dr. Woodfield planned to open up the patient in a laparotomy procedure for the purpose of lysing the adhesions, but, with urging and direction from Dr. Lovell, he accomplished the task with video-equipped laparoscope." (St. Ex. 12, p. 20)

3. Upon remand, the Idaho Board found that Dr. Woodfield had performed a laparotomy on the subject patient. The Idaho Board further found that it was standard practice to use laparoscopy, rather than laparotomy, to lyse adhesions, however. The Idaho Board stated that the fact that Dr. Woodfield had been unprepared to perform the procedure laparoscopically violated the standard of care, stating "Dr. Woodfield's failure to learn video use does not excuse him from the community standard of health care for lysing adhesions with a laparoscope." (St. Ex. 13, pp. 5-6)

4. Dr. Woodfield testified that he had seen adhesions under direct laparoscopy, and wanted to open the patient to lyse the adhesions. Dr. Woodfield stated that the proctor said that it should not be necessary to open the patient, that the procedure should be performed laparoscopically. Dr. Woodfield testified that he told the proctor that he had never done this before, but the proctor insisted. Dr. Woodfield testified that "at this point in time after being off on disability, current total disability, thinking that I was going to die, I was about ready to do anything to get back in practice. And I was kind of on the band wagon of wanting to please whoever might have helped me do that. So we went ahead and did the laparoscopy. Through my subsequent training I am finding that that was not a very good idea and it endangered that patient." Dr. Woodfield testified, however, that no bad outcome had resulted. (Tr. 32)

   Dr. Woodfield wrote that he had "clearly communicated" to the proctor that he had never performed the procedure through indirect laparoscopy or received the necessary training, yet the proctor had insisted that he proceed with that approach anyway. Dr. Woodfield further wrote that he has speculated that

there may have been some ulterior motive on the part of the proctor and/or the Idaho Board in insisting that he perform indirect laparoscopic dissection on this patient, as well as other patients. (Resp. Ex. G-1, p. 6)

Dr. Woodfield stated that it was not the standard of care in Idaho that all ob/gyns perform video laparoscopy to lyse adhesion. Dr. Woodfield further indicated that he believed that the proctor was biased against him. In addition Dr. Woodfield reiterated his assertion that, in 1991, only 20 percent of residency programs were teaching residents indirect laparoscopy. Finally, Dr. Woodfield took issue with the Idaho Board's refusal to correct its findings to reflect the fact that he had performed laparoscopy, rather than laparotomy, on the subject patient. (Resp. Ex. G-1, p. 6; Resp. Ex. G-3, pp. 58-67)

**Count Eight**

1. *Regarding Count Eight, "Dr. Woodfield exercised poor judgment by putting the patient at risk and sending the patient home under the circumstances constituted grossly substandard care." (State's Exhibit 8, p. 5)*

2. The Idaho Court of Appeals reversed the Idaho Board's conclusion that Dr. Woodfield's conduct constituted grossly substandard care, because the issue of sending the patient home with a suspected ectopic pregnancy had not been addressed in the Idaho Board's complaint. The complaint merely concerned Dr. Woodfield's inability to manage an evacuation of an ectopic pregnancy by a laparoscopic approach, which the Idaho Board found had not constituted a violation of the standard of care. (St. Ex. 12, pp. 21-22)

**Count Nine**

1. *Regarding Count Nine, the IHO found that Patient W.U. should have been managed medically rather than surgically for a diagnosis of ovarian cysts. Dr. Woodfield failed to diagnose the cysts as simple rather than complex; this distinction should have been readily apparent. (State's Exhibit 7, pp. 22-24)*

   The Idaho Board, in its original, 1993, Findings of Fact, Conclusions of Law, and Final Order, found as follows:

   > Dr. Woodfield performed an inadequate workup and unduly relied on vaginal ultrasounds. He exhibited poor surgical skills and misdiagnosis. Dr. Woodfield's statement that 'corpus luteum cysts' have one to three cavities and are abnormal is totally incorrect. The [Idaho] Board finds and concludes that Dr. Woodfield performed

> unnecessary surgery and exposed the patient to unnecessary trauma during the surgery. His handling of the patient failed to meet the community standard of care.

(St. Ex. 8, pp. 5-6)

2. The Idaho Court of Appeals upheld the Idaho Board's finding that Dr. Woodfield had performed an unnecessary laparotomy, thereby causing the patient to suffer unnecessary trauma. The court further upheld the Idaho Board's conclusion, based upon such finding, that Dr. Woodfield had breached the standard of care. However, "without more specific findings by the [Idaho] Board," the court refused to uphold the Idaho Board's ultimate finding that Dr. Woodfield had exhibited poor surgical skills which had exacerbated the trauma to the patient. (St. Ex. 12, pp. 21-23)

3. Upon remand, the Idaho Board found that Dr. Woodfield had performed a laparotomy to remove an ovarian cyst, and that Dr. Woodfield should have handled the matter either medically or with a laparoscopic approach. The Idaho Board found that the laparotomy had "exposed the patient to avoidable and unnecessary trauma." Nevertheless, the Idaho Board further found that, "[a]lthough there was testimony that Dr. Woodfield exhibited poor surgical technique, there was insufficient evidence to show that this was a violation of the community standard of health care." (St. Ex. 13, p. 7)

4. Dr. Woodfield testified that the proctor had seen this patient nine months earlier, and disrupted a paraovarian cyst via laparoscopy at that time. When the patient came to see Dr. Woodfield, he discovered a five cm. ovarian cyst. Dr. Woodfield testified that he removed the cyst via laparotomy. (Tr. 36)

   Dr. Woodfield testified that he had discussed the surgery with the patient and had offered to repeat the laparoscopy, but that the patient "was very adamant against that." Dr. Woodfield also testified that he had "[s]uggested birth control pills, although [he] didn't document very well, and she was very adamant against that." (Tr. 36-37)

   Dr. Woodfield testified that he does not believe that Count Nine should present a standard of care problem in Ohio. (Tr. 37)

   In his July 15, 1997, letter, Dr. Woodfield wrote, with regard to Counts Nine and Twelve, that he believed it would have been inappropriate for him to have disrupted the cysts laparoscopically, thus "spilling into the abdomen the contents of a cyst without knowing the nature of [the] contents." (Resp. Ex. G-1, p. 7)

**Count Ten**

1. *Regarding Count Ten, the IHO found that Dr. Woodfield engaged in improper sexual contact with Patient J.M. The IHO further found that Patient J.M. was emotionally unstable at the time the contact occurred. (State's Exhibit 7, pp. 24-26)*

   The Idaho Board, in its 1993 Findings of Fact, Conclusions of Law, and Final Order, found as follows:

   > Dr. Woodfield did engage in sexual improprieties with the patient. Further, it was unethical for Dr. Woodfield to try and talk the patient's husband into leaving his wife and using a diagnosis of ADD as an excuse. He used his professional role to manipulate the patient and knew the patient was on tranquilizers and pain pills which he had prescribed and which could impair her judgment. The [Idaho] Board finds and concludes that Dr. Woodfield's handling of this patient failed to meet the community standard of care and was an abuse or exploitation of the patient.

   (St. Ex. 8, p. 6)

2. The Idaho Court of Appeals upheld the findings of the Idaho Board and the IHO, and the concomitant conclusion that such conduct had constituted an abuse or exploitation of the patient. However, the court vacated the Idaho Board's conclusion that such conduct violated the standard of care, stating that further findings of fact would be necessary. The Idaho Board would have the opportunity to make such necessary findings on remand. (St. Ex. 12, pp. 23-25)

3. Upon remand, the Idaho Board found that Dr. Woodfield had engaged in improper sexual conduct with the subject patient. The Idaho Board further found that such conduct had been "a gross ethical violation" and exploitative or abusive of the patient. Further, "because no community's standard of care would or could tolerate professional health care which includes exploitive or abusive conduct of the patient," the Idaho Board found that Dr. Woodfield's conduct had violated the standard of care. In making these findings, the Idaho Board noted that it had found the testimony of the patient and her husband to be more credible than that of Dr. Woodfield. (St. Ex. 13, p. 8)

4. In his July 15, 1997, letter, Dr. Woodfield challenged the Idaho Board's findings. Among other things, Dr. Woodfield took issue with the Idaho Board's statement that the community could not tolerate "'professional health care which includes exploitive or abusive conduct **of the patient**[.]'" [emphasis Dr. Woodfield's] He further wrote that the Idaho Board's findings contained "pervasive, indiscreet inaccuracies[.]" Dr. Woodfield wrote that the medical care that he had provided to the subject patient was not inappropriate. (Resp. Ex. G-1, pp. 8-13)

   Dr. Woodfield stated that the "tranquilizer" referred to by the Idaho Board was Wellbutrin, which Dr. Woodfield described as an antidepressant that is used in the treatment of ADD. (Resp. Ex. G-1, p. 11)

   In his draft memorandum, Dr. Woodfield discussed at length his arguments concerning Count Ten. (Resp. Ex. G-3, pp. 67-73)

## Count Eleven

1. The Idaho Board found that no violation had occurred concerning Count Eleven. (St. Ex. 13, p. 8)

## Count Twelve

1. *Regarding Count Twelve, the Idaho Board found "that Dr. Woodfield pressured and rushed the patient into having an unnecessary surgery before other options of treatment were tried. ... The Board finds and concludes that the unnecessary surgery and the length of the ultrasound violated the community standard of care with respect to this patient." (State's Exhibit 8, p. 6)*

   In making these findings, the Idaho Board further found that Dr. Woodfield had lied concerning the length of the ultrasound. (St. Ex. 8, p. 6)

2. The Idaho Court of Appeals concluded "that the [Idaho] Board's finding, that Dr. Woodfield was lying with regard to the length of the ultrasound, was not supported by substantial evidence. * * * We uphold and adopt the district court's ruling overturning the [Idaho] Board's conclusion that Dr. Woodfield breached the standard of care by conducting an excessively long vaginal ultrasound on patient 12." (St. Ex. 12, pp. 8-9)

   In spite of the above conclusion, the Idaho Court of Appeals upheld the Idaho Board's finding that Dr. Woodfield had performed unnecessary surgery, and that such conduct had violated the standard of care. The court explained that "[h]ad

Dr. Woodfield elected to evaluate the patient's cyst through a laparoscopy prior to surgery, no breach of the standard could be found." (St. Ex. 12, pp. 25-27)

3. Upon remand, the Idaho Board found that Dr. Woodfield should have managed the patient's condition medically, or performed diagnostic laparoscopy, prior to performing a laparotomy. The Idaho Board further found that there was substantial evidence to support a finding that Dr. Woodfield's conduct had violated the standard of care. (St. Ex. 13, pp. 8-9)

4. Dr. Woodfield testified that the ultrasound that the Idaho Board had complained of actually consisted of two ultrasounds that occurred six months apart. Dr. Woodfield stated that the total time on the ultrasound machine had been about 43 minutes. Nevertheless, Dr. Woodfield testified, the Idaho Board believed the patient's allegation, although the IHO and the trial court judge did not. (Tr. 38-39)

   Concerning the surgery, Dr. Woodfield testified that the fact that he had removed a seven cm. cyst via laparotomy as opposed to laparoscopy should not be viewed as a standard of care violation. (Tr. 40)

   In his July 15, 1997, letter, Dr. Woodfield wrote that the patient had refused to take birth control pills for suppression of the cyst. Dr. Woodfield further wrote that he believed it would have been inappropriate for him to have disrupted the cysts laparoscopically, thus "spilling into the abdomen the contents of a cyst without knowing the nature of [the] contents." (Resp. Ex. G-1, p. 7)

## General Information Summary

1. Dr. Woodfield testified that, from July 1994 until recently, he had been working at the Carl Albert Health Facility in Oklahoma. Dr. Woodfield testified that he had not needed an Oklahoma license to work at this facility, which serves native Americans, and had worked there on his New York certificate. Dr. Woodfield testified that, after the New York Board sent him a notice of hearing, the clinical director at Carl Albert had asked him to resign. Dr. Woodfield testified that the Carl Albert facility had been aware of the Idaho action all along. He speculated that they had asked him to resign after they had learned that his New York license was in jeopardy. (Tr. 57-59)

   Dr. Woodfield testified that, at of the time of the July 21, 1997, hearing, he had not been actively practicing medicine. Nevertheless, Dr. Woodfield testified that he had continued to work during all but about 11 months since his problems in Idaho had begun. He stated that he had updated his training

and had worked on becoming a more proficient physician. Mrs. Woodfield testified that Dr. Woodfield had attended C.M.E. courses on critical care in February 1995, and surgical laparoscopy in December 1996. (Tr. 13-14, 21, 60)

2. In his draft memorandum, Dr. Woodfield stated that the Idaho Board had relied too heavily on its lay counsel, and that, consequently, the Idaho Board's judgments had had too little input from medical professionals. Dr. Woodfield further stated that the Idaho Board had acted against him out of prejudice concerning his ADD and the earlier misdiagnosis of organic dementia, and that the Idaho Board had thereby violated his civil rights and his rights under the Americans with Disabilities Act. Moreover, Dr. Woodfield stated that the Idaho Board had not acted in good faith. (Resp. Ex. G-3, pp. 1-3)

3. In his July 15, 1997, letter, Dr. Woodfield stated that Ohio should not find violations for conduct that Idaho had not yet reported to the National Practitioner Data Bank. Moreover, Dr. Woodfield testified that "if you just pushed everything aside and just took these counts as they are I don't think it would be enough to argue that I am a threat to anybody in Ohio. But having a license in Ohio is important because it allows me to practice in other places." (Resp. Ex. G-1, p. 20; Tr. 44)

**Dr. Woodfield's Current Licensure Status**

1. Dr. Woodfield testified that, besides his Ohio certificate, he also holds certificates in New York, Oregon, Nebraska, and Iowa. In addition, he testified that his Oregon, Nebraska, and Iowa licenses have lapsed. He further testified that an action is currently pending in New York based on the Idaho Board's action. Dr. Woodfield testified that, one week before the July 21, 1997, Ohio hearing, he had a hearing in New York concerning his New York certificate. (Tr. 54-57)

   Dr. Woodfield noted further that he has not renewed his Ohio license since this action commenced in March 1994. (Tr. 55)

2. Per the Affidavit of Debra L. Jones, the Board's Chief of C.M.E., Records, and Renewal, Dr. Woodfield's Ohio certificate "expired on September 30, 1994, due to non-renewal, and is currently lapsed and inactive." (Board Exhibit I)

## FINDINGS OF FACT

1. *On or about July 16, 1993, the Board of Professional Discipline, State of Idaho Board of Medicine, revoked the license of Brent E. Woodfield, M.D., to practice medicine and surgery in that state. The Idaho Board found that Dr. Woodfield failed to meet the minimum standard of care in his treatment of nine patients, engaged in sexual contact with one patient, and lied in testimony to the Idaho Board.*

   *By Memorandum Decision filed on May 5, 1994, the Ada County (Idaho) District Court vacated the decision and order of the Idaho Board and remanded the matter to the Board for further proceedings. The Idaho Board * * * appealed the District Court's decision.*

2. On or about November 1, 1995, the Idaho Court of Appeals affirmed the Idaho Board's conclusion that Dr. Woodfield had breached the standard of care with regard to Counts 1, 7, and 12. In addition, with regard to Counts 2, 6, and 9, the Idaho Court of Appeals agreed that Dr. Woodfield had breached the standard of care, but not for all of the bases found by the Idaho Board. Further, with regard to Counts 2, 4, 9, and 10, the Idaho Court of Appeals left it to the discretion of the Idaho Board to make additional findings and conclusions which would be consistent with the Idaho Court of Appeals' decision. Specifically with regard to Count 10, the Idaho Court of Appeals stated that the Idaho Board would not be precluded from finding that Dr. Woodfield's conduct had violated the standard of care, as well as having exploited the patient. Finally, with regard to Count 8, the Idaho Court of Appeals reversed the Idaho Board's findings and conclusion that Dr. Woodfield had breached the standard of care, and precluded the Idaho Board from making such findings and conclusions in the future with regard to that count.

   In addition, the Idaho Court of Appeals overturned the Idaho Board's finding, based upon the rebuttal testimony of an expert witness, that Dr. Woodfield had lied about his experience with video laparoscopy.

   Finally, the Idaho Court of Appeals remanded the matter to the Idaho Board for the Idaho Board to reconsider its decision in light of the court's ruling.

3. Following remand by the court, the Idaho Board, in Findings of Fact, Conclusions of Law, and Final Decision and Order dated March 11, 1996, concluded that Dr. Woodfield had breached the standard of care with regard to Counts 1, 2, 4, 6, 7, 9, 10, and 12. The Idaho Board further concluded, with regard to Count 10, that Dr. Woodfield had engaged in sexual conduct with the

patient, and that such conduct had been exploitative and abusive. Based on these conclusions, the Idaho Board revoked Dr. Woodfield's license.

4. The evidence presented supports the following Findings of Fact with regard to each of the aforementioned Counts:

(a) Count One

The Idaho Board found that Dr. Woodfield had performed unnecessary surgery on this patient, namely a D&C and conization. The Idaho Board further found that such surgery had been based upon a PAP smear showing "very few squamous cells of a benign nature" that Dr. Woodfield had "improperly elevated * * * to a dysplasia diagnosis[.]" In addition, the Idaho Board found that Dr. Woodfield had taken "an invasive surgical approach which was not warranted under the circumstances," and that Dr. Woodfield should have taken an additional PAP smear. Moreover, the Idaho Board found that Dr. Woodfield should have taken a biopsy when the colposcopy was done. Finally, the Idaho Board found that Dr. Woodfield's "failure to do an appropriate workup demonstrates a lack of understanding of the basic principles of the practice of medicine in a case of this nature."

At the July 21, 1997, Ohio hearing, Dr. Woodfield presented evidence that he had utilized a new testing procedure, the Bethesda system, that had indicated that surgery was necessary. Nevertheless, the Idaho Board had found that Dr. Woodfield's office records had not supported his diagnosis, or the testimony he had offered before the Idaho Board.

The Idaho Board's findings concerning Count One had been upheld by both the Idaho District Court and the Idaho Court of Appeals following an independent review of the Idaho hearing record by each of those courts. Although Dr. Woodfield contended that the surgery he performed had been indicated, based upon results obtained from a PAP smear using a new "Bethesda system," such contentions are deemed to be unconvincing in light of the conclusions reached by the Idaho Board and the Idaho courts.

The evidence is sufficient to support a finding that such conduct would, if committed in Ohio, fall below the minimal standards of care of similar practitioners in the same or similar circumstances.

(b) Count Two

The Idaho Board found that Dr. Woodfield had failed to properly identify the patient's sacral promontory, that Dr. Woodfield had thought that it was a pathological "bony mass," and that Dr. Woodfield had considered performing a biopsy on this structure before it was identified by other physician's as a normal anatomical structure. Finally, the Idaho Board found that "Dr. Woodfield's confusion in recognizing the sacral promontory, which represents an inability to recognize normal anatomic structures, constitutes a violation of the community standard of care."

The evidence indicated that this procedure had been performed via direct laparoscopy rather than indirect laparoscopy. The evidence further indicated that Dr. Woodfield was familiar with direct laparoscopy, at least as a diagnostic tool. This Count concerns a diagnostic issue.

Further evidence was presented that this patient's anatomy may have caused the sacral promontory to have appeared more prominent than would ordinarily be the case. Moreover, evidence was presented that, although Dr. Woodfield had initially been reluctant to accept the proctor's determination that the "bony mass" was a normal anatomical structure, he consulted with a third physician who agreed that the "bony mass" was unusual, and recommended a CT scan. Finally, the evidence indicated that Dr. Woodfield had contemplated performing a laparotomy to biopsy the "bony mass," but elected instead to perform a CT scan.

Based upon the foregoing, the Hearing Examiner cannot, without expert testimony on these issues, propose to the Board that it find that Dr. Woodfield's conduct in Count Two would have fallen below the minimal standard of care if committed in Ohio.

(c) Count Four

The Idaho Board found that the surgery involved a patient who had delivered a baby and had experienced post-partum hemorrhaging. The Idaho Board further found that Dr. Woodfield had "failed to insure adequate blood products were available or ordered prior to surgery, nor did he demonstrate an awareness of the patient's blood status and the need for blood products at the time he proceeded with the surgery, placing the patient at jeopardy." In addition, the Idaho Board found that Dr. Woodfield had relegated to the assisting surgeon the responsibility of managing and ordering blood products. Finally, the Idaho Board found

that Dr. Woodfield had misstated the total blood loss amount in his written summary of the surgery.

These findings were upheld by the Idaho Court of Appeals after its own independent review of the Idaho hearing record.

The evidence indicated that this situation was a life-threatening emergency. However, such a situation does not excuse Dr. Woodfield from following proper medical procedures. The evidence is sufficient to support a finding that such conduct would, if committed in Ohio, fall below the minimal standards of care of similar practitioners in the same or similar circumstances.

(d) Count Six

The Idaho Board found that Dr. Woodfield had not been prepared to perform a hysterectomy via the intrafascial method, and that such conduct violated the community standard of care. The Idaho Board further found that Dr. Woodfield's surgical technique had been "awkward and indecisive," and that this violated the community standard of care.

Dr. Woodfield denied that he had been unable to perform a hysterectomy via the intrafascial method, but had instead planned to perform this surgery via the extrafascial method. Dr. Woodfield presented evidence that the extrafascial method would have been an appropriate approach to this surgery.

Concerning the issue of Dr. Woodfield's surgical technique being "awkward and indecisive," the evidence further indicated that Dr. Woodfield was then into the third week of a proctoring program. This had followed an absence from the practice of medicine that had lasted approximately 22 months. There is no evidence in the record concerning what Dr. Woodfield actually did that was considered to be "awkward and indecisive."

Accordingly, the evidence does not support a finding that Dr. Woodfield's conduct in Count Six would have fallen below the minimal standard of care if committed in Ohio.

(e) Count Seven

The Idaho Board found that Dr. Woodfield had performed a laparotomy on the subject patient. The evidence presented indicated otherwise, however. Dr. Woodfield had planned to perform a laparotomy to lyse adhesions, but, at the urging of the proctor, performed the procedure via indirect laparoscopy. In light of the Idaho Board's erroneous finding, the evidence presented is not sufficient to support a finding of a violation of Ohio law concerning Count Seven.

(f) Count Nine

The Idaho Board found that Dr. Woodfield had performed a laparotomy to remove an ovarian cyst, and that Dr. Woodfield should have handled the matter either medically or with a laparoscopic approach. The Idaho Board found that the laparotomy had "exposed the patient to avoidable and unnecessary trauma." The Idaho Board's findings have been upheld by both the Idaho District Court and the Idaho Court of Appeals following an independent review of the Idaho hearing record by each of those courts.

Dr. Woodfield testified at the July 21, 1997, Ohio hearing that he performed a laparotomy because the patient had been adamantly against taking birth control pills to attempt to control her problem medically, and that she had been adamantly against a laparoscopic procedure. Dr. Woodfield further indicated that he had been reluctant to disrupt the cysts laparoscopically without knowing the nature of the contents. Nevertheless, such contentions are deemed to be unconvincing in light of the conclusions reached by the Idaho Board and the Idaho courts.

Accordingly, the evidence is sufficient to support a finding that such conduct would, if committed in Ohio, fall below the minimal standards of care of similar practitioners in the same or similar circumstances.

(g) Count Ten

The Idaho Board found that Dr. Woodfield had engaged in improper sexual conduct with the subject patient. The Idaho Board further found that such conduct had been "a gross ethical violation" and exploitative or abusive of the patient. Additionally, the Idaho Board found that Dr. Woodfield's conduct breached the standard of care. In making these findings, the Idaho Board noted that it had found the testimony of the patient and her husband to be more credible than that of Dr. Woodfield.

The evidence is sufficient to support a finding that such conduct would, if committed in Ohio, fall below the minimal standards of care of similar practitioners in the same or similar circumstances.

Moreover, the American Medical Association Principles of Medical Ethics state as follows:

> I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
>
> II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
>
> * * *
>
> IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
>
> * * *
>
> VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

(Board Exhibit G) (Although the document from which Board Exhibit G was excerpted was recently published, these Principles were in effect at all times relevant herein, and have been in effect since approximately 1980.)

The evidence presented is sufficient to support a finding that Dr. Woodfield's conduct with regard to Count Ten violated Principles I, II, and IV of the American Medical Association Principles of Medical Ethics. However, the evidence does not support a finding that Dr. Woodfield's conduct violated Principle VII of the American Medical Association Principles of Medical Ethics.

(h) Count Twelve

The Idaho Board found that Dr. Woodfield should have managed the patient's condition medically, or performed diagnostic laparoscopy, prior to removing a cyst via a laparotomy. This finding was upheld by the Idaho Board and the Idaho Court of Appeals.

Dr. Woodfield testified that he performed a laparotomy because the patient had refused to take birth control pills to suppress the cyst. Dr. Woodfield further testified that he had been reluctant to disrupt the cyst laparoscopically without knowing the nature of its contents. Nevertheless, such contentions are unconvincing in light of the conclusions reached by the Idaho Board and the Idaho Court of Appeals.

Accordingly, the evidence is sufficient to support a finding that such conduct would, if committed in Ohio, fall below the minimal standards of care of similar practitioners in the same or similar circumstances.

5. The Idaho Board, in its 1993 Findings of Fact, Conclusions of Law, and Final Order, found that Dr. Woodfield had lied about his experience with indirect laparoscopic dissection, and about the length of an ultrasound with regard to Count Twelve. However, both of these findings were overturned on appeal.

## CONCLUSIONS OF LAW

Conclusion 1 of the April 6, 1995, Report and Recommendation is hereby amended to read as follows:

1. The acts, conduct, and/or omissions of Brent E. Woodfield, M.D., as set forth in Findings of Fact 4(a), 4(c), 4(f), 4(g), and 4(h), 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)(a), Ohio Revised Code, as in effect prior to November 6, 1996. Further, the acts, conduct, and/or omissions of Brent E. Woodfield, M.D., as set forth in Findings of Fact 4(g), individually, and/or collectively, constitute "[t]he violation of any provision of a code of ethics of the American medical association * * *[,]" as that clause is used in Section 4731.22(B)(18)(a), Ohio Revised Code, to wit: Principles I, II, and IV of the American Medical Association Principles of Medical Ethics.

Therefore, the March 11, 1996, revocation of Dr. Woodfield's Idaho certificate by the Idaho Board, as set forth in Findings of Fact 1 through 3, constitutes "[t]he limitation, revocation or suspension by another state of a license or certificate to practice issued by the proper licensing authority of that state, the refusal to license, register, or reinstate an applicant by that authority, or the imposition of probation by that authority for an action that would also have been a violation of this chapter, except for nonpayment of fees," as that clause was used in Section 4731.22(B)(22), Ohio Revised Code, (as in effect prior to November 6, 1996), to wit: Section 4731.22(B)(6)(a), Ohio Revised Code, (as in effect prior to November 6, 1996), and Section 4731.22(B)(18), Ohio Revised Code, to wit: Principals I, II, and IV of the American Medical Association Principles of Medical Ethics.

2. As set forth in Finding of Fact 4(c), above, the Idaho Board found that Dr. Woodfield misstated the amount of a patient's blood loss in his written summary of the surgery. However, such finding is not sufficient to support a conclusion that such misstatement would constitute "publishing a false, fraudulent, deceptive, or misleading statement," as that clause is used in Section 4731.22(B)(5), Ohio Revised Code. Under Ohio law, it is necessary for the State to prove that such a misstatement had been made with an intent to deceive.[1] The Idaho Board made no such finding, and there is no evidence in this record to support such a finding.

   Accordingly, as set forth in Findings of Fact 4(c) and 5, Section 4731.22(B)(5), Ohio Revised Code, cannot be used as a basis for concluding that the acts, conduct, and/or omissions of Dr. Woodfield, individually and/or collectively, constitute "[t]he limitation, revocation or suspension by another state of a license or certificate to practice issued by the proper licensing authority of that state, the refusal to license, register, or reinstate an applicant by that authority, or the imposition of probation by that authority for an action that would also have been a violation of this chapter, except for nonpayment of fees," as that clause was used in Section 4731.22(B)(22), Ohio Revised Code, (as in effect prior to November 6, 1996), to wit: Section 4731.22(B)(5), Ohio Revised Code.

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There was evidence that Dr. Woodfield had exhibited some practice deficiencies while working in Idaho. Such deficiencies indicate that Dr. Woodfield should practice in a supervised structured environment, and should be subject to monitoring by this Board to ensure the safety of the health-care consuming public.

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[1] *Rajan v. State Medical Board* (February 13, 1997), 1997 Ohio App. LEXIS 535, Franklin App, No. 96APE07-914, unreported.

In addition, the evidence indicated that Dr. Woodfield may have placed too great a reliance on laparotomy as opposed to laparoscopy as an approach to his obstetrics and gynecological surgery. Such evidence may indicate that Dr. Woodfield needs additional training to bring his surgical skills up to date. Moreover, the evidence indicated that Dr. Woodfield had improper sexual relations with a patient. The Board has in the past decided that such conduct warrants a period of suspension from practice, and completion of a course dealing with professional ethics, followed by monitoring.

The evidence indicated that Dr. Woodfield's Ohio certificate lapsed in 1994 due to nonrenewal, and is currently inactive. Therefore, all proposed probationary terms and conditions shall be deemed to be minimum requirements that should be imposed if Dr. Woodfield applies for restoration and if such restoration is granted.

## PROPOSED ORDER

It is hereby ORDERED that:

1. Nothing herein shall be deemed to limit the discretion or authority of this Board concerning any reinstatement or restoration application that this Board may receive from Brent E. Woodfield, M.D.

2. The certificate of Dr. Woodfield to practice medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than two years. Because Dr. Woodfield's certificate expired on September 30, 1994, due to non-renewal, and is currently lapsed and inactive, such suspension shall become effective immediately if the Board grants or approves the restoration of Dr. Woodfield's Ohio certificate.

3. Following restoration of Dr. Woodfield's certificate, and the subsequent indefinite suspension of his certificate as described in paragraph 2, above, the Board shall not consider reinstatement of Dr. Woodfield's certificate to practice unless all of the following minimum requirements have been met:

    a. Dr. Woodfield shall submit an application for reinstatement, accompanied by appropriate fees. Dr. Woodfield shall not make such application for at least two years from the effective date of an Order from this Board granting the restoration of Dr. Woodfield's certificate as described in paragraph 2, above.

b. Dr. Woodfield shall provide documentation of successful completion of a course or courses dealing with professional ethics. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the biennial registration period(s) in which they are completed.

c. Dr. Woodfield shall provide acceptable documentation of satisfactory completion of a clinical education program, to be approved in advance by the Board or its designee, related to laparoscopic surgery. The exact number of hours and the specific content of the program shall be determined by the Board or its designee. The Board may require Dr. Woodfield to pass an examination related to the content of the program. This program shall be in addition to the Continuing Medical Education requirements for relicensure.

d. Dr. Woodfield shall notify the Board of any action in any state taken against a certificate to practice medicine held by Dr. Woodfield in that state. In addition, Dr. Woodfield shall immediately notify the Board in writing of any modification or change to any term, condition, or limitation imposed by any other state medical board. Moreover, Dr. Woodfield shall provide acceptable documentation verifying the other state boards' actions.

e. Within thirty (30) days of the restoration of Dr. Woodfield's certificate as described in paragraph 2, above, Dr. Woodfield 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. Dr. Woodfield further agrees to 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. Woodfield shall provide this Board with a copy of the return receipt as proof of notification within thirty (30) days of receiving that return receipt.

f. In the event that Dr. Woodfield has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of his fitness to resume practice.

4. Upon reinstatement, Dr. Woodfield's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least five years:

   a. Dr. Woodfield shall not request modification of the terms, conditions, or limitations of probation for at least one year after imposition of these probationary terms, conditions, and limitations.

   b. Dr. Woodfield shall obey all federal, state, and local laws, and all rules governing the practice of medicine in the state in which he is practicing.

   c. Dr. Woodfield shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of probation. The first quarterly declaration must be received in the Board's offices on the first day of the third month following the month in which the probation becomes effective, provided that if the effective date is on or after the 16th day of the month, the first quarterly declaration must be received in the Board's offices on the first day of the fourth month following. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

   d. Dr. Woodfield shall immediately notify the Board in writing of any modification or change to any term, condition, or limitation imposed by any other state medical board.

   e. Dr. Woodfield shall appear in person for interviews before the full Board or its designated representative within three months of the reinstatement of his certificate, at three month intervals thereafter, and upon his request for termination of the probationary period, or as otherwise requested by the Board.

      If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled. Although the Board will normally give him written notification of scheduled appearances, it is Dr. Woodfield's responsibility to know when personal appearances will occur. If he does not receive written notification from the Board by the end of the month in which the appearance should have occurred, Dr. Woodfield shall immediately submit to the Board a written request to be notified of his next scheduled appearance.

f. Dr. Woodfield shall refrain from commencing practice in Ohio without prior written Board approval. Moreover, should he commence practice in Ohio, the Board may place Dr. Woodfield's certificate under additional terms, conditions, or limitations, including the following:

i. Prior to commencement of practice in Ohio, Dr. Woodfield shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan, unless otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. Woodfield's activities will be directly supervised and overseen by a monitoring physician approved by the Board. The monitoring physician shall monitor Dr. Woodfield and provide the Board with reports on Dr. Woodfield's progress and status on a quarterly basis. All monitoring physician reports required under this paragraph must be received in the Board's offices no later than the due date for Dr. Woodfield's quarterly declaration. It is Dr. Woodfield's responsibility to ensure that the reports are timely submitted.

In the event that the approved monitoring physician becomes unable or unwilling to serve, Dr. Woodfield shall immediately notify the Board in writing and shall make arrangements for another monitoring physician as soon as practicable. Dr. Woodfield shall refrain from practicing until such supervision is in place, unless otherwise determined by the Board. Dr. Woodfield shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

ii. Dr. Woodfield shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order. In the event that Dr. Woodfield's supervising physician under this practice plan becomes unable or unwilling to so serve, Dr. Woodfield shall immediately notify the Board in writing, and make arrangements acceptable to the Board for another supervising physician as soon as practicable. Dr. Woodfield shall refrain from practicing unless and until such supervision is in place, unless otherwise determined by the Board.

iii. Dr. Woodfield shall obey all federal, state, and local laws, and all rules governing the practice of medicine in Ohio.

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iv. Dr. Woodfield shall appear in person for quarterly interviews before the full Board or its designated representative, or as otherwise directed by the Board.

If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled. Although the Board will normally give him written notification of scheduled appearances, it is Dr. Woodfield's responsibility to know when personal appearances will occur. If he does not receive written notification from the Board by the end of the month in which the appearance should have occurred, Dr. Woodfield shall immediately submit to the Board a written request to be notified of his next scheduled appearance.

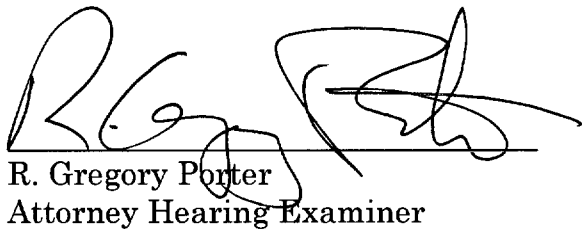
g. Within thirty (30) days of the reinstatement of Dr. Woodfield's certificate as described in paragraph 3, above, Dr. Woodfield shall provide a copy of this Order to all employers or entities with which he is under contract to provide physician services or is receiving training, and the Chief of Staff at each hospital where Dr. Woodfield has privileges or appointments. Further, Dr. Woodfield shall provide a copy of this Order to all employers or entities with which he contracts to provide physician services, or applies for or receives training, and the Chief of Staff at each hospital where Dr. Woodfield applies for or obtains privileges or appointments.

h. If Dr. Woodfield violates probation in any respect, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period.

i. If Dr. Woodfield violates probation in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of Dr. Woodfield's certificate.

5. Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Woodfield's certificate will be fully restored.

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



R. Gregory Porter
Attorney Hearing Examiner

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EXCERPT FROM THE DRAFT MINUTES OF NOVEMBER 12, 1997

REPORTS AND RECOMMENDATIONS

Ms. Noble announced that the Board would now consider the findings and orders appearing on the Board's agenda.

Ms. Noble asked whether each member of the Board had received, read, and considered the hearing record, the proposed findings, conclusions, and orders, and any objections filed in the matters of: William B. Beuchat, D.O.; Stephen J. Buday, M.D.; Ronald A. Landefeld, M.D.; Hillard M. Lazarus, M.D., et al., University Physicians, Inc.; Myron B. Renner, D.O.; Samson P. Reyes, Jr., M.D.; Howard E. Rissover, M.D.; and Semur P. Rajan, M.D.; and the report and recommendation upon remand in the matter of Brent E. Woodfield, M.D.

A roll call was taken:

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| ROLL CALL: | Mr. Albert | - aye |
| | Dr. Bhati | - aye |
| | Dr. Gretter | - aye |
| | Dr. Egner | - aye |
| | Mr. Sinnott | - aye |
| | Dr. Buchan | - aye |
| | Dr. Agresta | - aye |
| | Dr. Garg | - aye |
| | Dr. Steinbergh | - aye |
| | Ms. Noble | - aye |

Mr. Sinnott indicated that he did not read the materials in the matter of Ronald A. Landefeld, M.D.

Ms. Noble 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:

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| ROLL CALL: | Mr. Albert | - aye |
| | Dr. Bhati | - aye |
| | Dr. Gretter | - aye |
| | Dr. Egner | - aye |

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|---|---|
| Mr. Sinnott | - aye |
| Dr. Buchan | - aye |
| Dr. Agresta | - aye |
| Dr. Garg | - aye |
| Dr. Steinbergh | - aye |
| Ms. Noble | - aye |

In accordance with the provision in Section 4731.22(C)(1), 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.

Ms. Noble stated that if there were no objections, the Chair would dispense with the reading of the proposed findings of fact, conclusions and orders in the above matters. No objections were voiced by Board members present.

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

.....

BRENT E. WOODFIELD, M.D.

Ms. Noble directed the Board's attention to the matter of Brent E. Woodfield, M.D. She advised that objections to Hearing Examiner Porter's Report and Recommendation were filed and were previously distributed to Board members.

Ms. Noble noted that the objections filed on behalf of Dr. Woodfield included documents that were not part of the hearing record. Their inclusion has been construed as a request to admit additional evidence into the record. She asked for a motion concerning this request.

**DR. AGRESTA MOVED TO DENY DR. WOODFIELD'S REQUEST TO ADMIT ADDITIONAL EVIDENCE. DR. STEINBERGH SECONDED THE MOTION.** A vote was taken:

VOTE:

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|---|---|
| Mr. Albert | - abstain |
| Dr. Bhati | - aye |
| Dr. Gretter | - abstain |
| Dr. Egner | - aye |
| Mr. Sinnott | - aye |
| Dr. Buchan | - aye |
| Dr. Agresta | - aye |
| Dr. Garg | - aye |
| Dr. Steinbergh | - aye |

The motion carried.

Ms. Noble advised that a request to address the Board has been timely filed on behalf of Dr. Woodfield. Five minutes would be allowed for that address.

Dr. Woodfield introduced himself and his wife. He advised that eight years ago he was diagnosed with a terminal illness in Oregon and went on disability for 22 months. During that period, he went to a physician who diagnosed attention deficit disorder (ADD) with mild language problems and probably dyslexia. His wife also has ADD. He renewed his Oregon license and returned to practice in Rexburg, Idaho. The Idaho Board of Medicine subpoenaed nine proctoring complaints at the hospital that had not been acted on at the hospital. It included along with it three other patient complaints that were eventually included in an outside hearing by the Idaho Board of Medicine. They went ahead with the hearing and revoked his license on July 16, 1993. The case went to District Court, and Dr. Woodfield won and got his license back. During the process of that dispute, he filed a complaint with the Office of Civil Rights in Seattle, Washington. That office came out with its decision after the first court win. That office found the Idaho Board of Medicine non-discriminatory on the basis of his disability because they gave his license back, among other things.

Dr. Woodfield continued that the Idaho Board of Medicine on the second revocation has submitted to the Ohio Board findings under their Medical Practice Act of 5418.147 and 5418.22. The first part of that is their community standard of care statute. That basically, descriptively, follows along the phrase of failure to meet the community standard. The other is an ethical count involving exploitative or abusive conduct to a patient. The Office of Civil Rights in their decision favoring the Board found that the Idaho Board of Medicine is authorized to discipline physicians in Idaho under the Medical Practices Act. A report was submitted to the National Practitioners Data Bank (NPDB) after that first revocation with descriptive numbers and codes of those two sections. On the second revocation, which occurred May 22, 1996, they also submitted a report to the NPDB under descriptive terms of their malpractice codes. Dr. Woodfield stated that he has disputed that report.

Mrs. Woodfield interjected that Dr. Woodfield needs to tell the Board that he has practiced the whole time since Judge McKee's decision in Ada, Oklahoma, up until June 1997. The only reason the hospital let him go was because New York State was instituting actions just like this and they sent their notice of action, in person, to the hospital, and she believes the hospital sort of panicked. The CEO and the Clinical Director had both said at all the heads of department meetings that, as long as Dr. Woodfield had a New York license or whichever license he had maintained, he had a job there, because he was the most valued member of that department. He had the lowest complication rate. Last year he got a stay of revocation. That was the first stay of revocation of a physician's license in Idaho. His care was substantiated by ACOG guidelines. He was the only physician at his hearing citing ACOG guidelines in support of his care, yet he was the only physician not ACOG Board certified, only because he was ADD. Mrs. Woodfield stated that if the Board members had read the brief, they will have seen that the ADD and the dyslexia cause him to have problems in passing an oral exam. He didn't know about his ADD at the time. He

passed the written examinations with solid scores. When he attempted to take the orals, he didn't pass them because he has a problem with those kinds of confrontational, oral presentations. He did not know he was ADD at the time and was not on medication. His physician is one of the most respected physicians treating ADD in the nation, has written books on the subject, and has made annual presentations on adult ADD to the Psychiatric Association. The psychiatrist in Salt Lake City who first diagnosed Dr. Woodfield wrote glowing letters of recommendation to the hospital and to the Board, saying that there is no reason why this physician cannot practice medicine, and, in fact, should be a welcome addition to any staff.

Mrs. Woodfield continued that Dr. Woodfield's proctors were his competitors. They had been given information from the Board before the proctoring was started. Dr. Woodfield has not been allowed his rights of discovery.

Dr. Woodfield at this time explained to his wife that they were going to run out of time and she needed to finish.

Mrs. Woodfield stated that this is important, and that the Board needs to hear this. This Board is listening and this is important material. In Ohio a physician is allowed to see his record; that's in Ohio's statutes. That was denied him in Idaho. All they are asking for is due process to finally occur. Dr. Woodfield is an excellent physician. They have letters from staff members in Oklahoma.

Dr. Woodfield stated that what he would like to say is simply this: Idaho is now not only violating his rights according to what he deserves as a qualified individual with a disability, they are now violating his rights over the hearing process. That is what this whole thing was over. He has not been able to budge Civil Rights as of yet. Recently, they finally got part of the hospital Executive Committee on Count 10, which the Idaho Board of Medicine has not reported to the NPDB. The Executive Committee Chairman, who separately acted in the Board's hearing, said that that patient accused him of going to a ski resort with her on January 10, 1992. Dr. Woodfield stated that he saw this woman for the first time, as a patient, on February 18, 1992. Also, the remainder of what the Board has here are issues over ACOG guidelines and standard care based on that issue. Idaho's whole hearing against him was based on their local standard of care. There are Executive Committee minutes where the chief of staff and proctor at that hospital was instructed to see what the ACOG guidelines were on these issues. That was March 1992. The very next month, ACOG came out with their first guidelines on the operable camera laparoscopy, which stated that one should not do it unless one is trained. He was not trained at that time.

Ms. Noble thanked Dr. Woodfield and asked whether the Assistant Attorney General wished to respond.

Ms. Strait stated that the Board needs to focus on what this case is about, and that is the Idaho Board action, which went up through the appeal process, back down, and up through the appeal process again, until the Board finally has the final Idaho Order. She thinks Mr. Porter did an excellent job of summarizing and sorting out what ultimately, through the Idaho Court system, became the decision of the Idaho Board in terms of which findings were upheld and which findings were not. This Board does have the ability to look at this independently and make the determination as to whether or not it feels that those

violations are violations of Section 4731.22 (B)(6), Ohio Revised Code, departure from minimal standards of care, as well as the one ethical count. She asked that the Board consider the case from that perspective. This is an out-of-state action where the appellate process became somewhat complicated, but, ultimately, what the Board is left with are certain findings the Idaho Board made, at which this Board may look, determine whether or not it agrees, and take action accordingly. She again stated that the Hearing Examiner did a very good job of trying to summarize that for the Board in his Report and Recommendation.

**DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF BRENT E. WOODFIELD, M.D. DR. AGRESTA SECONDED THE MOTION.**

Ms. Noble stated that she would now entertain discussion concerning the Proposed Findings of Fact, Conclusions and Order in the matter of Brent E. Woodfield, M.D.

Dr. Steinbergh noted that Dr. Woodfield doesn't currently have an active Ohio license. The Proposed Order would go into effect only if Dr. Woodfield applies for restoration and the Board grants the restoration request. The Board isn't considering a restoration request at this time. She asked whether she understood this correctly. It was the consensus of the Board that she did.

Dr. Steinbergh stated that it is difficult for the Board to decide a case based on another state's actions. She does feel that the Proposed Order is probably appropriate, but she would like to hear from the OB/GYN experts on the Board.

Dr. Egner stated that, for her, this case is more about filling out a renewal application. When doing so, Dr. Woodfield indicated that there were no restrictions on his license, when, in fact, there were. As far as care given, it is difficult to say. She would defer to Dr. Bhati.

Dr. Bhati stated that Case #1 concerned an abnormal pap smear, showing a few squamous cells. It didn't show a whole lot of anomaly. Normally, in a situation like this, you go to a colposcopic to have a diagnosis made on it. Dr. Woodfield didn't do that, but went straight to the conization of the cervix. That is not an acceptable standard of care.

Dr. and Mrs. Woodfield disagreed.

Dr. Bhati stated that he has to go with the information he has.

Mrs. Woodfield again interrupted.

Ms. Noble asked her to allow Dr. Bhati to finish.

Dr. Bhati referred to Case #2, stating that in a laparoscopic examination, to look at the sacral promontory

and get confused with a "bony mass" is rather inadequate or sub-par examination and understanding. He would understand that Dr. Woodfield is not trained to do a regular laparoscopy; a lot of gynecologists are not. That's fine. He noted that 1997 medicine is different from 1991.

Dr. Bhati stated that he doesn't feel that the two cases he's mentioned are really the cause of action. The case concerning intrafascial hysterectomy versus extrafascial hysterectomy, either are okay as long as the physician does the proper job and the patient is taken care of without complications. There's no big fight on that issue. Post-partum hemorrhaging--one stated that it wasn't taken care of properly, but when you're talking about managing hundreds of patients, any doctor will have one or two cases where he didn't do well. Dr. Bhati stated that his problem with this case was Dr. Woodfield's reactions in filing applications, etc. He can understand having a hard time passing an oral examination with ADD; people have a hard time passing oral examinations without ADD.

Dr. Bhati stated that he believes that the Proposed Order is in order.

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

| VOTE: | | |
|---|---|---|
| | Mr. Albert | - abstain |
| | Dr. Bhati | - aye |
| | Dr. Gretter | - abstain |
| | Dr. Egner | - aye |
| | Mr. Sinnott | - aye |
| | Dr. Buchan | - aye |
| | Dr. Agresta | - aye |
| | Dr. Garg | - aye |
| | Dr. Steinbergh | - aye |

The motion carried.

Mrs. Woodfield stated that Dr. Woodfield is an excellent physician, and Ohio will be sued just like the other two states.

STATE OF IDAHO

BOARD OF MEDICINE

I, V. DARLEENE THORSTED, Quality Assurance Specialist for the Idaho State Board of Medicine, do hereby certify that the annexed is a true and complete copy of the Complaint, Findings Of Fact, Conclusions Of Law and Final Order taken by the Board of Professional Discipline in regards to Brent E. Woodfield, MD, Idaho license No. M-4578, as appears of record in this office as of this date.

DATED: December 28, 1993

IDAHO STATE BOARD OF MEDICINE

By: V. Darleene Thorsted
V. Darleene Thorsted, Quality Assurance Specialist
Board of Professional Discipline

STATE OF IDAHO
94 JAN -3 PM

State of Idaho )
)ss
County of Ada )

Subscribed and sworn to before me this 28th, day of December 19 93.

Notary Public Rhea F. Delasguen

Residing in Boise, Idaho
My commission expires

BEFORE THE BOARD OF PROFESSIONAL DISCIPLINE OF

THE IDAHO STATE BOARD OF MEDICINE

| | | |
|---|---|---|
| In the Matter of:<br><br>BRENT E. WOODFIELD, M.D.,<br>License No. M-4578,<br><br>Respondent. | ) | Case No. 91-064<br><br>FINDINGS OF FACT,<br>CONCLUSIONS OF LAW<br>AND FINAL ORDER |

This matter came on for consideration before the Board of Professional Discipline of the Idaho State Board of Medicine on June 11, 1993. All members of the Board of Professional Discipline who participated in this decision were provided with and read the record.

The Board hereby adopts and incorporates by reference the proposed Disciplinary Findings of the Hearing Officer, except as provided herein.

The Board finds and concludes that the Hearing Officer did not understand the function of the proctoring program. The proctors were not intended to be teachers, but rather were merely to observe and critique Dr. Woodfield's skills and his ability to practice with reasonable skill and safety to patients. The proctors observed and reported deficiencies in Dr. Woodfield's skills and abilities.

COUNT ONE

With respect to Count One, the Board finds and concludes that

this patient presented to Dr. Woodfield with the lowest level Pap smear reading. Dr. Woodfield improperly elevated that low reading to a Class III dysplasia diagnosis in order to improperly justify the surgery for D&C and conization. The surgery was handled ineptly with poor judgment on Dr. Woodfield's part. Further, Dr. Woodfield was dishonest and attempted to improperly justify the surgery by claiming he performed the D&C for abnormal bleeding when the chart does not mention abnormal uterine bleeding. He further violated the standard of care by failing to take a biopsy when the colposcopy was done.

The Board unanimously concluded that Dr. Woodfield's handling of this case did not meet the community standard of care in that the surgery was unnecessary and his failure to do an appropriate workup demonstrates a lack of understanding of the basic principles of the practice of medicine.

COUNT TWO

With respect to Count Two, the Board finds and concludes that Dr. Woodfield violated the community standard of care by inserting the knife too deeply, demonstrating a lack of skill which would have been possessed by a resident. Dr. Woodfield's confusion regarding recognition of the sacral promontory represents an inability to recognize normal anatomic structures. His surgical technique was inept, exhibited an inadequate degree of skill, and fell below the community standard of care.

COUNT FOUR

With respect to Count Four, the Board finds and concludes that Dr. Woodfield did violate the community standard of care by failing to insure that adequate blood products were available or ordered

prior to surgery. While the overall outcome of the surgery did meet the standard of care, Dr. Woodfield's participation was questionable and he cannot take responsibility for care of the patient. The Board further finds the surgical options were not clearly discussed with the patient and the patient's goals were not clearly established prior to the surgery. Dr. Woodfield's trial testimony was evasive in answering questions related to the lab work and he did not provide answers regarding orders for the PTT or PT. Further, Dr. Woodfield did not demonstrate a basic knowledge or understanding of coagulation studies, or an awareness of the patient's blood status and the need for blood products. Finally, Dr. Woodfield misstated the amount of blood loss.

The Board unanimously concluded that Dr. Woodfield violated the standard of care with respect to his handling of this patient.

COUNT FIVE

With respect to Count Five, the Board determined that Dr. Woodfield's judgment was within the standard of care, but there is a concern that his surgical skills were substandard and there was a lack of skill and protection during the trocar insertion.

COUNT SIX

With respect to Count Six, the Board finds and concludes that the Hearing Officer did not fully understand the nature of the evidence. The treatment was inappropriate because Dr. Woodfield thought he had an necrotic mass and did a hysterectomy without performing a biopsy to make sure there was no cervical carcinoma. He also failed to adequately workup the patient prior to surgery and placed a heavy reliance on vaginal ultrasounds. The Board further finds that Dr. Woodfield's approach was awkward, indecisive

and represented poor surgical technique. Finally, his workup of the patient was inadequate and awkward and he did not understand antibiotic therapy. The Board concludes that Dr. Woodfield violated the community standard of care with respect to his handling of this patient.

COUNT SEVEN

With respect to Count Seven, the Board finds and concludes that Dr. Woodfield's testimony that he had not used indirect video laparoscopy is false in view of the testimony from the Oregon physician. The Board has serious concerns regarding Dr. Woodfield's integrity and skills. Based upon his prior experience and practice, Dr. Woodfield should not have had any difficulty lysing the adhesions through a laparoscope. His inability to use the laparoscopic approach fell below the community standard of care.

COUNT EIGHT

With respect to Count Eight, Dr. Woodfield exercised poor judgment by putting the patient at risk and sending the patient home under the circumstances constituted grossly substandard care.

COUNT NINE

With respect to Count Nine, the Board finds that Dr. Woodfield performed an inadequate workup and unduly relied on vaginal ultrasounds. He exhibited poor surgical skills and misdiagnosis. Dr. Woodfield's statement that "corpus luteum cysts" have one to three cavities and are abnormal is totally incorrect. The Board finds and concludes that Dr. Woodfield performed unnecessary surgery and exposed the patient to unnecessary trauma during the

surgery. His handling of this patient failed to meet the community standard of care.

COUNT TEN

With respect to Count Ten, the Board finds and concludes that Dr. Woodfield did engage in sexual improprieties with the patient. Further, it was unethical for Dr. Woodfield to try to talk the patient's husband into leaving his wife and using a diagnosis of ADD as an excuse. He used his professional role to manipulate the patient and knew the patient was on tranquilizers and pain pills which he had prescribed and which could impair her judgment. The Board finds and concludes that Dr. Woodfield's handling of this patient failed to meet the community standard of care and was an abuse or exploitation of the patient.

COUNT ELEVEN

With respect to Count Eleven, the Board finds there was no violation of community standard of care.

COUNT TWELVE

With respect to Count Twelve, the Board finds that Dr. Woodfield pressured and rushed the patient into having an unnecessary surgery before other options of treatment were tried. Further, the Board finds that Dr. Woodfield lied about the time taken for the ultrasound and found the witness to be more truthful about the length of the ultrasound. The Board finds and concludes that the unnecessary surgery and the length of the ultrasound violated the community standard of care with respect to this patient.

## CONCLUSIONS OF LAW

The Board concludes Dr. Woodfield violated Idaho Code §54-1814(7) with respect to Counts One, Two, Four, Six, Seven, Eight, Nine, Ten and Twelve. The Board also concludes Dr. Woodfield violated Idaho Code §54-1814(22) with respect to Count Ten.

## ORDER

Based upon the foregoing, it is hereby ordered that Dr. Woodfield's license to practice medicine and surgery in the State of Idaho is hereby revoked.

DATED This 16 day of July, 1993.

BOARD OF PROFESSIONAL DISCIPLINE

Michael E. Estess M.D.

MICHAEL E. ESTESS, M.D.
Chairman

COPY

Jean R. Uranga
URANGA, URANGA & BIETER
714 North 5th Street
P.O. Box 1678
Boise, Idaho 83701
(208) 342-8931

Attorneys for the Board

BEFORE THE BOARD OF PROFESSIONAL DISCIPLINE OF

THE IDAHO STATE BOARD OF MEDICINE

| | |
|---|---|
| In the Matter of:<br><br>BRENT E. WOODFIELD, M.D.,<br>License No. M-4578,<br><br>Respondent. | Case No. 91-064<br><br>COMPLAINT |

Donald L. Deleski, Executive Director of the Idaho State Board of Medicine, on behalf of the Board of Professional Discipline, hereinafter referred to as the Board, complains and alleges as follows:

COUNT ONE

I

Respondent, Brent E. Woodfield, M.D., is the holder of an Idaho license to practice medicine and surgery, License No. M-4578, issued by the Idaho State Board of Medicine on November 6, 1982. Said license is subject to the provisions of Title 54, Chapter 18, Idaho Code, commonly referred to as the Medical Practice Act. The purpose of this disciplinary proceeding is to determine whether Respondent's Idaho license to practice medicine and surgery should be suspended, restricted or revoked.

II

On or around December 3, 1991, Respondent performed a conization of the cervix of Patient S.H.and D&C. There were no indications for either the D&C or the conization and Respondent failed to do appropriate workup prior to surgery.

III

The acts and practices of Respondent, as alleged in paragraph II above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT TWO

IV

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

V

On or around December 16, 1991, Respondent performed a laparoscopy on Patient S.R. During the procedure, Respondent improperly inserted the knife too deeply and while inspecting the pelvis, Respondent was incorrectly considering doing a laparotomy to biopsy a bony mass that turned out merely to be the sacral promontory.

VI

The acts and practices of Respondent, as alleged in paragraph V above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in

the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT THREE

VII

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

VIII

On or around January 31, 1992, Respondent performed an exploratory laparotomy and ovarian wedge resection on Patient E.M. Respondent performed surgery which was not indicated and Respondent should have managed the patient medically prior to performing surgery.

IX

The acts and practices of Respondent, as alleged in paragraph VIII above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT FOUR

X

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XI

On or around January 10, 1992, Respondent treated Patient L.K. for post-partum hemorrhaging. Prior to performing surgery, Respondent improperly failed to check the coagulation factors and platelets, improperly failed to treat the patient with fresh frozen

plasma and relegated most of the decision-making intraoperatively and during the surgery to the assisting surgeon regarding infusions and transfusions, surgical management, antibiotics and insertion of a drain tube.

XII

The acts and practices of Respondent, as alleged in paragraph XI above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT FIVE

XIII

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XIV

On or around January 17, 1992, Respondent treated Patient T.S. for chronic pelvic pain and diagnostic laparoscopy. During the procedure, Respondent improperly inserted the umbilical trochar without providing finger protection to protect the depth of the insertion. During the procedure, the patient was found to have an appendix which was adherent to the side wall of the pelvis and Respondent was not able to correctly decide that the appendix should be removed.

XV

The acts and practices of Respondent, as alleged in paragraph XIV above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the

standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT SIX

XVI

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XVII

On or around December 7, 1991, Respondent treated Patient C.B. with a hysterectomy for a necrotic mass protruding from the cervix. Respondent improperly handled the treatment of this patient by failing to obtain biopsies of the necrotic mass. In addition, Respondent's surgical technique was awkward and definitely poor and Respondent was unable to adequately perform the surgery without the assistance of the surgical assistant to guide him through the procedure and the antibiotic course to follow after surgery.

XVIII

The acts and practices of Respondent, as alleged in paragraph XVII above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT SEVEN

XIX

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XX

On or around December, 1991, Respondent performed a laparoscopy on Patient J.P. for chronic pelvic pain. During the procedure, Respondent had difficulty inserting the umbilical trochar and handling the camera and was unable to effectively use the laparoscopy approach to break adhesions and perform adhesiolysis using an electrocautery probe.

XXI

The acts and practices of Respondent, as alleged in paragraph XX above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT EIGHT

XXII

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XXIII

On or around December 7, 1991, Respondent treated Patient B.L. for a probable tubal pregnancy. During the course of the laparoscopy, Respondent was unable to manage the patient using the laparoscopic approach and the assistant surgeon was required to take over and perform the laparoscopic evacuation of the tubal pregnancy and adhesiolysis.

XXIV

The acts and practices of Respondent, as alleged in paragraph XXIII above, constitute violations of the Idaho Medical Practice

Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT NINE

XXV

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XXVI

On or around January 31, 1992, Respondent treated Patient W.U. for an ovarian cyst. During the laparotomy, Respondent provided substandard care in the following respects:

1. The procedure was unnecessary in view of the fact that this patient had had a prior evaluation one year earlier.

2. The use of a laparotomy was inappropriate since a laparoscopy would have been a better approach and less traumatic.

3. Respondent's surgical technique was poor with an unnecessarily large skin incision and an unnecessarily small facial opening and involved traumatic management of the tissue and resulted in unnecessary blood loss.

XXVII

The acts and practices of Respondent, as alleged in paragraph XXVI above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT TEN

XXVIII

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XXIX

Beginning in February, 1992, Respondent treated Patient J.M. Thereafter, Respondent saw Patient J.M. on various occasions, both in and out of his office. During various of those visits, Respondent improperly provided medications to the patient and engaged in improper sexual conduct with the patient.

XXX

The acts and practices of Respondent, as alleged in paragraph XXIX above, constitute violations of the Idaho Medical Practice Act in that:

(a) Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7); and

(b) Respondent's conduct results in an abuse or exploitation of a patient arising out of the trust and confidence placed in the physician by the patient, in violation of Idaho Code §54-1814(22).

COUNT ELEVEN

XXXI

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XXXII

On or around June, 1992, Respondent sent Patient D.B. to the proprietor of a sheep experiment station to have a human sperm

count check because Respondent did not trust the hospital lab results from another test.

XXXIII

The acts and practices of Respondent, as alleged in paragraph VIII above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT TWELVE

XXXIV

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XXXV

On or around July 15, 1992, Respondent evaluated Patient J.P. at his office. During that visit, Respondent performed a two and one-half hour long transvaginal ultrasound which was unnecessary and improperly performed and incorrectly advised her that she needed immediate surgery. In addition, on or around July 17, 1992, Respondent inappropriately performed a laparotomy on Patient J.P. when the patient should have been placed on birth control pills before being handled surgically.

XXXVI

The acts and practices of Respondent, as alleged in paragraph XXXV above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in

the same or similar communities, in violation of Idaho Code §54-1814(7).

PRAYER FOR RELIEF

WHEREFORE, Complainant prays that the Board:

1. Appoint a hearing officer and conduct a hearing upon the matters set forth herein;

2. Suspend, revoke or take such action with regard to Respondent's license as may be deemed just by the Board; and

3. Award the Board its costs and attorney's fees incurred in these matters.

DATED This 9th day of November, 1992.

BOARD OF PROFESSIONAL DISCIPLINE

DONALD L. DELESKI
Executive Director

STATE MEDICAL BOARD OF OHIO

May 12, 1995

Brent E. Woodfield, M.D.
8 Joshua's Way
Chatham, MA 02633

Dear Doctor Woodfield:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of R. Gregory Porter, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on May 10, 1995, including a Motion 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 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 741 124 582
RETURN RECEIPT REQUESTED

cc: Kevin P.Byers, Esq.
CERTIFIED MAIL RECEIPT No. P 741 124 583
RETURN RECEIPT REQUESTED

Mailed 5-12-95

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 R. Gregory Porter, Attorney Hearing Examiner, State Medical Board; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on May 10, 1995, including a Motion 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 Brent E. Woodfield, 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.

(SEAL)

Thomas E. Gretter, M.D.
Secretary

5/12/95
Date

STATE MEDICAL BOARD OF OHIO

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF *

*

BRENT E. WOODFIELD, M.D. *

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on the 10th day of May, 1995.

Upon the Report and Recommendation of R. Gregory Porter, 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.

It is hereby ORDERED that the Matter of Brent E. Woodfield, M.D., be REMANDED to the Hearing Examiner for further consideration following the outcome of the Idaho Board's appeal, or following remand and subsequent action by the Idaho Board.

Thomas E. Gretter, M.D.
Secretary

(SEAL)

5/12/95
Date

# REPORT AND RECOMMENDATION
# IN THE MATTER OF BRENT E. WOODFIELD, M.D.

The Matter of Brent E. Woodfield, M.D., came on for hearing before me, R. Gregory Porter, Esq., Hearing Examiner for the State Medical Board of Ohio, on November 15, 1994.

## INTRODUCTION

I. Basis for Hearing

A. By letter dated March 9, 1994 (State's Exhibit 1), the State Medical Board notified Brent E. Woodfield, M.D., that it proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio, based on the revocation of his Idaho license on or about July 16, 1993, and the facts upon which that revocation was based. The Board alleged that such acts, conduct, and/or omissions, individually and/or collectively, constituted: "'the limitation, revocation or suspension by another state of a license or certificate to practice issued by the proper licensing authority of that state, the refusal to license, register, or reinstate an applicant by that authority, or the imposition of probation by that authority for an action that would also have been a violation of this chapter, except for nonpayment of fees,' as that clause is used in Section 4731.22(B)(22), Ohio Revised Code, to wit: Sections 4731.22(B)(5), (B)(6)(a), and (B)(18), Ohio Revised Code to wit: Principals I, II, and VII of the American Medical Association Principles of Medical Ethics."

Dr. Woodfield was advised of his right to request a hearing in this Matter.

B. By letter received by the Board on April 8, 1994 (State's Exhibit 2), Kevin P. Byers, Esq., requested a hearing on behalf of Dr. Woodfield.

II. Appearances

A. On behalf of the State of Ohio: Lee I. Fisher, Attorney General, by Ava W. Serrano, Assistant Attorney General.

B. On behalf of Respondent: Kevin P. Byers, Esq.

## EVIDENCE EXAMINED

I. Testimony Heard

No testimony was presented

II. Exhibits Examined

In addition to State's Exhibits 1 and 2, noted above, the following exhibits were identified and admitted into evidence in this Matter:

A. Presented by the State:

1. State's Exhibit 3: April 12, 1994 letter to Brent E. Woodfield, M.D., from the Board, advising that a hearing initially set for April 22, 1994 was postponed pursuant to Section 119.09, Ohio Revised Code.

2. State's Exhibit 4: April 25, 1994 letter to Dr. Woodfield from the Board scheduling the hearing for August 18, 1994.

3. State's Exhibit 5: Respondent's August 12, 1994 Motion for Continuance. (5 pp.)

4. State's Exhibit 6: August 15, 1994 Entry denying the Respondent's Motion for Continuance, but rescheduling the hearing to November 15, 1994 for administrative reasons. (2 pp.)

5. State's Exhibit 7: Copy of the June 11, 1993 Disciplinary Findings of the Hearing Officer for the Board of Professional Discipline of the Idaho State Board of Medicine, in the Matter of Brent E. Woodfield, M.D. (30 pp.)

6. State's Exhibit 8: Certified copy of the Findings of Fact, Conclusions of Law and Final Order of the Board of Professional Discipline of the Idaho State Board of Medicine, in the Matter of Brent E. Woodfield, M.D., and December 28, 1993 Certification. (17 pp.)

B. Presented by the Respondent

1. Respondent's Exhibit A: Memorandum Decision of the Fourth Judicial District Court, Ada County, Idaho, filed on May 5, 1994, captioned *Brent E. Woodfield, M.D. vs. Idaho State Board of Medicine.* (31 pp.)

2. Respondent's Exhibit B: June 30, 1994 letter from Jean R. Uranga, Esq., to Joseph D. McCollum Jr., Esq., regarding Dr. Woodfield's Idaho license.

3. Respondent's Exhibit C: Copy of Dr. Woodfield's DEA Registration Certificate, issued September 27, 1994. which will expire on May 31, 1997.

4. Respondent's Exhibit D: August 11, 1994 letter from Attorney McCollum to Attorney Byers, regarding the status of Dr. Woodfield's Idaho license. (2 pp.)

5. Respondent's Exhibit E: August 15, 1994 letter from Dr. Woodfield to the Hearing Examiner, regarding the necessity for hearing.

6. Respondent's Exhibit F: November 7, 1994 Notice of Court Assignment for the Idaho Court of Appeals, indicating that Attorney Uranga requested oral argument before the court.

III. Post-Hearing Exhibits

On the Hearing Examiner's own motion, the following additional exhibit is admitted to the record:

Board Exhibit A: August 22, 1994 letter from the Hearing Examiner to the parties' representatives, enclosing Dr. Woodfield's August 15, 1994 letter; a duplicate of Respondent's Exhibit E is attached. (2 pp.)

## SUMMARY OF THE EVIDENCE

All transcripts of testimony and exhibits, whether or not specifically referred to hereinafter, were thoroughly reviewed and considered by the Hearing Examiner prior to his findings and recommendations in this Matter.

1. On or about November 9, 1992, the Board of Professional Discipline of the Idaho State Board of Medicine (Idaho Board) issued a Complaint against Brent E. Woodfield, M.D. The complaint alleged 12 counts of misconduct. Most of these counts alleged minimal standards problems. Count Ten also alleged an ethical violation arising from sexual improprieties between Dr. Woodfield and a patient. The minimal standards allegations related primarily to Dr. Woodfield's diagnostic and surgical skills in gynecology. (State's Exhibit 8, pp. 8-17) Count 3 of the Complaint was withdrawn by the Idaho Board during the hearing. (State's Exhibit 7, p. 9)

2. For eighteen months prior to setting up practice in Rexburg, Idaho, Dr. Woodfield had not been actively practicing medicine. His employer in Rexburg, Madison Memorial Hospital, was aware that he had been away from practice, and established a surgical proctoring program. (State's Exhibit 7, pp. 3-4) Whether that proctoring program was intended to simply observe and assess Dr. Woodfield's surgical skills, or whether it was also to provide some instruction to Dr. Woodfield, is unclear from the record. The Hearing Officer for the Idaho Board (IHO) found that it had a teaching aspect. (State's Exhibit 7, p. 4) The Idaho Board disagreed, finding that "[t]he proctors were not intended to be teachers, but rather were merely to observe and critique

Dr. Woodfield's skills and his ability to practice with reasonable skill and safety to patients." (State's Exhibit 8, p. 2) In vacating the decision and order of the Idaho Board, the Idaho District Court stated that the proctors acted as mentors and teachers, as well as observers. (Respondent's Exhibit A, pp. 22-24)

3. The remaining eleven counts against Dr. Woodfield were heard in February 1993. The IHO issued his Disciplinary Findings on June 11, 1993. He found that Dr. Woodfield had violated three of those counts, specifically, minimal standards as alleged in Counts One and Nine, and the ethical violation alleged in Count Ten. (State's Exhibit 7)

   Regarding Count One, the IHO found that Dr. Woodfield performed a conization of the cervix and a D&C on Patient S.H. based on an improper diagnosis. Dr. Woodfield diagnosed cervical dysplasia on the results of a single PAP test. "Rather than invasive surgical approach, the accepted standard of care indicates an additional PAP smear." Dr. Woodfield "failed to meet the standards of his profession when reaching the conclusion that surgical examination was needed." (State's Exhibit 7, pp. 6-7)

   Regarding Count Nine, the IHO found that Patient W.U. should have been managed medically rather than surgically for a diagnosis of ovarian cysts. Dr. Woodfield failed to diagnose the cysts as simple rather than complex; this distinction should have been readily apparent. (State's Exhibit 7, pp. 22-24)

   Regarding Count Ten, the IHO found that Dr. Woodfield engaged in improper sexual contact with Patient J.M. The IHO further found that Patient J.M. was emotionally unstable at the time the contact occurred. (State's Exhibit 7, pp. 24-26)

   The IHO recommended that Dr. Woodfield be required to seek further skill training, and that "[s]urgical suspension or limitation upon Respondent's license would seem to be in order until further training or retraining has been obtained." (State's Exhibit 7, p. 29) He also recommended that Dr. Woodfield be reprimanded and required to attend counseling, along with possible license suspension, for the ethical violation. (State's Exhibit 7, p. 29)

4. On July 16, 1993, the Idaho Board issued its Findings of Fact, Conclusions of Law and Final Order. The Board took issue with the Disciplinary Findings of the IHO. In addition to the violations found by the IHO, the Idaho Board found that Dr. Woodfield's conduct fell below the community standard of care as alleged in Counts Two, Four, Six, Seven, Eight, and Twelve. (State's Exhibit 8) The Idaho Board also found that Dr. Woodfield's treatment of the patient in Count Ten "failed to meet the community standard of care," in addition to the ethical violation found by the IHO. (State's Exhibit 8, p. 6)

Regarding Count Two, the Idaho Board found that Dr. Woodfield inserted a scalpel too deeply, and failed to recognize the sacral promontory. His surgical skill was inadequate. (State's Exhibit 8, p. 3)

Regarding Count Four, the Idaho Board found that Dr. Woodfield failed to discuss goals and surgical options with the patient prior to surgery, and failed to insure that enough blood was available prior to surgery. The Idaho Board found that Dr. Woodfield was evasive in his trial testimony. It found that he did not understand coagulation studies. He misstated the amount of the patient's blood loss. (State's Exhibit 8, pp. 3-4)

Regarding Count Six, The Idaho Board found that Dr. Woodfield failed to perform an adequate pre-surgical workup on the patient. He performed a hysterectomy without performing a biopsy to rule out cervical carcinoma. He did not understand antibiotic therapy. "Dr. Woodfield's approach was awkward, indecisive and represented poor surgical technique." (State's Exhibit 8, pp. 4-5)

In discussing Count Seven, the Idaho Board stated that Dr. Woodfield lied when he testified that he had not used indirect video laparoscopy. "His inability to use the laparoscopic approach [to lyse adhesions] fell below the community standard of care." (State's Exhibit 8, p. 5)

Regarding Count Eight, "Dr. Woodfield exercised poor judgment by putting the patient at risk and sending the patient home under the circumstances constituted grossly substandard care." (State's Exhibit 8, p. 5)

Regarding Count Twelve, the Idaho Board found "that Dr. Woodfield pressured and rushed the patient into having an unnecessary surgery before other options of treatment were tried. ... The Board finds and concludes that the unnecessary surgery and the length of the ultrasound violated the community standard of care with respect to this patient." (State's Exhibit 8, p. 6)

On the basis of its findings and conclusions, the Idaho Board revoked the license of Dr. Woodfield to practice medicine and surgery in that state. (State's Exhibit 8, p. 7)

5. Following the Idaho Board's revocation of his license, Dr. Woodfield appealed. On May 5, 1994, the Ada County District Court filed a lengthy Memorandum Decision. The Court vacated the decision and order of the Idaho Board, and remanded the case to the Board for further proceedings. (Respondent's Exhibit A) The Court determined that the Idaho Board had "erred in several significant aspects." (Respondent's Exhibit A, pp. 2-3) These errors, as articulated by the court, center on the Idaho Board's relying on inadmissible evidence, and on its failure to state the bases from the record for its findings. (Respondent's Exhibit A, pp. 3-8) The Court was also concerned that the Board had reached certain conclusions regarding the standard of care without offering

any explanation. The Board had apparently defined a standard of care that was at odds with the standards explained by the witnesses. The Court thought that the Idaho Board was sanctioning Dr. Woodfield "for the violation of a standard which it is creating or defining for the first time within the context of the present disciplinary proceedings ... ." (Respondent's Exhibit A, pp. 24-28)

The Court remanded the matter to the Idaho Board for further proceedings on the following issues:

a. Dr. Woodfield's truthfulness concerning his previous exposure to video laparoscopy. (Respondent's Exhibit A, pp. 29-30)

b. "[A] reexamination of the record and the preparation of additional findings and conclusions on all of those counts where the Board has departed from the hearing officer's recommendations." (Respondent's Exhibit A, pp. 30-31)

c. The Court did not disturb the findings in Counts One and Nine, or the ethical violation found in Count Ten. Nevertheless, the Court remanded the matter to the Board for further proceedings to reconsider the sanction to be imposed. (Respondent's Exhibit A, p. 29)

6. On or about June 7, 1994, the Idaho Board Appealed the District Court's decision. (Respondent's Exhibit D) Oral argument before the Idaho Court of Appeals was requested by Dr. Woodfield's Idaho counsel on November 8, 1994. (Respondent's Exhibit F) The Idaho Board renewed and extended Dr. Woodfield's license pending the outcome of the appeal. (Respondent's Exhibits B and D) Dr. Woodfield currently holds active licensure in Idaho (Respondent's Exhibit E), although he currently resides in Chatham, Massachusetts. (Stmt. of Attorney Byers, Tr. 4).

## FINDINGS OF FACT

1. On or about July 16, 1993, the Board of Professional Discipline, State of Idaho Board of Medicine, revoked the license of Brent E. Woodfield, M.D., to practice medicine and surgery in that state. The Idaho Board found that Dr. Woodfield failed to meet the minimum standard of care in his treatment of nine patients, engaged in sexual contact with one patient, and lied in testimony to the Idaho Board.

By Memorandum Decision filed on May 5, 1994, the Ada County (Idaho) District Court vacated the decision and order of the Idaho Board and remanded the matter to the Board for further proceedings. The Idaho Board has appealed the District Court's decision.

## CONCLUSIONS OF LAW

1. As set forth in Finding of Fact #1, above, the evidence is currently insufficient to support a conclusion that the acts, conduct, and/or omissions of Brent E. Woodfield, M.D., individually and/or collectively, constitute "'the limitation, revocation or suspension by another state of a license or certificate to practice issued by the proper licensing authority of that state, the refusal to license, register, or reinstate an applicant by that authority, or the imposition of probation by that authority for an action that would also have been a violation of this chapter, except for nonpayment of fees,' as that clause is used in Section 4731.22(B)(22), Ohio Revised Code, to wit: Sections 4731.22(B)(5), (B)(6)(a), and (B)(18), Ohio Revised Code to wit: Principals I, II, and VII of the American Medical Association Principles of Medical Ethics."

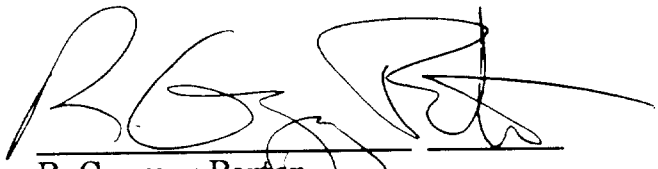
   The Board was substantially justified in bringing this action, inasmuch as the Idaho Board action was vacated by the Idaho District Court *after* this Board issued its notice letter.

## LEGAL ISSUES

Before this Matter could be considered by this Board, the Idaho disciplinary action against Dr. Woodfield's license was vacated on appeal. The Idaho Board has appealed that ruling, and the issue is pending in the Idaho Court of Appeals. No decision is yet available. At the present time, there is no "limitation, revocation or suspension by another state of a license or certificate to practice issued by the proper licensing authority of that state, ... or the imposition of probation by that authority ..." upon which this Board may now act. (R.C. §4731.22(B)(22)) Because of the serious nature of the allegations under appeal in Idaho, this Board may wish to remand this Matter to the Hearing Examiner for further consideration. The Hearing Examiner will hold the matter open until the Idaho Board's decision is affirmed, or, if it is not affirmed, until the Idaho Board has issued a new decision following remand.

## PROPOSED ORDER

It is hereby ORDERED that the Matter of Brent E. Woodfield, M.D., be REMANDED to the Hearing Examiner for further consideration following the outcome of the Idaho Board's appeal, or following remand and subsequent action by the Idaho Board.



R. Gregory Porter
Attorney Hearing Examiner

EXCERPT FROM THE DRAFT MINUTES OF MAY 10, 1995

REPORTS AND RECOMMENDATIONS

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Dr. Garg asked whether each member of the Board had received, read, and considered the hearing record, the proposed findings, conclusions, and orders, and any objections filed in the matters of: Michael Gerard Baggot, M.D.; Clyde D. Brown, M.D.; Michael E. Coutts, M.T.; Vincent Tripi, D.O.; John Sy Uy, M.D.; and Brent Woodfield, M.D. A roll call was taken:

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|---|---|---|
| ROLL CALL: | Mr. Albert | - aye |
| | Dr. Bhati | - aye |
| | Dr. Stienecker | - aye |
| | Dr. Gretter | - aye |
| | Dr. Egner | - aye |
| | Dr. Agresta | - aye |
| | Dr. Buchan | - aye |
| | Ms. Noble | - aye |
| | Mr. Sinnott | - aye |
| | Dr. Heidt | - aye |
| | Dr. Steinbergh | - aye |
| | Dr. Garg | - aye |

Mr. Sinnott noted that he did not read the hearing record in the matter of Clyde D. Brown, M.D.

Dr. Garg 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:

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|---|---|---|
| ROLL CALL: | Mr. Albert | - aye |
| | Dr. Bhati | - aye |
| | Dr. Stienecker | - aye |
| | Dr. Gretter | - aye |
| | Dr. Egner | - aye |
| | Dr. Agresta | - aye |
| | Dr. Buchan | - aye |
| | Ms. Noble | - aye |
| | Mr. Sinnott | - aye |

| | |
|---|---|
| Dr. Heidt | - aye |
| Dr. Steinbergh | - aye |
| Dr. Garg | - aye |

In accordance with the provision in Section 4731.22(C)(1), 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 this matter. Dr. Gretter did not serve as Secretary in any of these cases.

.....

Mr. Albert left the meeting at this time.

.....

REPORT AND RECOMMENDATION IN THE MATTER OF BRENT E. WOODFIELD, M.D.

.....

**DR. STIENECKER MOVED TO APPROVE AND CONFIRM MR. PORTER'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF BRENT E. WOODFIELD, M.D. DR. STEINBERGH SECONDED THE MOTION.**

.....

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

VOTE:

| | |
|---|---|
| Dr. Bhati | - abstain |
| Dr. Stienecker | - aye |
| Dr. Gretter | - aye |
| Dr. Egner | - aye |
| Dr. Agresta | - aye |
| Dr. Buchan | - aye |
| Ms. Noble | - aye |
| Mr. Sinnott | - aye |
| Dr. Heidt | - aye |
| Dr. Steinbergh | - aye |

The motion carried.

# STATE MEDICAL BOARD OF OHIO

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


March 9, 1994

Brent E. Woodfield, M.D.
79 W. Sunset Circle
Rexburg, ID 83440

Dear Doctor Woodfield:

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) On or about July 16, 1993, the Board of Professional Discipline, State of Idaho Board of Medicine, revoked your license to practice medicine and surgery. A copy of the Findings of Fact, Conclusions of Law and Final Order is attached hereto and incorporated fully herein.

The Idaho Board found that you failed to meet the minimum standard of care for nine patients, engaged in sexual improprieties with one patient and lied in testimony to the Board.

Your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "the limitation, revocation or suspension by another state of a license or certificate to practice issued by the proper licensing authority of that state, the refusal to license, register, or reinstate an applicant by that authority, or the imposition of probation by that authority, for an action that would also have been a violation of this chapter, except for nonpayment of fees," as that clause is used in Section 4731.22(B)(22), Ohio Revised Code, to wit: Sections 4731.22(B)(5), (B)(6)(a), and (B)(18), Ohio Revised Code to wit: Principles I, II, IV, and VII of the American Medical Association Principles of Medical Ethics.

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.

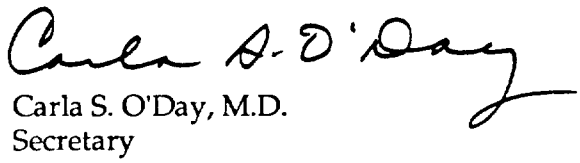
Mailed 3/10/94

March 9, 1994

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,



Carla S. O'Day, M.D.
Secretary

CSO:jmb

Enclosures:

CERTIFIED MAIL #P 348 885 076
RETURN RECEIPT REQUESTED