

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

FILED
COMMON PLEAS COURT
FRANKLIN CO. OHIO
2004 SEP 16 PM 2:09
CLERK OF COURTS - C-141

DAVID VINSON, JR., M.D.,

Appellant,

v.

STATE MEDICAL BOARD OF OHIO

Appellee.

Case No. 03CVF-06-7141

JUDGE REECE

TERMINATION NO. 10

BY: al 9-15-04

JUDGMENT ENTRY AFFIRMING THE STATE MEDICAL BOARD'S
JUNE 12, 2003 ORDER PERMANENTLY REVOKING
APPELLANT'S LICENSE TO PRACTICE MEDICINE AND SURGERY IN
OHIO

This case is before the Court upon the appeal, pursuant to R.C. 119.12, of the June 12, 2003 Order of the State Medical Board of Ohio which permanently revoked Appellant, David Vinson, Jr., M.D.'s license to practice medicine and surgery in Ohio. For the reasons stated in the decision of this Court rendered on August 31, 2004, and filed on September 1, 2004, which decision is incorporated by reference as if fully rewritten herein, it is hereby.

ORDERED, ADJUDGED AND DECREED that judgment is entered in favor of Appellee, State Medical Board of Ohio, and the June 12, 2003 Order of the State Medical Board in the matter of David Vinson Jr., M.D., is hereby AFFIRMED. Costs to Appellant.

IT IS SO ORDERED.

Date

Judge Guy L. Reece II

JUDGE GUY L. REECE

STATE MEDICAL BOARD
OF OHIO
2004 SEP 16 P 3:16

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

DAVID VINSON, JR., M.D.,] CASE NO. 03CVH06-7141
Appellant,] JUDGE REECE
vs.]
STATE MEDICAL BOARD OF OHIO,] HEALTH & HUMAN
Appellee.] SEP 07 2004

FILED
FRANKLIN COUNTY, OHIO
2004 SEP -1 PH 3:03
CLERK OF COURTS

SERVICES SECTION

**DECISION ON MERITS OF REVISED CODE 119.12 ADMINISTRATIVE
APPEAL, AFFIRMING ORDER ISSUED JUNE 12, 2003 BY STATE
MEDICAL BOARD OF OHIO, PERMANENTLY REVOKING APPELLANT'S
LICENSE TO PRACTICE MEDICINE AND SURGERY IN OHIO**

Rendered this 31st day of August 2004.

REECE, J.

This case is a Revised Code 119.12 administrative appeal, by David Vinson, Jr., M.D. ("Appellant"), from an Order that the State Medical Board of Ohio ("Medical Board" or "Board") issued on June 12, 2003, permanently revoking Appellant's license to practice medicine and surgery in Ohio.

I. PROCEDURAL HISTORY

By letter dated May 8, 2002, the Medical Board notified Appellant that it proposed to take disciplinary action against his license to practice medicine and surgery in Ohio. The Board's action was based upon allegations that, from 1998 to 2001, in Fulton and Paulding Counties, Appellant committed technical and judgmental errors during his care and treatment of ten surgical patients. The Board alleged that Appellant's conduct towards those patients constituted "[a] departure from, or the failure to conform to, minimal standards of care of similar

practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in R.C. 4731.22(B)(6).

Appellant requested and was granted an administrative hearing on the Board's charges. A Hearing Examiner conducted the hearing on February 4, 5, 6, and March 12, 2003.

In a Report and Recommendation issued on May 16, 2003, the Hearing Examiner recommended that the Board permanently revoke Appellant's medical license. The Hearing Examiner found that Appellant had committed technical and/or judgmental errors in his care and treatment of Patients 1 through 6, 9, and 10. The Hearing Examiner did not find that Appellant had committed technical or judgmental errors with respect to his care and treatment of Patients 7 and 8. The Hearing Examiner concluded that Appellant's conduct towards Patients 1 through 6, 9, and 10 constituted "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in R.C. 4731.22(B)(6). Appellant filed objections to the Hearing Examiner's Report and Recommendation.

The Medical Board considered this matter at its June 11, 2003 meeting. At the conclusion of the Board's discussion, the Board voted, over Appellant's objections, to adopt the Hearing Examiner's Report and Recommendation and permanently revoke Appellant's medical license. On June 12, 2003, the Board mailed a copy of its Order to Appellant.

This appeal followed.

II. FACTS OF THE CASE

At the Medical Board hearing, Edwin Christopher Ellison, M.D., testified as an expert witness for the State. Dr. Ellison is a 1976 graduate of the Medical College of Wisconsin, has been licensed to practice medicine and surgery in Ohio since 1976, and completed a residency in general surgery at The Ohio State University in 1983. From 1978 to 1980, as a Surgical Gastroenterology Research Fellow, Dr. Ellison performed two years of research in gastroenterology, focusing on pancreatitis-related illnesses and tumors of the pancreas. Dr. Ellison has been board-certified by the American Board of Surgery since 1984 and serves as an examiner for the board.

Dr. Ellison is the Chair of the Department of Surgery at The Ohio State University, where he serves as the Vice Dean of Clinical Affairs and as the Associate Vice President of Clinical Affairs of The Ohio State University Health System. Dr. Ellison, who has been widely published, serves on the editorial boards of *Current Surgery* and *The American Journal of Surgery*, and is an invited reviewer for *Annals of Surgery*, *Archives of Surgery*, *Journal of the American College of Surgeons*, and *Journal of Obstetrics and Gynecology*. At the Medical Board hearing, Dr. Ellison was qualified, without objection, to testify as an expert witness regarding Appellant's care and treatment of Patients 1 through 10.

At the Medical Board hearing, Appellant testified on his own behalf and did not present the testimony of an expert witness. Appellant is a 1986 graduate of Case Western Reserve University School of Medicine, completed a general surgical internship at University Hospitals of Cleveland in 1987, completed an additional surgical residency at Meridia Huron Hospital, in Cleveland, in 1992, and thereafter

completed a critical care fellowship in surgical intensive care at Cedars-Sinai Medical Center in Los Angeles.

In 1993, Appellant moved to South Carolina, where he worked in two private general surgery practices. In 1997 or 1998, Appellant relocated to Toledo, where he completed an additional year of general surgical training at the Medical College of Ohio. From approximately July 1999 through December 2000, Appellant engaged in a private general surgery practice in Fulton County. From approximately July 2000 through December 2000, Appellant also engaged in a separate private general surgery practice in Paulding County.

From April 2001 through November 2001, after leaving Paulding County, Appellant worked as a hospitalist but did not perform surgery. From November 2001 through April 2002, Appellant worked for Medical Doctors Associates, an organization that provides visiting physician services in Columbus. For several months thereafter, Appellant was unemployed and making applications to different Master's degree programs. From August 2002 until the Medical Board hearing in February and March 2003, Appellant attended the University of Illinois at Chicago, obtaining a Master's degree in Public Health. In August 2002, Appellant began an occupational medicine residency program at the University of Illinois at Chicago, but was discharged from the program in December 2002, because he had not yet obtained a license to practice medicine and surgery in Illinois, due to the action pending before the State Medical Board of Ohio.

At the Medical Board hearing, the State's expert witness, Dr. Ellison, testified in detail regarding Appellant's care and treatment of Patients 1 through 10. Dr. Ellison concluded, in each of the ten cases, that Appellant fell below the minimal

standards of care of similar practitioners under the same or similar circumstances, in that Appellant committed technical and judgmental errors arising out of the surgical procedures he performed on each of the ten patients.

For example, Patient 1 was a 65-year-old, morbidly obese man who presented to the hospital with severe abdominal pain and a large hiatal hernia. (Tr. 23-25, 31.) Appellant performed surgery on the patient to repair the hiatal hernia. (Tr. 27, 41-42.)

Five days later, Appellant performed a second surgery to repair the closure of the original abdominal incision, which had come apart. (Tr. 27-28, 43.) In the course of the second surgery, Appellant used an instrument known as a visceral retractor, also called a "fish" retractor; a visceral retractor is approximately twelve inches long and nine inches wide, oval-shaped, flat, and made of soft plastic. (Tr. 34, 36, 214-215.) A visceral retractor has a string attached to it, which remains outside the patient's body during surgery. (Tr. 35, 214-215.) When Appellant closed the surgical incision, he forgot to remove the retractor from the patient's abdomen. (Tr. 31-32, 34, 411-412.) The next day, Appellant was required to perform a third surgery on the patient to remove the retractor. (Tr. 40, 215, 411.)

Dr. Ellison testified that Appellant's conduct during the second surgery, in failing to adequately explore Patient 1's abdomen before closing, and in failing to identify and remove the retractor after the completion of the surgery, fell below the standards of care of similar practitioners under the same or similar circumstances. (Tr. 212-213, 215, 220.) Dr. Ellison testified that a visceral retractor is a large instrument, easily visualized, readily palpated with a finger, and should have been observed and removed by Appellant. (Tr. 217.) Dr. Ellison

testified that it was the responsibility of Appellant, as the surgeon, to explore the patient's abdomen, to make certain there were no foreign bodies remaining, and to remove any foreign bodies that remained. (Tr. 215-216, 218-220, 320.) Dr. Ellison testified that a surgeon cannot rely on instrument counts or on nursing personnel to inform the surgeon that an object remains in the patient's abdomen. (Tr. 215, 319-320.) Dr. Ellison testified that Appellant committed a technical error by leaving the retractor in the patient. (Tr. 220.)

In Appellant's testimony, he conceded that, when a foreign body is left in a patient, the primary responsibility for removing the object rests with the person who left the object in the patient, in this case Appellant. (Tr. 38, 44.) Appellant testified that he accepts responsibility for leaving the retractor in Patient 1, but he also asserted that the nursing staff should bear some of the responsibility, because he contends that they did not provide him with an accurate instrument count. (Tr. 38-39.)

Patient 2 was a 35-year-old woman who was admitted to the hospital, having presented to the emergency room one week earlier with heavy vaginal bleeding. (Tr. 45-46.) An earlier ultrasound revealed a large fibroid inside the patient's uterus. (Tr. 46, 51, 499-501.) When the patient was offered a choice between medication and a hysterectomy, she elected to have a hysterectomy. (Tr. 46.)

Appellant performed a total abdominal hysterectomy on the patient. (Tr. 47, 424.) During the surgery, Appellant injured both of the patient's ureters, which are the tubes that run from the kidneys to the bladder. (Tr. 47, 413.) Specifically, during Appellant's dissection of the patient's cervix, he accidentally tied off both of the ureters. (Tr. 47-48, 50.) Appellant thought that he was tying off blood vessels,

but he actually tied off the ureters instead. (Tr. 50.) Appellant also failed to recognize that he had committed the injuries during the course of the operation. (Tr. 222.)

Postoperatively, the patient developed the complication that she was making urine but the urine could not travel into her bladder to empty into the catheter bag. (Tr. 59.) The nurses caring for the patient discovered the problem, and the patient was transferred to another hospital the same day, for a urologist to repair the damage that Appellant had caused. (Tr. 62, 67, 420-424.)

Dr. Ellison testified that Appellant's conduct, in tying off Patient 2's ureters and in failing to recognize the injuries he had caused during the course of the operation, fell below the standards of care of similar practitioners under the same or similar circumstances. (Tr. 221-222, 230.) Dr. Ellison testified that, even with the large fibroid in the lower part of the uterus, the injuries were avoidable. (Tr. 227.) Dr. Ellison testified that Appellant committed a technical error, causing injuries that should have been avoided and, if not avoided, at a minimum recognized intraoperatively. (Tr. 230.)

In Appellant's testimony, he conceded that he was completely at fault for tying off Patient 2's ureters. (Tr. 56.) He testified, however, that he was fooled, by a prolapsed polyp, into dissecting distally farther than necessary because of the feel of the fibroid protruding into the cervical os. (Tr. 51-56.)

Patient 3 was a 37-year-old woman, referred to Appellant by the patient's oncologist, with a biopsy that tested positive for cancer in the left breast. (Tr. 69.) The patient had previously had a mastectomy of the right breast in 1990. (Tr. 69.)

Appellant performed a modified radical mastectomy of the patient's left breast, with axillary dissection, and inserted a Mediport catheter in the patient's left axillary vein, below the pectoralis muscle, to deliver chemotherapy. (Tr. 69-71, 74-75, 232.) Appellant placed the Mediport on the patient's left side, the same side as the mastectomy. (Tr. 71.) The catheter, however, was placed too deep to be accessed for the delivery of chemotherapy, and later had to be removed by another surgeon. (Tr. 75-76, 232, 235.)

Dr. Ellison testified that Appellant's conduct, in placing the Mediport on the same side of Patient 3's body as the mastectomy, fell below the standards of care of similar practitioners under the same or similar circumstances. (Tr. 230-231, 327, 392-393.) Dr. Ellison testified that it was inappropriate to put the Mediport into the mastectomy wound because a foreign body could increase the incidence of deep infection within a fresh surgical wound. (Tr. 232-234.) Dr. Ellison testified that Appellant's placement of the Mediport was also inappropriate because, immediately following the surgery, there would be swelling of the patient's left arm, and having a foreign body in the axillary vein, which is the main draining vein for the left arm, would exacerbate the left arm swelling and could potentially lead to post surgical thrombosis of the vein. (Tr. 234-237.) Dr. Ellison testified that Appellant increased the risk of infection by placing the Mediport on the same side of the patient's body as the mastectomy. (Tr. 237-238.) Dr. Ellison testified that Appellant committed a judgmental error by doing that and that his judgment fell below the standards of care. (Tr. 238-239, 333.)

Appellant testified that he placed the Mediport on the same side of the patient's body as the mastectomy for several reasons. (Tr. 71.) Appellant testified

that placing the Mediport on the non-operative side would have resulted in two separate incisions and two operative sites. (Tr. 71-72.) Appellant testified that, after a mastectomy, a patient is instructed not to allow use of the veins on the same side of the body as the mastectomy. (Tr. 72.) Appellant testified that, inasmuch as the patient had bilateral mastectomies, it had been "sort of a wash there as far as the side where to place the port." (Tr. 72.) Appellant testified that, because the patient had a previous implant on the right side, placing a foreign body there would have increased the risk of infection at the implant site. (Tr. 72-74.)

Patient 6 was an 86-year-old woman who was admitted to the hospital with a fecal impaction and increased difficulty voiding over the previous two or three days. (Tr. 122, 259, 449-450, 510-511.) There was evidence of renal insufficiency upon admission. (Tr. 259.) The patient's admitting physician, Robert W. Nyce, M.D., consulted Appellant because of the patient's continued problems with the fecal impaction. (Tr. 260, 538-539, 548, 550.) The patient had a condition known as mega colon, meaning that her sigmoid colon had lost its elasticity and could no longer move waste. (Tr. 125-126, 458.) The lack of elasticity in the mega colon caused the patient to be constipated. (Tr. 523.)

Appellant recommended that the patient have surgery. (Tr. 138.) Appellant removed the patient's sigmoid colon to relieve the fecal impaction, during the course of which he injured the patient's spleen and therefore had to remove it also. (Tr. 122-123, 130-131, 260-261.)

Postoperatively, the patient developed a subdural hematoma, or intracranial bleed, and had to be transferred to another hospital, in Toledo. (Tr. 143-144.) The patient died, having never recovered from the surgery. (Tr. 144, 261.) Appellant

performed the surgery without having obtained a cardiology consultation. (Tr. 135-137.)

Dr. Nyce, the admitting physician, testified that Patient 6 was admitted to the hospital primarily because she had cardiac failure with fecal impaction. (Tr. 537-538.) Dr. Nyce testified that the patient had intermittent episodes of atrial fibrillation, was anticoagulated with Coumadin, and while she was in the hospital she had irregular heart rhythm. (Tr. 538.) Dr. Nyce testified that, in order to manage the patient's fecal impaction, she needed either surgery or almost daily enemas. (Tr. 538, 555-556.)

Dr. Nyce testified that he suggested to the patient and to her nephew, who had power of attorney, that the patient have a cardiology work-up before any surgery. (Tr. 539-541, 548.) Dr. Nyce testified that, considering the patient's age and cardiac status, the surgery that Appellant was contemplating, removal of the sigmoid colon, was "certainly a very serious procedure." (Tr. 555.)

Dr. Ellison testified that Appellant's conduct, in failing to obtain a cardiology consultation, in removing the sigmoid colon at all, and in injuring Patient 6's spleen during the surgery, fell below the standards of care of similar practitioners under the same or similar circumstances. (Tr. 258-259, 266-267, 273, 277, 395.) Dr. Ellison testified that the surgery was contraindicated for the patient, that the patient was in no condition to undergo surgery of such magnitude, and that she should not have had the surgery at all. (Tr. 258-259, 261-262, 268, 275-276.) Dr. Ellison testified that the surgery was "clearly" the event that precipitated the subdural hematoma and led to the patient's death. (Tr. 261, 356, 368.) Dr. Ellison testified that this was a case of "very serious mistakes." (Tr. 265.)

Appellant testified that, in evaluating the risks and benefits of surgery for Patient 6, he considered the fact that she had benign disease, which is generally treated conservatively. (Tr. 127.) Appellant testified that he met with the patient and her only living relative, a nephew, that the patient and the nephew advised Appellant that she had been fighting constipation for many years, that she had been hospitalized previously because of it, and that her bowels moved only once or twice a month. (Tr. 127-129.) Therefore, Appellant concluded, it was "a matter of lifestyle." (Tr. 129.) Appellant advised the patient that Appellant "could go either way" and either perform the surgery or continue medical treatment. (Tr. 128-129.) Appellant testified that he decided to abide by whatever decision the patient and her nephew made, and that the patient was "eager for surgery." (Tr. 128-129)

Dr. Ellison testified in great detail regarding the remainder of Appellant's ten patients. Dr. Ellison testified that, in all ten cases, Appellant's conduct, in caring for and treating those patients, fell below the standards of care of similar practitioners under the same or similar circumstances.

In summarizing his opinions regarding Appellant's care and treatment of Patients 1 through 10, Dr. Ellison testified:

I think that taken as a collection of cases, I think that it indicates that Dr. Vinson's technical skill is below the standard level for a surgeon, and the judgmental requirements and care given to the patients is below the standard of care for all physicians.

*** These are serious cases in my opinion. Some of them they had okay outcomes but that doesn't justify the deviations from the standard of care. The one case in the elderly woman with constipation [Patient 6] in and of itself is so severe and egregious that it stands alone in my opinion in terms of breach of standard of care. As a collection of cases, I think that there is ample evidence that Dr. Vinson does not practice within the standards of the state of Ohio.

I think the general pattern that I saw was one where he just wanted to do too much. Overaggressive surgery, too much surgery, recommending operations that were not appropriate, not preparing the patient well for surgery. Case No. 6 was an obvious example of that, glaring example of that. I think that type of judgmental error is well below the standard of care.

I think that there certainly is a pattern of excessive surgery in my opinion. I'm not sure you can correct that pattern with education.

(Tr. 313-315, 402-403.)

Appellant testified that he has not practiced surgery since April 2001 and that he does not intend to practice surgery again, but that he intends to practice medicine again. (Tr. 495.) He testified as follows:

Q. *** Doctor, you heard yesterday Dr. Ellison describe you as an aggressive physician. Do you agree with that assessment, actually an aggressive surgeon?

A. Not to play on words, okay, because, for instance, assertive and aggressive, you know, tend to mean the same thing. People tend to use aggressive in a negative way and assertive in a positive way. When people come to me they are looking for help. And, you know, it is so easy to take the difficult cases and just have somebody else do them. And when you treat patients, you're not only treating the medical condition, but even with surgery, you're treating that patient's psyche. And to just send patients away, you know, I can't do it.

As long as you stay in the realm of what is acceptable care, even though there are people that agree with it, as long as there are people - - I'm sorry, even though there are people that disagree with it, as long as it's being taught somewhere, as long as it's being published and you can help that person, then I try to help that person.

So if that makes me assertive/aggressive, then I would have to agree with what Dr. Ellison said. And I know a lot of people who practice medicolegal surgery. Stay away from the tough cases, you won't get sued. You won't get called before boards and

stuff like that, but, you know, you won't help very many people either so.

Q. In your practice of surgery at both Fulton and Paulding Hospitals, did you strive to render the best possible care to your patients?

A. Yes, I did.

(Tr. 495-497.)

III. FINDINGS AND CONCLUSIONS OF THE MEDICAL BOARD

In the Hearing Examiner's 57-page Report and Recommendation, she reviewed the evidence in great detail and concluded that Appellant's conduct, in his care and treatment of Patients 1 through 6, 9, and 10, constituted "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in R.C. 4731.22(B)(6). The Hearing Examiner recommended that the Medical Board permanently revoke Appellant's medical license, stating as follows:

Overall, the record reveals that Dr. Vinson practiced aggressively and without due care. As noted by Dr. Ellison, Dr. Vinson does not practice within the standards of the State of Ohio. In fact, Dr. Vinson's care and treatment of Patient 6 alone was so egregious that it justifies severe Board action. Throughout the hearing and in his written closing arguments, Dr. Vinson repeatedly blamed other practitioners for his judgmental and technical errors. It is clear that Dr. Vinson fails to appreciate the magnitude of his errors and the enormous consequences his patients suffered.

It is significant that Dr. Vinson demonstrated such deficiencies in his technical skills despite extensive surgical training, including a residency, critical care fellowship, and an additional year of general surgical training at the Medical College of Ohio. Moreover, Dr. Vinson demonstrated such extremely poor judgment in his practice that Dr. Ellison concluded that Dr. Vinson's deficiencies cannot be corrected with reeducation. Accordingly, the Board has no alternative but to permanently revoke Dr. Vinson's certificate to practice medicine and surgery in this state.

When the Medical Board considered this matter at its June 11, 2003 meeting, the comments of the Board members included the following:

Dr. Kumar stated that he is a surgeon, and performs surgery close to the kinds described by Dr. Vinson. On one hand he can sort of agree that some of the things are judgment calls, but two or three things are very troubling to him. It appears that Dr. Vinson is a careless person when he is in the operating room. Dr. Kumar stated that he can't accept someone leaving in a fish retractor when he placed it there himself [Patient 1]. It's right there in your face. There's no issue of instrument count. ***

Dr. Kumar stated that, concerning the case involving the implantation of the port, the side doesn't matter [Patient 3]. What is very troubling is that Dr. Vinson implanted it deep into the pectoralis major muscle, making it inaccessible. That is basically simple carelessness. It's not an issue of choosing a side, it's that he's not paying attention to what he's doing.

Dr. Egner continued that the case to which she can best relate is, obviously, the hysterectomy [Patient 2]. Even today she cannot understand exactly what the problem was. If there was an eight centimeter fibroid that was up in the uterus and during the course of that case pedunculated and went through the cervix, into the vagina, that is a tennis ball moving from the uterus into the vagina. You'd have to notice a change in the volume of the uterus. You would feel that there is a mass in the vagina. There are other things to do for that in order to take that out that would have probably avoided this situation. ***

Dr. Steinbergh stated that the Board has, in the past, revoked physician licenses for fewer numbers of cases; for example, the Board revoked the license of a physician for one particularly egregious case. The number of cases that this physician [Appellant] misperformed was incredible to her. She stated that she focused on one case, because she knew that there were surgeons on the Board who would absolutely know the surgical difficulties. As a family physician who sees patients go to surgery frequently and who has an opportunity to review the operative notes and sees what goes on, she feels that she can adequately evaluate these cases.

Dr. Steinbergh continued that the one case that stuck out in her mind that comes to judgment and the inability, in her mind, of this physician

to continue, is patient #6, this 86-year-old woman whom he took to surgery for constipation. This was an 86-year-old woman who, when she presented to the emergency department, was diagnosed with severe dehydration, hyponatremia, hyperkalemia, anemia, urinary retention, constipation, and excessive anticoagulation. She noted that the anemia was never addressed in this case. The patient had been living at home and caring for herself. This woman was ill, but did not need to go to surgery. There was no crisis here, no reason to take this patient to surgery. The question of anemia was never addressed. The patient had a hemoglobin of 10.8 and 33.9 and Dr. Vinson went on to give her a unit of packed blood cells. Even after the transfusion her hemoglobin was lower, and it continued to be low. No one addressed the issue of her anemia during the time of her workup. Dr. Steinbergh stated that it was clear that this patient did not need surgery. There was no reason to take her to surgery. Dr. Vinson's answer was that the patient had all this constipation, she had a megacolon, and he had permission from the patient and from her nephew. These are not people who can make decisions about whether or not this 86-year old woman should go to surgery. This is common sense, and it's at the very basis of medicine. Dr. Vinson then failed to get an appropriate cardiac consultation. Dr. Steinbergh stated that she feels confident that this woman would never have been cleared for surgery. She stated that she also faults the family physician, who participated in the case and did not order a cardiac consult.

Dr. Steinbergh stated that in this one case alone, besides the other cases in which she finds fault, she does not believe that Dr. Vinson has the ability to perform appropriately as a physician.

At the conclusion of the Board's discussion, the Board voted 7 to 0 to adopt the Report and Recommendation of the Hearing Examiner and permanently revoke Appellant's medical license. The Board issued its Order of permanent revocation on June 12, 2003.

IV. STANDARDS OF APPELLATE REVIEW

When considering an appeal from an order of the State Medical Board of Ohio, this Court must uphold the order if it is supported by reliable, probative, and substantial evidence, and is in accordance with law. R.C. 119.12; *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St. 3d 619, 621; *Landefeld v. State Med. Bd. of Ohio* (June 15, 2000), Franklin App. No. 99AP-612, unreported.

The Ohio Supreme Court has recognized that the General Assembly granted the Medical Board a broad measure of discretion. See *Arlen v. State* (1980), 61 Ohio St. 2d 168, 174. In *Farrand v. State Med. Bd. of Ohio* (1949), 151 Ohio St. 222, 224, the Ohio Supreme Court stated:

*** The purpose of the General Assembly in providing for administrative hearings in particular fields was to facilitate such matters by placing the decision on facts with boards or commissions composed of men equipped with the necessary knowledge and experience pertaining to a particular field. ***

"Accordingly, when courts review a medical board order, they are obligated to accord due deference to the board's interpretation of the technical and ethical requirements of the medical profession." *Landefeld, supra*.

V. COURT'S FINDINGS AND CONCLUSIONS

Before addressing the merits of this appeal, the Court is compelled to address the documents that the parties have attached to their briefs.

Revised Code 119.12 provides in pertinent part:

Unless otherwise provided by law, in the hearing of the appeal, the court is confined to the record as certified to it by the agency. Unless otherwise provided by law, the court may grant a request for the admission of additional evidence when satisfied that such additional evidence is newly discovered and could not with reasonable diligence have been ascertained prior to the hearing before the agency.

The parties have not requested that the Court admitted additional evidence pursuant to R.C. 119.12. Accordingly, to the extent that the documents attached to the parties' briefs are not also contained in the record that the Medical Board has certified to the Court, they have not been considered by this Court.

Appellant has asserted, on appeal, that the Medical Board's Order revoking his medical license is not supported by reliable, probative, and substantial evidence. For the following reasons, the Court disagrees.

Dr. Ellison testified to the accepted and prevailing standards for medical care and testified that Appellant's care and treatment of Patients 1 through 6, 9, and 10 violated those standards. Dr. Ellison testified that Appellant's care and treatment of those patients failed to conform to minimal standards of care for similar practitioners under the same or similar circumstances, which constitutes a violation of R.C. 4731.22(B)(6).

The Court finds that Dr. Ellison's testimony constitutes reliable, probative, and substantial evidence supporting the Medical Board's Order. The Court is to "give due deference to the administrative resolution of evidentiary conflicts" because the fact finder, in this case the Hearing Examiner, had the opportunity to observe the witnesses and weigh their credibility. *Univ. of Cincinnati v. Conrad* (1980), 63 Ohio St. 2d 108, 111. The Court "will not substitute its judgment for the board's where there is some evidence supporting the board's order." *Harris v. Lewis* (1982), 69 Ohio St. 2d 577, 578.

Revised Code 4731.22(B)(6) provides:

§ 4731.22. Grounds for discipline ***

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

(6) 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 [.]

Dr. Ellison's testimony constitutes reliable, probative, and substantial evidence that Appellant, in his care and treatment of Patients 1 through 6, 9, and 10, failed to conform to minimal standards of care of similar practitioners under the same or similar circumstances. Pursuant to the authority granted by R.C. 4731.22(B)(6), the Medical Board properly revoked Appellant's medical license.

Appellant has also asserted, on appeal, that the Medical Board's Order is not in accordance with law. Specifically, Appellant contends, the Board erred by not granting Appellant's two motions to dismiss the disciplinary proceedings against him. For the following reasons, the Court does not find Appellant's assertion to be well taken.

On November 22, 2002, before the Medical Board, Appellant filed a motion to dismiss the disciplinary proceedings against him. Appellant contended, in his motion, that the Fulton County Health Center unlawfully reported its peer review proceedings against him to the Medical Board, and that, inasmuch as the subject of those peer review proceedings was Appellant's care and treatment of Patients 1 and 3 through 10, the Medical Board should have dismissed the charges against Appellant concerning those nine patients.

Revised Code 4731.224(A) provides:

*** Within sixty days after the imposition of any formal disciplinary action taken by any health care facility, including a hospital, *** against any individual holding a valid certificate to practice issued pursuant to this chapter, the chief administrator or executive officer of the facility shall report to the state medical board the name of the individual, the action taken by the facility, and a summary of the underlying facts leading to the action taken. *** As used in this division, "formal disciplinary action" means any action resulting in the revocation, restriction, reduction, or termination of clinical privileges for violations of professional ethics, or for reasons of medical incompetence, medical malpractice, or drug or alcohol abuse. ***

Appellant contends that the Fulton County Health Center did not impose "formal disciplinary action" against him and was therefore prohibited from reporting the peer review proceedings to the Medical Board. The Court disagrees.

In June 2000, the Medical Executive Committee of the Fulton County Health Center recommended to its Board of Trustees that Appellant be required to have a general surgeon scrub for all surgical cases scheduled by Appellant. The purpose of the surgeon scrubbing was to evaluate Appellant's surgical expertise during surgical procedures and to offer advice on improvement in surgical technique. The Medical Executive Committee recommended one exception to the general surgeon's presence at Appellant's cases, and that was during Cesarean sections, because physicians practicing obstetrics scrub in during Cesarean sections. In July 2000, the Board of Trustees adopted the recommendations of the Medical Executive Committee, as the decision of the Board of Trustees.

Appellant contends that the Fulton County Health Center did not place "restrictions" on his clinical privileges and therefore, he argues, the hospital did not impose any "formal disciplinary action" against him, as that clause is used in R.C. 4731.224(A). He asserts that, inasmuch as the hospital did not impose any "formal disciplinary action" against him, the hospital was prohibited from reporting the peer review proceedings to the Medical Board.

This argument simply defies reason. In July 2000, the Fulton County Health Center restricted Appellant's clinical privileges by authorizing him to perform surgery only when attended by another general surgeon, whose specific function was to evaluate Appellant's surgical abilities and advise Appellant how to improve his surgical techniques. The only exception to the foregoing was when Appellant

performed Cesarean sections, because an obstetrician would already be scrubbing in during any of Appellant's Cesarean sections. This was unquestionably a restriction on Appellant's clinical privileges at the hospital and, as such, it constituted "formal disciplinary action" that the hospital was obligated to report to the State Medical Board of Ohio, pursuant to R.C. 4731.224(A). The Medical Board did not err by not granting Appellant's November 22, 2002 motion to dismiss the Board's proceedings as to Patients 1 and 3 through 10.

On December 11, 2002, before the Medical Board, Appellant filed a second motion to dismiss the disciplinary proceedings against him. Appellant contended, in the second motion to dismiss, that the Board should dismiss the proceedings because the Board allegedly failed to comply with R.C. 4731.224(G), which provides:

*** Except for reports filed by an individual pursuant to division (B) of this section, the board shall send a copy of any reports or summaries it receives pursuant to this section to the individual who is the subject of the reports or summaries. The individual shall have the right to file a statement with the board concerning the correctness or relevance of the information. The statement shall at all times accompany that part of the record in contention.

Appellant contends that the Board did not send him copies of reports or summaries it received from the Fulton County Health Center or the Paulding County Hospital, as required by R.C. 4731.224(G)

This argument is not well taken. Even if the Board did not send Appellant such documents, which fact is not established by the record, Appellant has failed to demonstrate how the Board's alleged failure prejudiced him in any way. On May 8, 2002, the Board notified Appellant of the charges against him. By December 5, 2002, at the latest, the State had provided Appellant with all of the records for

Patients 1 through 10, as well as Dr. Ellison's expert report offering his opinions on Appellant's care and treatment of those patients. The evidentiary hearing on the Board's charges against Appellant did not begin until almost two months later, on February 4, 2003. Appellant has not demonstrated that his alleged lack of the hospitals' reports in any way prevented him from anticipating the State's case against him, or from preparing his own case in defense of the State's charges. Appellant was provided with all of the patients' records and the State's expert's report almost two months before the hearing began. It is difficult to envision how the hospitals' reports of their peer review proceedings could have had any effect on Appellant's preparation for the hearing, inasmuch as the content of any such reports would be merely duplicative of the content of documents already in Appellant's possession.

Moreover, this Court does not conclude that the Board's alleged failure to comply with R.C. 4731.224(G) precluded the Board, as a matter of law, from prosecuting its case against Appellant. To the contrary, R.C. 4731.22(F)(1) provides:

*** The board shall investigate evidence that appears to show that a person has violated any provision of this chapter or any rule adopted under it. Any person may report to the board in a signed writing any information that the person may have that appears to show a violation of any provision of this chapter or any rule adopted under it. ***

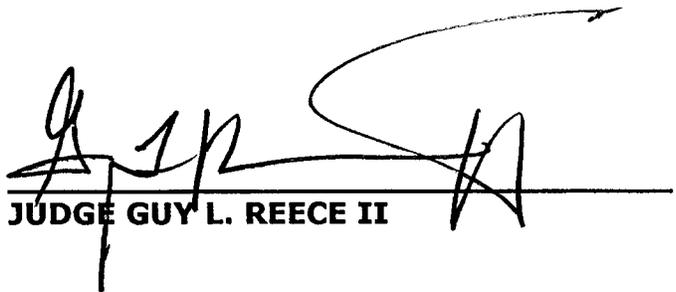
The statute mandates that the Board investigate evidence that a physician has violated R.C. Chapter 4731 or any rule promulgated under it. Compliance with R.C. 4731.224(G) simply is not a condition precedent for the institution of disciplinary proceedings pursuant to R.C. 4731.22(F)(1).

Finally, the record reflects that, at the administrative hearing on February 4, 2003, even before the Hearing Examiner heard testimony from any witness, the State moved for the admission of State's Exhibits 1 through 10, which are the patient records corresponding to Patients 1 through 10. (Tr. 5.) Appellant did not object to their admission, thereby waiving any claimed error as to their admissibility. For this reason also, therefore, the Board did not err in denying Appellant's two motions to dismiss.

VI. CONCLUSION

Having considered the record that the State Medical Board of Ohio has certified to this Court, as well as the parties arguments as set forth in their briefs, the Court finds that the Medical Board's June 12, 2003 Order, permanently revoking Appellant's certificate to practice medicine and surgery in Ohio, is supported by reliable, probative, and substantial evidence, and is in accordance with law. The Order is therefore **AFFIRMED**.

Counsel for Appellee shall prepare, circulate, and submit an appropriate journal entry, in accordance with Local Rule 25.


A handwritten signature in black ink, consisting of a stylized 'G' followed by 'L. R.' and a large, sweeping flourish that extends to the right and then loops back down. The signature is written over a horizontal line.

JUDGE GUY L. REECE II

Copies mailed to:

KEVIN P. BYERS, ESQ. (0040253), Counsel for Appellant
MARK A. MICHAEL, AAG (0063652), Counsel for Appellee

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

David Vinson, Jr., M.D.,
903 Ashland Avenue
Chicago, Illinois 60607
Appellant,

v.

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

*

*

*

03CVH06 07141

CASE NO. _____

JUDGE _____

03
JUL 14 PM 12:02

Appeal from the State Medical Board of Ohio

APPELLANT'S NOTICE OF APPEAL

Pursuant to RC 119.12, notice is hereby given that Appellant, David Vinson, Jr., M.D., appeals the order of the State Medical Board dated June 11, 2003, and mailed June 12, 2003, (copy attached as Exhibit A.) The Medical Board order is not supported by the necessary quantum of reliable, probative, and substantial evidence nor is it in accordance with law.

Respectfully submitted,

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

KPB=RS

Kevin P. Byers 0040253
Fifth Third Center
21 East State Street, Suite 220
Columbus, Ohio 43215
614.228.6283 Fax 228.6425

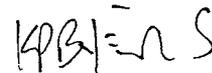
Attorney for David Vinson, Jr., M.D.

CPC original

FILED
COMMON PLEAS COURT
FRANKLIN COUNTY, OHIO
2003 JUN 27 11:10:57
CLERK OF COURTS-CV

Certificate of Service

I certify that an original of the foregoing document was hand delivered this 27th day of June, 2003, to the State Medical Board, 77 South High Street, 17th Floor, Columbus, Ohio 43266-0315 and a copy was placed in first class U.S. Mail this same date addressed to Senior Assistant Attorney General Mark A. Michael, Health & Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215-3428.



Kevin P. Byers

03 JUL 14 PM 12:02





State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

June 11, 2003

David Vinson, Jr., M.D.
903 S. Ashland Avenue
Chicago, IL 60607

Dear Doctor Vinson:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Sharon W. Murphy, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on June 11, 2003, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

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

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

THE STATE MEDICAL BOARD OF OHIO

Anand G. Garg, M.D.
Secretary

AGG:jam
Enclosures

CERTIFIED MAIL NO. 7000 0600 0024 5151 1145
RETURN RECEIPT REQUESTED

Cc: Kevin P. Byers, Esq.
CERTIFIED MAIL NO. 7000 0600 0024 5151 1121
RETURN RECEIPT REQUESTED

Mailed 6-12-03

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Sharon W. Murphy, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on June 11, 2003, 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 David Vinson, Jr., 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)



Anand G. Garg, M.D.
Secretary

June 11, 2003

Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

DAVID VINSON, JR, M.D.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on June 11, 2003.

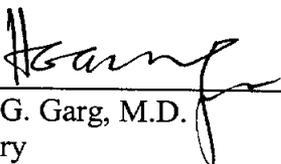
Upon the Report and Recommendation of Sharon W. Murphy, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the approval and confirmation by vote of the Board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

It is hereby ORDERED that:

The certificate of David Vinson, Jr., M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

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

(SEAL)



Anand G. Garg, M.D.
Secretary

June 11, 2003

Date

2003 MAY 16 A 11: 33

**REPORT AND RECOMMENDATION
IN THE MATTER OF DAVID VINSON, JR., M.D.**

The Matter of David Vinson, Jr., M.D., was heard by Sharon W. Murphy, Attorney Hearing Examiner for the State Medical Board of Ohio, on February 4, 5, 6, and March 12, 2003.

INTRODUCTION

I. Basis for Hearing

- A. By letter dated May 8, 2002, the State Medical Board of Ohio [Board] notified David Vinson, Jr., M.D., that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board's action was based on allegations that Dr. Vinson had committed technical and/or judgmental errors during his care and treatment of ten patients. The Board further alleged that Dr. Vinson's conduct constitutes "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code. Accordingly, the Board advised Dr. Vinson of his right to request a hearing in this matter. (State's Exhibit 11A).

On May 29, 2002, Michael R. Moran, Esq., submitted a written hearing request on behalf of Dr. Vinson. (State's Exhibit 11C).

II. Appearances

- A. On behalf of the State of Ohio: Jim Petro, Attorney General, by Mark A. Michael and Rebecca J. Albers, Assistant Attorneys General.
- B. On behalf of the Respondent: Kevin P. Byers, Esq.

EVIDENCE EXAMINED

I. Testimony Heard

- A. Presented by the State
1. David Vinson, Jr., M.D., as upon cross-examination
 2. Edwin Christopher Ellison, M.D.
 3. Robert W. Nyce, M.D.

B. Presented by the Respondent

David Vinson, Jr., M.D.

II. Exhibits Examined

A. Presented by the State

1. State's Exhibits 1-10: Patient medical records for Patients 1 through 10. (Note: Exhibits sealed to protect patients' confidentiality.)
2. State's Exhibits 11A-11X: Procedural exhibits. (Note: State's Exhibits 11B is a confidential patient key which will be sealed protect patients' confidentiality. Moreover, State's Exhibits 11M, Attachment A, is a confidential peer review document which will be sealed to protect confidentiality.)
3. State's Exhibit 12: Curriculum vitae of E. Christopher Ellison, M.D., F.A.C.S.
4. State's Exhibit 13: Copy of a March 20, 2002, report by Dr. Ellison.
5. State's Exhibit 14: State's Closing Argument.

B. Presented by the Respondent

1. Respondent's Exhibit A: Curriculum vitae of David Vinson, Jr., M.D.
2. Respondent's Exhibit B: Excerpt from Dr. Vinson's office record for Patient 3. (Note: Exhibit sealed to protect patient confidentiality.)
3. Respondent's Exhibit C: Greason, K.L., "Incidental Laparoscopic Appendectomy for Acute Right Lower Quadrant Abdominal Pain," Surgical Endoscopy (1998) 12:223-225.
4. Respondent's Exhibit D: Bragg, Larry E., "Concomitant Cholecystectomy for Asymptomatic Cholelithiasis," Archives of Surgery (1989) 124:460-462.
5. Respondent's Exhibit E: Juhasz, Eva S., "Incidental Cholecystectomy During Colorectal Surgery," Annals of Surgery (1994), Vol. 219, 5:467-474.
6. Respondent's Exhibit F: Yau-Tong You, M.D., "Segmental Colectomy in the Management of Colonic Inertia," American Surgeon (1998), 64:775-777.

7. Respondent's Exhibit G: Paajanen, Hannu, "A Chance of Misdiagnosis Between Acute Appendicitis and Renal Colic," Scandinavian Journal of Urology and Nephrology (1996) 30: 363-366.
 8. Respondent's Exhibit H: Kozar, Rosemary A., "The Appendix," Principles of Surgery, Chapter 27, 1383-1394.
 9. Respondent's Exhibits I and J: Excerpts from a medical record for Patient 10. (Note: Exhibit sealed to protect patient confidentiality.)
 10. Respondent's Exhibit K: Excerpt from a medical record for Patient 2. (Note: Exhibit sealed to protect patient confidentiality.)
 11. Respondent's Exhibit L: Respondent's Summation.
- B. Presented by the Attorney Hearing Examiner, sua sponte
- Board Exhibit 1: BMI information.

PROCEDURAL MATTERS

1. On August 14, 2002, Dr. Vinson filed a motion to continue the hearing in this matter, initially set to convene on September 3, 2002. Later that day, a teleconference was held among Counsel for the parties and the Attorney Hearing Examiner. At that time, the Attorney Hearing Examiner advised that she would consider granting the continuance if the parties would first submit an executed Interim Agreement between Dr. Vinson and the Board by which Dr. Vinson would agree to refrain from practicing in Ohio until the allegations set forth in the May 8, 2002, Notice of Opportunity for Hearing had been resolved. The parties agreed to the conditions set forth by the Attorney Hearing Examiner. Moreover, on August 14, 2002, the State filed the State's Response to Respondent's Motion for Continuance, in which the State objected to a continuance should Dr. Vinson not execute the Interim Agreement. On August 27, 2002, Dr. Vinson signed the Interim Agreement, which became effective on August 30, 2002. (See State's Exhibits 11H through 11K).
2. Section 4731.224, Ohio Revised Code, is entitled, "Health care facilities, licensees, professional associations and insurers to report misconduct." Subsection (A) provides, in part, as follows:

Within sixty days after the imposition of any formal disciplinary action taken by any health care facility, including a hospital, health care facility operated by a health insuring corporation, ambulatory surgical center, or similar facility, against

any individual holding a valid certificate to practice issued pursuant to this chapter, the chief administrator or executive officer of the facility shall report to the state medical board the name of the individual, the action taken by the facility, and a summary of the underlying facts leading to the action taken. Upon request, the board shall be provided certified copies of the patient records that were the basis for the facility's action. Prior to release to the board, the summary shall be approved by the peer review committee that reviewed the case or by the governing board of the facility. As used in this division, "formal disciplinary action" means any action resulting in the revocation, restriction, reduction, or termination of clinical privileges for violations of professional ethics, or for reasons of medical incompetence, medical malpractice, or drug or alcohol abuse. "Formal disciplinary action" includes a summary action, an action that takes effect notwithstanding any appeal rights that may exist, and an action that results in an individual surrendering clinical privileges while under investigation and during proceedings regarding the action being taken or in return for not being investigated or having proceedings held. "Formal disciplinary action" does not include any action taken for the sole reason of failure to maintain records on a timely basis or failure to attend staff or section meetings.

R.C. §4731.224(A) (emphasis added).

On November 22, 2002, Dr. Vinson filed the Respondent's Motion to Dismiss or, in the Alternative, Motion in Limine. In that document, Dr. Vinson argued that, in its May 8, 2002, Notice of Opportunity for Hearing, the Board had based its allegations regarding Patients 1 and 3 through 10 on information the Board had received unlawfully from the Fulton County Health Center pursuant to R.C. §4731.224(A). In support of his argument, Dr. Vinson stated that, in July 2000, the Fulton County Health Center had imposed a monitoring requirement on Dr. Vinson's practice following a peer review proceeding by that institution. Dr. Vinson further stated that the Fulton County Health Center had reported its action to the Board.

Dr. Vinson argued that the Fulton County Health Center had not been permitted to report its action to the Board because the action had been based on confidential peer review activities rather than a formal disciplinary action as contemplated by R.C. §4731.224(A). Dr. Vinson further argued that the Board should not have issued its May 2, 2002, Notice of Opportunity for Hearing based on that information. Therefore, Dr. Vinson contended that the only reasonable remedies available to Dr. Vinson are dismissal of the allegations which were based on the illegally obtained information or exclusion of all evidence or testimony regarding Patients 1 and 3 through 10. (State's Exhibit 11M).

On December 9, 2002, the State filed the State Medical Board's Memorandum Contra to Respondent's Motion to Dismiss, or in the Alternative, Motion in Limine. The State noted, first, that there is no evidence in the record that the Fulton County Health Center had made

any report to the Board regarding Dr. Vinson. Second, the State noted that, pursuant to R.C. §4731.22(F), Ohio Revised Code, the Board is precluded from revealing the identity of any person or entity who files a complaint with the Board. (State's Exhibit 11Q).

Nevertheless, the State argued that, even if the allegations against Dr. Vinson had derived from a report by the Fulton County Health Center, the monitoring requirement was a restriction of Dr. Vinson's privileges and constituted a formal disciplinary action as contemplated by R.C. §4731.224(A). Therefore, had the Fulton County Health Center reported the action to the Board, it would have been appropriate, as well as mandated, by R.C. §4731.224(A). (State's Exhibit 11Q).

On January 7, 2003, a telephone conference was held among Counsel for the parties and the Attorney Hearing Examiner, the Attorney Hearing Examiner advised that the State's arguments were persuasive; therefore, the Attorney Hearing Examiner advised that she would not recommend that the Board dismiss the allegations in this matter.

3. Section 4731.224(G), Ohio Revised Code, provides, in part, as follows:

[T]he board shall send a copy of any reports or summaries it receives pursuant to this section to the individual who is the subject of the reports or summaries. The individual shall have the right to file a statement with the board concerning the correctness or relevance of the information. The statement shall at all times accompany that part of the record in contention.

R.C. §4731.224(G).

On November 22, 2002, Dr. Vinson filed the Respondent's Second Motion to Dismiss. In the Respondent's Second Motion to Dismiss, Dr. Vinson argued that,

Pursuant to Section 4731.224(A), 'formal disciplinary action' by certain healthcare entities must be reported to the State Medical Board. The statute directs that a summary of the underlying facts shall be submitted to the Board. Furthermore, the statute mandates that 'the board shall send a copy of any reports or summaries it receives pursuant to this section to the individual who is the subject of the reports or summaries.' R.C. §4731.224(G).

(State's Exhibit 11R at 1).

In the Respondent's Second Motion to Dismiss, Dr. Vinson advised that the Board had sent him inquiries based on information the Board had received from two hospitals regarding his clinical skills. Moreover, Dr. Vinson advised that the Board had failed to enclose copies of any reports or summaries the Board had received from those hospitals. Dr. Vinson argued

that the Board's failure to provide copies of the reports or summaries had prejudiced him. Dr. Vinson argued that,

Had the Board provided the reports and summaries, he could have timely responded in a meaningful fashion and perhaps avoided the whole public debacle of the instant proceeding. Alternatively, at a minimum, Dr. Vinson would have had sufficient time to mount a credible defense since he would have known the Board's concerns at least sixteen months earlier.

(State's Exhibit 11R at 2). Therefore, Dr. Vinson argued that the Board's "failure to abide by the law must result in dismissal of the allegations within the May 8, 2002, notice of opportunity for hearing." (State's Exhibit 11R at 1-2).

On December 18, 2002, the State filed the State Medical Board's Memorandum Contra to Respondent's Second Motion to Dismiss. In that document, the State argued, in part, that Dr. Vinson had not provided any legal support for his contention that a violation of R.C. §4731.224(G), Ohio Revised Code, precludes the Board's authority to institute disciplinary proceedings against an individual. (State's Exhibit 11S). Dr. Vinson filed a reply on December 20, 2002. (State's Exhibit 11T).

On January 7, 2003, a telephone conference was held among Counsel for the parties and the Attorney Hearing Examiner. At that time, the Attorney Hearing Examiner advised that she would not recommend that the Board dismiss the allegations in this matter. The reasons for that determination include the following:

- (1) Nothing in R.C. §4731.224(A) suggests that if the Board violates that statute, the Board is thereafter precluded from initiating a disciplinary action against a respondent;
- (2) There is no evidence in the record that the Board did, in fact, receive reports or summaries regarding Dr. Vinson; and
- (3) If the Board did receive reports or summaries regarding Dr. Vinson, any prejudice to the respondent in connection with the present hearing is relieved by the fact that the hearing did not commence until nine months after the issuance of the notice of opportunity for hearing.

Accordingly, the Attorney Hearing Examiner denied the Respondent's Second Motion to Dismiss.

4. The hearing record in this matter was held open to allow the parties an opportunity to submit written closing arguments. The parties' written closing arguments were submitted on May 2, 2003, and were admitted to the record as State's Exhibit 14 and Respondent's Exhibit L. The hearing record closed at that time.

SUMMARY OF THE EVIDENCE

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

David Vinson, Jr., M.D.: Background and Education

1. David Vinson, Jr., M.D., testified that he had received a medical degree in 1986 from Case Western Reserve University in Cleveland, Ohio. In 1987, Dr. Vinson completed a surgical internship at University Hospitals of Cleveland and, in 1991, completed a surgical residency at Meridian Huron Hospital. Finally, he completed a critical care fellowship in Surgical Intensive Care at Cedar Sinai Medical Center in Los Angeles, California. (Hearing Transcript [Tr.] at 14-15, 483-485; Respondent's Exhibit [Resp. Ex.] A).

Dr. Vinson testified that, in 1993, he had moved to South Carolina and worked in two private general surgery practices in that state. Dr. Vinson testified that, after a few years, he decided to leave South Carolina. In 1997 or 1998, Dr. Vinson relocated to Toledo, Ohio, and completed another year of general surgical training at the Medical College of Ohio. He explained that it was not "an official thing," although he did receive a certificate of completion. (Tr. at 14-16).

Thereafter, from approximately July 1999 through December 2000, Dr. Vinson had a general surgery private practice in Fulton County, Ohio. Moreover, from approximately July 2000 through December 2000, Dr. Vinson operated a separate general surgery practice in Paulding County, Ohio. (Tr. at 12-13).

After leaving Paulding County, from April through November 2001, Dr. Vinson worked as a hospitalist, but did not perform surgery. From November 2001 through April 2002, Dr. Vinson had a brief tenure with Medical Doctors Associates, an organization that provides visiting physician services in Columbus, Ohio. For several months thereafter, Dr. Vinson was unemployed, and making applications to different Master's degree programs. (Tr. at 10-12).

Dr. Vinson testified that, since August 2002, he has been attending the University of Illinois at Chicago obtaining a Master's degree in public health. Dr. Vinson explained that, in August 2002, he had also started the occupational medicine residency program at the University of Illinois at Chicago, but was discharged from that program in December 2002. Dr. Vinson testified that he had been unable to complete the program because he had not yet obtained a license to practice medicine and surgery in Illinois due to the pending action by the Ohio Board. (Tr. at 9-10, 489-491).

Report and Recommendation

In the Matter of David Vinson, Jr., M.D.

Page 8

2. Dr. Vinson testified that the only license to practice medicine and surgery he holds is his Ohio license. Nevertheless, Dr. Vinson testified that he is unable to practice in Ohio because he has signed an Interim Agreement with the Board in which he agreed to refrain from practicing in Ohio until the allegations set forth in the May 8, 2002, Notice of Opportunity for Hearing had been resolved. (Tr. at 491-492; State's Exhibit [St. Ex.] 11J).
3. Dr. Vinson testified that, at the age of forty-three, he has decided to change his field of practice from surgery to occupational medicine for a number of reasons. Dr. Vinson testified that he enjoys his patients, and his patients enjoy him. He testified that many patients have asked him to be their family physician, but that he has had to refuse since he was a surgeon. (Tr. at 492).

Dr. Vinson further testified that there is a part of medicine that he does not enjoy, that being the part:

which has come out in this proceeding, where you basically you can have different opinions about taking care of a patient, about the care that was rendered a patient and both sides can verify that with data and basically the way you verify it with data is basically with journals, you know, and whatnot. And yet the other side's saying, you know, one side's saying that you're below the standard of care. Well, see, I don't understand how you can say that if you can produce literature that states, that clearly states that, you know, this is safe. This is the way we do it. It's recommended.

And the problem with surgery is that you're going to always have complications. You know, it would be nice if everybody lived, you know. It would be nice if, you know, nobody had a wound infection, nobody had a wound dehiscence. It would be nice if a ureter was never tied off, if a spleen never had to come out.

(Tr. at 493). Dr. Vinson concluded that he does not intend to practice surgery at any time in the future, but he hopes to practice medicine again. (Tr. at 494).

The State's Expert Witness: Edwin Christopher Ellison, M.D.

4. Edwin Christopher Ellison, M.D., testified at hearing on behalf of the State. Dr. Ellison testified that he had received a doctorate of medicine degree from the Medical College of Wisconsin in 1976. Dr. Ellison then completed an internship and residency in general surgery at The Ohio State University [OSU]. During that time, Dr. Ellison also completed two years of research in gastroenterology, focusing on pancreatitis-related illnesses and tumors of the pancreas. Dr. Ellison completed his residency in 1983. (Tr. at 200-201; St. Ex. 12).

Dr. Ellison testified that he is currently the Chair of the Department of Surgery at OSU and also Vice Dean of Clinical Affairs and Associate Vice President of Clinical Affairs of the OSU health system. Dr. Ellison explained that administrative responsibilities consume about fifteen percent of his time. He oversees quality assurance and risk management areas, new business plan development, new program development for the organization, and recruitment of new clinical faculty. Dr. Ellison also runs the department's day-to-day activities, evaluates faculty, and assures that the teaching programs are working effectively throughout the department. (Tr. at 201-202; St. Ex. 12).

Dr. Ellison testified that he spends about sixty percent of his time in direct patient care and about twenty percent of his time teaching. He stated that he administers patient care during that time, but that a resident or a medical student is with him, whether making rounds, doing clinics, or in the operating room. In addition, Dr. Ellison spends about five percent of his time doing research, preparing manuscripts, attending research meetings, and participating in other similar activities. (Tr. at 202, 317-318; St. Ex. 12).

Dr. Ellison is on the editorial board of the American Journal of Surgery and has been for seven years. Dr. Ellison reviews approximately thirty to forty papers per year prior to their publication. In addition, Dr. Ellison is an invited reviewer for the Journal of Obstetrics and Gynecology, Archives of Surgery, Annals of Surgery, and Journal of the American College of Surgeons. Dr. Ellison is also on the editorial board of Current Surgery. (Tr. at 205; St. Ex. 12).

Dr. Ellison is a member of American Surgical Association and was recently made a member of the JAMS IV Association of Surgeons, the American Association of Clinical Endocrinologists, the Society of University Surgeons, the Central Surgical Association, and the American College of Surgeons. Dr. Ellison also has numerous publications in peer reviewed journals, national and international paper presentations, and invited lectureships and professorships. (Tr. at 206-207; St. Ex. 12).

Dr. Ellison is certified in surgery by the American Board of Surgery, an ABMS organization. He is also an examiner for the American Board of Surgery, during which he participates in administering the certifying examination for the American Board of Surgery. (Tr. at 208-209; St. Ex. 12).

Dr. Vinson's Practice, In General

5. Dr. Vinson provided a general description of the care he would have provided a patient who had been referred to him for a surgical consultation. Dr. Vinson testified that it had been his practice to first review the patient's chart, look at any relevant x-rays, talk to the patient, and obtain a history. Next, Dr. Vinson performed a physical examination, and ordered any tests that he felt would be appropriate. After reviewing all of the information available to him, he formed an opinion regarding the patient's situation and what needed to be done.

When considering recommending surgery to a patient, Dr. Vinson first determined that the benefits of surgery would outweigh the risks of not having surgery. Dr. Vinson testified that he would then talk to the patient and the patient's family physician. (Tr. at 19-22).

Dr. Vinson testified that he had discussed the situation with the patient "every step of the way." Dr. Vinson testified that he had done so because he had wanted to be sure that the patient made an informed decision. He noted that "a well-informed patient will be a happier patient regardless of the outcome, positive or negative." (Tr. at 19-20, 488-489).

Dr. Vinson's Practice in Fulton and Paulding Counties

6. Dr. Vinson acknowledged that the allegations made by the Board in the May 8, 2002, Notice of Opportunity for Hearing involved patients he had treated in two rural Ohio counties, Fulton County and Paulding County. Dr. Vinson testified that he had maintained private surgical practices in each county. He further testified that most patients had been referred to him by a family physician, and some had come to him through the hospital emergency room. (Tr. at 16-18).

Dr. Vinson testified that Paulding County is approximately twenty miles from Fort Wayne, Indiana, the closest large city. Dr. Vinson further testified that the Fulton County Health Center is in Wauseon, Ohio, which is approximately forty miles from Toledo. Dr. Vinson testified that there are several large hospitals in Toledo, including Saint Vincent's Hospital and the Medical College of Ohio. (Tr. at 498-499).

Patient 1

Allegations

7. In its May 8, 2002, Notice of Opportunity for Hearing, the Board alleged that Dr. Vinson had made a technical error during his care and treatment of Patient 1. More specifically, the Board alleged that, in performing surgery on Patient 1, Dr. Vinson had failed to adequately explore Patient 1's abdomen prior to closure and he had failed to remove a visceral retractor. (St. Ex. 11A).

Medical Records for Patient 1

8. In approximately March 1999, an Upper Endoscopy [EGD] and an Upper GI was performed on Patient 1, a sixty-five year old man. The Upper GI revealed a large sliding type hiatal hernia and gallstones. Patient 1 underwent a laparoscopic cholecystectomy at that time. (St. Ex. 1 at 14).

Six months later, on September 21, 1999, Patient 1 was admitted to the Fulton County Health Center with severe abdominal pain, nausea, and vomiting. Patient 1 was diagnosed as having an incarcerated hiatal hernia and a gastric volvulus or twisting of the stomach. On

September 23, 1999, Dr. Vinson performed an exploratory laparotomy, an open reduction of the incarcerated hiatal hernia, a partial omentectomy, a Nissan fundoplication, and an incidental splenectomy. (St. Ex. 1 at 9-11, 14, 18, 58-59).

On the fifth postoperative day, September 28, 1999, Patient 1 had increased incisional drainage. Dr. Vinson removed two of the incisional staples, which revealed a fascial dehiscence or a failure of the fascia to close properly. Dr. Vinson performed a second operation for closure of the fascial dehiscence. (St. Ex. 1 at 24, 25, 68).

On September 29, 1999, Patient 1 returned to the operating room for the third time. Dr. Vinson reopened the incision to remove a visceral retractor or "fish retractor" which, inadvertently, Dr. Vinson had left in Patient 1's abdomen during the second surgery. (St. Ex. 1 at 11, 26-27, 74).

Testimony of Dr. Vinson

9. Dr. Vinson testified that a fish retractor is used any time it is difficult to close a patient's abdomen, especially in patients who have dehisced. Dr. Vinson noted that, after a dehiscence, the bowels can swell and fill with fluid and it may be difficult to compress the intestines to place them back into the abdominal cavity. Therefore, a fish retractor is placed on top of the organs, but underneath the fascia being sutured, to protect the bowel. With the fish retractor in place, the needle placing the sutures will hit the retractor instead of the patient's organs. (Tr. at 32-34).

Dr. Vinson noted that the fish retractor has a string which is normally left outside of the patient's body. Dr. Vinson testified, however, that when there is difficulty closing an abdominal incision, the string gets in the way. (Tr. at 34-35). Dr. Vinson stated that,

[Y]ou probably have, I don't know, 15 or 20 sutures, you know, going across the abdomen and each one has two hemostat clamps on it. So you probably have 15 or 20 sutures, you know, and 30 to 40 hemostat clamps along with other instruments. So at some point in placing these sutures, the string gets in the way. So you try to move it around, but sometimes the only way to get it out of your way is to just put it in the abdominal cavity.

(Tr. at 35-36).

Dr. Vinson further testified that, at Fulton County Health Center, the nurses recorded instrument counts that they had not actually done. Dr. Vinson stated that the medical record for Patient 1 indicates that an instrument count had been performed and that the instrument count had been accurate. Dr. Vinson testified that he had later learned that the instrument count had not been done, despite such documentation and despite hospital policy mandating that instrument counts be done. Nevertheless, Dr. Vinson acknowledged that he

had been responsible to assure that no instruments had been left in Patient 1's abdomen. (Tr. at 37-40, 44; St. Ex. 1 at 72).

Testimony of Dr. Ellison

10. Dr. Ellison testified that, based in part upon his review of the medical records for Patient 1, he believed that the care Dr. Vinson provided to Patient 1 had fallen below the minimal standards of care. In reaching that conclusion, Dr. Ellison cited the fact that, during an abdominal surgery on Patient 1, Dr. Vinson had failed to adequately explore the abdomen prior to closure and had left a fish retractor in the abdomen. (Tr. at 212-213).

Dr. Ellison described the fish retractor as a plastic, heart-shaped device which is approximately ten inches long and eight inches wide. Dr. Ellison stated that there is a string attached to one end that is brought out through the lower end of the incision. When the fish retractor is used properly, the string remains on the outside of the abdomen. The surgeon is then able to remove the fish retractor after placing the fascial sutures. Dr. Ellison testified that the fish retractor is used to protect the underlying intestine or organs from the sutures being placed in the abdominal wall fascia. (Tr. at 214-215).

Dr. Ellison explained that, in properly closing a patient's abdomen using a fish retractor, the surgeon inserts his or her finger into the incisional opening prior to closing the last stitch. He stated that the fish retractor is a big piece of plastic which can be easily felt. He added that,

I'm not certain how one could possibly leave it in. It's sitting right there while you're closing. And it is not clear to me how one would conceivably leave that in other than making an error, which in my opinion was the case here. I think that sometimes that string gets in the way of your suture closure but it should never be put in the abdomen. It should always be kept outside. That little string is going to be your index that you have something in there.

(Tr. at 216). Dr. Ellison added that the surgeon is looking at the retractor the entire time he or she is placing sutures to close the incision. Dr. Ellison testified that Dr. Vinson should have been aware that the retractor had been left in the abdomen. Dr. Ellison further testified that a surgeon cannot rely on "instrument counts" by other operating room personnel to determine that all of the surgical instruments have been removed from a patient's body. Dr. Ellison stated that it is helpful to have that information, but it does not exonerate the surgeon from the responsibility of exploring the abdomen and making certain that no foreign objects have been left behind. (Tr. at 216-220, 319-322).

Dr. Ellison concluded that, in his care and treatment of Patient 1, Dr. Vinson had made the proper diagnoses and appropriately repaired the hernia. Dr. Ellison stated that, overall, Dr. Vinson had managed Patient 1 appropriately but for the technical error in failing to find

the fish retractor prior to closing the abdomen. Dr. Ellison concluded that this failure had been “clearly” below the minimal standards of care. (Tr. at 215, 220-221).

Patient 2

Allegations

11. In its May 8, 2002, Notice of Opportunity for Hearing, the Board alleged that Dr. Vinson had made a technical error during his care and treatment of Patient 2. More specifically, the Board alleged that Dr. Vinson had caused a bladder and/or ureteral injury when performing a laparoscopic hysterectomy on Patient 2. In addition, the Board alleged that Dr. Vinson had failed to recognize the bladder and/or ureteral injury during the course of the surgery. (St. Ex. 11A).

Medical Records for Patient 2

12. On February 16, 2001, Patient 2, a thirty-five year old woman, presented to Paulding County Hospital for a total abdominal hysterectomy. One week earlier, Patient 2 had been seen in the emergency department for complaints of heavy vaginal bleeding and abdominal cramping over the past several months. A pelvic ultrasound had revealed a large uterine fibroid “occupying the lower uterine segment” and “partially obstructing the cervical os.” (St. Ex. 2 at 16, 43; Resp. Ex. K).

On February 16, 2001, Dr. Vinson performed a total abdominal hysterectomy. Dr. Vinson removed a uterus measuring 8 x 6.5 x 5 cm. The cervical os was “dilated to 2 cm. to accommodate a protruding, pedunculated nodule, 8 x 6.5 x 5 cm.” During the surgery, both ureters and the bladder were injured. (St. Ex. 2 at 16, 29, 45).

The surgery started at 11:15 am. At 1:00 pm, the operating room nurses notified Dr. Vinson that Patient 2’s urine output was low, at approximately 30 ccs per hour, and that her urine was bloody. The nurses continued “to notify Dr. Vinson of urine output status thru-out case.” Patient 2 was transferred to the recovery room at 3:05 pm. (St. Ex. 2 at 16, 29, 35a, 37a, 37b).

At 5:20 pm, Dr. Vinson wrote that Patient 2 had not made any urine while in the recovery room. Dr. Vinson further noted that Patient 2’s foley catheter had been irrigated and changed with no improvement. Dr. Vinson ordered an IVP to rule out ureteral obstruction. (St. Ex. 2 at 45).

The IVP revealed that,

IV contrast was administered and multiple overhead images were obtained. The kidneys are not well visualized bilaterally. There is no contrast noted in the collecting systems at 20 minutes. Differential diagnosis includes

extravasation of IV contrast into the soft tissues vs. bilateral hydronephrosis with delayed nephrograms. Given patient's history of recent surgery, a C.T. scan is recommended for further evaluation.

(St. Ex. 2 at 25).

A C.T. scan of the abdomen and pelvis performed at approximately 8:00 pm listed impressions as follows:

1. [B]oth kidneys are enlarged and there is evidence of moderate hydronephrosis bilaterally with evidence of bilateral hydroureters, right greater than left. There is also evidence of perinephric fluid collections bilaterally secondary to forniceal ruptures. These findings are felt to be secondary to tying off of ureters bilaterally during recent hysterectomy. Clinical correlation is recommended. Also a cystogram can be performed for further evaluation.

2. There is no free fluid noted in the pelvis. There is free air noted in the pelvis from patient's recent surgery.

(St. Ex. 2 at 17, 19). A cystogram report stated that "[f]ree spillage of contrast is noted probably secondary to bilateral transection of the ureters from recent surgery." (St. Ex. 2 at 19).

At 8:00 pm, Dr. Vinson noted that he had contacted a urologist and had arranged to have Patient 2 transferred to another hospital. At that time, Dr. Vinson noted that Patient 2 was stable but developing a fever. At the new hospital, Patient 2 underwent a second surgery to have the problems repaired. (St. Ex. 2 at 45, 46).

Testimony of Dr. Vinson

13. Dr. Vinson testified that, during the course of Patient 2's hysterectomy, he had caused injuries to both ureters and to the bladder. (Tr. at 47-48, 66-67; St. Ex. 2 at 29, 45).

Dr. Vinson testified that the procedure he performed on Patient 2 is a rather difficult procedure. Dr. Vinson testified that, around the cervix at the base of the uterus, there are ligaments that protect prominent vessels. In addition, the ureters descend toward the bladder. Dr. Vinson stated that, in dissecting the cervix, one must clamp or tie off the blood vessels to prevent bleeding. Moreover, in finding the appropriate place to tie off the blood vessels, the surgeon must "hug the cervix" to assure that the ureter is not injured. Dr. Vinson testified that, during the dissection of the cervix, he had accidentally tied off the ureters, one on each side of the uterus, instead of the blood vessels. Dr. Vinson explained that, after tying off the ureters, he had cut them. (Tr. at 47-49, 412-420; St. Ex. 2 at 29).

Dr. Vinson further testified that Patient 2 had had an extremely large fibroid protruding from her cervix. Therefore, as Dr. Vinson had not recognized the lips of the cervix as he felt along sides of the cervix, he went further down than he should have. Dr. Vinson explained that, because he had gone too far down the cervix, he had brought the ureters into the field of surgery, and he had cut the ureters without realizing that he had done so. (Tr. at 48-49, 51-54, 56-57, 412-420; St. Ex. 2 at 29). Dr. Vinson acknowledged that tying off the ureters is an uncommon injury for this type of procedure. (Tr. at 59).

Dr. Vinson testified that he had not realized that he had cut the ureters, in part, because it had appeared that the ureters were functioning properly. Dr. Vinson further testified that, before closing, he had pinched the ureters with a forceps which caused waves of urine inside the ureters. Dr. Vinson testified that he had interpreted this as an indication that the ureters were still functioning. Nevertheless, Dr. Vinson testified that he had realized later that there had been a wave of fluid despite the injury because the injury to the ureters had occurred so far down the ureters. (Tr. at 49-50, 51-54, 56-57; St. Ex. 2 at 29).

Dr. Vinson testified that he had also injured the bladder during the course of the surgery. Dr. Vinson added that the only way to know that you have injured the bladder is to see urine in the abdominal cavity. He stated that, if fluid is found in the abdomen, adding dye to the urine, which is clear, helps to confirm that the fluid is urine. Dr. Vinson explained, however, that, despite an injury to the bladder, there had been no fluid in the abdominal cavity because the ureters had been cut and no urine was being delivered to the bladder. Therefore, Dr. Vinson had not realized that there had also been an injury to the bladder. (Tr. at 57-58).

Dr. Vinson noted that, postoperatively, Patient 2 had developed complications. He stated that, in the recovery room, it was noted that there was no urine in Patient 2's foley bag. Dr. Vinson explained that, since the ureters had been tied during surgery, the urine produced by Patient 2's kidneys had had "nowhere to go." The ureters were dilating and the urine was backing up into the kidneys. Dr. Vinson denied, however, that there had been a potential for damage to the kidneys because the problem had been discovered "rather quickly" in the recovery room. (Tr. at 59-62).

Dr. Vinson testified that he takes full responsibility for the injuries that resulted from Patient 2's surgery. Nevertheless, Dr. Vinson added that there were other circumstances which had contributed to the unfortunate injury. (Tr. at 56).

Testimony of Dr. Ellison

14. Dr. Ellison testified that, based in part upon his review of the medical records for Patient 2, he believed that the care Dr. Vinson provided to Patient 2 had fallen below the minimal standards of care. In reaching that conclusion, Dr. Ellison cited two reasons. First, Dr. Ellison stated that Dr. Vinson had caused a bladder and/or ureteral injury when

performing an open hysterectomy on Patient 2. Second, Dr. Vinson failed to recognize that injury during the procedure. (Tr. at 222).

Dr. Ellison noted that the large uterine fibroid had been an appropriate indication for performing a total abdominal hysterectomy. Nevertheless, Dr. Ellison testified that the injury to Patient 2's bladder and ureters had occurred during the course of the hysterectomy and that such injuries are "probably avoidable in most cases, if not all." He further testified that "the incidence of this type of injury with hysterectomy is well below one percent overall." (Tr. at 222-224, 324-325).

Dr. Ellison further testified that this had been a difficult case. He stated, however, that, in a difficult case, the surgeon must take extra precautions to avoid injury. Dr. Ellison testified that there had been several ways to do that in this case. Dr. Ellison testified that Dr. Vinson could have left part of the cervix in place to avoid dissection in the lower part of the uterus near the trigonal bladder. Dr. Ellison stated that, if Dr. Vinson had decided to take the whole cervix anyway, he should have obtained a pyelogram or injected a dye such as methylene blue. Dr. Ellison testified that injecting methylene blue allows the surgeon to see urine in the abdominal or pelvic cavity if there should be a leak. Therefore, Dr. Ellison concluded that Dr. Vinson's care had been below the standard of care. (Tr. at 224-225).

When asked why, if an injury to the bladder or a ureter is not a common complication, the surgeon should take such precautions, Dr. Ellison testified that, in a difficult hysterectomy, one of the worst complications is an injury to the ureter. He added that it is particularly unusual to injure both ureters as Dr. Vinson did. Nevertheless, a surgeon needs to be aware that this can happen and needs to be prepared to diagnose and manage it. Dr. Ellison stated that the best time to diagnose is intraoperatively in order to prevent damage to the kidneys or continued leakage of urine. Dr. Ellison testified that, in this situation, both ureters had been tied off, and there was a hole in the bladder, which was a contaminating situation. (Tr. at 225-226).

A question was presented to Dr. Ellison that was based on Dr. Vinson's explanation that the problems he had encountered during this case had been caused, in part, by the existence of a fibroid tumor that had extended through the cervix. When asked if the existence of that fibroid changed his opinion regarding the care provided by Dr. Vinson, Dr. Ellison testified that it did not. Dr. Ellison restated his opinion that, with proper care, the injury should have been avoided. Dr. Ellison stated that "there was an ample opportunity during the dissection to stay close to the uterus and the cervix and avoid injury to the ureters and trigonal bladder." He added that, "with good mobilization of the bladder you should really be able to pull the bladder completely up off of that area. And * * * you should be able to put a retractor between the bladder and just pull it up out of the way basically avoiding the injury." Moreover, Dr. Ellison testified that, once the injury had occurred, Dr. Vinson should have recognized the problem and taken steps to minimize the complications. (Tr. at 226-228).

Dr. Ellison concluded that the technical skills exercised by Dr. Vinson were below the standard of care as the injury should have been avoided. He added that, at a minimum, Dr. Vinson should have recognized the injury intraoperatively. (Tr. at 230).

Patient 3

Allegations

15. In its May 8, 2002, Notice of Opportunity for Hearing, the Board alleged that Dr. Vinson had made a judgmental error during his care and treatment of Patient 3. More specifically, the Board alleged that, during the performance of a modified radical mastectomy on Patient 3, Dr. Vinson had inappropriately placed a Mediport catheter in Patient 3's left axillary vein, on the same side as the modified radical mastectomy and below the pectoralis muscle, resulting in the catheter being inaccessible for use. (St. Ex. 11A).

Medical Records for Patient 3

16. On September 11, 1998, Patient 3 was admitted to the Fulton County Health Center with a diagnosis of cancer of the left breast. Patient 3 was a thirty-seven year old woman who had undergone a right modified radical mastectomy in 1990 for cancer of the right breast. At that time, Patient 3 had had positive lymph nodes and had undergone chemotherapy postoperatively. Subsequently, Patient 3 had had an implant placed in the right side for reconstruction and had a reduction mammoplasty on the left breast. (St. Ex. 3 at 29).

On September 11, 1998, Dr. Vinson performed a left modified radical mastectomy and left axillary dissection for the removal of lymph nodes. During the surgery, under fluoroscopy, Dr. Vinson inserted a Mediport or portacath into the left axillary vein. (St. Ex. 3 at 31, 34-35).

On September 17, 1998, Dr. Vinson wrote an office note regarding Patient 3 which states, in part,

It chest – incision with mild ecchymoses and mild skin necrosis. mild edema of ant chest wall, port palp deep to pect maj muscle. drain sites clean. * * *
port can be used at any time.

(Resp. Ex. B).

On November 23, 1998, Patient 3 underwent a second operation for the removal of the portacath. The admission sheet states that the port was to be removed because it was “too deep to be available for oncology treatments.” (St. Ex. 3 at 3, 6).

Testimony of Dr. Vinson

17. Dr. Vinson testified that Patient 3 had been referred to him by Patient 3's oncologist. Dr. Vinson testified that the patient and the oncologist had been eager to start chemotherapy as soon as possible. Dr. Vinson noted that this was the second incidence of cancer in a fairly young woman and that, in general, cancers in young women tend to be aggressive. (Tr. at 68-70).

Dr. Vinson testified that, during the surgery, he had placed a portacath in Patient 3's left chest so that Patient 3 could receive chemotherapy post-operatively. Dr. Vinson testified that a portacath is an intravenous catheter that sits below skin. The other end of the catheter is inserted into the axillary vein. The catheter has a plastic housing that can be palpated through the skin. The person administering chemotherapy can feel for the plastic housing beneath the skin to locate the part of the portacath into which the IV needle can be inserted. The needle is then inserted through the skin and into the portacath to allow delivery of the intravenous chemotherapy. (Tr. at 70-71).

Dr. Vinson testified that he had placed the portacath on the same side as the mastectomy for several reasons. Dr. Vinson testified that placing it on the non-operative side would have resulted in two separate incisions and two operative sites. Dr. Vinson further testified that, after a mastectomy, a patient is instructed not to allow use of the veins on the side of the mastectomy. Dr. Vinson testified that Patient 3 had bilateral mastectomies; therefore, it had been "sort of a wash there as far as the side where to place the port." (Tr. at 71-72, 74).

Finally, Dr. Vinson testified that, any time you put a foreign body in a patient, there is an increased risk of infection in the wound. Dr. Vinson testified that Patient 3 had had a previous implant on the right side, and placing a foreign body there would have increased the risk of infection at the implant site. He stated that Patient 3 had been concerned about losing the implant should an infection occur. (Tr. at 72-74).

When presented with the fact that the catheter had been placed too deeply and had had to be removed, Dr. Vinson stated that, "that determination is relative, but that is what happened." (Tr. at 75).

Testimony of Dr. Ellison

18. Dr. Ellison testified that, based in part upon his review of the medical records for Patient 3, he believed that the care Dr. Vinson provided to Patient 3 had fallen below the minimal standards of care. In reaching that conclusion, Dr. Ellison cited the fact that, during the performance of a modified radical mastectomy, Dr. Vinson had inappropriately placed a portacath in Patient 3's left axillary vein on the same side as the new mastectomy. In addition, Dr. Ellison noted that Dr. Vinson had placed the portacath below the pectoralis muscle which had resulted in the catheter being inaccessible for use. (Tr. at 230-231).

Dr. Ellison testified that it is inappropriate to put a foreign body such as a portacath into a fresh mastectomy wound, first, because a foreign body could increase the incidence of deep infection within the fresh surgical wound. Dr. Ellison noted that Dr. Vinson's post-operative office note revealed that there was mild ecchymosis, skin necrosis, and chest wall edema. Dr. Ellison stated this could have indicated a deep tissue infection and is an example of the problems that can result when a foreign body is inserted into a fresh surgical wound. (Tr. at 232-234, 238; Resp. Ex. B).

Dr. Ellison testified that the second reason why it is inappropriate to put a foreign body such as a portacath into a fresh mastectomy wound is that, immediately following a mastectomy, there will be swelling of the arm on the side of the surgery. Dr. Ellison stated that, having a foreign body in the axillary vein, which is the main draining vein for the arm, will exacerbate the swelling. Moreover, it could lead to thrombosis of the vein with a possible complication of pulmonary embolus. (Tr. at 234-235).

Dr. Ellison concluded that it would have been more appropriate either to defer the placement of the portacath or to insert, instead, a PICC line [percutaneous infusion catheter]. Dr. Ellison explained that a PICC line is an intravenous line that could have been placed in the brachial vein of the opposite arm. Dr. Ellison testified that this would have been preferable even though Patient 3 had had a previous mastectomy on that side, because that mastectomy was remote and was not a fresh wound. (Tr. at 235, 328-330).

Dr. Ellison testified that his opinion would not change even if the patient and the oncologist had wanted to start chemotherapy immediately. Dr. Ellison testified that the chemotherapy would not begin until the wound was healed. (Tr. at 235-236).

Dr. Ellison further testified that, if the patient had had an implant on the left side, he "certainly would have to think about where to put the catheter." Dr. Ellison testified that he would still think that the brachial vein would be the best site, although he would also consider a cephalic vein cut-down or a port into the internal jugular. He stated that he would still not consider the subclavian or axillary veins. (Tr. at 236, 328-329).

In addition, Dr. Ellison testified that his opinion would not change even if delaying placement of the catheter would require a second surgery and a second surgical site. Dr. Ellison testified that placement of the catheter is an outpatient procedure, and that the catheter easily could have been placed in a clean site that was not prone to surgical infection. (Tr. at 237).

Finally, Dr. Ellison testified that, simply using common sense, it is obvious that a new surgical site is not an appropriate site for catheter placement. Dr. Ellison noted that the new wound was likely quite tender, and trying to access a port that is underneath the skin in a fresh surgical area would have been difficult and painful for the patient. Dr. Ellison concluded that, in placing the portacath on the same side as the fresh mastectomy,

Dr. Vinson's judgment had been "so wrong" that it had fallen below the minimal standard of care. (Tr. at 237-239).

Dr. Vinson's Response

19. Dr. Vinson testified that PICC lines are only appropriate for short-term use. Dr. Vinson testified that PICC catheters are small; they are the same size as a regular I.V. Dr. Vinson testified that most hospitals have policies that I.V.'s must be changed every two to four days. Dr. Vinson further testified that, because they are small, they can only be placed in small arm veins. Therefore, because patients use their arms, PICC lines occlude frequently. Dr. Vinson added that, for the same reasons, PICC lines are not routinely used for chemotherapy. (Tr. at 430-432).

Dr. Vinson testified that Patient 3 was planning to receive chemotherapy over several months and a PICC catheter would not have been an option for her unless she was going to frequently change it. Dr. Vinson testified that that would have been a problem because there are only a limited number of veins in which a PICC line could be placed. Dr. Vinson concluded that "they just don't use the PICC lines for chemotherapy." (Tr. at 432-433).

Dr. Ellison's Response

20. When asked if the PICC line is prone to occlusion, Dr. Ellison testified that it is similar to any other central line. If the line is maintained properly and flushed on a regular basis, it will work very well and can remain in place for four to six months. In addition, Dr. Ellison denied that a PICC line inhibits the patient's use of the arm in which the line is placed. (Tr. at 330-331).

Patient 4

Allegations

21. In its May 8, 2002, Notice of Opportunity for Hearing, the Board alleged that Dr. Vinson had made a judgmental error during his care and treatment of Patient 4. More specifically, the Board alleged that, while performing surgery to address Patient 4's perforated duodenal ulcer, Dr. Vinson had performed a cholecystectomy on Patient 4 although it had not been indicated. (St. Ex. 11A).

Medical Records for Patient 4

22. On September 26, 1999, Patient 4, a seventy-six year old woman, was admitted to the emergency department at the Fulton County Health Center complaining of severe abdominal pain. Patient 4 stated that the pain had begun the prior evening, had increased in severity, and was associated with nausea, vomiting, weakness and lightheadedness. (St. Ex. 4 at 4, 6).

Upon admission to the emergency department, a chest x-ray demonstrated free air under the diaphragm. A C.T. scan of the abdomen and pelvis [ordered by the emergency room physician] revealed free oral contrast in the peritoneal cavity and dilated intrahepatic bile ducts. Patient 4 had elevated BUN, creatinine, liver enzymes and bilirubin. She was hypotensive with blood pressures of 78/48 and 70/50, her CO₂ was low at 15, and she had an elevated white blood cell count—16,900—with a marked left shift. (St. Ex. 4 at 4, 7, 17, 25, 31-33, 46, 52).

On September 26, 1999, at 10:30 pm, Dr. Vinson performed an exploratory laparotomy which revealed a perforated prepyloric ulcer. Dr. Vinson repaired the prepyloric ulcer with a Graham patch. Dr. Vinson noted that gastric juice and oral contrast has spilled into the peritoneal cavity. Moreover, during the surgery Dr. Vinson found palpable gallstones and performed a cholecystectomy with an intraoperative cholangiogram. (St. Ex. 4 at 4-5, 8, 25). The pathology report noted “[m]arked diffuse chronic cholecystitis” and “[c]holelithiasis, solitary, large, mixed type.” (St. Ex. 4 at 43).

Postoperatively, Patient 4 developed complications, including renal failure, an unexplained elevated white blood cell count, and lethargy. Patient 4 was transferred via emergency ambulance to a Toledo hospital for nephrology consultation and possible hemodialysis. (St. Ex. 4 at 5).

Testimony of Dr. Vinson

23. Dr. Vinson concluded that the incidental cholecystectomy had been appropriate for Patient 4. Dr. Vinson testified that he had taken Patient 4 to surgery and repaired the perforated prepyloric ulcer, and that he had completed that portion of the surgery rather quickly. Dr. Vinson further testified that he explores the entire abdominal cavity every time he opens an abdomen unless the patient is unstable. Dr. Vinson testified that Patient 4 had been stable throughout the surgery; therefore, he had explored her abdomen. Dr. Vinson added that, upon exploring Patient 4’s abdomen, he had found gallstones and removed the gallbladder. (Tr. at 79-81, 83; 437-439).

Dr. Vinson testified that he had removed Patient 4’s gallbladder during the course of the surgery because the incidence of experiencing problems due to gallstones is significantly higher in persons who have had recent abdominal surgery. He further noted that several studies have shown that removing the gallbladder during the course of another abdominal procedure provides “little to no more increased morbidity.” Therefore, Dr. Vinson testified that he had decided to remove Patient 4’s gallbladder. Dr. Vinson further testified that, in patients whose gallbladders were not removed during the course an abdominal procedure, a second surgery for cholecystectomy is frequently required. He added that, in such cases, the procedure is more difficult than if the gallbladder had been removed during the initial surgery. (Tr. at 81-83, 434-435).

Finally, Dr. Vinson initially testified that there had been no way to know at the time of the first surgery whether Patient 4 would have been one of those people who required a cholecystectomy shortly after the first surgery. Nevertheless, Dr. Vinson later testified that he had had reason to believe that Patient 4 would probably experience trouble from her gallbladder post-operatively because Patient 4 had had an elevated bilirubin and liver enzymes upon admission to the hospital. Dr. Vinson testified that liver enzymes give an indication of the status of the gallbladder. (Tr. at 82-83, 87-88; St. Ex. 4 at 32).

24. Dr. Vinson testified regarding a study documented in an article by Larry E. Bragg, entitled, "Concomitant Cholecystectomy for Asymptomatic Cholelithiasis," which had been published in Archives of Surgery in 1989. Dr. Vinson testified that the article noted that "the outcome of 68 patients with asymptomatic cholelithiasis undergoing laparotomy for other conditions was reviewed to determine those most likely to become symptomatic postoperatively. Thirty-seven patients [fifty-four percent] became symptomatic postoperatively." Eight patients [twenty-two percent] had required cholecystectomy within thirty days of the original surgery. (Tr. at 434-435; Resp. Ex. D).

Dr. Vinson explained that the reason patients with asymptomatic cholelithiasis become symptomatic after abdominal surgery is that patients do not eat for several days after abdominal surgery. Dr. Vinson further explained that the gallbladder functions as a storage pouch for bile made in the liver. "When we eat, the gallbladder squeezes bile into the bile duct and then into the small intestine where it helps to digest food." Dr. Vinson testified that it is eating that stimulates the gallbladder to contract and expel the bile. Therefore, if the patient does not eat, bile continues to accumulate in the gallbladder and the gallbladder dilates. If the patient has pre-existing stones, the stones get bigger and sludge forms. The sludge occludes the opening to the gallbladder, causing symptoms. (Tr. at 435-437).

25. Dr. Vinson testified regarding a study documented in an article by Eva S. Juhasz, entitled, "Incidental Cholecystectomy During Colorectal Surgery," and published in Annals of Surgery in 1994. (Tr. at 437-438; Resp. Ex. E). The article concluded that,

Incidental cholecystectomy was not associated with increased postoperative morbidity, whereas the long-term risk that previously asymptomatic gallstones would become symptomatic was substantial. Unless there are clear contraindications, patients with asymptomatic gallstones who have colorectal surgery should have concomitant cholecystectomy.

(Tr. at 438-439; Resp. Ex. E). Dr. Vinson further testified that the study had looked at colorectal surgery, which is one of the biggest and most difficult procedures that can be performed in the abdomen. Dr. Vinson testified that the article concludes that, even in colorectal surgery, if there is evidence of asymptomatic gallstones, the gallbladder should be removed. Dr. Vinson concluded that the article supports his contention that an incidental cholecystectomy had been appropriate for Patient 4. (Tr. at 437-439).

26. Dr. Vinson acknowledged that Patient 4 had developed renal failure postoperatively. Dr. Vinson stated that he had been unable to determine the cause of her renal failure because she had not had a history of renal failure. Dr. Vinson testified, however, that, retrospectively, he had realized that it must have been caused by the unnecessary C.T. scan performed in the emergency department prior to surgery. Dr. Vinson testified that the abdominal films performed in the emergency department had shown free air; therefore, it had been clear that Patient 4 had a perforated bowel. Dr. Vinson testified that it had been unnecessary to also obtain a C.T. scan. Nevertheless, it had been ordered and the contrast had leaked into the peritoneal cavity eventually causing her to develop renal failure. Dr. Vinson concluded that the unnecessary test ordered by someone other than Dr. Vinson had caused Patient 4's renal failure. (Tr. at 84; St. Ex. 4 at 24-25).

When it was noted that Patient 4 had arrived in the emergency department with a high normal bun and an elevated creatinine, Dr. Vinson acknowledged that it was true. Nevertheless, Dr. Vinson testified that these results had not been an indication of impending renal failure. Instead, Dr. Vinson contended that these findings resulted from Patient 4 becoming dehydrated after several episodes of nausea and vomiting, and spillage of intestinal contents into the abdominal cavity which had caused those tissues to absorb fluid. (Tr. at 85-86; St. Ex. 4 at 4, 33).

Testimony of Dr. Ellison

27. Dr. Ellison testified that, based in part upon his review of the medical records for Patient 4, he believed that the care Dr. Vinson provided to Patient 4 had fallen below the minimal standards of care. In reaching that conclusion, Dr. Ellison cited the fact that Dr. Vinson had performed an unnecessary cholecystectomy while performing surgery to address Patient 4's patient's perforated duodenal ulcer and sepsis. (Tr. at 240, 251).

Dr. Ellison testified that Dr. Vinson had diagnosed and treated the perforated ulcer appropriately. Nevertheless, Dr. Ellison testified that Dr. Vinson had inappropriately performed a cholecystectomy in the face of peritonitis. Dr. Ellison acknowledged that, in a patient with peritonitis, the gallbladder appears abnormal. Nevertheless, the abnormality is due to the peritonitis and not due to gallstones or any other problem intrinsic to the gallbladder. (Tr. at 240-242).

Dr. Ellison further testified that, the risk to this patient of doing additional surgery had been substantial. Dr. Ellison explained that Patient 4 had already been facing problems which predicted a poor outcome. Moreover, by cutting into the gallbladder, Dr. Vinson had cut into as yet non-contaminated planes which created additional potential problems that should have been avoided. (Tr. at 242-243).

Dr. Ellison testified that one of Patient 4's additional risk factors was the elevated creatinine. Dr. Ellison stated that a study done a few years ago at the Ohio State University had addressed factors that predicted a poor outcome for patients with perforated ulcers. The study demonstrated that the passage of more than twenty-four hours from the onset of symptoms to surgery was an indicator of a poor outcome. Moreover, in patients who had abnormal serum creatinine levels, the mortality rate jumped substantially. Dr. Ellison explained that Patient 4's elevated bilirubin and creatinine were indications that she was in sepsis due to the perforated ulcer, because sepsis affects liver and kidney function. Dr. Ellison concluded that Patient 4 had been at high risk of dying from the perforated ulcer. Dr. Ellison stated that the additional surgery for removal of her gallbladder was an unnecessary risk. He stated that, if she had had gallstones, that could have been addressed at a later time. (Tr. at 243-244, 245-246, 333-334).

Dr. Ellison testified that the basic standard is, "when you have an emergency situation, you take care of the emergency and you get out of the abdomen." Dr. Ellison testified that all residents are taught that and that it is so important that it is included among the questions on the certification examination of the American Board of Surgery. Dr. Ellison stated that it is "very common knowledge in the practice of surgery." (Tr. at 244).

Dr. Ellison testified that, if the operation being performed is an elective procedure rather than an emergency procedure, and the patient is stable, it is appropriate to remove a gallbladder at the same time. Nevertheless, in emergency situations with critically ill patients, no more than what is needed to be done to correct the problem should be done. Dr. Ellison concluded that it had been a judgmental error on Dr. Vinson's part to perform an unnecessary cholecystectomy during a surgery to treat a perforated ulcer. (Tr. at 247-248).

28. Dr. Ellison was presented with Dr. Vinson's testimony that, in a patient with a history of gallstones, simply having abdominal surgery would increase their risk of developing complications with the gallbladder by twenty to thirty percent. Dr. Ellison responded that Dr. Vinson's conclusion is inaccurate. Dr. Ellison explained that, every year, approximately two percent of patients who have gallstones develop symptoms relative to their gallbladder. Dr. Ellison added that patients who have abdominal surgery have a slightly higher incidence of developing symptoms, but not been in the range cited by Dr. Vinson. (Tr. at 244-246).
29. Regarding the Bragg article published in 1989 in Archives of Surgery, Dr. Ellison agreed that the study would support the need to do cholecystectomies in certain circumstances. Nevertheless, Dr. Ellison noted that the study had been done more than fourteen years ago and, based on more current statistics, the incidence of developing postoperative cholecystitis is much lower today. Moreover, Dr. Ellison testified that the study did not support doing an elective cholecystectomy during the course of an emergency operation for another procedure. (Tr. at 250-251, 334-336, 340, 394; Resp. Ex. D).

30. Regarding the Juhasz article published in 1994 in Annals of Surgery, Dr. Ellison noted, first of all, that none of the patients had had a perforated ulcer. Secondly, he noted that only three of the cholecystectomies had been performed during the course of an emergency operation. Furthermore, Dr. Ellison noted that the article does not disclose the condition of the patients at the time of the surgery. In addition, Dr. Ellison testified that the fact that only three had been done in emergency situations supports his contention that, in most cases, it is inappropriate to do a cholecystectomy in an emergency situation, unless the gallbladder is the cause of the emergency. Dr. Ellison concluded that nothing in the article justifies the type of care rendered by Dr. Vinson. (Tr. at 248-250; Resp. Ex. E).

Dr. Ellison later acknowledged that the article states that thirty-four patients had undergone primary procedures that were performed emergently and only ten (twenty-nine percent) had had concomitant cholecystectomy. Nevertheless, Dr. Ellison stated that this did not change his opinion. (Tr. at 337-338).

Patient 5

Allegations

31. In its May 8, 2002, Notice of Opportunity for Hearing, the Board alleged that Dr. Vinson had made a technical error during his care and treatment of Patient 5. More specifically, the Board alleged that, during the course of Patient 5's gastric resection, Dr. Vinson had caused injury to Patient 5's ampulla of Vater by going too distal in the patient's duodenum. (St. Ex. 11A).

Medical Records of Patient 5

32. On September 21, 1998, Patient 5, a sixty year old male, was admitted to the Fulton County Health Center by his family physician. Patient 5 had been complaining of upper abdominal pain and fullness, intolerance of fatty and spicy foods, nausea and vomiting. Upon admission to the hospital, an EGD, or upper endoscopy, was performed. The EGD revealed severe erosive esophagitis, inflammation, and stricture of the second part of the duodenal sweep with retained gastric fluid. (St. Ex. 5 at 47, 65, 70, 82).

On September 26, 1998, after medical intervention had failed, the family physician consulted Dr. Vinson. Later that evening, Dr. Vinson took Patient 5 to surgery with a preoperative diagnosis of peptic ulcer disease and gastric outlet obstruction. Dr. Vinson performed a vagotomy, an antrectomy, a Billroth II anastomosis, a Roux-en-y cholecystojejunostomy, insertion of a cholecystostomy tube and insertion of a triple lumen CVP catheter. During the surgery, Dr. Vinson also placed a Jackson-Pratt drain. (St. Ex. 5 at 47, 48, 83-85).

In his handwritten "Brief Op Note," Dr. Vinson recorded his findings as "Ulcer * * * adherent to pancreas, also involving sphincter of Oddi, requiring biliary drainage

procedure. Common bile duct normal size.” Dr. Vinson listed complications as “none.” (St. Ex. 5 at 48).

In his dictated operative note, Dr. Vinson stated that “no mass effect was able to be appreciated in the duodenum or the pancreas.” (St. Ex. 5 at 84). Dr. Vinson further wrote that,

[I]nspection of the pancreatic head was suspicious for a bile leak. Neither the biliary sphincter nor the pancreatic sphincter were able to be visualized, but bile was visualized in the wound. * * * Due to the fact that a biliary leak could not be ruled out, and that the common bile duct was normal size, the decision was made to perform a Roux-en-Y cholecystojejunostomy.”

(St. Ex. 5 at 84).

On September 30, 1998, a pathology report of the specimens Dr. Vinson removed during the surgery revealed that Patient 5 had adenocarcinoma of the pylorus of the stomach which had infiltrated through the muscular layer and into the subserosa. The serosa was negative, and no lymph nodes were identified. The pathology report further indicated that the margins of the tissue Dr. Vinson had removed were clean. (St. Ex. 5 at 124).

The pathology report also indicated that the portion of the duodenum Dr. Vinson had removed measured 5 by 4 centimeters. (St. Ex. 5 at 124).

On October 5, 1998, during the same hospital stay, Dr. Vinson performed a second surgery on Patient 5. Dr. Vinson performed a colonoscopy, an exploratory laparotomy, lysis of adhesions, partial omentectomy, true-cut pancreatic biopsies with frozen section, resection of cholecystojejunostomy and closure of cholecystotomy, and pancreaticojejunostomy anastomosis [Roux-en-Y]. (St. Ex. 5 at 56, 65, 92). Biopsies performed on surrounding tissues were negative. (St. Ex. 5 at 125). After the second surgery, Patient 5 was transferred to the CCU in guarded condition. (Tr. at 56).

Dr. Vinson’s operative note states that “the site of bile leakage was able to be identified, and it was felt that this could represent the sphincter of Oddi.” (St. Ex. 5 at 92).

On October 12, 1998, Patient 5 was discharged from the hospital to his home. Patient 5 still had a Jackson Pratt drain which was draining pancreatic fluid and a T-tube in his gallbladder which was draining bile. (St. Ex. 5 at 67).

Four days after discharge, Patient 5 returned to the Fulton County Health Center with complaints of continued pancreatic juice draining from the Jackson-Pratt drain. Dr. Vinson noted that Patient 5’s wound was not healing well and that Patient 5 was not eating. Dr. Vinson inserted a double lumen Hickman Catheter into the left subclavian vein.

Dr. Vinson instructed Patient 5 to take nothing by mouth and started parenteral feedings. (St. Ex. 5 at 14-15, 18).

Testimony of Dr. Vinson

33. Dr. Vinson testified that, during the course of the first surgery, there had been injury to the distal common bile ducts. Dr. Vinson explained that he is not sure exactly where the injury occurred. He stated that the injury had occurred because there had been significant inflammation in the small intestine near the insertion of the ampulla of Vater. Dr. Vinson referred to the September 21, 1998, EGD report which had found "inflammation with stricture of the second part of the duodenal sweep with retrained gastric fluid." Dr. Vinson explained that the report indicates that "all that tissue is just stuck together," and that Dr. Vinson had had to cut through it in order to remove a portion of the stomach. Dr. Vinson concluded that it had been during that dissection that the injury had occurred. (Tr. at 94-97, 101-102; St. Ex. 5 at 82).

Dr. Vinson further explained that bile is green; therefore, he had seen the bile leaking into the abdominal cavity. He stated that he had tried to find the source of the leak, but had not been able to find it. Dr. Vinson stated, that because of the leak, he had had to perform procedures that he had not originally intended to perform. He stated that the first was the Roux-en-y cholecystojejunostomy, in which he had attached the gallbladder to the jejunum, another part of the small intestine, which had allowed the gallbladder to drain. Dr. Vinson stated that he had hoped that the bile would drain from the liver, into the gallbladder, and then into the small intestine. He stated that he had also inserted a T-tube into the gallbladder for access to help determine if the leak had healed on its own. He also inserted a Jackson Pratt drain to allow leakage to drain from the abdominal cavity. (Tr. at 97-99, 101-105; St. Ex. 5 at 66, 67).

Dr. Vinson testified that a pathology report had indicated that Patient 5 had had cancer of the pylorus as well as significant inflammation in his duodenum. Dr. Vinson testified that, because he had not believed that all of the cancer had been removed and to ascertain the source of the bile leak, he had taken Patient 5 back to surgery. At hearing, Dr. Vinson testified that he had been unable to identify the source of the leak during the second surgery. Nevertheless, he acknowledged that his operative note states that "the site of bile leakage was able to be identified, and it was felt that this could represent the sphincter of Oddi." [Note: Dr. Vinson testified that the sphincter of Oddi is another term for the ampulla of Vater.] (Tr. at 109-110, 441-442; St. Ex. 5 at 92-93).

34. Dr. Vinson testified that, subsequent to the second surgery, Patient 5 developed a leak of pancreatic fluid. (Tr. at 443). Dr. Vinson acknowledged that, upon discharge, pancreatic fluid had still been draining from Patient 5's Jackson Pratt drain and that Dr. Vinson has still not determined the site of the leakage. (Tr. at 101-105; St. Ex. 5 at 66, 67). When asked if

he had been concerned that pancreatic fluid was draining from Patient 5's abdomen without knowing the source of the leak, Dr. Vinson testified that he had not been concerned,

because there's some injury in that area and so as long as you can collect it and it doesn't pool, then you hope with conservative therapy it will just seal itself and not drain anymore. Because there isn't anything else you can do short of going back to surgery and trying to figure it out, and any time you're dealing with the pancreas, it's a little bit more complicated surgery. So these leaks, like I mentioned earlier, either bile leak or pancreatic leak, as long as they're being collected and not allowed to lie freely in the peritoneal cavity [are not of great concern].

(Tr. at 106-109).

35. Dr. Vinson testified that he had not believed that the cancer had been limited to the gastric area because of the amount of inflammation that he had found in the duodenum and overlying the pancreas. He stated that he had suspected duodenal cancer, bile duct cancer, or pancreatic cancer. Dr. Vinson testified that during the second surgery he had performed biopsies of the pancreas, omentum and lymph nodes. Dr. Vinson testified that all of the additional biopsies had been negative. (Tr. at 112-113, 441-442; St. Ex. 5 at 124).

Dr. Vinson testified that he should have been aware of the cancer prior to the first surgery. Dr. Vinson testified that, when the EGD was performed, the pylorus had been visible, and the cancer should have been detected. He stated that, had it been detected, it could have been biopsied prior to surgery. (Tr. at 113- 115).

Dr. Vinson testified that the existence of cancer is significant because, with cancer, the surgical strategy is different than with ulcerative disease. Instead of taking out the last third of the stomach and the first part of the duodenum and carefully dissecting through the inflamed tissue, it may have been appropriate to "remove the entire area." He added that, "if you know there's cancer there, you don't go cutting and digging into that because you are cutting across cancer lines." (Tr. at 115-117). Dr. Vinson concluded that the injury had occurred,

because there was cancer there that was missed that should have been caught because the right study to find that cancer was done, it was just missed. So I come in behind them, I do an operation, I'm cutting across planes that I shouldn't be cutting across because I'm thinking he's got benign disease. I didn't do a cancer operation the first time. I did an operation for a benign disease. * * * So I end up getting into a mess because I thought I was operating for benign disease when I was operating for cancer.

(Tr. at 117-118).

Dr. Vinson testified that, had he known pre-operatively that Patient 5 had had cancer of the pylorus, Dr. Vinson should have transferred the patient to a larger hospital in case Patient 5 would have needed a resection of the pancreatic head well as the duodenum, bile duct and gallbladder. (Tr. at 120).

Dr. Vinson acknowledged that the pathology report indicates that the cancer had been limited to the pylorus. Nevertheless, Dr. Vinson testified that "cancer does not always spread by direct extension," and that "metastatic disease means that cancer is at a different location than where it started." Dr. Vinson concluded that he could not rely on the pathology report to be certain that tissue beyond the pylorus was not cancerous. (Tr. at 118; St. Ex. 5 at 124).

Dr. Vinson further acknowledged that biopsies performed on surrounding tissues had been negative. Nevertheless, Dr. Vinson testified that, when performing biopsies of solid organs such as the head of the pancreas, the biopsy needle may miss the cancerous tissue, and the biopsy will come back negative. Therefore, Dr. Vinson concluded that the fact that the biopsies were negative did not necessarily mean that the other tissues were not cancerous. (Tr. at 118-120).

Dr. Vinson testified that he had referred Patient 5 to an oncologist after discharge. Dr. Vinson further testified that Patient 5 had died approximately one year later as a result of metastatic cancer. (Tr. at 443-446).

Testimony of Dr. Ellison

36. Dr. Ellison testified that, based in part upon his review of the medical records for Patient 5, he believed that the care Dr. Vinson provided to Patient 5 had fallen below the minimal standards of care. In reaching that conclusion, Dr. Ellison cited the fact that, during a gastric resection, Dr. Vinson had caused injury to Patient 5's ampulla of Vater. (Tr. at 252-253).

Dr. Ellison testified that, during the first surgery on Patient 5, Dr. Vinson had removed more duodenum than was necessary, which had resulted in an injury to the ampulla of Vater. Dr. Ellison explained that the ampulla of Vater is very important in regulating bile and pancreatic juice flow, and is located approximately four to five centimeters from the pylorus. Dr. Ellison referred to the pathology report which indicated the portion of the duodenum removed by Dr. Vinson had measured 5 by 4 centimeters. (Tr. at 253-254, 342; St. Ex. 5 at 124).

Dr. Ellison testified that, when removing the pylorus, whether there is cancer or simply an ulcer, only a two centimeter margin needs to be removed. Dr. Ellison testified that if the tumor is further down in the duodenum which would require removal of more length of the

duodenum, then a Whipple operation needs to be done. Dr. Ellison testified that a Whipple procedure includes removal of the head of the pancreas, the bile duct, and the total duodenum, followed by reconstruction. Dr. Ellison testified that a Whipple had not been indicated in this case. Therefore, Dr. Ellison concluded that Dr. Vinson had performed the appropriate procedure, but had performed it improperly. (Tr. at 254-255, 344-345).

Dr. Ellison testified that Dr. Vinson had removed the ampulla of Vater, and had “left it sitting on the pancreas leaking bile.” During the surgery, Dr. Vinson had identified the bile leakage, but had not been able to determine its source. Therefore, Dr. Vinson had performed a bypass on the gallbladder, trying to get the bile to drain another way. Dr. Ellison testified that this was a difficult situation, and that he would not expect the surgeon to be able to identify the source of the bile leakage in all cases. Dr. Ellison further testified that one would need a detailed understanding of the anatomy in this area, loop magnification, special instruments, and possibly a cholangiogram. Nevertheless, Dr. Ellison testified that Dr. Vinson’s error had occurred when he removed too much of the duodenum. Dr. Ellison testified that this was a technical error on Dr. Vinson’s part. (Tr. at 255-256, 346-347).

37. Dr. Ellison was presented with Dr. Vinson’s testimony that, despite the preoperative EGD, Patient 5’s cancer had not been diagnosed prior to surgery and that, had Dr. Vinson been aware of the tumor, he would have performed a different procedure. Dr. Ellison testified that, even given that information, his opinion regarding the care Dr. Vinson had provided to Patient 5 did not change. Dr. Ellison testified that the type of procedure Dr. Vinson performed had been the appropriate procedure even had he been aware of Patient 5’s cancer. (Tr. at 256-257, 341-342).

Dr. Ellison concluded that Dr. Vinson’s technical skills had fallen below the standard of care. Dr. Ellison further testified that this was “an unacceptable outcome in a patient having a gastric surgery.” (Tr. at 257-258).

Patient 6

Allegations

38. In its May 8, 2002, Notice of Opportunity for Hearing, the Board alleged that Dr. Vinson had made a judgmental error during his care and treatment of Patient 6. More specifically, the Board alleged that Dr. Vinson had performed surgery on Patient 6 for constipation although the surgery had not been indicated. The Board further alleged that Dr. Vinson had failed to follow the recommendation of another physician to obtain a cardiology consult prior to performing surgery on Patient 6. (St. Ex. 11A).

Medical Records for Patient 6

39. On November 26, 1998, Patient 6, an eighty-six year old woman, presented to the Fulton County Health Center emergency department with a number of complaints, including

constipation and difficulty voiding. A foley catheter was inserted and drained 2000 cc of urine. The emergency department physician diagnosed severe dehydration, hyponatremia, hyperkalemia, anemia, urinary retention, constipation, and excessive anticoagulation. Prior to admission, Patient 6 had been living alone at home and caring for herself. (St. Ex. 6 at 6, 30).

Patient 6 was admitted to the hospital by her family physician, Robert W. Nyce, M.D. Dr. Nyce noted that Patient 6 had had a history of atrial fibrillation, and was taking anti-coagulants as a result. At the time of admission, Patient 6 had a fecal impaction, "a huge amount of retained urine," anemia, and electrolyte imbalance. Impressions were listed as: atrial fibrillation, controlled; coronary artery disease; cardiac failure; fecal impaction; urinary retention; renal insufficiency; and osteoarthritis. (St. Ex. 6 at 6-7).

On admission, Patient 6's labwork revealed the following:

- a. an elevated white blood cell count of 12.9, [normal 4.3-11.0];
- b. a low hemoglobin of 10.8, [normal 12.0-16.0];
- c. a low hematocrit of 33.9, [normal 38.0-47.0];
- d. an elevated prothrombin time of 50.7, [therapeutic 10.3-12.8];
- e. an elevated INR of 4.23, [therapeutic for atrial fibrillation at 2.0-3.0];
- f. a low albumen of 3.4, [normal 3.9-5.1];
- g. an elevated creatinine of 4.8, [normal 0.4-1.5];
- h. an elevated BUN of 84, [normal 5-25];
- i. a low sodium of 129, [normal 135-148];
- j. an elevated potassium of 5.4, [normal 3.5-5.0]; and
- k. a low chloride of 93, [normal 98-115].

(St. Ex. 6 at 44-47).

On November 27, 1998, Dr. Nyce noted that Patient 6 had started passing stool with enemas. He also noted that her BUN remained elevated. (St. Ex. 6 at 9).

On November 28, 1998, Patient 6 received one unit of red blood cells. (St. Ex. 6 at 65).

On November 30, 1998, Dr. Nyce consulted Dr. Vinson to address Patient 6's "persistent constipation." (St. Ex. 6 at 11). On November 30, Patient 6's labwork revealed the following:

- a. a normal white blood cell count of 5.1, [normal 4.3-11.0];
- b. a low hemoglobin of 8.4, [normal 12.0-16.0];
- c. a low hematocrit of 27.9, [normal 38.0-47.0];
- d. an elevated prothrombin time of 37.7, [therapeutic 10.3-12.8];
- e. an elevated INR of 3.16, [therapeutic for atrial fibrillation 2.0-3.0];

- f. a low albumen of 1.9, [normal 3.9-5.1];
- g. an elevated creatinine of 1.6, [normal 0.4-1.5];
- h. an elevated BUN of 27, [normal 5-25];
- i. a normal sodium of 135, [normal 135-148];
- j. a normal potassium of 3.7, [normal 3.5-5.0]; and
- k. a normal chloride of 101, [normal 98-115].

(St. Ex. 6 at 44-49).

On December 2, Dr. Nyce noted that Dr. Vinson had recommended using intravenous Reglan to help clear Patient 6's bowels. The following day, Patient 6 had a large bowel movement. A KUB was performed. Dr. Nyce noted that Dr. Vinson would see Patient 6 in the morning. (St. Ex. 6 at 12-13).

On December 3, 1998, Patient 6's labwork revealed the following:

- a. a normal white blood cell count of 6.1, [normal 4.3-11.0];
- b. a low hemoglobin of 8.5, [normal 12.0-16.0];
- c. a low hematocrit of 27.1, [normal 38.0-47.0];
- d. an elevated prothrombin time of 15.5, [therapeutic 10.3-12.8];
- e. a low INR of 1.31, [therapeutic for atrial fibrillation 2.0-3.0];
- f. a low albumen of 3.4, [normal 3.9-5.1];
- g. a normal sodium of 137, [normal 135-148];
- h. a normal potassium of 4.2, [normal 3.5-5.0]; and
- i. a normal chloride of 104, [normal 98-115].

(St. Ex. 6 at 48-50).

On December 4, 1998, Dr. Vinson performed a colonoscopy which demonstrated a redundant sigmoid colon and sigmoid diverticulosis. (St. Ex. 6 at 14, 15, 34).

On December 5, 1998, Dr. Nyce noted that "Dr. Vinson felt that the patient has a rather enlarged colon and she might benefit from surgery. I can discuss it with the patient and her representatives and we'll determine whether surgery should be done or not." (St. Ex. 6 at 17).

That afternoon, Dr. Vinson wrote that he had discussed the possibility of surgery with Patient 6. He further noted that Patient 6 would discuss the matter with her family and make a decision. (Tr. at 18).

On December 6, 1998, Dr. Nyce wrote that,

The patient has been seen by Dr. Vinson and it's been discovered that she has a rather large megacolon which is sure to give her more trouble with her

bowels than she has had previously and will need a partial colonoscopy [sic] and has been scheduled for tomorrow. The patient in the past has had atrial fibrillation. She is not fibrillating at this point. She has a very elevated prothrombin time which is now back to normal. The patient has not had any chest pain nor has she had any chest pain [sic] or shortness of breath or ankle edema and her respiratory rate is regular. She has been advised that it might be wise to have a cardiac consult. She wants to have her surgery tomorrow. She might [illegible] and doesn't want further work up if she doesn't have to. The patient's nephew who is returning will be calling this afternoon and he will also be advised that a cardiac consult might be advisable even though this has to be scheduled later for whatever cardiac condition she has. This will be decided after talking to her nephew.

(St. Ex. 6 at 19).

On December 6, 1998, Patient 6 received two units of red blood cells. (St. Ex. 6 at 65).

On December 7, 1998, Dr. Nyce noted that Patient 7 had been scheduled for surgery with Dr. Vinson that day. He stated that Patient 6 had had an "extremely low potassium" for which she was being given potassium therapy. Dr. Nyce further stated that Patient 7 was "quite anemic" and that she had been given one unit of packed red cells. Finally, Dr. Nyce noted that,

Again Dr. Vinson has decided that she does not need a cardiac consult even though it was advised by myself that I thought that should be done. He feels that if any cardiac problems arise he can call cardiology to surgery if necessary. The patient is prepared for surgery. Her nephew who is the executor of her estate and she had both agreed to do the surgery.

(St. Ex. 6 at 21).

On December 7 at 6:35 am, Patient 6's labwork revealed the following:

- a. a low albumen of 1.9, [normal 3.9-5.1];
- b. a normal creatinine of 1.3, [normal 0.4-1.5];
- c. a normal BUN of 10, [normal 5-25]; and
- d. a low potassium of 2.3, [normal 3.5-5.0].

(St. Ex. 6 at 5).

At 8:30 am, Dr. Vinson ordered 100 cc of normal saline with potassium chloride 10 mEq to be administered intravenously over thirty minutes and to be repeated three times. Dr. Vinson also ordered the infusion of two units of packed red blood cells. At 8:49 am, Patient 6's

potassium was 2.2, [normal 3.5-5.0]. At 9:10 am, Dr. Vinson transferred Patient 6 to the intensive care unit. (St. Ex. 6 at 53, 146, 147).

At 10:40 am, Dr. Vinson ordered a total of four bags of 100 cc of normal saline with potassium chloride 10 mEq to be administered intravenously over thirty minutes each. At 12:24 pm, Patient 6's potassium was 2.8, [normal 3.5-5.0]. (St. Ex. 6 at 53, 148).

At 1:02 pm, Patient 6's hemoglobin was 8.5, [normal 12.0-16.0]. (St. Ex. 6 at 52).

At approximately 2:00 pm, Dr. Vinson took Patient 6 to surgery for an exploratory laparoscopy, open laparotomy with sigmoid and left colectomy, intraoperative colonoscopy, splenectomy, and removal of accessory spleen. Although not included in Dr. Vinson's reports, the operative nursing notes and the recovery room record also indicate that an attempted repair of a perforated bowel and repair of splenic lacerations had been performed. During surgery, Dr. Vinson ordered, among other things, blood transfusions and intravenous potassium. (St. Ex. 6 at 20, 38, 40a, 42, 148).

Patient 6 was transferred to the recovery room at approximately 8:30 pm. Dr. Vinson noted that Patient 6 had been "awakened from anesthesia" and "transferred to the recovery room in satisfactory condition." Nevertheless, the recovery room nurses notes indicate that Patient 6 was non-responsive and breathing with the assistance of a ventilator. From the recovery room, Patient 6 was transferred to the intensive care unit. Moreover, Patient 6 did not awaken after surgery and remained responsive only to painful stimuli. (St. Ex. 6 at 1, 23-26, 39, 42a).

On December 8, 1998, Patient 6's labwork revealed the following:

- a. an elevated white blood cell count of 19.4, [normal 4.3-11.0];
- b. a low hemoglobin of 10.1, [normal 12.0-16.0];
- c. a low hematocrit of 29.9, [normal 38.0-47.0];
- f. a low albumen of 1.4, [normal 3.9-5.1]; and
- h. a low potassium of 3.2, [normal 3.5-5.0].

(St. Ex. 6 at 52-53).

On December 10, 1998, a report of C.T. scan of the brain without contrast concluded "subacute epidural and subdural hematoma on the left as well as some fresh blood in the left temporal horn. The possibility of infarction cannot be excluded and a contrast enhanced study may be helpful." (St. Ex. 6 at 80).

On December 10, 1998, Patient 6 was transferred per Life Flight to a Neurological ICU at Toledo Hospital. (St. Ex. 6 at 1, 2, 157). Patient 6 subsequently passed away. (Tr. at 144).

Testimony of Dr. Vinson

40. Dr. Vinson testified that he had been contacted for a surgical consultation related to constipation on November 30, 1998, four days after Patient 6's admission to the hospital. Dr. Vinson testified that, if constipation is intractable to conservative management, surgery is appropriate. (Tr. at 123-124; St. Ex. 6 at 11).

Dr. Vinson stated that his original plan had been to perform a colonoscopy to evaluate the appearance of the colon and to determine if cancer was the cause of Patient 6's constipation. Dr. Vinson testified that he had performed the colonoscopy on December 4, 1998. The preoperative diagnosis was "severe constipation," and the postoperative diagnosis was "redundant sigmoid colon" and "sigmoid diverticulosis." Dr. Vinson explained that a redundant sigmoid colon implies that there is more sigmoid colon than necessary. He further explained that diverticulosis indicates "little out-pouches in the wall of the colon." (Tr. at 124-126; St. Ex. 6 at 34).

Dr. Vinson testified that he had performed the surgery to relieve Patient 6's chronic constipation. Dr. Vinson testified that, in evaluating the risks and benefits of surgery for Patient 6, he had considered the fact that she had benign disease, which is generally treated conservatively. Dr. Vinson testified that he had met with Patient 6's nephew, Patient 6's only living relative. The nephew and Patient 6 advised Dr. Vinson that she had been fighting constipation for many years and had been hospitalized previously because of it. Patient 6 advised Dr. Vinson that her bowels moved only once or twice a month. Therefore, Dr. Vinson decided that "it was a matter of lifestyle." He advised Patient 6 that he "could go either way," and do the surgery or continue medical treatment. He decided to follow whatever decision Patient 6 and her nephew made. Dr. Vinson testified that Patient 6 had been "eager" for surgery. (Tr. at 127-129, 459-460).

41. Dr. Vinson testified that he and Dr. Nyce had discussed the possibility of obtaining a cardiac consultation for Patient 6 prior to surgery and that Dr. Nyce had written a progress note recommending it. Dr. Vinson denied, however, that he had decided not to obtain a cardiac consultation despite the fact that Dr. Nyce had written a note to that effect. Moreover, Dr. Vinson testified that he did not know why Dr. Nyce had written a note indicating that Dr. Vinson had stated that if cardiac problems arose, he could call a cardiologist to surgery. Dr. Vinson denied having made that statement. (Tr. at 131-132, 135; St. Ex. 6 at 19).

Dr. Vinson further testified that he and Dr. Nyce had had a conversation during which it had been noted that Patient 6 had had a history of atrial fibrillation. Nevertheless, Patient 6 had not had any cardiac problems during the hospitalization. Moreover, it had been noted that Patient 6's prothrombin time had been elevated upon admission, but that that problem had been resolved. Dr. Vinson testified that he had told Dr. Nyce that he, Dr. Vinson, did not have strong feelings about a cardiac consultation and that he would be satisfied if Dr. Nyce simply cleared Patient 6 for surgery. Dr. Vinson further testified that he had interpreted

Dr. Nyce's later note that "the patient is prepared for surgery" as Dr. Nyce's statement that Patient 6 had been medically cleared for surgery. (Tr. at 132-135; St. Ex. 6 at 21).

Dr. Vinson testified that, when an elderly patient goes to surgery, the primary care physician always makes the medical decision that the patient is ready for surgery. Therefore, it had been Dr. Nyce's responsibility to contact the cardiologist. Dr. Vinson added that, if there had been an obvious indication that Patient 6 would not tolerate surgery, he would not have taken her to surgery even with medical clearance. (Tr. at 137-143).

Dr. Vinson testified that he had told Dr. Nyce specifically that Dr. Nyce must give Patient 6 medical clearance for surgery and that Dr. Nyce had specifically told Dr. Vinson that Patient 6 was "unequivocally" cleared for surgery. Dr. Vinson further testified that, although Dr. Nyce had originally wanted a cardiac consultation, after being informed that Patient 6 did not want one, Dr. Nyce had changed his mind. Moreover, Dr. Vinson denied that he had ever represented to Dr. Nyce that Patient 6 did not need a cardiac consultation or that he would call a cardiologist during surgery if a problem arose at that time. (Tr. at 510). Dr. Vinson further testified that he had not advised Patient 6 or her nephew against getting a cardiac consultation. (Tr. at 507-510, 525).

Testimony of Dr. Nyce

42. Robert W. Nyce, M.D., testified at hearing on behalf of the State. Dr. Nyce testified that it is his belief that a surgeon should make the determination that a particular surgery is appropriate for a patient. Dr. Nyce testified that the hospital did not have a policy regarding that issue, but that he would assume it is the surgeon's responsibility. (Tr. at 539, 548-550).

Dr. Nyce stated that he had not advised Patient 6 to have surgery. Dr. Nyce stated that he had explained to Patient 6 that the surgery was not an emergency and that he recommended that Patient 6 have a cardiac consultation prior to undergoing surgery. Dr. Nyce testified that he had suggested to Patient 6 and her nephew that that it would be a good idea to have a cardiac consultation prior to surgery because she had had previous cardiac problems. (Tr. at 539-541, 548-550, 552-553; St. Ex. 6 at 19).

Regarding his note that Dr. Vinson had not wanted a cardiac consultation, Dr. Nyce testified that he had received that information from Patient 6. (Tr. at 557-558).

Regarding his December 5, 1998, note which states, "we'll determine whether surgery should be done," Dr. Nyce testified that he had meant that Dr. Vinson would make that determination along with the patient. Dr. Nyce admitted that he should have written "Dr. Vinson will determine," rather than "we'll determine." (Tr. at 540, 551-552; St. Ex. 6 at 16).

Regarding his notation that Patient 6 had been “prepared for surgery,” Dr. Nyce testified that he had been talking primarily about Patient 6’s mental state. Dr. Nyce further testified that he had written the note because Patient 6 had wanted to go to surgery and did not want a cardiac consultation. Dr. Nyce explained that the note was not an indication that he had cleared Patient 6 medically for surgery. He added that, if he had intended to indicate that she was medically cleared for surgery, he would have written that specifically. Moreover, Dr. Nyce denied that Dr. Vinson had ever asked him to provide medical clearance for Patient 6’s surgery. In fact, Dr. Nyce testified that he did not remember having any discussions with Dr. Vinson regarding Patient 6. (Tr. at 541-543, 557, 554-555; St. Ex. 6 at 21).

Testimony of Dr. Ellison

43. Dr. Ellison testified that, based in part upon his review of the medical records for Patient 6, he believed that the care Dr. Vinson provided to Patient 6 had fallen below the minimal standards of care. In reaching that conclusion, Dr. Ellison cited the fact that Dr. Vinson had performed surgery for megacolon constipation when such surgery was not indicated and when Patient 6 was “in no condition to undergo an operation of such magnitude.” Dr. Ellison stated that Dr. Vinson had made an error in judgment. (Tr. at 258-259).

Dr. Ellison noted that a decision had been made to recommend surgery apparently for what was thought to be a megacolon and constipation. Dr. Ellison testified that megacolon is a condition in which the colon is dilated and contracts slowly. Dr. Ellison testified that there are a number of medications that can be given these patients to avoid fecal impactions. In addition, patients can use enemas or manual disimpaction. Dr. Ellison surmised that half of the population of eighty-six year olds are living with a redundant sigmoid colon and diverticular disease. (Tr. at 260-261, 262-263).

44. Dr. Ellison noted that, on November 30, 1998, Patient 6 had had a low serum albumen of 1.9, which was an indication that she was malnourished. Dr. Ellison testified that a low albumen is a significant predictor of a poor outcome in a surgical patient. Dr. Ellison further testified that there are several studies that indicate that an albumen below 2 is critical and that a patient should not undergo an elective operation with an albumen below 2 without efforts first being made to correct it. He further testified that, without sufficient albumen, the body is unable to produce the protein necessary for healing and the chances of recovery are extremely low. (Tr. at 261, 263-264).
45. Dr. Ellison further noted that, on the day of surgery, Patient 6 had had a potassium level of 2.3 and had required vigorous potassium resuscitation prior to the operation. Dr. Ellison testified that, because of the low potassium and the need to replace it, the operation was not performed until later in the day. Dr. Ellison testified that this had been an elective procedure, and that the patient had not been well prepared for surgery. (Tr. at 261).

Dr. Ellison testified that a low potassium is significant because, with a low potassium at the induction of anesthesia, the patient has a tendency toward cardiac arrhythmias that could lead to ventricular tachycardia, ventricular fibrillation and death. Dr. Ellison stated that patients who have potassium levels as low as Patient 6's usually do not undergo an elective operation. Since it was an elective surgery, Dr. Ellison testified that it should have been postponed. (Tr. at 264-265).

46. Dr. Ellison noted that, subsequent to surgery, Patient 6 had experienced a cerebral vascular accident [CVA] or stroke. Dr. Ellison concluded that Patient 6 should not have had the operation and that, even in a healthy patient, this operation is generally not performed on eighty-six year old people. (Tr. at 261-262).

Dr. Ellison further noted that Patient 6 had last had an INR done four days prior to surgery and that Patient 6 had suffered either an embolic or hemorrhagic cerebral vascular accident. Dr. Ellison also noted that Patient 6 had had a history of atrial fibrillation and that one of the risks associated with atrial fibrillation is clot formation in the heart. Dr. Ellison further explained that, with a low potassium, Patient 6 had been at greater risk for cardiac arrhythmias with the induction of anesthesia, which increases the risk of atrial or ventricular irritability and, with that, the possibility that a clot will dislodge and result in an embolic cerebral vascular accident. Dr. Ellison stated that this is one of the reasons that a cardiology consultation had been critical for Patient 6. (Tr. at 365-367).

47. Dr. Ellison noted that Dr. Nyce had recommended a cardiology consultation preoperatively. Dr. Ellison stated that Patient 6 should have been seen by a cardiologist prior to surgery. Dr. Ellison testified that Dr. Vinson may argue that it was the family physician's responsibility to order the cardiology consultation, but Dr. Ellison testified that it had been Dr. Vinson's responsibility to assure that the patient was properly evaluated before Dr. Vinson took her to surgery. Dr. Ellison testified that the cardiology consult was an integral part of the preoperative surgical management of this patient. Dr. Ellison concluded that it had been below the minimal standard of care for Dr. Vinson to proceed to surgery on Patient 6 without first obtaining a cardiology consultation. (Tr. at 265-270, 273-274).
48. Dr. Ellison concluded that Dr. Vinson had made "a series of very serious mistakes" in his care and treatment of Patient 6. (Tr. at 265). Dr. Ellison further concluded that Patient 6 had been a high risk patient, she had had a low potassium level which had required aggressive therapy on the day of surgery, and she had had a low albumen which was not treated. Finally, Dr. Ellison concluded that the surgery had not even been indicated for Patient 6's problems. Dr. Ellison testified that he would not have recommended this surgery for Patient 6 even as a matter of lifestyle based on a long history of constipation. (Tr. at 268, 273).

Dr. Ellison was asked if the fact that both Patient 6 and her nephew had been enthusiastic for the surgery to be performed would alter his opinion. Dr. Ellison testified that it would

not change his opinion as neither Patient 6 nor her nephew had the knowledge and background to make a decision on whether a surgical procedure is appropriate. Dr. Ellison testified that the family relies on the surgeon to present the case as to why to do the surgery. Dr. Ellison testified that, if the family had insisted that the surgery be done, he would have referred the patient to another surgeon. He stated that he would not have “touched this case.” (Tr. at 274-275).

49. Dr. Ellison was referred to a study documented in an article by Yau-Tong You, M.D., entitled, “Segmental Colectomy in the Management of Colonic Inertia,” and published in American Surgeon in 1998. Dr. Ellison testified that the study dealt with patients between the ages of twenty and seventy, with two-thirds of the patients between the ages of twenty and forty. Dr. Ellison concluded that, for that reason alone, the study had no applicability to an eighty-six year old patient. Dr. Ellison further testified that the patients in the study had undergone numerous colon motility tests and anorectal function examinations which included colon transit time, balloon expulsion test, anal sphincter resting and squeeze pressures, rectoanal inhibitory reflexes, and defecography. Dr. Ellison noted that none of these tests had been performed on Patient 6. Dr. Ellison concluded that there is “no way” that the article could be used to justify the surgery performed on Patient 6. (Tr. at 276-277).

Response of Dr. Vinson

50. Dr. Vinson testified that there is a relationship between hydration levels and albumin levels and that Patient 6’s albumin levels had not been as low as they had appeared to be. Dr. Vinson stated that if a person is treated with fluids for dehydration when the person is not dehydrated, the actual values appear to be low when they are not. Dr. Vinson further testified that Patient 6 had not really been dehydrated despite the admission diagnosis of severe dehydration. Dr. Vinson testified that, although the emergency room physician had diagnosed severe dehydration, Dr. Nyce had not included that diagnosis in his history and physical. (Tr. at 446-450; St. Ex. 6 at 138).

Dr. Vinson further explained that dehydration is caused by not taking fluids in or by excessive fluid output. Dr. Vinson concluded that, because Patient 6 had not been vomiting and had not been voiding, she could not have been dehydrated. When confronted with the fact that Patient 6’s bladder had contained “a huge amount of urine,” Dr. Vinson reiterated his statement that Patient 6 had not been urinating. Dr. Vinson did not respond to the fact that, since Patient 6’s bladder was retaining a large amount of urine, her kidneys had been producing urine. (Tr. at 449-453).

51. Regarding the low potassium level, Dr. Vinson testified that, on the morning of surgery, he had transferred Patient 6 to a cardiac intensive care unit [CCU], and had ordered aggressive potassium replacement, a blood transfusion, and central line insertion. Moreover, he had ordered that the patient be placed on telemetry cardiac monitoring in order to watch for arrhythmias. (Tr. at 453-457; St. Ex. 6 at 146).

Dr. Vinson testified that potassium is something that can be corrected quickly and that, once it's corrected, "it's just as if it was never abnormal." Therefore, there had been no risk in taking Patient 6 to surgery once her potassium level had returned to normal. (Tr. at 455).

52. Dr. Vinson disagreed with Dr. Ellison's assessment that Patient 6 had been very ill at the time of surgery. Dr. Vinson testified that Patient 6 had been walking and talking prior to surgery and she "wasn't having any problems." Dr. Vinson testified that, if he had not done surgery, she would have been discharged to home where she had been taking care of herself and was functioning well. Dr. Vinson further testified that, if Patient 6 had been discharged without surgery, she would have had to rely on more conservative measures to treat her chronic constipation. Dr. Vinson acknowledged that those measures had been working in the hospital prior to surgery. Dr. Vinson testified, however, that it would have been difficult for Patient 6 to give herself an enema at home. Nevertheless, he admitted that a visiting nurse could have administered it for her. (Tr. at 457-458, 510-512).

Patient 7

Allegations

53. In its May 8, 2002, Notice of Opportunity for Hearing, the Board alleged that Dr. Vinson had made a technical error during his care and treatment of Patient 7. More specifically, the Board alleged that Dr. Vinson had caused injury to Patient 7's spleen during surgery, resulting in an incidental splenectomy. (St. Ex. 11A).

Medical Records for Patient 7

54. [Note: The medical records for Patient 7 include records for more than one hospital admission. The records at issue in this matter are those for the admission of January 11, 1999, through January 22, 1999. These records can be found in State's Exhibit 7, starting on page 174.]

On January 11, 1999, Patient 7, a sixty-nine year old woman, presented to the Fulton County Health Center with complaints of abdominal pain. An x-ray revealed dilated loops of the large bowel. Her liver enzymes were elevated, and a C.T. scan of the abdomen revealed "some air in the biliary tree consistent with emphysematous cholecystitis." Her admission diagnosis was ileus versus a bowel obstruction. (St. Ex. 7 at 183).

On January 12, 1999, Dr. Vinson attempted a laparoscopic cholecystectomy which, during the course of the surgery, he converted to an open procedure. After opening the abdomen, Dr. Vinson found that the gallbladder had adhered to the proximal transverse colon. Dr. Vinson dissected the colon from the gallbladder, and found a cholecystocolonic fistula.

Dr. Vinson resected the fistula. Thereafter, Dr. Vinson dissected the gallbladder from the liver and removed the gallbladder. (St. Ex. 7 at 206-207, 235, 236).

Dr. Vinson then explored the abdomen and palpated a mass in the sigmoid colon. Dr. Vinson noted that the mass appeared to be a large gallstone which had impacted in the sigmoid colon and was obstructing the colon. Dr. Vinson was unable to move the stone, so performed a colotomy and extracted the stone. The stone measured 4 cm in diameter. (St. Ex. 7 at 207, 235).

Thereafter, Dr. Vinson had been unable to close the colotomy to due to the fragility of the colon wall. Accordingly, Dr. Vinson performed a colostomy. In doing so, Dr. Vinson mobilized the left colon "from the proximal stump to the distal transverse colon in order to be able to deliver the proximal stump to the abdominal wall without any tension." (St. Ex. 7 at 207, 235).

Subsequently, Dr. Vinson noted bleeding from the spleen. After packing with laparotomy tapes, electrocautery, and suture ligation failed to stop the bleeding, Dr. Vinson performed a splenectomy. (St. Ex. 7 at 207-208, 235, 236).

Testimony of Dr. Vinson

55. Dr. Vinson testified that Patient 7 was a very obese woman, and he had had to free a substantial length of colon in order to reach the abdominal wall without causing tension on the colon. Dr. Vinson added that the colon had been dilated due to the trauma of the stone, and the dilated colon had blocked his view of the abdomen. Dr. Vinson testified that, during the procedure to mobilize the colon, there had been an injury to the spleen which had resulted in bleeding that could not be controlled with conservative measures. Therefore, he had removed her spleen. (Tr. at 151).

Testimony of Dr. Ellison

56. Dr. Ellison testified that, based in part upon his review of the medical records for Patient 7, he believed that the care Dr. Vinson provided to Patient 7 had fallen below the minimal standards of care. In reaching that conclusion, Dr. Ellison cited the fact that Dr. Vinson had injured Patient 7's spleen during the course of surgery. Dr. Ellison testified that the injury to the spleen in this case had been avoidable and was below the minimal standard of care. (Tr. at 278-280, 283).

Dr. Ellison explained that, when removing a section of the sigmoid colon, it is necessary to attach the proximal portion of the intestine to the abdominal wall to create a colostomy. Dr. Ellison testified that Dr. Vinson had done that in this case, which was appropriate based on the findings. Dr. Ellison further testified, however, that the question remained as to how

much mobilization was necessary and whether it is within the standard of care to injure the spleen during that mobilization. (Tr. at 280-281).

Dr. Ellison testified that it is normally not necessary to mobilize the splenic flexure in order to get adequate length of bowel to form the necessary colostomy. Dr. Ellison further testified that, when it is necessary to mobilize the splenic flexure, there are techniques to take down the splenic flexure by which injury to the spleen can be avoided. Dr. Ellison concluded that Dr. Vinson had not appropriately employed these techniques and, as a result, the spleen was injured. Therefore, Dr. Ellison stated that it had been below the minimal standard of care to remove the spleen during the resection of the bowel. (Tr. at 281-284).

Response of Dr. Vinson

57. Dr. Vinson testified that he had needed to mobilize a greater length of Patient 7's bowel because Patient 7 was morbidly obese. (Tr. at 463-466)

Response of Dr. Ellison

58. Dr. Ellison testified that morbid obesity can impact the mobilization of the sigmoid colon because, depending on how thick the abdominal wall is, greater length of the sigmoid colon may be needed to mobilize the splenic flexure in an obese patient. Dr. Ellison further testified that, in a morbidly obese patient, it would certainly be a higher risk situation. Finally, Dr. Ellison concluded that, if Patient 7 had had a BMI over 40, that could potentially change his opinion and would "lessen the strength of [his] argument" that Dr. Vinson's care had fallen below the minimal standard of care. (Tr. at 370-371, 396-398).

Patient 7's Weight and BMI

59. A review of the medical record reveals that Patient 7 was 5' 3" tall. During the course of the hospitalization, Patient 7 weighed between 244.2 pounds, a BMI of 43.3, and 273.1 pounds, a BMI of 48.4. (St. Ex. 7 at 203a, 203b, 204a, 292, 296; Board Exhibit 1).

Patient 8

Allegations

60. In its May 8, 2002, Notice of Opportunity for Hearing, the Board alleged that Dr. Vinson had made a judgmental error during his care and treatment of Patient 8. More specifically, the Board alleged that Dr. Vinson had failed to perform an axillary dissection at the time he performed a mastectomy on Patient 8, resulting in an additional operation. (St. Ex. 11A).

Medical Records for Patient 8

61. On August 12, 1998, Patient 8, a seventy-five year old woman, was admitted to the Fulton County Health Center. Dr. Vinson noted that Patient 8 had a large left breast mass

approximately 5 cm in diameter, with nipple retraction and ulceration below the nipple. She also had palpable left axillary lymph nodes. (St. Ex. 8 at 7-8). In his Impression, Dr. Vinson stated that,

This most assuredly represents a breast cancer, probably metastatic to the left axillary lymph nodes. She has not had a mammogram, which I feel is necessary to evaluate the right breast. I feel a biopsy under local anesthesia [is] needed for a tissue diagnosis and cell type, and then consultation with an oncologist for the most appropriate treatment. I do not feel she is a candidate for aggressive surgical treatment. * * *

(St. Ex. 8 at 8).

On August 12, 1998, Dr. Vinson performed an excisional biopsy of the mass which encompassed almost the entire left breast, including the skin. The pathology report demonstrated a 5 by 4 by 2.5 cm infiltrating ductal carcinoma with invasion of the skin, nipple, and lymphatics. (St. Ex. 8 at 11, 17).

On October 2, 1998, during a second hospitalization, Patient 8 underwent a left axillary dissection. In his admission note, Dr. Vinson stated,

She has been seen by Oncology and plans have been made to proceed with radiation and Tamoxifen. She now presents for axillary node dissection as well as possible re-excision of chest wall margins. * * *

(St. Ex. 8 at 59).

Testimony of Dr. Vinson

62. Dr. Vinson testified that Patient 8 had presented to his office in early August 1998. After examining Patient 8, Dr. Vinson had had little doubt that Patient 8 had breast cancer. He stated that he had discussed it with Patient 8 who had been adamant that she did not want any aggressive therapy, including major surgery, radiation or chemotherapy. Dr. Vinson testified that he had convinced Patient 8 to allow him to biopsy the breast. Dr. Vinson further testified that, because of the size of the tumor in relation to the patient's breast, the biopsy had, in actuality, been a simple mastectomy. (Tr. at 158-163, 470-472).

Dr. Vinson testified that, after the pathology report confirmed cancer, he had been able to convince Patient 8 to see an oncologist. He further testified that the oncologist was later able to convince Patient 8 to undergo chemotherapy and radiation. Dr. Vinson testified that the oncologist would not initiate chemotherapy without a tissue diagnosis of positive lymph nodes. Therefore, both the oncologist and the patient had requested that Dr. Vinson perform the second surgery for an axillary dissection. (Tr. at 164-165)

Testimony of Dr. Ellison

63. Dr. Ellison testified that, based in part upon his review of the medical records for Patient 8, he believed that the care Dr. Vinson provided to Patient 8 had fallen below the minimal standards of care. In reaching that conclusion, Dr. Ellison cited the fact that Dr. Vinson had failed to perform an axillary dissection during the mastectomy which had resulted in Patient 8 undergoing an additional operation. Dr. Ellison testified that it would have been appropriate either to perform both procedures at the same time or to forego the axillary dissection at the later date. (Tr. at 284-285).

Dr. Ellison was asked if his opinion regarding Dr. Vinson's failure to dissect the axillary nodes during the initial procedure would change if, prior to the initial surgery Patient 8 had told Dr. Vinson that she would not have radiation or chemotherapy regardless of the outcome. Dr. Ellison replied that, if that was the case, it would have been "perfectly appropriate." Dr. Ellison testified, however, that he would then question Dr. Vinson's decision to go back later and dissect the axillary nodes. (Tr. at 288-290).

Dr. Ellison testified that axillary dissection does not do anything for the therapeutics of breast cancer; it simply stages the progression of the disease. He further testified that a patient such as Patient 8 would have received therapy no matter what the axillary nodes revealed. Dr. Ellison stated that, based on the size of the lesion, the fact that there was skin infiltration, and the fact that there was lymphatic infiltration within the breast tissue itself, Patient 8 had not been an appropriate candidate for axillary dissection. (Tr. at 286-287).

When asked if his opinion would change if an oncologist had requested that Dr. Vinson perform the second surgery for the axillary dissection, Dr. Ellison stated he did not know. He stated that it was a question for Dr. Vinson to decide based on what the oncologist said and what the benefit to the patient would be. Subsequently, Dr. Ellison stated that if the patient had later requested the axillary dissection, it would have been appropriate for Dr. Vinson to perform the procedure. (Tr. at 278, 372-373).

Patient 9

Allegations

64. In its May 8, 2002, Notice of Opportunity for Hearing, the Board alleged that Dr. Vinson had made a judgmental error during his care and treatment of Patient 9. More specifically, the Board alleged that Dr. Vinson had performed an exploratory laparoscopy and an appendectomy on Patient 9 although they were not indicated and although treatment with antibiotics would have been appropriate. (St. Ex. 11A).

Medical Records for Patient 9

65. On January 5, 1999, at approximately 2:00 am, Patient 5, a twenty year old woman, presented to the emergency department at Fulton County Health Center. Patient 9 complained of severe abdominal pain radiating to the vaginal area, with nausea and vomiting. Patient 9 also complained that she felt as if she needed to urinate but that she had been unable to do so. The onset of her abdominal pain had been approximately 12:30 am. (St. Ex. 9 at 5, 23-25).

On physical examination, Patient 9 had tenderness and voluntary guarding in the lower part of the mid-abdomen, and right costovertebral angle tenderness. An IVP revealed an enlarged right kidney with poor visualization of the intrarenal collecting system. The impression was "a relatively high grade obstruction of the right kidney." At that time, Patient 9's temperature was 99.6, her pulse was 100, and her blood pressure was 110/58. (St. Ex. 9 at 2, 5-6, 7, 27).

At 2:38 am, Patient 9's urinalysis revealed 5-9 white blood cells, 2-4 red blood cells, and a small amount of leukocyte esterase. At 3:05 am, Patient 9's labwork revealed a normal white blood cell count of 8.4 with 1 band. At 8:00 am, Patient 9's temperature spiked to 102.9. (St. Ex. 9 at 3, 60, 61, 91a).

At 8:25 am, Patient 9 was admitted to the hospital under the care of G.M. Gensolin, M.D. Dr. Gensolin ordered a urology consultation "in AM." Dr. Gensolin also ordered Bactrim DS twice daily. Patient 9 received her first dose of Bactrim DS at noon. (St. Ex. 9 at 5, 107, 120).

On January 5, 1999, at 1:35 pm, Patient 9's labwork revealed the following:

- a. an elevated white blood cell count of 23.0, [normal 4.3-11.0];
- b. band neutrophils of 48, [normal 0-6]; and
- c. a left shift.

(St. Ex. 9 at 60). Dr. Gensolin ordered Cipro 400 mg intravenously every twelve hours. Patient 9 received her first dose at 4:00 pm. (St. Ex. 9 at 107, 119).

At 4:00 pm, Patient 9's blood pressure was 81/43. Her IV fluids were increased to 250 cc per hour. (St. Ex. 9 at 91a). At 6:30 pm, Dr. Gensolin ordered Gentamycin 80 mg IV. (St. Ex. 9 at 108, 119). At 9:15 pm, Dr. Gensolin increased Patient 9's IV rate to 500 cc per hour for one hour. (St. Ex. 9 at 108).

At 9:15 pm, Dr. Gensolin ordered a consultation with Dr. Vinson. At 10:20 pm, Dr. Vinson ordered Fortaz, 1 gm IV "now." (St. Ex. 9 at 108). Nevertheless, Patient 9 did not receive Fortaz until 4:00 am the next day. (St. Ex. 9 at 122).

Dr. Vinson wrote a surgical consultation note at 10:00 pm. Dr. Vinson noted that, by that time, Patient 9 had been experiencing pain for twenty-two hours. (St. Ex. 9 at 9, 30). In his Impressions, Dr. Vinson wrote,

The patient's presentation is consistent with appendicitis and her presentation at this time is consistent with ruptured appendicitis. I doubt any gynecological pathology, as the patient is not sexually active, although she could have a torsion of her ovary which is possibly also ruptured. The patient could also have a Meckel's diverticulitis. The patient could also have a gangrenous gallbladder. Due to the fact that the patient has a surgical abdomen, I do not feel that further diagnostic work up is indicated at this time.

(St. Ex. 9 at 30).

Dr. Vinson diagnosed acute appendicitis and, at 10:55 pm, took Patient 9 to surgery for a laparoscopy and appendectomy. During the operation, Dr. Vinson found a grossly normal appendix, and he removed the appendix. During the night, Patient 9's temperature was 103.1 axillary, and her respirations were 163. (St. Ex. 9 at 9, 34-35, 110a, 111a).

The next morning, January 6, 1999, Patient 9 was seen by G.K. Emmert, Jr., M.D., a urologist. Dr. Emmert diagnosed right hydronephrosis with obstruction, urosepsis with impending shock, and status post laparoscopy and appendectomy. At 8:00 am, Dr. Emmert performed a cystoscopy, right retrograde pyelogram, and complicated placement of right ureteral stent with fluoroscopy. (St. Ex. 9 at 2, 10, 31-32, 45-46, 111a).

On January 7, 1999, a urine sample taken January 5, 1999, at 2:40 am, revealed growth of *E. coli*. Moreover, a blood sample drawn January 5, 1999, at 1:25 pm, revealed a heavy growth of gram negative bacilli. Patient 9 was discharged home on January 12, 1999. (St. Ex. 9 at 3, 51, 54).

Testimony of Dr. Vinson

66. Dr. Vinson testified that, by the time he saw Patient 9, she had been complaining of abdominal pain for twenty-two hours. Dr. Vinson testified that there had not been a "clear-cut picture" of the source of Patient 9's pain. He admitted that there had been "strong evidence for a kidney stone," but he stated that he had not been sure. Dr. Vinson testified that he had been concerned that Patient 9 was facing a ruptured appendix; therefore, he had decided to perform a laparoscopic appendectomy to rule out a ruptured appendix. Dr. Vinson testified that the risks of a laparoscopic appendectomy are minimal compared to the risks of a ruptured appendix. Dr. Vinson testified that he had chosen to risk making an error "on the side of taking out a normal appendix versus sitting on a ruptured appendix." (Tr. at 167-168, 171-175, 179, 180).

Dr. Vinson testified that he had been concerned that Patient 9 may have been suffering from acute appendicitis based on her physical examination and laboratory findings. Dr. Vinson testified that Patient 9's white blood cell count had increased to 23,000 with 48 bands, which was indicative of "acute active inflammatory/infectious process." Dr. Vinson further explained that, with a kidney stone, white cells generally remain normal. With appendicitis, however, white cells generally do not above 18,000 and, with a ruptured appendix, white cells are often greater than 20,000. (Tr. at 168-171).

Dr. Vinson further testified that Patient 9's urinalysis had revealed 5 to 9 white blood cells and only 2 to 4 red cells. Dr. Vinson testified that one of the hallmarks for kidney stones is red cells in the urine, generally too numerous to count. Dr. Vinson testified that that fact that Patient 9 only had 2 to 4 red cells in her urine was significant. Finally, Dr. Vinson testified that kidney stones do not generally cause right lower quadrant pain, but cause flank and right upper quadrant pain. (Tr. at 168-171, 174-175).

67. Dr. Vinson cited literature which he believes supports his position regarding Patient 9. The literature he cited is the following:

- an article by K.L. Greason entitled "Incidental Laparoscopic Appendectomy for Acute Right Lower Quadrant Abdominal Pain," and published in Surgical Endoscopy in 1998;
- an article by Hannu Paajanen entitled "A chance of Misdiagnosis Between Acute Appendicitis and Renal Colic," and published in Scandinavian Journal of Urology and Nephrology in 1996; and
- a textbook chapter by Rosemary A. Kozar entitled "The Appendix," and published in Principles of Surgery, Chapter 27.

(Tr. at 475; Resp. Exs. C, G, and H).

Testimony of Dr. Ellison

68. Dr. Ellison testified that, based in part upon his review of the medical records for Patient 9, he believed that the care Dr. Vinson provided to Patient 9 had fallen below the minimal standards of care. In reaching that conclusion, Dr. Ellison cited the fact that Dr. Vinson had performed an appendectomy on Patient 9 when it had been clear that Patient 9 had an obstructed ureter from a kidney stone, most likely with urosepsis as a cause of the ureterolithiasis. (Tr. at 290-291).

Dr. Ellison testified that this was a difficult case. Dr. Ellison testified that, if Patient 9 had not had a kidney stone on her IVP, Dr. Ellison would have had no criticism of Dr. Vinson's

management of Patient 9. Nevertheless, Dr. Ellison testified that Patient 9's IVP had shown was a high-grade obstruction of the ureter. Moreover, Patient 9's findings strongly suggested a diagnosis of urosepsis and kidney stone. Dr. Ellison added that it is very well known that impacted kidney stones can create symptoms that are similar to appendicitis. Dr. Ellison testified that one of the basic principles of medicine is not to assign two diagnoses to a patient. He explained that, when you have a diagnosis that accounts for all of the patient's problems, you do not try to invent another diagnosis. (Tr. at 292-297, 374).

Dr. Ellison testified that it is unusual for a patient with appendicitis to have a white cell count of 23,000 and 43 bands even with a perforated appendix. Dr. Ellison testified that such a patient would normally have a white cell count of 12,000 to 17,000. He stated that Patient 9's white cell count had been an indication of septicemia. He stated that a ruptured appendix can do that, but that it is very unusual. (Tr. at 294).

When asked if fear that her appendix might rupture during the night would justify Dr. Vinson's actions, Dr. Ellison testified that it would not. He reiterated that the problem had been an error in diagnosis because Patient 7 had not had appendicitis. Therefore, there should have been no concern that her appendix might rupture. (Tr. at 297-298).

Dr. Ellison concluded that, because the IVP had indicated that Patient 9 had had a kidney stone, appropriate management required that Patient 9 be treated with a stent and antibiotics. Dr. Ellison acknowledged that Patient 9 had received a few doses of antibiotics, but stated that what she received by that time had not been sufficient to manage her sepsis before Dr. Vinson took her to surgery. Moreover, Dr. Ellison stated that the ureter had not been drained, the stone had not been removed, and a stent had not been placed. (Tr. at 374-375).

69. Dr. Ellison acknowledged that morbidity and mortality rates from missed ruptured appendices are high. Nevertheless, Dr. Ellison testified that it would have been appropriate for Dr. Vinson to have obtained a C.T. scan prior performing an unnecessary appendectomy. Dr. Ellison testified that a C.T. scan can be very helpful in the diagnosis of appendicitis. Moreover, the C.T. scan would have revealed a ruptured appendix. Dr. Ellison further testified that Dr. Vinson should have ordered antibiotics, drained the ureter and ordered a C.T. scan before taking Patient 9 to surgery. (Tr. at 293, 294-295, 377, 383).
70. Dr. Ellison testified regarding the article by Hannu Paajanen entitled "A Chance of Misdiagnosis Between Acute Appendicitis and Renal Colic," and published in Scandinavian Journal of Urology and Nephrology in 1996. Dr. Ellison testified that the article depicted a perspective comparative study of 185 patients with ureteral stone and 188 patients with acute appendicitis. Dr. Ellison testified that the most important fact in the paper is that only one of 188 patients with ureteral stone was initially misdiagnosed. He noted that that patient was later operated on because of a perforated appendix. Dr. Ellison concluded that the risk was that one out of 188 patients, which is less than 1 percent, would have a ruptured appendix.

Dr. Ellison concluded that the study supported his position in this case, and that that the chances had been less likely that Patient 9 would have had a ruptured appendix than that she had had an asymptomatic ureteral stone with infection. (Tr. at 299-30; Resp. Ex. G).

On cross examination, Dr. Ellison acknowledged that there would be no way to tell, in the next 188 patients, which one would have a ruptured appendix. (Tr. at 379).

71. Dr. Ellison testified regarding the article by K.L. Greason entitled "Incidental Laparoscopic Appendectomy for Acute Right Lower Quadrant Abdominal Pain," and published in Surgical Endoscopy in 1998. Dr. Ellison testified that the article discusses incidental laparoscopic appendectomies. Dr. Ellison stated that he agrees with the article in that, when performing a laparoscopy for suspected appendicitis, it is appropriate to remove the appendix in order to avoid further operations. He added, however, that that was not the basis of his criticism of Dr. Vinson on this case. Dr. Ellison reiterated that it was the fact that Dr. Vinson had made an error in diagnosis which formed the basis of Dr. Ellison's criticism. (Tr. at 300).
72. Dr. Ellison testified that, although the discharge sheet lists acute appendicitis as a discharge diagnosis, that was incorrect. He stated that Patient 7's appendix had been normal. (Tr. at 301-302; St. Ex. 9 at 1-2, 71).

Dr. Vinson's Response

73. Dr. Vinson testified that C.T. scans are not available in the middle of the night at Fulton County Health Center. (Tr. at 514). Dr. Vinson continued that,

You can get them during the day. And it's nice when -- if you can get the technician, because, see, the problem is that not all the technicians, and I think there's only one technician that did C.T. scans, you know. They are not all trained in the same things. And the ones that are there in the evening, and I'm even trying to remember if there is a technician there all night or not. You can get a chest x-ray. You can get a KUB, but sometimes, you know, 5:00, 6:00, 7:00 in the evening you can get a C.T. scan if the technician is there. But in the middle of the night, you know --

Ms. Murphy: They can't call someone in on an emergency?

Dr. Vinson: Well, you could but, you know, people are good at not answering their phone, you know, if they don't want. So you can always call somebody and say, look, can you please come in? But you're at their mercy. They are not required to do it. So they may be nice enough to say yes, but I never

saw that happen. And as a matter of fact, routinely if the patient's in the E.R. and something like that they thought was needed, you know, if the patient was that sick, they'd probably just send them on to Toledo. Because they were notorious for not wanting to get into trouble, especially before I came. Because the other surgeon was an older surgeon and really didn't want to operate at night, you know. And so I'm this young guy who didn't mind. So patients frequently got shipped out for just stuff like you couldn't get a C.T. scan or stuff like that.

Mr. Michael: Do you remember what time of day you were initially consulted with this patient? Feel free to look in your record.

Dr. Vinson: No, I don't. All I can say is the timing of my note is at 10:00 at night

(Tr. at 514-516).

74. There is no indication in the medical record that Dr. Vinson attempted to contact the C.T. technician. (St. Ex. 7).

Dr. Ellison's Response

75. When asked what Dr. Vinson should have done if a C.T. scan was not available, Dr. Ellison testified that Dr. Vinson should have realized that the diagnosis was most likely urosepsis and consulted a urologist. Dr. Ellison continued that, if no urologist was available, Dr. Vinson should have provided adequate hydration, antibiotics, and blood cultures. Dr. Ellison testified that if there had been no C.T. scan, no urologist, and if the antibiotics were not effective, it would have been "a tough situation," and it may have been appropriate for Dr. Vinson to take Patient 9 to surgery for an appendectomy. Nevertheless, Dr. Ellison stressed that it may have been appropriate only under the circumstances that there had not been a C.T. scan or urologist available and Patient 9 was not responding to the antibiotics. (Tr. at 295-296, 379-382, 399-401).

Patient 10

Allegations

76. In its May 8, 2002, Notice of Opportunity for Hearing, the Board alleged that Dr. Vinson had made a judgmental error during his care and treatment of Patient 10. More specifically, the Board alleged that Dr. Vinson had performed a splenectomy and a cholecystectomy on Patient 10 although neither procedure had been indicated. (St. Ex. 11A).

Medical Records for Patient 10

77. Patient 10, a seventy year-old man, was admitted to the Fulton County Health Center on September 8, 1998, with complaints of abdominal pain, anorexia, and weight loss. A surgical evaluation revealed "one calcified stone" in the gallbladder and "slight prominence of the size of the spleen." A cholecystectomy was recommended. Patient 10's medical history included chemotherapy several years earlier for non-Hodgkin's lymphoma. Patient 10 was discharged home with plans to schedule an elective cholecystectomy. (St. Ex. 10 at 6; Resp. Exs. I and J).

Subsequently, Patient 10 developed pain in the abdomen, loss of appetite, nausea, and continued weight loss. Patient 10 was readmitted to the Fulton County Health Center on October 9, 1998. He was found to be cachectic with a distended abdomen, visible peristalsis, high-pitched bowel sounds, and definite muscle wasting. Patient 10's family physician consulted Dr. Vinson. Dr. Vinson ordered a KUB, which revealed dilated loops of the small bowel and slow passage of contrast medium. Dr. Vinson diagnosed partial small bowel obstruction and noted that he would "continue to observe." (St. Ex. 10 at 6-7, 9, 38).

Patient 10 received conservative treatment until October 16, 1998, when Dr. Vinson took Patient 10 to surgery with a preoperative diagnoses of small bowel obstruction and chronic cholecystitis. Dr. Vinson performed an exploratory laparotomy, with small bowel resection and primary anastomosis. During the course of the surgery, Dr. Vinson performed a cholecystectomy, a splenectomy, and excision of accessory spleen. Dr. Vinson listed his postoperative diagnoses as small bowel obstruction secondary to inflammatory lesion of the terminal ileum, acute cholecystitis, and perisplenitis. (St. Ex. 10 at 9-14, 23).

In his operative note, Dr. Vinson stated that the gallbladder had been "thickened and inflamed." Dr. Vinson further stated that the spleen "was completely embedded within a thickened white capsule." In his discharge summary, however, Dr. Vinson noted that the spleen had been completely surrounded by a "yellow capsule." The pathology report revealed changes in the small intestine consistent with Crohn's disease, chronic cholecystitis with no gallstones, and benign spleen and accessory spleen. (St. Ex. 10 at 5, 23, 35-36).

Patient 10 recovered from surgery and was discharged home on October 22, 1998. (St. Ex. 10 at 4-5).

Testimony of Dr. Vinson

78. Dr. Vinson testified that he had not been sure of the cause of the bowel obstruction, and that the only thing he had known was that Patient 10 had gallstones. Dr. Vinson testified that he had planned to do a surgery for the small bowel obstruction, etiology being unknown, to

remove the gallbladder, and to explore the abdomen to see if he could find anything else. (Tr. at 186-191; St. Ex. 10 at 23).

Dr. Vinson testified that his pre-operative diagnoses had been small bowel obstruction and cholecystitis. During the surgery, Dr. Vinson learned that Patient 10 had had a small bowel obstruction secondary to Crohn's disease, acute cholecystitis, and inflammation around the spleen. Dr. Vinson testified that Patient 10's spleen had been "completely white." He added that the finding regarding the spleen had been significant because lymphoma frequently involves the spleen. Dr. Vinson noted that the spleen is often removed in patients who have lymphoma. (Tr. at 191-193).

Testimony of Dr. Ellison

79. Dr. Ellison testified that, based in part upon his review of the medical records for Patient 10, he believed that the care Dr. Vinson provided to Patient 10 had fallen below the minimal standards of care. In reaching that conclusion, Dr. Ellison cited the fact that Dr. Vinson had performed an unwarranted splenectomy and cholecystectomy during the course of the surgery for a small bowel obstruction. (Tr. at 302-303).

Dr. Ellison testified that Patient 10's surgery had not been an elective procedure, but had been instead "an urgent necessary operation." Moreover, Dr. Ellison stated that Patient 10 had not been in good condition at the time of surgery, as evidenced by his cachexia and muscle wasting. (Tr. at 306, 384-385).

Dr. Ellison testified that the surgery for the small bowel obstruction had been appropriate. The small bowel had shown Crohn's disease, which was the reason for the obstruction. Dr. Ellison further testified that he believed that Patient 10's symptoms one month earlier had been due to the Crohn's disease, not gallstones. Dr. Ellison testified that the Crohn's disease had also accounted for Patient 10's cachexia and malnutrition. (Tr. at 306, 382-384).

Dr. Ellison testified that Dr. Vinson had inappropriately removed Patient 10's gallbladder because Patient 10 had not had gallstones. Dr. Ellison testified that, even if Patient 10 had had gallstones in the past, that finding would not justify Dr. Vinson's removal of the gallbladder during the course of surgery on the bowel because there were no gallstones at the time of Dr. Vinson's surgery. Dr. Ellison concluded that the gallstone, if it had existed, had been asymptomatic and should have been ignored until a time at which it became symptomatic. (Tr. at 304, 306, 308-310, 382-384).

Dr. Ellison further testified that Dr. Vinson had inappropriately removed Patient 10's spleen. Dr. Ellison noted that the spleen had been normal on pathologic examination. Dr. Ellison explained that a white coating on a spleen is not unusual in patients that have had chemotherapy or in elderly patients. Dr. Ellison added that it is "certainly not" a reason to remove the spleen. Dr. Ellison explained that, if you remove the spleen at the same time

you open the intestine, you expose the patient to considerable risk in terms of an abscess or postoperative infection. He added that this is a very well known fact in surgery. Moreover, Dr. Ellison further testified that the x-ray report notation of "slight prominence of the size of the spleen," did not justify removal of the spleen. Dr. Ellison explained a spleen may be enlarged due to an inflammatory process such as Crohn's disease, but that does not justify removal of the spleen. (Tr. at 306-307, 308, 310-311, 385-386; Resp. Ex. J).

Dr. Ellison testified that Dr. Vinson had taken very good medical care of Patient 10 in general. However, Dr. Ellison stated that Dr. Vinson's intraoperative decision-making had been below the standard of care. (Tr. at 307).

Dr. Ellison's Overall Conclusions

80. Dr. Ellison testified that, generally, Dr. Vinson had taken good care of his patients. Nevertheless, Dr. Ellison concluded that Dr. Vinson had made "critical decisions that were in error" and which had led to poor outcomes. (Tr. at 389).

Dr. Ellison concluded that Dr. Vinson's technical skills are below the standard level for a surgeon. He further testified that Dr. Vinson's judgmental errors were below the standard of care for all physicians. (Tr. at 313-314). Dr. Ellison explained that judgment is important because,

Surgeons and physicians need to make judgments on a daily basis. They need to be able to objectively assess data, to know the natural history of disease, to know when to intervene and when not to intervene, to know when to prescribe treatment and when not to, to know when to order certain x-rays and when not to. And I think that the evidence that's presented in these ten cases indicates that there's a judgmental cognitive practice of medicine deficiency in Dr. Vinson that is below the standard of care. * * * These are serious cases in my opinion. Some of them had okay outcomes but that doesn't justify the deviations from the standard of care. The one case of the elderly woman with constipation in and of itself is so severe and egregious that it stands alone in my opinion in terms of breach of standard of care. As a collection of cases, I think that there is ample evidence that Dr. Vinson does not practice within the standards of the State of Ohio.

(Tr. at 313-315).

81. Dr. Ellison further explained that the general pattern he observed in Dr. Vinson's practice is that Dr. Vinson "simply did too much surgery." Dr. Ellison testified that Dr. Vinson was very aggressive, recommended operations that were not appropriate, and failed to prepare patients well for surgery. Dr. Ellison concluded that these are the kinds of problems that most likely cannot be corrected with education. (Tr. at 402-403).

Dr. Vinson's Overall Conclusions

82. Dr. Vinson testified that "standard of care" is a broad term, but that the standard of care is derived from studies and what is being taught in residency programs and medical schools. (Tr. at 478-480, 516-521).

When questioned about Dr. Ellison's description of him as an aggressive physician, Dr. Vinson testified that many physicians avoid difficult cases and he does not do so. Moreover, Dr. Vinson testified that, as long as you stay in the realm of what is acceptable care, even though some physicians might disagree with you, and "as long as it's being taught somewhere, as long as it's being published and you can help that person," then the physician should try to help the patient. Dr. Vinson testified that, with this understanding, he agrees with Dr. Ellison that he is an assertive or aggressive physician. Dr. Vinson concluded that, in his practice of surgery at both Fulton County Health Center and Paulding County Hospital, he had tried to render the best care possible to his patients. (Tr. at 496-497).

FINDINGS OF FACT

1. In performing surgeries on Patients 1, 2, and 5, David Vinson, Jr., M.D., committed technical errors including, but not limited to the following:
 - a. In performing surgery on Patient 1, Dr. Vinson failed to adequately explore the patient's abdomen prior to closure and failed to remove a visceral retractor. Patient 1 required an additional surgery to remove the visceral retractor.
 - b. When performing a laparoscopic hysterectomy on Patient 2, Dr. Vinson caused injuries to both ureters and to the bladder, a combination of injuries that is exceedingly rare. In addition, Dr. Vinson failed to recognize the bladder or ureteral injuries during such surgery. Dr. Vinson failed to recognize the injuries despite the nurses advising him two hours prior to the end of the procedure that Patient 2's urine output was low and that her urine was bloody. Moreover, the nurses continued to advise him of Patient 2's low urine output throughout the case and in the recovery room. Nevertheless, it was several hours before Dr. Vinson addressed the problem.
 - c. During the course of Patient 5's gastric resection, Dr. Vinson caused injury to the ampulla of Vater by removing more of the duodenum than was necessary or appropriate. In his closing argument, Dr. Vinson argued that the injury to the ampulla of Vater had been "unavoidable" if Dr. Vinson was to remove the suspected cancerous tissue. Nevertheless, Dr. Ellison's testimony was persuasive that Dr. Vinson could have safely and adequately removed the cancerous tissue by removing only the recommended two centimeters of duodenum.

Dr. Vinson further argued that Patient 5's injury had occurred because the physician doing the preoperative EGD had failed to diagnose the cancer. Dr. Vinson argued that, had he been aware of the tumor preoperatively, he would have performed a different procedure. Nevertheless, Dr. Ellison's testimony was persuasive in that the procedure Dr. Vinson performed had been the appropriate procedure even had he been aware of Patient 5's cancer. The problem was not the procedure itself, but the fact that Dr. Vinson performed the procedure in an inappropriate manner.

2. In his treatment of Patients 3, 4, 6, 9 and 10, Dr. Vinson committed judgmental errors including, but not limited to the following:
 - a. During the performance of a modified radical mastectomy on Patient 3, Dr. Vinson inappropriately placed a Mediport catheter in Patient 3's left axillary vein, on the same side as the modified radical mastectomy. Dr. Vinson's testimony that he had placed the portacath on the same side as the new mastectomy to avoid a second operative site, because it had been "sort of a wash" as far as which mastectomy site to chose, and because he had feared causing an infection in the old implant site rather than the fresh mastectomy wound are not convincing. Nonetheless, regardless of where Dr. Vinson chose to place the port, he placed it inappropriately making it inaccessible for use and causing Patient 3 to undergo a second surgery for removal of the port.
 - b. While performing surgery to address Patient 4's perforated duodenal ulcer, Dr. Vinson performed a cholecystectomy on Patient 4 although it was not indicated. In doing so, Dr. Vinson cut into as yet non-contaminated planes which created potential problems that should have been avoided. The additional surgery for removal of the patient's gallbladder was an unnecessary risk and could have been performed at a later time.
 - c. Dr. Vinson performed surgery on Patient 6 for constipation although the surgery was not indicated. Moreover, Dr. Vinson failed to follow the recommendation of another physician to obtain a cardiology consult prior to performing surgery on Patient 6.

Patient 6 was a high risk patient. She had a low potassium level which had required aggressive therapy on the day of surgery. In addition, she had a critically low albumen which, alone, would have been reason to postpone an elective surgery. Moreover, Patient 6 had a history of atrial fibrillation which increased the chances that, with the induction of anesthesia, Patient 6 would experience cardiac arrhythmias. Nevertheless, Dr. Vinson chose to take Patient 6 for an elective procedure.

Dr. Vinson's testimony that he had allowed the patient and her nephew to make the decision to go to surgery is alarming. Neither Patient 6 nor her nephew had the knowledge and background to make a decision on whether surgery was appropriate. Furthermore, Dr. Vinson's rationale that Patient 6's albumen levels had appeared to be low only because Patient 6 had been given fluids to treat dehydration when she was

not really dehydrated is unconvincing. Dr. Vinson testified that Patient 6 was not really dehydrated, in part, because dehydration is caused by excess urination and Patient 6 was not making urine. Dr. Vinson believed that Patient 6 was not making urine because she was not urinating, despite the fact that she had retained a “huge amount of urine” —2000 cc—in her bladder. Dr. Vinson’s reasoning is absurd. Finally, Dr. Vinson testified that Patient 6 had not been very ill at the time of surgery because she was “walking and talking.” That a practicing physician could put forth such unsubstantiated theories is disturbing.

- d. Dr. Vinson performed an exploratory laparoscopy and an appendectomy on Patient 9 although they were not indicated and although treatment with antibiotics would have been appropriate. Dr. Vinson performed the appendectomy on Patient 9 despite the fact that an IVP had revealed that Patient 9 had an obstructed ureter from a kidney stone. Moreover, it was likely that Patient 9 had urosepsis.

Dr. Vinson’s testimony that he had performed the surgery due to the risk that Patient 9 had had a ruptured appendix is not convincing. As noted by Dr. Ellison, Dr. Vinson could have ordered a C.T. scan of the abdomen to rule out appendicitis or a ruptured appendix. Dr. Vinson’s testimony that he did not order a C.T. scan because the technician might not have answered the telephone is ludicrous.

- e. During the course of bowel surgery on Patient 10, Dr. Vinson performed a splenectomy and a cholecystectomy although neither procedure was indicated. Dr. Vinson removed Patient 10’s gallbladder when Patient 10 had not had gallstones. Moreover, Dr. Vinson removed Patient 10’s spleen although the spleen was normal on pathologic examination. Finally, Dr. Vinson performed these unnecessary procedures during an urgently necessary operation on a patient who was not in good condition at the time of surgery, as evidenced by cachexia and muscle wasting.
3. The evidence did not support the Board’s allegation that Dr. Vinson had committed technical errors by causing injury to Patient 7’s spleen during surgery. Patient 7 was morbidly obese with a BMI of between 43.3 and 48.4. Even Dr. Ellison acknowledged that morbid obesity can impact the mobilization of the sigmoid colon because, with a thicker abdominal wall, greater length of the sigmoid colon is needed to mobilize the splenic flexure in an obese patient. Therefore, the injury to the spleen did not necessarily indicate that Dr. Vinson’s conduct had fallen below the minimal standards of care.
 4. The evidence did not support the Board’s allegation that, in performing surgeries on Patient 8, Dr. Vinson had committed judgmental errors by failing to perform an axillary dissection at the time he performed a mastectomy on Patient 8. As acknowledged by Dr. Ellison, if, as Dr. Vinson testified, Patient 8 and/or her oncologist had made the decisions not to perform an axillary dissection at the time of the mastectomy and to perform

a second surgery for the axillary dissection, then Dr. Vinson's judgment in this case may have been appropriate.

CONCLUSIONS OF LAW

The conduct David Vinson, Jr., M.D., as set forth in Findings of Fact 1 and 2, constitutes "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

* * * * *

Overall, the record reveals that Dr. Vinson practiced aggressively and without due care. As noted by Dr. Ellison, Dr. Vinson does not practice within the standards of the State of Ohio. In fact, Dr. Vinson's care and treatment of Patient 6 alone was so egregious that it justifies severe Board action. Throughout the hearing and in his written closing arguments, Dr. Vinson repeatedly blamed other practitioners for his judgmental and technical errors. It is clear that Dr. Vinson fails to appreciate the magnitude of his errors and the enormous consequences his patients suffered.

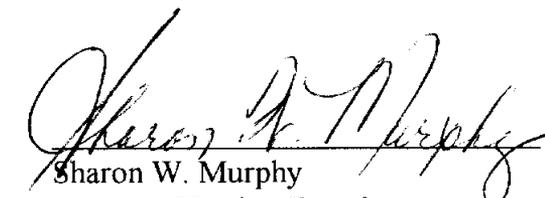
It is significant that Dr. Vinson demonstrated such deficiencies in his technical skills despite extensive surgical training, including a residency, critical care fellowship, and an additional year of general surgical training at the Medical College of Ohio. Moreover, Dr. Vinson demonstrated such extremely poor judgment in his practice that Dr. Ellison concluded that Dr. Vinson's deficiencies cannot be corrected with reeducation. Accordingly, the Board has no alternative but to permanently revoke Dr. Vinson's certificate to practice medicine and surgery in this State.

PROPOSED ORDER

It is hereby ORDERED that:

The certificate of David Vinson, Jr., M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

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


Sharon W. Murphy
Attorney Hearing Examiner



State Medical Board of Ohio

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EXCERPT FROM THE DRAFT MINUTES OF JUNE 11, 2003

REPORTS AND RECOMMENDATIONS

Mr. Browning announced that the Board would now consider the findings and orders appearing on the Board's agenda. He 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: Ashfaq Taj Ahmed, M.D.; Anil K. Bajaj, M.D.; Steven W. Crawford, M.D.; Ryan Hanson, M.D.; Rezso Spruch, M.D.; and David Vinson, Jr., M.D. A roll call was taken:

ROLL CALL:	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye
	Mr. Browning	- aye

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

ROLL CALL:	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye

Dr. Steinbergh - aye
Mr. Browning - aye

Mr. Browning noted that, in accordance with the provision in Section 4731.22(F)(2), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters.

Mr. Browning 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.

.....

DAVID VINSON, JR., M.D.

.....

DR. BHATI MOVED TO APPROVE AND CONFIRM MS. MURPHY'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF DAVID VISON, JR., M.D. DR. STEINBERGH SECONDED THE MOTION.

.....

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

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- abstain
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- abstain
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

The motion carried.

**INTERIM AGREEMENT
BETWEEN
DAVID VINSON, JR., M.D.
AND
THE STATE MEDICAL BOARD OF OHIO**

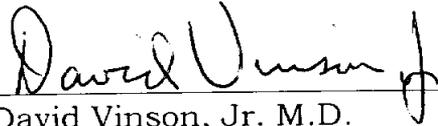
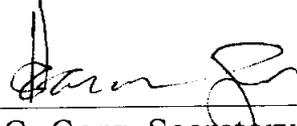
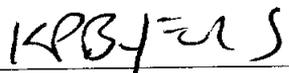
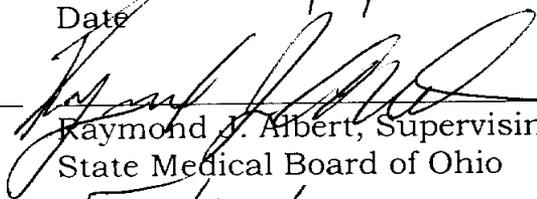
STATE MEDICAL BOARD
OF OHIO
2002 AUG 30 A 8:28

David Vinson, Jr., M.D., hereby agrees that, until the allegations contained in the State Medical Board of Ohio's (hereinafter Board) May 8, 2002 Notice of Opportunity for Hearing have been fully resolved by the Board, he will not practice medicine in the State of Ohio in any form. Dr. Vinson further agrees that any violation of the above-referenced limitation shall subject him to further disciplinary action pursuant to Section 4731.22, Ohio Revised Code.

The State Medical Board of Ohio, by its acceptance of this Interim Agreement, hereby agrees not to object, through its counsel, to the granting of a continuance of the administrative hearing on the above-referenced matter, currently scheduled for September 3 - 6, 2002 and September 30 - October 4, 2002.

This Interim Agreement shall not be construed as an admission by Dr. Vinson to the allegations contained in the May 8, 2002 Notice of Opportunity for Hearing.

This Interim Agreement shall become effective immediately upon the last date of signature below.

 _____ David Vinson, Jr. M.D.	 _____ Anand G. Garg, Secretary State Medical Board of Ohio
<u>8/27/02</u> _____ Date	<u>08/30/02</u> _____ Date
 _____ Kevin Byers Attorney for Dr. David Vinson	 _____ Raymond J. Albert, Supervising Member State Medical Board of Ohio
<u>8/28/02</u> _____ Date	<u>8/30/02</u> _____ Date



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

May 8, 2002

David Vinson, Jr., M.D.
764 Parkgrove Way
Lewis Center, Ohio 43035

Dear Doctor Vinson:

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, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand or place you on probation for one or more of the following reasons:

- (1) In the routine course of your surgical practice, you undertook the treatment of Patients 1 through 10 (as identified on the attached Patient Key--Key confidential to be withheld from public disclosure).
- (2) In performing surgeries on Patients 1, 2, 5 and 7, you committed technical errors including, but not limited to the following:
 - (A) In performing surgery on Patient 1, you failed to adequately explore the patient's abdomen prior to closure and failed to remove a visceral retractor;
 - (B) You caused a bladder and/or ureteral injury when performing a laparoscopic hysterectomy on Patient 2. In addition, you failed to recognize the bladder and/or ureteral injury during such surgery;
 - (C) During the course of Patient 5's gastric resection, you caused injury to Patient 5's Ampulla of Vater by going too distal in the patient's duodendum; and
 - (D) You caused injury to Patient 7's spleen during surgery, resulting in an incidental splenectomy.
- (3) In your treatment of Patients 3, 4, 6, 8, 9 and 10, you committed judgmental errors including, but not limited to the following:

- (A) During the performance of a modified radical mastectomy on Patient 3, you inappropriately placed a Mediport catheter in Patient 3's left axillary vein, on the same side as the modified radical mastectomy and below the pectoralis muscle, resulting in the catheter being inaccessible for use;
- (B) While performing surgery to address Patient 4's perforated duodenal ulcer, you performed a cholecystectomy on Patient 4 although it was not indicated in this case;
- (C) You performed surgery on Patient 6 for constipation although the surgery was not indicated. You also failed to follow the recommendation of another physician to obtain a cardiology consult prior to performing surgery on Patient 6;
- (D) You failed to perform an axillary dissection at the time you performed a mastectomy on Patient 8, resulting in an additional operation;
- (E) You performed an exploratory laparoscopy and an appendectomy on Patient 9 although they were not indicated in this case and although treatment with antibiotics would have been appropriate; and
- (F) You performed a splenectomy and a cholecystectomy on Patient 10 although neither procedure was indicated in this case.

Your acts, conduct, and/or omissions as alleged in paragraphs (2) and (3) above, individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

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

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

In the event that there is no request for such hearing received within thirty (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,

permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, effective March 9, 1999, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Anand G. Garg, M.D.
Secretary

AGG/blt
Enclosures

CERTIFIED MAIL # 7000 0600 0024 5141 7515
RETURN RECEIPT REQUESTED