BEFORE THE STATE BOARD OF MEDICAL EXAMINERS
STATE OF COLORADO

Case No. ME 2005-

FORMAL COMPLAINT OF THE ATTORNEY GENERAL, NOTICE TO SET, NOTICE OF HEARING, AND NOTICE OF DUTY TO ANSWER

IN THE MATTER OF THE DISCIPLINARY PROCEEDING REGARDING THE LICENSE TO PRACTICE MEDICINE IN THE STATE OF COLORADO OF DENISE E. CRUTE, M.D., LICENSE NUMBER 35721.

Respondent.

FORMAL COMPLAINT

COMES NOW the Colorado State Board of Medical Examiners ("Board"), Inquiry Panel A ("Panel"), by the Colorado Attorney General, and makes this Formal Complaint against Denise E. Crute, M.D. ("Respondent"), pursuant to §12-36-118(5), C.R.S.:

Jurisdiction and Case History

1. The Board and Panel possess jurisdiction over Respondent and the subject matter of these proceedings as set forth in the Colorado Medical Practice Act, §§12-36-101 to 202, C.R.S., and the State Administrative Procedure Act, §§ 24-4-101 to 108, C.R.S.

2. Respondent was licensed to practice medicine in the state of Colorado on November 14, 1996 and was issued license number 35721, which Respondent has held continuously since that date.

3. Respondent is a board-certified neurosurgeon.

4. At all times relevant to this Formal Complaint, Respondent had privileges to practice medicine at Saint Mary-Corwin Medical Center ("SMC") and Parkview Medical Center ("PMC").

5. At all times relevant to this Formal Complaint, Respondent was the supervisor for a physician assistant ("PA"). All references in this Formal Complaint to Respondent's PA refer to the same individual.

6. On July 12, 2004, the Panel issued to Respondent a Notice of Right to Request Pre-

Suspension Hearing pursuant to Board Rule 280, 3 C.C.R. § 713-18 to determine whether summary suspension of Respondent's license was warranted pursuant to § 24-4-104(4), C.R.S.

7. Effective August 18, 2004, Respondent and the Panel entered a Stipulation for Interim Evaluation and Monitoring of Practice ("Interim Stipulation") in lieu of suspending Respondent's license pursuant to § 24-4-104(4), C.R.S. pending additional investigation and evaluation of Respondent's practice to determine what further actions, if any, were warranted.

8. The Interim Stipulation provides that Respondent must comply with all recommendations made by the Colorado Physician Health Program ("CPHP") following her initial appointment on August 13, 2004 and that all of Respondent's surgeries shall be observed by a board-certified neurosurgeon approved by the Panel ("surgical monitor"), who must be present in the operating room for a substantial majority of the time the procedure is occurring. The surgical monitor must evaluate Respondent's medical and surgical judgment and technique for compliance with the generally accepted standards of neurosurgical practice, and must evaluate Respondent's operative reports for accuracy and completeness.

9. The Interim Stipulation is by its terms indefinite and continues until replaced by further Order of the Board.

10. The Interim Stipulation does not prevent the Panel from initiating disciplinary action pursuant to §12-36-118, C.R.S. or seeking any sanctions permitted thereunder or taking any other lawful action.

11. On January 12, 2005, the Panel reviewed case numbers 5102011440; 5103011900; 2004-003221-A; 2005-000374-A; 2005-000505-A; 2005-000674-A; and 2005-001050-A. The Panel thereupon referred this case to the Attorney General pursuant to §12-36-118(4)(c)(IV), C.R.S.

PATIENT A

12. On June 30, 2004, Respondent performed surgery on Patient A, a 48-year old woman with multiple injuries following a severe motor vehicle accident three days earlier.

13. Respondent did not document post-operative neurosurgical orders in Patient A's patient records on the day of surgery.

14. On July 1, 2004 at approximately 10:30 a.m., Respondent appeared at PMC and placed post-operative neurosurgical orders in Patient A's medical chart.

15. Respondent backdated the post-operative neurosurgical orders for Patient A to make it appear as if they were created on June 30, 2004.

16. Respondent then accused the nursing staff of failing to carry out her post-

operative neurosurgical orders for Patient A.

17. On September 28, 2004, the Board sent Respondent a letter requesting information concerning a complaint issued pursuant to section 12-36-118(4), C.R.S. related to, *inter alia,* Respondent's care and treatment of Patient A ("September 28 Board Letter").

18. In response to the September 28 Board Letter, Respondent wrote:

> I understand that on the morning of post-operative day number one, an ICU nurse reported seeing me write post-operative orders, backdate them to the day before, and put them in the patient's chart ...I did not do that.

UNPROFESSIONAL CONDUCT: PATIENT A

19. Respondent's evaluation and/or treatment of Patient A failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent failed to document post-operative neurosurgical orders in Patient A's medical records in a timely manner; and/or

b. Respondent backdated post-operative neurosurgical orders for Patient A to make it appear as if the orders had been documented in a timely manner.

20. Respondent failed to make essential entries and/or made incorrect essential entries in Patient A's patient records and/or falsified Patient A's patient records and, thus, engaged in unprofessional conduct as defined by §12-36-117(1)(cc), C.R.S. for one or more of the following reasons:

a. Respondent failed to document post-operative neurosurgical orders for Patient A in a timely manner; and/or

b. Respondent backdated post-operative neurosurgical orders in Patient A's medical chart to make it appear as if the orders had been documented in a timely manner.

21. Respondent failed to provide an honest and/or materially responsive response to the informal complaint issued pursuant to §12-36-118(4), C.R.S. thus engaged in unprofessional conduct as defined by §12-36-117(1)(gg), C.R.S. when Respondent denied writing post-operative orders on the first post-operative day, backdating the post-operative orders and/or inserting the orders into Patient A's chart on the first post-operative day.

PATIENT B

22. Respondent evaluated Patient B, a 73 year-old man from Mexico, on March 17, 2004.

23. Patient B brought to the March 17, 2004 evaluation films from a cerebral angiogram performed in Mexico ("Mexican Angiogram") and a report (written in Spanish) from a neurologist ("Angiogram Report").

24. The Angiogram Report indicated that the Mexican Angiogram showed the presence of a possible right posterior communicating artery ("PCoA") aneurysm in Patient B's head.

25. Respondent reviewed the Mexican Angiogram and the Angiogram Report.

26. The Mexican Angiogram was of poor quality.

27. On or about March 9, 2004, a radiologist in Alamosa, Colorado reviewed the Mexican Angiogram and concluded that the angiogram revealed a 3 to 4 mm aneurysm.

28. Patient B had a history of a right-sided stroke in 2001, which resolved, a subsequent cataract operation in September 2003 and a reported third nerve palsy.

29. Following the March 17, 2004 evaluation, Respondent diagnosed an unruptured right 6-mm PCoA aneurysm and recommended elective surgery.

30. On April 22, 2004, Patient B signed an informed consent form agreeing to undergo a craniotomy for clipping of the aneurysm.

31. On April 26, 2004, Patient B was admitted to PMC, and Respondent's PA performed a pre-operative history and physical and documented that Patient B had a normal neurological exam.

32. Respondent did not consult with a radiologist concerning the interpretation of the Mexican Angiogram.

33. Respondent did not repeat diagnostic studies to confirm or rule out the presence of an aneurysm prior to surgery.

34. On April 26, 2004, Respondent performed elective surgery on Patient B.

35. In the operative report, Respondent documented that Patient B had either a small aneurysm or a dilated segment of the PCoA that she characterized as an "infundibulum."

36. Respondent wrapped the segment of PCoA she characterized as an infundibulum with cotton fragments.

37. A radiologist performed a magnetic resonance angiogram ("MRA") on April 27, 2004 and concluded that an aneurysm was not visualized at Patient B's PCoA.

38. On May 17, 2004, the Board sent Respondent a letter requesting information concerning a complaint issued pursuant to section 12-36-118(4), C.R.S. related to, *inter alia,* Respondent's care and treatment of Patient B ("May 17 Board Letter").

39. In response to the May 17 Board Letter, Respondent indicated that she treated an aneurysm during Patient B's surgery.

40. Patient B did not have an aneurysm.

41. Respondent acknowledged during the surgery that Patient B did not have an aneurysm.

UNPROFESSIONAL CONDUCT – PATIENT B

42. Respondent's evaluation and/or treatment of Patient B failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent performed unnecessary elective surgery on Patient B;

b. Respondent relied upon an inadequate angiogram when deciding to perform the surgery;

c. Respondent failed to obtain adequate pre-operative diagnostic studies on Patient B prior to performing surgery;

d. Respondent misdiagnosed Patient B pre-operatively; and/or

e. Respondent misdiagnosed Patient B post-operatively.

43. Alternatively to the allegations of paragraph 42(e), Respondent failed to make essential entries on and/or made incorrect essential entries on and/or falsified Patient B's patient records by characterizing the segment of artery that she wrapped as a small aneurysm or an infundibulum and, thus, engaged in unprofessional conduct as defined by §12-36-117(1)(cc), C.R.S.

44. Respondent failed to respond to a complaint issued pursuant to § 12-36-118(4), C.R.S. in an honest and/or materially responsive manner in violation of § 12-36-117(1)(gg), C.R.S. when, in response to the May 17 Board Letter, Respondent misrepresented that she

treated an aneurysm during Patient B's surgery.

PATIENT C

45. On March 26, 2004, Patient C, a 55 year-old woman with Down's syndrome, was admitted to Mt. San Rafael Hospital with a history of multiple falls.

46. On March 26, 2004, a computerized tomography ("CT") scan of Patient C's head was performed at Mt. San Rafael Hospital ("March 26 CT").

47. The March 26 CT showed a large chronic subdural hematoma in the right frontal parietal region of Patient C's head.

48. The March 26 CT did not show a left-sided hematoma or hygroma in Patient C's head.

49. On March 26, 2004, Patient C was transferred by ambulance to PMC.

50. Respondent admitted Patient C to PMC.

51. Due to her mental status, Patient C was not competent to sign her own informed consent, and Respondent communicated regarding Patient C's care with Patient C's family.

52. On March 26, 2004, Respondent obtained informed consent from Patient C's sister to perform "burr hole evacuation subdural hematoma" on Patient C ("Patient C Informed Consent").

53. The Patient C Informed Consent indicated that the reason for the procedure was "[c]hronic subdural hematoma."

54. The Patient C Informed Consent did not contain any reference to a subdural hygroma.

55. As of March 26, 2004, Respondent had diagnosed Patient C with a chronic subdural hematoma on the right side of her head.

56. On March 27, 2004, Respondent performed surgery on Patient C ("March 27 Surgery").

57. During the March 27 Surgery, Respondent placed burr holes on the left frontal and parietal areas of Patient C's head and opened the dura.

58. No medical indication for the placement of a burr hole on the left side of Patient C's head existed on March 27, 2004.

59. After placing burr holes on the left side of Patient C's head, Respondent stated to other personnel in the operating room that she was on the wrong side.

60. Respondent subsequently performed burr holes on the right side of Patient C's head and completed the surgery with a successful outcome.

61. Prior to beginning the March 27 Surgery, Respondent did not perform a "time out" to assure she was operating on the correct side of Patient C's head.

62. Respondent dictated an operative report for the March 27 Surgery that characterized the left sided burr holes as "planned incisions."

63. Respondent's operative report for the March 27 Surgery listed a right convexity subdural hematoma as a pre-operative and a post-operative diagnosis.

64. Respondent's operative report for the March 27 Surgery listed "[p]ronounced cerebral atrophy with small left subdural hygroma" as a pre-operative diagnosis.

65. Respondent's operative report for the March 27 Surgery listed "[p]ronounced bilateral cerebral atrophy with thin chronic left subdural hematoma" as a post-operative diagnosis.

66. Respondent's discharge summary omitted the side of Patient C's subdural hematoma.

67. Respondent did not inform Patient C's family that she performed burr holes on both sides of Patient C's head on March 27, 2004.

68. On May 17, 2004, the Board sent Respondent a letter requesting information concerning a complaint issued pursuant to section 12-36-118(4), C.R.S. related to, *inter alia,* Respondent's care and treatment of Patient C ("May 17 Board Letter").

69. In response to the May 17 Board Letter, Respondent stated that Patient C's "surgical site was apparently marked pre-operatively: [sic] by the patient, on the left forehead."

70. Patient C did not pre-operatively mark the surgical site on her own left forehead.

71. In response to the May 17 Board Letter, Respondent wrote: "Although scheduled as a right-sided case, the room and the patient were set up and prepared for left sided burr holes. I did not recognize this until the left burr holes were made . . ."

72. At all times relevant, it was Respondent's pattern and practice to personally prepare her patients for surgery.

73. Respondent prepared Patient C for left sided burr holes.

74. In response to the May 17 Board Letter, Respondent wrote that Patient C's films "did reveal a left-sided hemorrhage, but in retrospect this was a cortical intracerebral hemorrhage rather than a subdural hemorrhage."

75. Respondent wrote a letter to the Board dated July 27, 2004 for review in connection with her Presuspension Hearing ("July 27 Letter"). In her July 27 Letter, Respondent stated: "I had considered and discussed bilateral burr holes with the family the night before based on my pre-operative assessment of imaging studies."

76. Respondent did not discuss performing bilateral burr holes on Patient C with Patient C's family prior to surgery.

77. On September 2, 2004, the Board sent Respondent a second letter requesting information concerning a complaint issued pursuant to section 12-36-118(4), C.R.S. related to Respondent's care and treatment of Patient C ("September 2 Board Letter").

78. In response to the September 2 Board Letter, Respondent wrote that "prepping the patient is something I routinely do, and no doubt did in this case."

79. In response to the September 2 Board Letter, Respondent stated: "Although I initially reported that the patient had 'apparently' marked herself pre-operatively, I cannot now say that I recall seeing this mark myself."

UNPROFESSIONAL CONDUCT: PATIENT C

80. Respondent's evaluation and/or treatment of Patient C failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent performed burr hole surgery on the left side of Patient C's head without a medical basis;

b. Respondent misdiagnosed Patient C with a left-sided subdural hygroma;

c. Respondent misdiagnosed Patient C with a left-sided subdural hematoma;

d. Respondent changed her pre-operative diagnosis of Patient C from left-sided subdural hygroma to a left-sided subdural hematoma without basis;

e. Respondent failed to obtain informed consent to perform left-sided burr holes on Patient C;

f. Respondent failed to perform a "time out" prior to initiating the surgical procedure to verify that she was operating on the correct side of Patient C's head;

g. Respondent documented in Patient C's operative report that incisions on the left side of Patient C's head were "planned" and "appropriate;"

h. Respondent documented incorrect diagnoses in Patient C's operative report; and/or

i. Respondent failed to notify Patient C's family that she performed burr hole surgery on the left side of Patient C's head.

81. Respondent failed to make essential entries and/or made incorrect essential entries in Patient C's patient records and/or falsified Patient C's patient records and, thus, engaged in unprofessional conduct as defined by §12-36-117(1)(cc), C.R.S. for one or more of the following reasons:

a. Respondent dictated an operative report after the March 27 Surgery that characterized the left sided burr holes as "planned incisions;" and/or

b. Respondent's operative report for the March 27 Surgery listed "[p]ronounced bilateral cerebral atrophy with thin chronic left subdural hematoma" as a post-operative diagnosis, thus misrepresenting her surgical error as planned and intentional.

82. Respondent failed to respond to a complaint issued pursuant to §12-36-118(4), C.R.S. in an honest and/or materially responsive manner, in violation of §12-36-117(1)(gg) for one or more of the following reasons:

a. Respondent misrepresented to the Board that Patient C had apparently marked her own head for surgery;

b. Respondent misrepresented to the Board that someone other than Respondent prepared Patient C for the March 27 Surgery by stating : "Although scheduled as a right-sided case, the room and the patient were set up and prepared for left sided burr holes. I did not recognize this until the left burr holes were made . . ."; and/or

c. In her July 27 Letter, Respondent misrepresented to the Board: "I had considered and discussed bilateral burr holes with the family the night before based on my pre-operative assessment of imaging studies."

PATIENT D

83. Respondent evaluated Patient D, a 34 year-old man, in January 2003.

84. Patient D reported a variety of symptoms including but not limited to right upper extremity tremor, severe headaches, hearing loss, visual loss, and vertigo.

85. Respondent reported that a magnetic resonance imaging ("MRI") scan revealed a 14-mm non-enhancing cystic mass at the quadrigeminal plate/pineal region ("pineal cyst").

86. Not all of Patient D's pre-operative symptoms were referable to the pineal cyst.

87. On January 27, 2003, Respondent performed a fenestration and biopsy of the pineal cyst using a supracerebellar approach ("January 2003 Surgery").

88. Following the January 2003 Surgery, Patient D had insomnia and nightmares related to his surgery and was diagnosed with depression and possible posttraumatic stress disorder.

89. In February and March 2004, Patient D reported recurrent headaches, blurred vision, hearing loss in the left ear, total blackness in the eye on the left side, right hand tremor, strange smell and taste, poor appetite and weight loss.

90. On March 8, 2004, Respondent performed a repeat fenestration of the pineal cyst on Patient D and placed a cystosubarachnoid shunt tube (from the cyst into the cisterna magna) ("shunt") ("March 8, 2004 Surgery").

91. A CT scan of Patient D's head was performed on March 9, 2004 ("March 9 CT").

92. The March 9 CT revealed evidence that the shunt placed during the March 8, 2004 Surgery was not placed correctly.

93. Respondent did not timely respond to the incorrect positioning of the shunt shown on the March 9 CT.

94. Respondent did not document in Patient D's medical records a response to the incorrect positioning of the shunt shown on the March 9 CT.

95. A CT scan of Patient D's head was performed on March 10, 2004 ("March 10 CT").

96. The March 10 CT revealed evidence that the shunt placed during the March 8, 2004 Surgery was not placed correctly.

97. Respondent did not timely respond to the incorrect positioning of the shunt shown on the March 10 CT.

98. Respondent did not document in Patient D's medical records a response to the incorrect positioning of the shunt shown on the March 10 CT.

99. The March 10 CT showed the presence of more air in the ventricles and subarachnoid space than the March 9 CT.

100. The March 10 CT showed that the shunt's external drain had moved one or two centimeters from the position shown in the March 9 CT.

101. Respondent did not timely respond to the presence of more air in the ventricles and subarachnoid space shown on the March 10 CT.

102. Respondent did not document in Patient D's medical records a response to the presence of more air in the ventricles and subarachnoid space shown on the March 10 CT.

103. Respondent did not timely respond to the movement of the shunt shown on the March 10 CT.

104. Respondent did not document in Patient D's medical records a response to the movement of the shunt shown on the March 10 CT.

105. On March 11, 2004, Respondent documented that upon attempted removal of the external drain, the drain "fractured" and that approximately 6 cm of the drain was retained intracranially in the subgaleal space.

106. Respondent documented in the March 11, 2004 progress note that she would consult with the manufacturer regarding removal versus leaving in place.

107. On March 12, 2004, Respondent returned Patient D to surgery ("March 12, 2004 Surgery") and documented that the indication for the surgery was "removal of this catheter fragment, which was not designed for nor intended to be an implant."

108. The shunt catheter is not contraindicated for implantation.

109. The operative report for the March 12, 2004 Surgery does not address any other indication for surgery.

110. On March 13, 2004, a post-operative CT of Patient D's head was obtained ("March 13 CT").

111. The March 13 CT revealed evidence that the external catheter was removed during the March 12, 2004 Surgery.

112. The March 13 CT revealed evidence that the shunt was repositioned during the March 12, 2004 Surgery but was still not correctly positioned.

113. Respondent did not timely respond to the incorrect positioning of the shunt shown on the March 13 CT.

114. Respondent did not document in Patient D's medical records a response to the incorrect positioning of the shunt shown on the March 13 CT.

115. On or about September 28, 2004, the Board sent Respondent a letter requesting information concerning a complaint issued pursuant to section 12-36-118(4), C.R.S. related, *inter alia*, to Respondent's care and treatment of Patient D ("September 28 Board Letter").

116. In her response to the September 28 Board Letter, Respondent wrote, "On post-operative day three, as my [PA] was attempting to remove the drainage catheter, a portion of the catheter sheared off and was retained intracranially."

117. In her response to the September 28 Board Letter, Respondent wrote that the reason for the March 12, 2004 Surgery was to remove the catheter fragment.

118. In her response to the September 28 Board Letter, Respondent did not address any other indication for the March 12, 2004 Surgery.

UNPROFESSIONAL CONDUCT: PATIENT D

119. Respondent's evaluation and/or treatment of Patient D failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent failed to counsel Patient D appropriately regarding the relationship of the pineal cyst to his symptoms;

b. Respondent failed to obtain appropriate informed consent for the January 2003 Surgery;

c. Respondent failed to obtain appropriate informed consent for the March 8, 2004 Surgery;

d. During the March 8, 2004 Surgery, Respondent incorrectly placed the shunt;

e. Respondent failed to timely recognize she did not position the shunt correctly during the March 8, 2004 Surgery;

f. Respondent failed to timely recognize she did not position the shunt correctly following the March 8, 2004 Surgery;

g. Respondent failed to timely respond to post-operative CT findings following the March 8, 2004 Surgery indicating that Patient D's shunt was misplaced;

h. Respondent failed to obtain appropriate informed consent for the March 12, 2004 Surgery;

i. During the March 12, 2004 Surgery, Respondent failed to position the

shunt correctly;

j. Respondent failed to recognize that she did not position the shunt correctly during the March 12, 2004 Surgery; and/or

k. Respondent failed to timely respond to post-operative CT findings following the March 12, 2004 Surgery indicating that Patient D's shunt was misplaced.

120. Respondent failed to make essential entries and/or made incorrect essential entries in Patient D's patient records and/or falsified Patient D's patient records and, thus, engaged in unprofessional conduct as defined by §12-36-117(1)(cc), C.R.S. for one or more of the following reasons:

a. Respondent failed to document appropriate review of post-operative CT scans in the patient's records;

b. On March 12, 2004, Respondent returned Patient D to surgery and documented that the indication for the surgery was "removal of this catheter fragment, which was not designed for nor intended to be an implant;"

c. Respondent did not document any other indication for the March 12, 2004 Surgery; and/or

d. Respondent failed to document that she repositioned the shunt during the March 12, 2004 Surgery.

121. Respondent failed to respond to the September 28 Board Letter in an honest and/or materially responsive manner in violation of §12-36-117(1)(gg), C.R.S. by misrepresenting to the Board the reasons for the March 12, 2004 surgery and by omitting any reference to repositioning the shunt.

PATIENT E

122. On January 25, 2004, Respondent evaluated Patient E, a 41 year-old woman, for evaluation of a previously placed ventriculoperitoneal ("VP") shunt.

123. Following a history, physical and collection of data, Respondent concluded the previously placed VP shunt required revision or replacement.

124. Respondent diagnosed Patient E with a right frontal temporal mass, probable meningioma, hydrocephalus, and skin breakdown with cellulitis overlying the left occipital VP shunt.

125. Respondent operated on Patient E on January 27, 2004 to remove the right sided mass, remove the left occipital shunt, and replace the shunt with a right frontal approach VP

shunt ("January 27 Surgery").

126. After the January 27 Surgery, Patient E was slow to wake up, with unresolved and continued raised intracranial compression.

127. Following the January 27 Surgery, a shunt tap was performed on Patient E's shunt placed during the January 27 Surgery ("Shunt Taps").

128. The Shunt Taps were dry.

129. Respondent did not timely respond to the dry Shunt Taps.

130. Respondent did not document a response to the dry Shunt Taps in Patient E's patient records.

131. A CT scan of Patient E's head was performed on January 28, 2004 ("January 28 CT").

132. The January 28 CT revealed evidence that the VP shunt catheter placed during the January 27 Surgery was not placed correctly.

133. The January 28 CT revealed evidence that Patient E may have suffered a stroke.

134. Respondent did not timely respond to the incorrect positioning of the VP shunt catheter shown on the January 28 CT.

135. Respondent did not timely respond to the evidence of a possible stroke on the January 28 CT.

136. Respondent did not document in Patient E's medical records a response to the incorrect positioning of the VP shunt catheter shown on the January 28 CT.

137. Respondent did not document in Patient E's medical records a response to the evidence of a possible stroke on the January 28 CT.

138. A CT scan of Patient E's head was performed on January 31, 2004 ("January 31 CT").

139. The January 31 CT revealed evidence that the VP shunt catheter placed during the January 27 Surgery was not placed correctly.

140. The January 31 CT revealed evidence that Patient E may have suffered a stroke.

141. Respondent did not timely respond to the incorrect positioning of the VP shunt catheter shown on the January 31 CT.

142. Respondent did not timely respond to the evidence of a possible stroke on the January 31 CT.

143. Respondent did not document in Patient E's medical records a response to the incorrect positioning of the VP shunt catheter shown on the January 31 CT.

144. Respondent did not document in Patient E's medical records a response to the evidence of a possible stroke on the January 31 CT.

145. A third post-operative CT scan of Patient E's head was obtained on February 1, 2004 ("February 1 CT").

146. The radiologist report regarding the February 1 CT states: "The lateral ventricles have increased slightly in size when compared to 1/31/04. Recommend clinical correlation with any concern for shunt malfunction."

147. The February 1 CT revealed evidence that the VP shunt catheter placed during the January 27 Surgery was not placed correctly.

148. The February 1 CT revealed evidence that Patient E may have suffered a stroke.

149. Respondent did not timely respond to the incorrect positioning of the VP shunt catheter shown on the February 1 CT.

150. Respondent did not timely respond to the evidence of a possible stroke on the February 1 CT.

151. Respondent did not document in Patient E's medical records a response to the incorrect positioning of the VP shunt catheter shown on the February 1 CT.

152. Respondent did not document in Patient E's medical records a response to the evidence of a possible stroke on the February 1 CT.

153. Following the January 27 Surgery, Patient E progressed slowly with continued lethargy.

154. Following the January 27 Surgery, Patient E's condition was worse than her pre-operative condition.

155. On February 3, 2004, Respondent performed a second surgical revision of Patient E's VP shunt ("February 3 Surgery").

156. A CT scan obtained on February 4, 2004 showed no improvement in ventricular size ("February 4 CT").

157. Respondent did not timely respond to the findings in the February 4 CT.

158. Respondent did not document in Patient E's medical records a response to the findings in the February 4 CT.

159. Following the February 3 Surgery, Patient E progressed slowly with continued lethargy.

160. Respondent did not order any CT scans of Patient E's head after the February 4 CT.

161. On February 25, 2004, Patient E was discharged to a nursing home.

162. Respondent's PA documented in Patient E's discharge summary: "The patient's prognosis is good to return to baseline given continued supportive care and time." Respondent co-signed the discharge summary.

163. On March 31, 2004, Respondent's PA evaluated Patient E.

164. Patient E died on April 5, 2004 in a nursing home.

UNPROFESSIONAL CONDUCT: PATIENT E

165. Respondent's evaluation and/or treatment of Patient E failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent failed to document review of or response to post-operative CT findings following the January 27 Surgery indicating that Patient E's shunt catheter was incorrectly positioned;

b. Respondent failed to timely respond to post-operative CT findings indicating that Patient E's shunt catheter was incorrectly positioned;

c. Respondent failed to timely respond to the dry Shunt Taps;

d. Respondent failed to perform an adequate assessment of Patient E's shunt placement following the January 27 Surgery;

e. Respondent failed to respond appropriately to post-operative CT findings indicating that Patient E may have suffered a stroke;

f. Respondent failed to perform a second surgical revision of Patient E's VP shunt in a timely manner; and/or

g. Following the February 3 Surgery, Respondent failed to order adequate post-operative CT scans.

166. Respondent failed to document essential entries and/or made incorrect essential entries in Patient E's patient records and/or falsified Patient E's patient records and, thus, engaged in unprofessional conduct as defined by §12-36-117(1)(cc), C.R.S. for one or more of the following reasons:

a. Respondent failed to document review of or response to post-operative CT findings following the January 27 Surgery indicating that Patient E's shunt catheter was incorrectly positioned;

b. Respondent failed to document review of or response to post-operative CT findings evidence of a possible stroke following the January 27 Surgery;

c. Respondent failed to document review of or response to post-operative CT findings following the February 3 Surgery; and/or

d. Respondent did not document a rationale for her failure to address the VP shunt misplacement surgically between the January 27 Surgery and February 3, 2004.

PATIENT F

167. On September 26, 2003 at approximately 10:18 p.m., Patient F, a 72 year-old man, was admitted to the emergency room at PMC after being found outside his home.

168. Respondent was the on-call neurosurgeon at PMC when Patient F was admitted.

169. A head CT performed on Patient F at approximately 11:00 p.m. on September 26, 2003 showed that Patient F had sustained significant head injuries.

170. Patient F was admitted to the PMC neurosurgical intensive care unit ("NICU") at approximately 12:45 a.m. in Respondent's name under orders of the emergency room physician.

171. Prior to transfer to the NICU, the emergency room physician communicated with Respondent by telephone.

172. Between arrival in the emergency room and arrival in the NICU, Patient F's neurological status declined from a state of talking and answering some questions appropriately, to a deep coma on arrival at the NICU.

173. At approximately 1:45 a.m., Respondent made a telephone order for intubation of Patient F in response to seizures and his unresponsive state.

174. At approximately 2:00 a.m., another physician was called to the NICU to intubate Patient F and did intubate Patient F.

175. At approximately 4:00 a.m., Respondent was notified of Patient F's neurological

and hypotensive status.

176. Respondent dictated a history and physical ("H&P") for Patient F at 7:08 a.m. on September 27, 2003.

177. Respondent's H&P excluded Patient F's neurological deterioration from arrival at the PMC emergency room to arrival in the NICU.

178. Respondent made a handwritten hospital chart progress note on September 27, 2003 at some time after 11:00 a.m. ("September 27 Progress Note").

179. In the September 27 Progress Note, Respondent wrote that she "will try to contact family members regarding poor prognosis."

180. Respondent decided not to perform surgery on Patient F

181. Respondent did not counsel Patient F's family or legal representative prior to making the decision not to perform surgery on Patient F.

182. Respondent did not make a good faith effort to locate Patient F's family or legal representative prior to making the decision not to perform surgery on Patient F.

183. On or about May 17, 2004, the Board sent Respondent a letter requesting information concerning a complaint issued pursuant to section 12-36-118(4), C.R.S. related, *inter alia*, to Respondent's care and treatment of Patient F ("May 17 Board Letter").

184. In her response to the May 17 Board Letter, Respondent stated: "I was called at approximately 23:00 and did see this patient and review his CT late in his ER stay [on September 26, 2003], just before his admission to the NICU around midnight."

185. Patient F's patient records do not reflect that Respondent personally evaluated or attended to Patient F until approximately 7:00 a.m. on September 27, 2003.

186. Respondent did not personally evaluate or attend to Patient F until approximately 7:00 a.m. or later on September 27, 2003.

187. In her response to the May 17 Board Letter, Respondent described her alleged actions during the evening of September 26, 2003 and stated: "I spoke with the neighbor who found him, and he informed me of the patient's living will and advanced directive, stating that the patient would not want surgery or extraordinary measures unless I could assure a good chance of return to independent living post-operatively."

188. Respondent did not speak to Patient F's neighbor concerning Patient F's living will or advanced directive on September 26 or September 27, 2003.

189. In her response to the May 17 Board Letter, Respondent wrote: "Attempts to

contact family members were unsuccessful [the evening of September 26, 2003.]"

190. Patient F's patient records do not indicate that Respondent attempted to contact Patient F's family members during the evening of September 26, 2003.

191. In her response to the May 17 Board Letter, Respondent wrote: "Family members were contacted later the morning of 9/27/03, and confirmed a desire for no surgical intervention."

192. Patient F's patient records do not indicate that Respondent contacted family members during the morning of September 27, 2003.

193. In Respondent's response to the May 17 Board Letter, Respondent wrote: "The ER note has apparently been lost."

194. No other patient records appear to be lost.

UNPROFESSIONAL CONDUCT: PATIENT F

195. Respondent's evaluation and/or treatment of Patient F failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent failed to examine and attend to Patient F in person in a timely manner; and/or

b. Respondent committed to a non-surgical expectant care plan without first communicating with Patient F's family.

196. Alternatively to the allegations in paragraph 195, Respondent failed to make essential entries on and/or made incorrect essential entries on and/or falsified Patient F's patient records and, thus, engaged in unprofessional conduct as defined by §12-36-117(1)(cc), C.R.S.

197. Respondent failed to respond to a complaint issued pursuant to §12-36-118(4), C.R.S. in an honest and/or materially responsive manner in violation of §12-36-117(1)(gg) for one or more of the following reasons:

a. Respondent misrepresented to the Board that she evaluated Patient F in person between 23:00 and midnight on September 26, 2003;

b. Respondent misrepresented to the Board that she spoke with the neighbor who found Patient F and discussed Patient F's living will and advanced directive on September 26, 2003 by stating: "I spoke with the neighbor who found [Patient F], and he informed me of the patient's living will and advanced directive, stating that the patient

would not want surgery or extraordinary measures unless I could assure a good chance of return to independent living post-operatively;"

c. Respondent misrepresented to the Board that she attempted to contact Patient F's family on September 26, 2003 by stating that "[a]ttempts to contact family members were unsuccessful that evening;"

d. Respondent misrepresented to the Board that she contacted Patient F's family members on the morning of September 27, 2003 by stating that Patient F's "[f]amily members were contacted later the morning of 9/27/03, and confirmed a desire for no surgical intervention;" and/or

e. Respondent misrepresented to the Board her actions on September 26, 2003 related to documentation of care of Patient F by stating that her emergency room note "has apparently been lost."

PATIENT G

198. On February 25, 2003, Respondent's partner evaluated Patient G, 63 year-old man with a long history of chronic cervical myofascial pain.

199. Respondent's partner performed an examination and found Patient G to be neurologically intact, without evidence of spinal cord compression, and with findings consistent with a diagnosis of fibromyalgia.

200. Respondent's partner ordered MRI scans of Patient G's cervical and thoracic spine, and, after reviewing the scans, referred Patient G to Respondent "to learn about surgical possibilities."

201. On March 27, 2003, Respondent examined Patient G.

202. Respondent read a thoracic spine MRI of Patient G as indicting "pronounced T10-12 stenosis due to posterior element hypertrophy, greater on right than left. There is canal and foraminal compromise at these levels which is very dramatic."

203. Based upon his signs and symptoms, Patient G was a candidate for C4-6 decompression and fusion.

204. Respondent recommended and advised Patient G to undergo microendoscopic decompression of T10-T12 immediately to avoid potentially catastrophic nerve damage and paralysis from a minor accident.

205. Patient G had no symptoms referable to his T10-T12 levels, and no neurological findings corresponding to nerve root or spinal cord compression at the T10-T12 level.

206. Respondent performed right T10–T11, T11-T12 microendoscopic foraminotomy and decompression on Patient G at PMC on April 18, 2003 ("April 18 Surgery").

207. Respondent initially recommended discharge within hours of the April 18 Surgery.

208. Following the April 18 Surgery, Patient G developed post-surgical complications including urinary retention and abdominal fullness, and was admitted overnight by a neurosurgeon covering for Respondent.

209. Patient G was discharged from PMC on April 19, 2003.

210. On April 21, 2003, Patient G returned to Respondent's office with severe abdominal pain and distension, which was diagnosed by Respondent's PA as post-operative ileus (intestinal hypoactivity) and constipation. Patient G was treated appropriately for these conditions at that time.

211. On May 13, 2003, Respondent evaluated Patient G. His constipation had resolved, but he complained of bilateral groin numbness, which Respondent characterized as "perhaps related to intraoperative positioning." Respondent treated Patient G with Celebrex.

212. On July 10, 2003, Respondent characterized Patient G's persistent lower abdominal and groin symptoms as "T12 and L1 sensory radiculopathy" and attempted to pursue a work-up with a thoracic MRI to assess the operative site.

213. On October 10, 2003, a neurologist examined Patient G and found evidence of painful numbness in a T12 (groin) distribution.

214. On November 24, 2003, Patient G was seen by another neurosurgeon who stated that Patient G suffered possibly a "neuropraxic injury" to the thoracic nerve roots, or possibly a "spinal cord contusion in the dorsal root entry zone of T11 and T12 nerve roots on the right side" during the April 18 Surgery.

215. The neurosurgeon did not recommend further surgery due to Patient G's poor outcome and Patient G's distress from the April 18 Surgery.

UNPROFESSIONAL CONDUCT: PATIENT G

216. Respondent's evaluation and/or treatment of Patient G failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent failed to provide Patient G with adequate information concerning alternative treatment options;

b. Respondent inaccurately advised Patient G of the necessity and benefits of surgery on his thoracic spine;

c. Respondent performed the April 18 Surgery on Patient G without adequate medical indication;

d. Respondent performed the April 18 Surgery using an endoscope;

e. Respondent planned the April 18 Surgery as same-day surgery; and/or

f. Respondent surgically injured Patient G during the April 18 Surgery.

PATIENT H

217. On or about March 8, 2002, Respondent examined Patient H, a 33 year-old man for a subarachnoid hemorrhage.

218. An initial head CT scan of Patient H was performed at the SMC emergency room on March 8, 2002 and was read as normal and without evidence of subarachnoid hemorrhage.

219. Following the initial CT scan, a spinal tap was performed with results consistent with a recent subarachnoid hemorrhage.

220. Patient H was transferred and admitted to PMC on March 8, 2002.

221. Following Patient H's admission to PMC, Respondent ordered a cerebral angiogram.

222. A cerebral angiogram performed on March 9, 2002 showed a 7.4 x 6.2 mm lobulated anterior communicating artery ("ACoA") aneurysm, fed by a dominant left anterior cerebral artery ("March 9 Angiogram").

223. The radiologist dictated an addendum to the report regarding the March 9 Angiogram on March 10, 2002 and noted a possible small left posterior inferior cerebellar artery ("PICA") aneurysm, versus overlying vessels.

224. On March 11, 2002, Respondent performed a left-sided frontal craniotomy for clip ligation of the ACoA aneurysm ("First Patient H Surgery").

225. During the First Patient H Surgery, Respondent encountered what appeared to be both acute and subacute subarachnoid blood and reduced brain swelling with placement of ventricular catheter.

226. During the First Patient H Surgery, Respondent placed a single curved Yasargil

clip across the neck of the ACoA aneurysm.

227. As Respondent was closing the First Patient H Surgery, Patient H's brain began to swell and blood poured from the ventriculostomy drain Respondent had previously placed.

228. Respondent closed the dura and scalp, leaving out the bone plate, and emergently transported Patient H to the CT scanner for an emergency CT scan of the brain ("Emergency CT").

229. The Emergency CT showed a large intraventricular and right medial frontal hemorrhage in the immediate vicinity of the aneurysm clip Respondent had placed on the ACoA aneurysm neck.

230. Respondent then took Patient H back to surgery and performed a right frontal craniotomy and evacuation of the right frontal intercerebral hemorrhage as well as placement of ventriculostomy and replacement of the left bone flap ("Second Patient H Surgery").

231. During the Second Patient H Surgery, Respondent placed a second angled aneurysm clip in tandem with the Yasargil clip placed during the First Patient H Surgery on the ACoA aneurysm.

232. During the Second Patient H Surgery, Respondent did not perform any procedure to address a rupture of the PICA aneurysm.

233. The Emergency CT did not show that the PICA aneurysm had ruptured.

234. Patient H never regained consciousness following the Second Patient H Surgery and died on March 13, 2002.

235. Respondent dictated the operative report for both the First Patient H Surgery and the Second Patient H Surgery on March 24, 2002.

236. In the operative report Respondent dictated for the First Patient H Surgery, she included, *inter alia*, a post-operative diagnosis of "3. Apparent very recent, probably same day, recurrent subarachnoid hemorrhage and intraoperative rupture of the [PICA]."

237. In the operative report Respondent dictated for the Second Patient H Surgery, Respondent stated that "the previously placed aneurysm clip was noted to completely occlude the [ACoA] aneurysm and both A-2 segments of the anterior cerebral arteries were noted to be patent and pulsating nicely, with no occlusion of the vessels."

238. On or about August 11, 2004, the Board sent Respondent a letter requesting information concerning a complaint issued pursuant to section 12-36-118(4), C.R.S. related, *inter alia*, to Respondent's care and treatment of Patient H ("August 11 Board Letter").

239. In Respondent's response to the August 11 Board Letter, Respondent stated: "At the time, because the clip appeared to be in good position and the initial clip placement was achieved without untoward event, I believed the intraoperative hemorrhage arose from spontaneous rupture of the [PICA] aneurysm, with massive ventricular hemorrhage dissecting into the frontal lobe via the third ventricle and lamina terminalis or via the lateral ventricle. This, however, could not be confirmed, and the actual source of the hemorrhage remains unproven."

240. The Emergency CT revealed findings consistent with a hemorrhage from an ACoA aneurysm.

241. The Emergency CT did not reveal findings consistent with a hemorrhage from the PICA aneurysm.

242. There is no medically reasonable explanation for Respondent's placement of a second aneurysm clip in tandem with the aneurysm clip placed on the ACoA aneurysm during the First Patient H Surgery unless Respondent believed the actual source of the pre-operative and intraoperative ruptures to be the ACoA aneurysm and not the PICA aneurysm.

UNPROFESSIONAL CONDUCT: PATIENT H

243. Respondent's evaluation and/or treatment of Patient H failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent dictated the operative note for the First Patient H Surgery on March 24, 2002, thirteen days after the First Patient H Surgery was performed;

b. Respondent dictated the operative note for the Second Patient H Surgery on March 24, 2002, thirteen days after the Second Patient H Surgery was performed; and/or

c. Respondent attributed the intraoperative hemorrhage and brain swelling that occurred during the First Patient H Surgery to a rupture of the PICA aneurysm.

244. Alternatively to the allegations in paragraph 243(c), Respondent falsified and/or made incorrect essential entries in Patient H's patient records by including in the operative report for the First Patient H Surgery a "Post-operative Diagnosis" of "3. Apparent very recent, probably same day, recurrent subarachnoid hemorrhage and intraoperative rupture of the [PICA]," and, thus, committed unprofessional conduct as defined by §12-36-117(l)(cc).

245. Alternatively to the allegations in paragraph 243(c), Respondent's failed to respond in an honest and/or materially responsive manner to the compliant issued pursuant to §12-36-118(4), C.R.S., and, thus, committed unprofessional conduct as defined by §12-36-

117(1)(gg), C.R.S. by misrepresenting to the Board that "at the time" she believed the likely cause of the intraoperative hemorrhage and brain swelling that occurred during the First Patient H Surgery to a spontaneous rupture of the PICA aneurysm.

PATIENT I

246. Patient I, a 34 year-old man, was injured on March 8, 2002 in an all-terrain vehicle rollover accident in which he sustained a T12 vertebral body fracture.

247. Patient I was initially examined at Mt. San Rafael Hospital in Trinidad, Colorado and was transferred to PMC on March 8, 2002.

248. On March 8, 2002, Patient I was examined in the PMC emergency room, where Patient I denied any numbness, tingling or loss of function in the extremities, and also denied any radiation of pain.

249. On March 8, 2002, Patient I was admitted to PMC to Respondent's care.

250. On or about March 8, 2002, Respondent diagnosed Patient I with a T12 compression fracture with posterior element disruption and facet dislocation.

251. On March 10, 2002, an MRI of Patient I's lower thoracic and upper lumbar spine was performed at PMC.

252. On March 11, 2002, a CT scan of Patient I's lumbar spine was performed at PMC.

253. On March 12, 2002, Respondent performed a four-level spinal fusion on Patient I, inserting rods and pedicle screws two spinal levels above and below the T12 fracture ("March 12 Surgery").

254. Respondent dictated the operative report for the March 12 Surgery on March 21, 2002.

255. In the operative report for the March 12, 2002 surgery, Respondent diagnosed Patient I with a "T12 burst fracture with kyphotic deformity secondary to trauma."

256. Radiological findings from studies performed on March 10, 2002 and March 11, 2002 were not consistent with a "burst" fracture.

257. Patient I's T12 fracture was not a "burst" fracture.

258. Patient I's T12 fracture did not require surgical intervention.

259. On April 24, 2002, Respondent dictated the H&P for Patient I's March 8, 2002

admission to PMC.

UNPROFESSIONAL CONDUCT: PATIENT I

260. Respondent's evaluation and/or treatment of Patient I failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent performed an unnecessary surgical procedure on Patient I without adequate clinical or medical justification;

b. Respondent failed to conduct an adequate trial of conservative treatment;

c. Respondent failed to timely dictate an H&P for Patient I's March 8, 2002 admission to PMC; and/or

d. Respondent misdiagnosed Patient I with a "burst" fracture.

261. Alternatively to the allegations in paragraph 260, Respondent falsified and/or made incorrect essential entries in Patient I's patient records and, thus, engaged in unprofessional conduct as defined by §12-36-117(1)(cc), C.R.S. by characterizing Patient I's T12 fracture as a "burst" fracture.

PATIENT J

262. On February 6, 2002, Respondent performed a C4-5, C5-6 anterior cervical decompression and fusion with allograft, AGF and Atlantis plating on Patient J, a 62 year-old woman at PMC ("February 6 Surgery").

263. On February 7, 2002, Patient J complained of left-arm weakness and severe difficulty swallowing.

264. Post-operative imaging studies of Patient J performed on February 7, 2002, February 9, 2002, February 10, 2002 and February 11, 2002 showed a progressive migration of the Atlantis plate and screws from their original position.

265. After the February 6 Surgery, Patient J exhibited signs and symptoms of impingement on her esophagus not consistent with normal post-surgical swelling.

266. By February 11, 2002, Patient J demonstrated signs and symptoms indicating that the Atlantis plate had migrated off the inferior C6 vertebral body and that the screws placed during the February 6 Surgery were backing out of the C6 vertebral body.

267. On February 21, 2002, Patient J underwent an esophagogastroduodenoscopy

with placement of a percutaneous endoscopic gastronomy feeding tube due to Patient J's inability to swallow without aspiration.

268. On February 28, 2002, Patient J had a swallowing function test performed that demonstrated that the inferior portion of the Atlantis plate placed during the February 6 Surgery extended 3-4 mm anteriorly and that "[t]he metallic plate does impinge on the posterior esophagus to some extent."

269. On March 1, 2002, Respondent stated in Patient J's medical records that the "3 mm impingement lower C-spine does not appear to be the cause of current swallowing dysfunction."

270. On March 4, 2002, Patient J was transferred from PMC to a skilled nursing facility.

271. On March 7, 2002, additional x-rays of Patient J's cervical spine were taken showing that the screws implanted during the February 6 Surgery had backed out of the C6 vertebral body, and the Atlantis plate was positioned forward of the spine likely indenting the esophagus with superior migration of the upper plate over the C3-4 disc space.

272. On March 13, 2002, Patient J underwent surgery performed by another neurosurgeon to remove the Atlantis plate and screws placed during the February 6 Surgery.

273. On April 11, 2002, Respondent's PA dictated the discharge summary for Patient J, approximately 38 days after Patient J was discharged from PMC. Respondent co-signed the discharge summary.

UNPROFESSIONAL CONDUCT: PATIENT J

274. Respondent's evaluation and/or treatment of Patient J failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent failed to recognize or diagnose progressive migration of the Atlantis plate and screws in a timely manner;

b. Respondent failed to adequately treat Patient J's post-surgical complications, including swallowing difficulty and direct impaction of the dislodged cervical plate against Patient J's esophagus; and/or

c. Respondent failed to timely dictate a discharge summary for Patient J after discharge from PMC.

PATIENT K

275. On or about April 12, 1999, Respondent examined Patient K, a 46 year-old man with chronic low back pain, end-stage alcoholic liver disease with cirrhosis, complicated by hepatitis C.

276. On June 11, 1999, Respondent advised Patient K: "given his tobacco smoking and ethanol abuse history, that surgery should only be considered as a last resort."

277. Respondent next examined Patient K on April 13, 2001. At that time, Patient K complained of increasing bilateral leg pain. Respondent ordered an MRI of Patient K's lumbar spine, liver function tests and coagulation studies.

278. On May 9, 2001, an MRI of Patient K's lumbar spine was performed. The radiologist report indicates that Patient K had, *inter alia*, a herniated disc at the L4-5 level that was not seen on prior radiological studies.

279. On June 26, 2001, Respondent recommended that Patient K undergo an L4-5 microendoscopic diskectomy and obtained informed consent from Patient K.

280. On July 2, 2001, Respondent sent Patient K's family physician a letter stating that if Patient K's history of alcoholism, and hepatitis C with abnormal liver function "represent a significant morbidity or mortality risk, we will obviously not undertake surgical intervention for his herniated disc."

281. To determine pre-operative risk, the family physician arranged for a pre-operative liver biopsy.

282. On August 1, 2001, the family physician sent Respondent a facsimile indicating that the pre-operative liver biopsy confirmed "chronic hepatitis, established cirrhosis and observed hemochromatosis. This along with his hepatitis C history, puts him at high risk for surg[ery]. However, I would proceed with acknowledged risks."

283. On August 2, 2001, Respondent performed a left L4-5 microendoscopic diskectomy under general anesthesia on Patient K. ("August 2 Surgery").

284. Respondent planned the August 2 Surgery as a same-day surgery.

285. The August 2 Surgery was uncomplicated and the patient reported marked improvement in his leg pain post-surgery.

286. On August 2, 2001, Respondent discharged Patient K from the hospital with instructions to "[k]eep the wound clean and dry by showering daily and changing the band aid. Do not soak in a tub for 2 weeks" and to avoid long car trips.

287. Patient K was non-compliant with Respondent's post-surgical instructions. Patient K drove a considerable distance the next day to a location where, *inter alia*, he soaked in a hot tub.

288. Patient K woke on approximately August 10, 2001 immobilized with severe back and leg pains and was airlifted to Penrose-St. Francis Hospital ("Penrose") in Colorado Springs, Colorado.

289. An MRI performed on approximately August 10, 2001 at Penrose showed a recurrent herniated disc at the site of the August 2 Surgery.

290. On August 10, 2001, Patient K was transferred from Penrose to PMC, where Respondent noted that Patient K had pain on motion in the back and left leg, a macerated incision but without erythema or discharge from the wound.

291. On August 10, 2001, Respondent re-admitted Patient K to PMC with the diagnosis of acute recurrent L4-L5 herniated disk ("August 10 Hospitalization").

292. On August 12, 2001, Patient K had signs and symptoms of a deep staphylococcus aureus ("staph aureus") infection, including elevated white blood cell count, purulent drainage from his surgical wound and decreased mental status.

293. On August 13, 2001, Patient K was transferred to the NICU at PMC secondary to decreased level of consciousness.

294. By August 13, 2001, lab results confirmed that Patient K was infected with staph aureus.

295. On August 14, 2001, Patient K exhibited further signs of staph aureus sepsis including headache. extremely rigid neck in flexion, neck pain, and altered mental status and was additionally diagnosed with bacterial meningitis.

296. On August 14, 2001, Respondent diagnosed Patient K with "purulent drainage from previous microdiskectomy incision and superficial wound infection" and performed "irrigation and debridement of the superficial wound infection" at the patient's bedside.

297. Patient K condition declined with sepsis, pulmonary failure, hepatic failure, and acute renal failure.

298. Patient K died on August 30, 2001, after withdrawal of full life-support.

299. Respondent dictated the H&P for Patient K's August 10 Hospitalization on September 4, 2001, approximately four days after Patient K's death.

300. In the H&P, Respondent stated that she "will not entertain performance of a

repeat diskectomy, as the surgical risk is quite high, due to the patient's preexisting liver failure."

UNPROFESSIONAL CONDUCT: PATIENT K

301. Respondent's evaluation and/or treatment of Patient K failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent failed or refused to re-operate on Patient K during the August 10 Hospitalization to address his signs and symptoms of infection;

b. Respondent misdiagnosed Patient K with a "superficial wound infection;"

c. Respondent inadequately treated Patient K's wound infection during Patient K's August 10 admission;

d. Respondent failed or refused to provide appropriate continued surgical care to Patient K to address complications following the August 2 Surgery; and/or

e. Respondent did not dictate Patient K's H&P for the August 10 Hospitalization until September 4, 2001, four days after Patient K's death.

PATIENT L

302. On July 20, 2001, Patient L, a 39 year-old woman, presented to Respondent with complaints of a three-year history of shoulder pain, hand numbness and hand tingling.

303. Respondent diagnosed Patient L with C5-6 and C6-7 large herniated discs with corresponding radiculopathies.

304. Respondent recommended that Patient L undergo an anterior cervical decompression, diskectomy and fusion with allograft and plating at the C5-6 and C6-7 levels.

305. On August 1, 2001, Respondent performed a C5-6 and C6-7 anterior cervical decompression, diskectomy and fusion with tricorticate allograft, autologous growth factor and Atlantis plating on Patient L. ("August 1 Surgery").

306. During the August 1 Surgery, an Atlantis plate was used to secure the fusion from C5-C7.

307. Following the August 1 Surgery, Patient L developed post-operative complications including swallowing difficulty and pain, persistent numbness in the fingers on

her left hand, neck pain, right shoulder pain, and right arm pain.

308. Patient L presented to Respondent on September 7, 2001, with complaints of facial and right arm swelling, right ptosis and mild right-sided weakness including her leg.

309. Respondent noted that Patient L's facial and right arm swelling had "essentially resolved" but Patient L continued to have facial and right arm swelling on September 7, 2001.

310. On September 7, 2001, Respondent noted that Patient L had post-operative Horner syndrome on the right, with some central findings and generalized right-sided weakness.

311. On February 27, 2002, Patient L underwent a second surgery performed by another neurosurgeon to remove the plate inserted during the August 1 Surgery and revise the fusion.

UNPROFESSIONAL CONDUCT: PATIENT L

312. Respondent's evaluation and/or treatment of Patient L failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent failed to adequately and timely address Patient L's post-operative symptoms;

b. Respondent failed to diagnose displacement of hardware placed during the August 1 Surgery in a timely manner; and/or

c. Respondent failed to diagnose Patient L's post-operative complications in a timely manner.

PATIENT M

313. On October 17, 2000, Respondent evaluated Patient M, a 45 year-old woman, for primary complaints of left leg and foot pain.

314. Respondent diagnosed Patient M with L5-S1 spondylolisthesis with a possible L5 pars defect on the left.

315. On December 13, 2000, Respondent performed an L5-S1 decompression and posterior spinal fusion L5-S1 with pedicle screw fixation, laminar allograft, AlloMatrix and ProOsteon bone substitutes ("December 13 Surgery").

316. During the December 13 Surgery, Respondent utilized lateral x-rays to confirm positioning of the pedicle screws.

317. Respondent did not obtain anterior/posterior x-rays during the December 13 Surgery.

318. During the December 13 Surgery, Respondent inserted the right S1 pedicle screw so that the screw was in direct contact with Patient M's right S1 nerve root.

319. Respondent either failed to probe within the pedicle screw tap before placing the pedicle screws in Patient M's spine during the December 13 Surgery or failed to document that she performed such a probe during the December 13 Surgery.

320. Respondent either failed to inspect the spinal canal and foramen along the S1 nerve root after placement of the pedicle screws during the December 13 Surgery to determine if the screw was placed in the S1 foramen or failed to document that she performed such an inspection during the December 13 Surgery.

321. Patient M was admitted to the recovery room following surgery at 12:52 p.m. on December 13, 2000 with the Respondent's PA.

322. Upon admission to the recovery room, Patient M complained of right leg pain that was not relieved with medication.

323. Patient M was transferred from the recovery room to a hospital room at approximately 3:30 p.m. on December 13, 2000.

324. Between approximately 4:00 p.m. on December 13, 2000 and 6:00 a.m. on December 14, 2000, Patient M was given 22 mg of morphine through a patient controlled analgesic ("PCA") device. During this same period of time, Patient M attempted to use the PCA device 29 times.

325. At some time before 8:33 a.m. on December 14, 2000, Respondent's PA examined Patient M and noted in the patient's medical records that Patient M had severe pain in the right leg, was moving very poorly, needed assistance moving, and was "not using PCA effectively."

326. Respondent dictated her operative report for the December 13 Surgery on December 14, 2000 at approximately 4:21 p.m., approximately 27 hours after Patient M complained of right leg pain in the recovery room.

327. On December 15, 2000, Patient M was "unable to move" because of severe burning right leg pain in the S1 distribution.

328. On December 15, 2000, Respondent ordered a lumbar CT that demonstrated that "the right inferior transpedicular screw appears to extend into the right first neural foramen likely contacting the right S1 nerve root" ("December 15 CT").

329. Respondent interpreted the December 15 CT in her December 15, 2000 progress note as showing "loose [right] S1 pedicle screw with medial and inferior deviation compared with intraop and immediately post op films. Screw encroaches on [right] S1 foramen, likely responsible for S1 distribution pain post-op."

330. The only radiological studies reported in Patient M's record prior to the December 15 CT were the intraoperative lateral x-rays.

331. On December 15, 2000, Respondent re-operated on Patient M and removed the right S1 screw.

332. Patient M continued to suffer exertional pain, muscle spasms, right S1 distribution numbness, and loss of ankle reflex for at least six months post-operatively.

333. On April 2, 2002, approximately 16 months after the December 13 Surgery, Respondent noted that Patient M was experiencing "fluctuating calf pain and numbness with gluteal muscle spasms on right, improving very slowly."

334. On or about August 25, 2004, the Board sent Respondent a letter requesting information concerning a complaint issued pursuant to section 12-36-118(4), C.R.S. related to, *inter alia*, Respondent's care and treatment of Patient M. ("August 25 Board Letter").

335. In her response to the August 25 Board Letter, Respondent stated that "comparison of the intraoperative and post-operative imaging studies shows that though the S1 pedicle screw was properly placed at the time of surgery, it subsequently moved. This movement is clearly evident on imaging studies."

336. The December 15 CT shows that the inferior right pedicle screw was initially placed directly through the right S1 foramen, which is occupied by the right S1 nerve root.

337. The December 15 CT shows no fracture around the screw or other evidence that the screw migrated or moved after the December 13 Surgery.

UNPROFESSIONAL CONDUCT: PATIENT M

338. Respondent's evaluation and/or treatment of Patient M failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. During the December 13 Surgery, Respondent failed to position the right S1 pedicle screw correctly;

b. Respondent failed to timely recognize that the right S1 pedicle screw was incorrectly positioned during the December 13 Surgery;

c. Respondent failed to order or obtain anterior/posterior x-rays during the December 13 Surgery;

d. Respondent failed to probe within the pedicle screw tap before placing the pedicle screws in Patient M's spine during the December 13 Surgery;

e. Respondent failed to inspect the spinal canal and foramen along the S1 nerve root after placement of the pedicle screws during the December 13 Surgery;

f. Respondent failed to timely order post-operative radiological studies after the December 13 Surgery in light of Patient M's post-surgical symptoms;

g. Respondent failed to diagnose and treat Patient M's right leg pain following the December 13 Surgery in a timely manner; and/or

h. In her December 15, 2000 progress note, Respondent wrote that films were taken immediately post-operatively after the December 13 Surgery, when no such films were taken.

339. Respondent failed to make essential entries and/or made incorrect essential entries in Patient M's patient records and/or falsified Patient M's patient records and, thus, engaged in unprofessional conduct as defined by §12-36-117(1)(cc), C.R.S. for one or more of the following reasons:

a. Alternatively to the allegations in paragraph 338(d), Respondent failed to document in Patient M's medical records that she probed within the pedicle screw tap before placing the pedicle screws in Patient M's spine during the December 13 Surgery;

b. Alternatively to the allegations in paragraph 338(e), Respondent failed to document in Patient M's medical records that she inspected the spinal canal and foramen along the S1 nerve root after placement of the pedicle screws during the December 13 Surgery; and/or

c. In her December 15, 2000 progress note, Respondent wrote that films were taken immediately post-operatively after the December 13 Surgery, when no such films were taken.

340. Respondent failed to respond to a complaint issued pursuant to §12-36-118(4), C.R.S. in an honest and/or materially responsive manner, in violation of §12-36-117(1)(gg) for one or more of the following reasons:

a. Respondent misrepresented to the Board that the intraoperative films taken during the December 13 Surgery showed proper pedicle screw placement at the time of surgery; and/or

b. Respondent misrepresented to the Board that pedicle screw "movement is clearly evident on imaging studies."

PATIENT N

341. On April 4, 2000, Respondent evaluated Patient N, a sixty-six year-old man who was experiencing low back pain radiating down both legs.

342. Respondent diagnosed Patient N with severe lumbar stenosis secondary to L4-5 spondylolisthesis and L4-5 herniated nucleus pulposis.

343. On April 19, 2000, Respondent performed elective and corrective spine surgery on Patient N at SMC.

344. The procedures performed at that time included L3-4 through L5-S1 decompressive laminectomy, L4-5 diskectomy, L4-S1 posterior spinal fusion with Stealth guidance, pedicle screw fixation, right iliac crest with bone graft, and bone graft stimulator.

345. After Patient N was anesthetized and positioned for surgery, but before the first incision was made, Respondent left SMC to attend to an emergency at PMC, where she was on call.

346. PMC is more than four miles away from SMC.

347. Respondent instructed her PA to initiate and proceed with Patient N's elective surgery while Respondent was away from SMC.

348. The PA performed the initial dissection down to Patient N's spine while Respondent was away from SMC.

349. At least 45 minutes after leaving SMC, Respondent returned to SMC and completed Patient N's surgery under the same anesthetic and positioning.

350. Respondent documented in the medical record that the case was "delayed temporarily for approximately 45 minutes due to an emergency. On return, the dissection was continued . . ."

351. Respondent did not document the PA's role in performing surgery in Patient N's operative report.

352. The medical staff at SMC intervened and told Respondent to return to SMC or cancel Patient N's case.

353. The PA was not authorized by SMC's protocols to perform the above-listed acts.

354. Upon returning to SMC, Respondent was critical of the SMC staff for suggesting that the PA stop operating during Respondent's absence and for criticizing Respondent's decision.

355. Effective April 21, 2000, SMC placed Respondent on a 14-day investigative suspension due to Respondent's order that her PA initiate and proceed with surgery on Patient N in Respondent's absence.

356. On or about July 13, 2004, the Board sent Respondent a letter requesting information concerning a complaint issued pursuant to section 12-36-118(4), C.R.S. related to Respondent's care and treatment of Patient N ("July 13 Board Letter").

357. In her response to the July 13 Board Letter, Respondent stated that she made changes to her practice to assure that this type of incident would not be repeated.

358. In her response to the July 13 Board Letter, Respondent stated, "I have not acted in this way again."

359. On or about March 13, 2002, Respondent left the same PA in an operating room at PMC while Respondent scrubbed in on another case in the PMC NICU.

360. Respondent instructed the same PA to initiate and perform surgery on a different patient in Respondent's absence.

361. Respondent was absent from the operating room on March 13, 2002 for approximately 45 minutes.

362. When confronted by the staff at PMC regarding the incident on or about March 13, 2002, Respondent's PA stated that she "does this" "all the time."

UNPROFESSIONAL CONDUCT: PATIENT N

363. Respondent's evaluation and/or treatment of Patient N failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent performed elective surgery at SMC while on call at PMC without making appropriate contingency arrangements;

b. Respondent left SMC while Patient N remained anesthetized and positioned for surgery;

c. Respondent instructed a PA to initiate and proceed with an operation after she left SMC; and/or

d. Respondent failed to provide adequate personal and responsible direction and supervision for her PA under the circumstances.

364. Respondent's evaluation and/or treatment of Patient N violated §12-36-106(5), C.R.S. and/or Board Rule 400, 3 C.C.R. 713-7 and, thus, constituted unprofessional conduct as defined by §§12-36-117(1)(n) and/or 12-36-117(1)(u), C.R.S. for one or more of the following reasons:

a. Respondent instructed a PA to proceed with an operation after she left SMC; and/or

b. Respondent failed to provide adequate personal and responsible direction and supervision for her PA under the circumstances.

365. Respondent failed to respond to a complaint issued pursuant to §12-36-118(4), C.R.S. in an honest and/or materially responsive manner, in violation of §12-36-117(1)(gg) for one or more of the following reasons:

a. Respondent misrepresented to the Board that she made changes to her practice to assure that this type of incident would not be repeated; and /or

b. Respondent misrepresented to the Board that she "ha[s] not acted in this way again."

PATIENT O

366. On approximately July 14, 1998, Patient O, a 38 year-old man, presented to Respondent's office with pain in his lower back, numbness in his right leg, hip and low back, and significant weakness in his right leg and ankle.

367. On July 7, 1998, Patient O underwent an MRI of his lumbar spine, which revealed desiccation of the L2-3 and L3-4 disc spaces but "no disc bulges or herniation identified" in those spaces ("July 7 MRI").

368. The July 7 MRI revealed "[a]t L4-5 there is a right sided disc extrusion with free fragment ends ending inferior to the disc level posterior to the L5 vertebral body."

369. The radiologist reviewing the July 7 MRI concluded that the right L5 nerve root was impinged secondary to a free fragment.

370. On July 14, 1998, Respondent reviewed the July 7 MRI and concluded that Patient O had a right L4-L5 large herniated disk with an apparent extruded sequestered fragment extending down over the L5 vertebral body.

371. On July 14, 1998, Respondent recommended that Patient O undergo

microendoscopic diskectomy on the right at L4-5.

372. On July 14, 1998, Respondent presented Patient O with an informed consent form indicating that Respondent would perform a "right L4-5 microendoscopic diskectomy."

373. On August 3, 1998, Respondent performed an L3-4 microendoscopic diskectomy at L3-4 with L4 laminotomy ("L3-4 Surgery") on Patient O.

374. Respondent did not have Patient O's radiological films in the operating room when she performed the L3-4 Surgery.

375. Respondent relied upon radiological films from a patient other than Patient O as a basis for performing surgery at L3-4 level.

376. Respondent used radiological films from a patient other than Patient O during the L3-4 Surgery.

377. After the L3-4 Surgery, Respondent met with Patient O and informed him that she had identified and corrected pathology at the L3-4 level during the L3-4 Surgery.

378. Subsequently, Patient O informed Respondent that he continued to have persistent numbness and weakness of his right leg and foot.

379. After the L3-4 Surgery, Patient O's wife told Respondent that the intended surgery was at the L4-5 level and not at the L3-4 level.

380. Respondent then returned Patient O to the operating room and performed a right L4-5 microendoscopic diskectomy ("L4-5 Surgery").

381. The L4-5 Surgery was completed at approximately 9:43 p.m. on August 3, 1998.

382. Prior to performing the L3-4 Surgery, Respondent did not document in Patient O's patient records any signs, symptoms or indications of disc pathology requiring surgery at the L3-4 level.

383. After performing the L3-4 Surgery and the L4-5 Surgery, at approximately 11:06 p.m. on August 3, 1998, Respondent dictated an H&P for Patient O.

384. In the H&P, Respondent stated that "On review of his radiographic studies, [Patient O] has a bulging disk at L3-4. . . ."

385. Respondent altered her PA's progress note dated August 3, 1998 by adding reference to L3-4 and L4-5 pathology and deleting an entry under the heading "pre-op dx." Respondent co-signed the PA's progress note.

386. In Respondent's operative note for the L3-4 Surgery, dictated at 12:04 p.m. on

August 4, 1998, Respondent documented that Patient O was returned to the operating room because "it was thought that a disc fragment down low, between L4 and L5, had been missed."

387. In Respondent's operative note for the L4-5 Surgery, dictated at 12:09 p.m. on August 4, 1998, Respondent documented that Patient O's pre-operative diagnosis was "[p]ersistent neurologic deficit following a diskectomy with residual disc fragment in the foramen at L4-5."

388. On or about August 25, 2004, the Board sent Respondent a letter requesting information concerning a complaint issued pursuant to section 12-36-118(4), C.R.S. related, *inter alia*, to Respondent's care and treatment of Patient O. ("August 25 Board Letter").

389. In her response to the August 25 Board Letter, Respondent stated, "Unfortunately, when I reviewed the patient's films just prior to surgery, I actually looked at another patient's films that had been inadvertently included within Patient O's film jacket. Those films disclosed pathology that was remarkably similar to Patient O's, but at the L3-4 level."

390. In her response to the August 25 Board Letter, Respondent stated, "My error was compounded by the fact that upon exposing the L3-4 disc space, I did find a disc herniation with free fragments at this level, which I removed."

391. The July 7 MRI showed no evidence of free fragment disc herniation at the L3-4 level.

392. Patient O did not have a disc herniation with free fragments at the L3-4 level.

UNPROFESSIONAL CONDUCT: PATIENT O

393. Respondent's evaluation and/or treatment of Patient O failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent surgically removed Patient O's L3-4 disk without medical indication;

b. Respondent performed the L3-4 surgery without informed consent;

c. Respondent failed to timely dictate Patient O's pre-operative H&P;

d. Respondent performed surgery on the wrong level of Patient O's spine; and/or

e. Respondent made material misstatements in Patient O's medical records.

394. Respondent failed to make essential entries and/or made incorrect essential entries in Patient O's patient records and/or falsified Patient O's patient records and, thus, engaged in unprofessional conduct as defined by §12-36-117(1)(cc), C.R.S. for one or more of the following reasons:

a. In the H&P, Respondent stated that "On review of his radiographic studies, [Patient O] has a bulging disk at L3-4 . . . ;"

b. Respondent altered her PA's progress note dated August 3, 1998 by adding reference to L3-4 and L4-5 pathology and deleting an entry under the heading "pre-op dx;"

c. In Respondent's operative note for the L3-4 Surgery, dictated at 12:04 p.m. on August 4, 1998, Respondent misrepresented that Patient O was returned to the operating room because "it was thought that a disc fragment down low, between L4 and L5, had been missed;" and/or

d. In Respondent's operative note for the L4-5 Surgery, dictated at 12:09 p.m. on August 4, 1998, Respondent misrepresented that Patient O's pre-operative diagnosis was "[p]ersistent neurologic deficit following a diskectomy with residual disc fragment in the foramen at L4-5."

395. Respondent failed to respond to a complaint issued pursuant to §12-36-118(4), C.R.S. in an honest and/or materially responsive manner, in violation of §12-36-117(1)(gg) for one or more of the following reasons:

a. Respondent misrepresented to the Board that: "when I reviewed the patient's films just prior to surgery, I actually looked at another patient's films that had been inadvertently included within Patient O's film jacket. Those films disclosed pathology that was remarkably similar to Patient O's, but at the L3-4 level;" and/or

b. Respondent misrepresented to the Board that: "My error was compounded by the fact that upon exposing the L3-4 disc space, I did find a disc herniation with free fragments at this level, which I removed."

PATIENT P

396. In April 1998, Patient P, a 30 year-old woman with amenorrhea and galactorrhea that were unresponsive to medical treatment, was referred to Respondent for evaluation and treatment.

397. Patient P had radiological evidence of microadenomas occupying the left side of her pituitary gland.

398. On May 11, 1998, Respondent performed surgery upon Patient P ("May 11 Surgery").

399. Respondent intended to perform a transsphenoidal resection of the pituitary microadenomas.

400. During the May 11 Surgery, Respondent operated on the incorrect structures in Patient P's brain.

401. During the May 11 Surgery, Respondent did not recognize that she was operating on the incorrect structures in Patient P's brain.

402. During the May 11 Surgery, Respondent biopsied a mass she characterized as "an extremely vascular mass, purplish in color, and extremely atypical for a pituitary adenoma" ("vascular mass").

403. The biopsy caused profuse bleeding.

404. The specimen was sent to the pathology department for analysis.

405. The pathology department's analysis of the biopsy of the vascular mass indicated normal blood vessels with some apparent intervening normal neural tissue.

406. Respondent aborted the May 11 Surgery.

407. Patient P awoke from the May 11 Surgery with profound or complete visual loss in the right eye and with diminished vision in the left eye.

408. Patient P remained in the hospital for nine days following the May 11 Surgery ("May 11 Hospitalization").

409. During the nine-day post-operative period, Patient P had fever, cerebral spinal fluid ("CSF") rhinorrhea and severe headaches in the hospital.

410. Patient P was discharged from the hospital on May 20, 1998.

411. Respondent's PA dictated the discharge summary for the May 11 Hospitalization on June 4, 1998. Respondent co-signed the discharge summary.

412. The discharge summary from the May 11 Hospitalization notes a "transient leakage of cerebrospinal fluid from the nares which resolved spontaneously."

413. Patient P was discharged from the May 11 Hospitalization without adequate treatment for her post-operative symptoms.

414. On or about Friday May 22, 1998, Patient P's husband called Respondent to

report that Patient P was experiencing concerning symptoms.

415. The symptoms reported by Patient P's husband were consistent with meningitis.

416. Respondent called in a prescription for an oral antibiotic and provided assurance that Patient P would probably feel better soon.

417. On May 24, 1998, Patient P contacted Respondent, who advised her to report to the emergency room.

418. Patient P was readmitted to the hospital on May 24, 1998 ("May 24 Hospitalization").

419. Respondent's H&P for the May 24 Hospitalization indicated that Patient P was unresponsive to oral antibiotics at home.

420. Following readmission on May 24, 1998, Patient P was diagnosed with meningitis.

421. Respondent treated Patient P with intravenous antibiotics and lumbar spinal fluid drainage.

422. During the May 24 Hospitalization, Patient P experienced CSF rhinorrhea.

423. Respondent performed a right frontal craniotomy and repair of the CSF leak with resection of sellar mass on June 10, 1998 ("June 10 Surgery").

424. Respondent performed the June 10 Surgery transcranially.

425. Respondent documented in the operative report for the June 10 Surgery that she biopsied a vascular mass, which proved on frozen section to be consistent with packing material placed during the May 11 Surgery.

426. The final pathology report indicated that the material removed during the June 10 Surgery consisted of sponge material, fibrin, minute fragments of bone, abundant acute inflammatory debris, focal foreign body granulomatous response and "minute fragments of neurohypophysis (adenohypophysis, adenoma and other tumor not identified)."

427. Respondent dictated the operative report for the June 10 Surgery on March 5, 1999.

428. During the June 10 Surgery, Respondent injured Patient P's pituitary gland.

429. After the June 10 Surgery, Patient P developed diabetes insipidus.

430. After the June 10 Surgery, Respondent informed Patient P that the microadenoma

was no longer present in her pituitary gland as a result of Respondent's actions.

431. A neurosurgeon who evaluated Patient P in 1999 found that the pre-surgical microadenomas were still present in Patient P's pituitary gland.

UNPROFESSIONAL CONDUCT: PATIENT P

432. Respondent's evaluation and/or treatment of Patient P failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent failed to operate in the correct anatomical area during the May 11 Surgery;

b. Respondent did not timely recognize that she was not oriented appropriately during the May 11 Surgery;

c. Respondent biopsied the wrong area of Patient P's brain on May 11, 1998;

d. Respondent partially blinded Patient P during the May 11 Surgery;

e. During the May 11 Hospitalization, Respondent failed to manage Patient P's post-operative symptoms appropriately;

f. Respondent failed to timely dictate the discharge summary after the May 11 Hospitalization;

g. Respondent discharge of Patient P at the conclusion of the May 11 Hospitalization was premature;

h. Respondent failed to timely diagnose Patient P's post-operative meningitis;

i. Respondent inappropriately responded to Patient P's significant post-discharge symptoms on or about May 22, 1998;

j. Respondent performed the June 10 Surgery to repair Patient P's CSF leak transcranially;

k. Respondent attempted to biopsy the pituitary gland transcranially during the June 10 Surgery;

l. Respondent biopsied the wrong area of Patient P's brain during the June 10 Surgery;

m. Respondent failed to timely dictate an operative report following the June 10 Surgery; and/or

n. Respondent misrepresented to Patient P that her pituitary microadenoma was no longer present as a result of Respondent's actions.

PATIENT Q

433. On October 30, 1997, Patient Q, a 44 year-old man, was involved in a motor vehicle accident.

434. On October 31, 1997, Patient Q was admitted to the St. Thomas More Medical Center ("STM") emergency room in Canon City, Colorado for evaluation.

435. On October 31, 1997 CT scan of Patient Q's head was performed at STM and read by a radiologist as showing "subarachnoid hemorrhage . . . more suggestive of an aneurysm rather than trauma" ("October 31 CT").

436. On November 1, 1997, Patient Q was transferred to SMC and admitted by Respondent after Respondent took Patient Q's history and performed a physical examination.

437. After admission to SMC, Patient Q exhibited signs and symptoms consistent with an aneurysmal hemorrhage.

438. Respondent reviewed the October 31 CT and diagnosed Patient Q with "traumatic subarachnoid hemorrhage."

439. Respondent discharged Patient Q from SMC on November 2, 1997.

440. On discharge, Respondent instructed Patient Q to consult with a neurosurgeon in Denver in two to four weeks.

441. Respondent did not review the radiologist's report interpreting the October 31 CT prior to discharging Patient Q.

442. Respondent did not order additional diagnostic tests to evaluate Patient Q while he was present at SMC.

443. Respondent discharged Patient Q without evaluating Patient Q for a possible cerebral aneurysm.

444. On November 21, 1997, Patient Q collapsed with a subarachnoid hemorrhage with intracerebral and intraventricular hemorrhages.

445. Patient Q was taken to St. Anthony Hospital in Denver where he was diagnosed

with a ruptured anterior communicating artery aneurysm.

446. Patient Q underwent aneurysm surgery but remained in a vegetative state in a nursing facility until his death approximately two years later.

UNPROFESSIONAL CONDUCT: PATIENT Q

447. Respondent's evaluation and/or treatment of Patient Q failed to meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by §12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent misinterpreted the October 31 CT;

b. Respondent failed to order appropriate diagnostic tests of Patient Q, including, but not limited, to an MRA or cerebral arteriogram;

c. Respondent failed to perform an appropriate work-up of Patient Q's condition;

d. Respondent failed to review or obtain the radiology report regarding the October 31 CT in a timely manner; and/or

e. Respondent misdiagnosed Patient Q with a traumatic, rather than an aneurysmal, hemorrhage.

UNPROFESSIONAL CONDUCT: DOCUMENTATION OF ESSENTIAL ENTRIES

448. Respondent repeatedly failed to make essential entries in patient records as set forth in paragraphs 20, 43, 81, 120, 166, 196, 339, and/or 394 and thus, engaged in unprofessional conduct as defined by §12-36-117(1)(cc), C.R.S.

449. Respondent repeatedly made incorrect essential entries in patient records as set forth in paragraphs 20, 43, 81, 120, 166, 196, 244, 261, 339, and/or 394 and thus, engaged in unprofessional conduct as defined by §12-36-117(1)(cc), C.R.S.

WHEREFORE the Panel respectfully requests that appropriate disciplinary action, as provided by law, be imposed.

NOTICE TO SET

YOU ARE HEREBY NOTIFIED that the attorneys for Inquiry Panel A of the Colorado State Board of Medical Examiners will appear on **Friday, March 25, 2005 at 9:00 a.m.** in the Office of the Division of Administrative Hearings, 1120 Lincoln Street, Suite 1400, Denver,

Colorado 80203 in order to set a date and obtain a location for a hearing regarding the preceding Formal Complaint. You may be present in person, by counsel, or by telephone by calling the Division of Administrative Hearings at (303) 764-1400 at the time and date specified above.

On March 21, 2005, undersigned counsel consulted with counsel for the Respondent, Robert Spencer, who consented to holding a setting conference on Friday March 25, 2005, four days after the filing of this Formal Complaint.

NOTICE OF HEARING

YOU ARE HEREBY NOTIFIED that pursuant to § 12-36-118, C.R.S., and § 24-4-105, C.R.S., a hearing on the Formal Complaint of the Attorney General will be held before an administrative law judge, on a date to be set, for the purpose of determining whether you engaged in unprofessional conduct as set forth in § 12-36-117(1)(n), 117(1)(p), 117(1)(u), 117(1)(cc) and/or 117(1)(gg), C.R.S. of the Colorado Medical Practice Act, and whether your license to practice medicine in Colorado should be revoked, suspended, or otherwise disciplined, pursuant to § 12-36-118(5), C.R.S. of the Colorado Medical Practice Act.

At the hearing, you shall have the right to appear in person with legal counsel, to cross-examine any witness, to rebut any evidence presented by the complainant, and to present evidence in your own defense.

NOTICE OF DUTY TO ANSWER

YOU ARE HEREBY NOTIFIED that, pursuant to § 24-4-105(2)(b), C.R.S., you are required to file a written answer to the Formal Complaint with the Division of Administrative Hearings, 1120 Lincoln Street, Suite 1400, Denver, Colorado 80203, within 30 days after the service or mailing of this Formal Complaint of the Attorney General, Notice to Set, Notice of Hearing, Notice of Duty to Answer and Statement With Regard to Alternative Dispute Resolution. You must also mail a copy of such answer to the Panel's attorneys, Claudia Brett Goldin and Steven R. Kabler, Assistant Attorneys General, Office of the Attorney General, 1525 Sherman St., 5th Floor, Denver, Colorado 80203.

If you fail to file your written answer within the applicable time period, an order entering a default decision may be issued against you for the relief requested in the Formal Complaint of the Attorney General, without further notice, or such other penalties which may be provided for by law, without further notice.

Dated: March 21, 2005.

JOHN W. SUTHERS
Attorney General

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