Iowa Board of Medicine
(Formerly Iowa Board of Medical Examiners)

Peer Review Manual

Iowa Board of Medicine
400 S.W. 8th Street, Ste. C
Des Moines, IA 50309

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INTRODUCTION

The Board uses peer review in selected competency investigation after the Board finds evidence of one or more possible violations of the accepted standard of care. Peer Reviewers are usually selected from physicians who practice in the same specialty as the physician under investigation. The Peer Reviewer's job is to assist the Board in determine whether, and to what extent, a physician has breached the applicable standards of care in a certain case. Peer review is the final step of the investigative process and must be completed before the Board can make a decision on a case. The Peer Reviewer's timely submission of a report to the Board is vital to expeditious resolution of the case.

In the event that the Peer Review Report establishes grounds for initiating formal disciplinary actions, the Board files charges against the physician and the case proceeds to hearing. Once or more of the Peer Reviewers may be called upon to serve as an expert witness and to testify at a formal hearing.

LEGAL STANDARDS FOR DISCIPLINE

The Board has authority to discipline a physician for violations of the laws and rules governing the practice of medicine in Iowa. Peer Reviewer's determination of whether the physician's treatment is within the standard of care will help the Board determined whether the physician has committed any of the following:

- **Professional incompetency:**
    - A substantial lack of knowledge or ability to discharge professional obligations within the scope of the physician's practice.
    - A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other physicians in Iowa acting in the same or similar circumstances.
    - A failure to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician in Iowa acting in the same or similar circumstances.
    - A willful or repeated departure from the minimum standards of acceptable and prevailing practice of medicine in Iowa.
    - A failure to conform to the minimum standards of acceptable and prevailing practice of medicine in Iowa.
    - A failure to meet the acceptable and prevailing standard of care when delegating or supervising medical services provided by another physician, health care practitioner, or other agent, employee, or associate of the physician responsible for a patient's care.

- **Practice Harmful or Detrimental to the Public:**
    - Failure to possess and exercise the degree of skill, learning and care expected of a reasonable, prudent physician acting in the same or similar circumstances in this state. Proof of actual injury need not be established.

- **Willful or Repeated Gross Malpractice:**

    - Repeated malpractice is more than one decision or act that fails to meet the standard of care applicable in the case. The decisions or acts maybe with respect to a single patient.
    - Willful malpractice is an act, not meeting the standard of care, which is done intentionally to harm OR unreasonably in disregard of an obvious risk and the likely harm that would follow.

- **Willful or Gross Negligence:**

    - Willful or gross negligence is an act, not meeting the standard of care, which is done intentionally to harm OR unreasonably in disregard of an obvious risk and the likely harm that would follow. It must be, for some reason, more culpable than ordinary negligence.

PEER REVIEW APPOINTMENT

The State of Iowa agreement process requires peer reviewers to have two agreements - a General Agreement to do peer reviewing and a Specific Agreement for each peer review assignment. The Board's General Agreements last five years and are typically entered into before peer review is needed; this, physicians in several practice specialties are on stand-by and ready to serve when the Board orders a case to be peer reviewed. Early General Agreements reduce the delay in getting peer reviewers started on their assignments.

When the Board orders a peer review, it indicates the ideal number of peer reviewers and their areas of practice for the particular cases. The Board's Medical Advisor contacts potential peer reviewers to determine if they are available at this time for the review and if any conflict of interests exists. If the Peer Reviewer is a good match for the review, the Medical Advisor will see that a Specific Agreement and case information is sent to the Peer Reviewer. Case information includes investigative records and pertinent medical records, as well as the name and contact information for the other Peer Reviewers, if any are assigned to the case.

TIMELY SUBMISSION OF REPORT

As cases referred for peer review tend to be serious, the Board requests that completed Peer Review Reports be returned within a specified time (usually, 45 days). The Board is aware that peer review is a time-consuming process and that Peer Reviewers are very busy with practices of their own. However, because a substandard practitioner poses a potential risk to the public, the Board requests that reviews be completed promptly. The Chair of the Peer Review Committee should notify the Board office if, for any reason, the Peer Reviewers cannot return the report with the specified time.

CONFIDENTIALITY

State law requires that peer reviewers maintain the confidentiality of the investigative materials received form the Board as part of the peer review process. **Therefore, Peer Reviewers must maintain the confidentiality of the identity of all persons involved, all medical records and any other information included in the review.** All materials should be returned to the Board office at the completion of a review.

Peer Reviewers should **not** contact any Board members or any of the patients, physicians or other persons involved or under review. If additional information is needed from any of these sources, the Peer Reviewer should address its questions to the Board's Medical Advisor. Peer reviewers are encouraged to perform any medical research necessary to assist them in determining the applicable standard(s) of care but should **not** make any effort to investigate the case any further.

CONFLICTS OF INTEREST

Peer Reviewers' objectivity is vital to the integrity of the peer review process. Actual and perceived objectivity is paramount. It is incumbent on Peer Reviewers to conduct reviews in an impartial manner. Peer Reviewers should not consider the race, national origin, creed, gender, marital status, age or sexual orientation of the licensee under review when evaluating a case. To ensure impartiality and the integrity of the peer review process, Peer Reviewers should not participate in any peer review in which there is the potential for conflicts of interest. Peer Reviewers should "recuse", or remove themselves from a case in the following circumstances:

1. The Peer Reviewer has/had a close personal relationship with the physician under review;

2. An arrangement exists in which the Peer Reviewer routinely refers patients or receives referrals from the physician subject to review;

3. The Peer Reviewer has treated any of the patients whose care is under review;

4. The Peer Reviewer's practice competes directly with that of the physician under review;

5. Now, or was in the past, a business or professional relationship existed with the physician under review which could bias, or appear to bias, the Peer Reviewer's judgment;

6. The Peer Reviewer is privy to, or has prior knowledge of, information about the practice of the physician other than that related to the current investigation, which could bias, or appear to bias, judgments about the case under review;

7. The Peer Reviewer has otherwise been in a position to form a preexisting opinion about the practice, skills, or character of the physician under review; or

If you practice in the same hospital or practice setting as the physician under review, please notify the Board so that legal counsel can determine whether this presents a conflict of interest.

Please consider this issue carefully as failure to disclose a conflict of interest has serious consequences for the peer review. If a Peer Reviewer has a conflict of interest but does not recuse, the Board may be unable to discipline the physician or may have to commission a new peer review. If a conflict is not discovered until after discipline is imposed, the Board's decision may be overturned on Judicial Review.

Peer Reviewers who are unsure whether a possible conflict of interest exists should contact the Board's Medical Advisor to determine the propriety of a reviewer's participation in a case. If the Peer Reviewer must recuse, he or she, should return all materials on this case to the Board office.

CIVIL IMMUNITY

Peer Reviewers are provided the same statutory immunity from civil liability as Board members. Iowa Code section 272C.8 (1) states, "A person shall not be civilly liable as a result of the person's acts, omissions or decisions in good faith as a member of a licensing Board or as an employee or agent in connection with the person's duties". **However, the immunity from civil liability does not apply if the action of the Peer Reviewer is done with malice.** "Malice" in this context means intentionally or recklessly committing a wrongful act in the course of your work for the Board. If you follow the guidelines put forward in this Manual, especially those regarding confidentiality and conflict of interest, you will be provided immunity. If you disregard these rules intentionally or are careless about following them, you may lose, it.

Discussing a case with any person outside the peer review process is an example of action which could result in the loss of immunity for Peer Reviewers and the denial of the confidentiality protection and due process rights provided by law to the physician under review.

SETTING UP PAYMENT

Terms of payment for peer review services are established in the Specific Agreement, also known as the Payment Agreement. The law requires that a level of flat fee compensation be agreed upon for each peer review assignment. Make sure that the compensation listed in paragraph 10 section (a) of the Peer Review Agreement and the Payment Agreement is agreeable with you. Discuss any concerns about the appropriateness of this level of compensation with the Medical Advisor before you do the peer review.

CONDUCTING A PEER REVIEW

Each Peer Reviewer assigned a particular case will receive the written Investigative Report accompanied by any interview summaries, correspondence and medical records. A cover letter from the Board's peer review contact person will address any specific concerns the review should address.

Please let the Board know as soon as possible if you think you have a conflict or if you think you do not have sufficient expertise or experience to review the case.

STANDARD OF CARE

The standard of care is typically defined as, "What a reasonably prudent physician in Iowa would do under the same or similar circumstances".

Sometimes, the standard of care is specifically defined, such as:

- A widely accepted textbook definition of specific aspects of diagnosis or treatment
- A hospital policy that has proven effective in managing conditions such as post-operative deep vein thrombosis, prevention of nosocomial infection, et.

- A well-recognized, reputable national organization has published guidelines for diagnosis and/or treatment. Examples may include:

    - The Adult Treatment Panel III/National Cholesterol Education Program guidelines for diagnosing and treating hyperlipidemia.

    - The American Diabetes Association guidelines for diagnosing Impaired Glucose Metabolism (pre-diabetes) and overt diabetes.

PEER REVIEW CONSENSUS

Once each Peer Reviewer has reviewed the material provided, the Peer Reviewers should schedule a time to meet, either in-person or by telephone, to discuss the case. Board staff can, upon request, assist in making the arrangements for this conference. The Peer Reviewers should confer and reach a consensus in their review of the case. It is important that the Peer Reviewers reach consensus, when possible, as to the applicable standard(s) of care and any breach that may have occurred. The Peer Reviewers, in their report to the Board, should make note of any issues in which they are unable to reach agreement.

IMMEDIATE RISK TO THE PUBLIC

If Peer Reviewers conclude that there are violations of the standard of care, they should consider whether those violations pose an immediate danger to the public health, safety, or welfare. If so, this should be stated in the written report. The Board has the authority to impose an immediate emergency suspension of a physician's license in those rare cases where it concludes such a danger exists, and in making this determination would consider the opinion of the Peer Reviewers.

WHAT TO WRITE IN THE REPORT

The Peer Reviewers should submit on written report, signed by each Peer Reviewer, which includes:

1. A summary of each case reviewed, including

    a) The name and case number of each patient[1] in a case
    b) A narrative of the treatment and care provided by the physician
    c) All relevant medical facts, physician decisions/diagnoses and issues/concerns raised by each case.

2. The standard of care which applies in each case, and supporting rationale, if available and used. Supporting rationale should be based on practice guidelines, published references, or community standard, for example. The Board expects the Peer Reviewer to be familiar with all published standards and, if one applies, for the Peer Reviewer to cite it.

[1] Patient Names will not become public because Peer Review Reports are confidential.

3. A response to the specific concerns outlined earlier in the letter from the Board's peer review contact person that accompanies the Board materials.

4. An answer to this question for each case: "Is there sufficient evidence of one or more substantial, willful or repeated violations of the applicable standard(s) of care?"

5. Your final conclusion regarding the standard of care should be one of the following:

   a) The standard of care was not met with respect to _____.
   b) The standard of care was met with respect to _____.
   c) It is impossible to determine whether the standard of care was met on the basis of the information available for review.

6. A statement of other concerns, resulting from this review, even if they are not the focus of this review. Any issues that my require further review by the Board of another peer reviewer should also be identified.

7. Reference to any sources relied upon, e.g., reference books, professional journals, studies, and the source of practice standards used. This greatly assists the Board in reviewing the report, and will support the Peer Review Report if the case proceeds to a formal hearing.

8. All Peer Reviewers' signatures.

The Peer Review Report should be clear and detailed. The Board will use the Peer Review Report to determine whether formal disciplinary charges should be filed. If charges are filed, the report will be provided to the physician under review and will be subject to great scrutiny in the formal disciplinary process. If charges are not filed, the Board may use the Peer Review Report to advise the physician under review of the nature of concerns regarding the physician's practice, and the changes the Board expects the physician to make to meet the standard of care in his or her practice. It is therefore critical that the report be thorough, detailed, and supported by the discussion of the materials reviewed.

Please do **not** suggest what action the Board should take unless emergency action is warranted.

The Peer Review Worksheet (Appendix A) and the Sample Peer Review Reports (Appendix B) may be helpful when preparing the Peer Review Report.

POST PEER REVIEW

BOARD OPTIONS

Once a Peer Review Report is submitted to the Board office, staff sends it to the Board for its review at an upcoming meeting. The Board then determines how to proceed with the case. The Board has considerable discretion and may take one of the following actions:

Option No. 1: Close with No Action

The Board may close the file without action when it determines, based on the Peer Review Report, that no breach of the applicable standards of care occurred or that any violations found were not substantial, willful or repeated. Evan if the peer review concludes that the licensee breached the applicable standards of care in a substantial, willful or repeated manner, the Board has discretion in deciding whether to proceed with disciplinary action.

Option No. 2: Take Informal Action

The Board frequently uses informal Letters of Warning or Education in cases where the Board has concerns about the care provided by the licensee but the concerns do not rise to the level of formal disciplinary action. Letters of Warning or Education are confidential communications between the Board and the licensee. The Board relies on the information from the Peer Review Report to advise the physician of practice concerns and recommended corrective action. The informal action becomes part of the licensee's permanent record and the Board may share this information with other regulatory bodies; however, these actions are not available to the public.

Option No. 3: File Formal Charges

In the event that the Peer Review Report establishes grounds for initiating formal disciplinary action and the Board elects to proceed, the Board files charges against the physician. The facts establishing any violation of the applicable standards of care are included in the legal documents when the physician is charged.

THE PEER REVIEWER'S INVOLVEMENT IN THE HEARING PROCESS

In the event the Board reviews the case and decides no formal disciplinary charges are warranted against the physician under review, your services are no longer needed on this case.

In the event that Board files formal charges, it is likely you will not be contacted again about the case. That is because most Board disciplinary cases are resolved via settlement and do not require a disciplinary hearing.

However, if a case is not settled and proceeds to hearing, the State's attorney, an Assistant Attorney General, may contact you because one or more of the Peer Reviewers may be needed to serve as an expert witness. If you are contacted to serve as an expert witness at hearing, you will be asked to meet with the Assistant Attorney General to prepare for testifying at the hearing before the Board. Also, before the hearing you may be asked by the physician's attorney to give a deposition. Finally, you may need to testify at hearing.

Timing

After the Board files charges, a case can proceed quickly to hearing. However, it may also, for various reasons, take up to a year or more for a hearing to take place. Please keep in mind that you may be asked to testify sometime after you complete your peer review, and that you may at that time have to refresh our memory in order to testify.

If you are asked to submit to a deposition by the physician under review, an Assistant Attorney General will work with you to prepare and to accommodate your schedule.

If you have questions at any time about the status of the case, you may call Kent Nebel at the Board's office or contact the Attorney General's office.

Payment for Participation

With regard to payment for these additional services, the following applies. Time spent by physician in assisting the State with discovery, preparing for a pre-hearing deposition, preparing to testify at hearing, and testifying at hearing shall be reimbursed by the Board at $300 per hour[2]. Physician shall submit monthly invoices for these services in accordance with the provisions of paragraph 10, section (f).

GETTING PAID

- **Completed Peer Review Report.** To receive payment when the peer review is complete, submit to the Board's peer review contact person a request for payment and return all of the investigative materials.

- **Depositions.** The Peer Reviewer may charge the licensee the Peer Reviewer's usual and customary fee for time spent in deposition.

[2] Time actually spent by physician in testifying at a pre-hearing deposition at the request of the physician who is the subject of the review is to be billed at physician's usual and customary rete for such testimony, and is not billed under the terms of this Peer Review Agreement. The Assistant Attorney General will assist physician in submitting a bill for the deposition.

APPENDIX A

PEER REVIEW WORKSHEET

The Peer Review Worksheet can be used to assist the peer reviewer record notes for each patient under review.

Peer Reviewer's Name:_____

Name of Physician Under Review: _____

Date of Referral from IBM:_____

_____

Due Date: _____

Patient Name:_____ **Case #:**_____

Narrative of care given:_____

_____

_____

_____

_____

_____

_____

Standard(s) of care met?:_____

_____

_____

_____

_____

_____

_____

APPENDIX B

SAMPLE PEER REVIEW REPORTS

Physician's Name: Dr. A.

File No: 02-20005-000

Reason for Review:

IBM requested review of medical care given to Patient X on January 23, 2005, by Dr. A to determine whether or not there was a deviation from standard of care.

Materials Reviewed:

1. Investigative report dated June 1, 2005.
2. Complaint and Statement of Charges, November 13, 2004.
3. Complaint and Statement of Charges, January 12, 2002.

Findings:

1. Written complaint was submitted by Dr. C on January 26, 2005. Dr. C indicated Patient X was seen at his group practice clinic on January 26, 2005, for gastritis secondary to medication prescribed by another physician. This medication Tylenol #3 was written as #30 with five refills over six months. Dr. C was concerned that this was an inappropriate number of refills. During a subsequent telephone conversation recorded by the investigator, Dr. C indicated his primary concern was the inappropriate number of refills.

2. Notes from ER visit of Patient X by Dr. A and a dictated note on same date, January 26, 2005, confirm that indeed Dr. A did see Patient X and prescribe 30 Tylenol #3 with five refills over six months. He also apparently dispensed 6 Tylenol #3 from the ER pharmacy. Dr. A offered explanation that medication would be needed after tooth was extracted as the need for more refills. This explanation was obtained by a report from Dr. A to the investigator.

3. The ER notes and dictated note by Dr. A had no recorded significant past history for a new patient. The only physical exam was the diagnosis of infected wisdom tooth and mention that exam was performed.

4. Pharmacy invoice indicated dispensing of 30 Tylenol #3 with no refills.

5. Patient X was seen by Dr. Y in Dr. Z's office for gastrointestinal symptoms believed to be related to the previous medications prescribed, i.e. Tylenol #3.

6. Dr. A has been cited previously for substandard care and probation violations. Substandard care included failing to properly prescribe medications and failing to maintain an adequate medical record.

Conclusion:

Dr. A's care of Patient X demonstrated a failure to conform to the minimal standards of acceptable and prevailing practice of medicine in Iowa. There were two standards of care issues. Number one was excessive prescribing; the second was inadequate documentation in the medical record of history and physical findings.

1. Prescribing pain medication (Tylenol # 3) with five refills over six months was excessive for a limited problem of an abscessed tooth. Reasoning by physician that further medication would be needed after extraction still does not justify the number of refills given.

2. A documentation of past history, particularly with reference to prior tolerance of pain medications and co-morbid conditions is essential for proper patient care.

3. An accurate physical exam should always be a part of good medical care even for a limited minor problem, i.e. how much swelling, any drainage, any lymph gland involvement, any signs of systemic infection, etc.

Dr. A has established a pattern of substandard care violations with this particular case being one of three complaints, according to information provided to me. This would suggest a repeated departure from minimum standards of acceptable and prevailing practice of medicine in Iowa. There are also reported probation violations. Although one could perform her review of Dr. A's medical care from his records, this would appear to be adequate representation of his substandard care.

_____
Peer Reviewer

_____
Date

Name of Physician Under Review: Dr. H.
File No: 02-2004-000
License No: MD-XXXX
Specialty: Psychiatry
Date of Referral from IBM: February 22, 2006
Date of Report: April 24, 2006
Type of Review: Practice
Number of Patient Care Records Included in the Review: One
Source of Complaint: Husband of Patient X.

REASON FOR REFERRAL:

This case was referred by the investigator as a result of a complaint filed by the patient's husband regarding the psychiatric care rendered to Patient X, by Dr. H. Patient X, herself, had no complaints about her psychiatric treatment, and considered Dr. H to be an "outstanding psychiatrist". The husband alleged that Dr. H has had "some type of unnatural influence over his wife or there is hypnosis going on". The husband alleges that his wife's symptoms have worsened during her treatment with Dr. H, including abuse of Prozac; threatening suicide; alienation from her family members; substantial weight gain; and memory difficulties. He alleges that Dr. H had not involved the family in the care of the patient. He alleges that Dr. H refused to explain the treatment or care provided and persuaded Patient X not to seek a second opinion that her husband desired.

INFORMATION REVIEWED:

The investigative report submitted by the investigator was reviewed, including the narrative statements of the husband, Patient X and Dr. H. Also reviewed were Attachment A, a copy of the complaint; Attachment B, Patient X's records from Dr. H's office; and Attachment C, various related letters. No hospital records or other records were available or considered relevant to the case. Documentation of outpatient office records was complete; handwritten, but mostly legible; sufficiently detailed; and does not record an adverse outcome for the patient. The history on initial interview and assessment was appropriately documented. Medication was ordered and administered properly. The records indicate a psychoanalytically based psychodynamic psychotherapy treatment was used, which is within the generally accepted standard of care in psychiatry, particularly for the diagnoses with which the patient presented. The patient was seen for two to three one-hour sessions each week from July 2002 until November 2005, when sessions largely became one two-hour session weekly until the records end in February 2006.

DISCUSSION:

Although psychoanalytically-based psychodynamic psychotherapy is not commonly practiced by psychiatrists in the state of Iowa, it is a generally accepted psychiatric treatment modality in the specialty. Frequent therapy sessions, even daily, would be considered standard of care in this type of treatment. It would not be considered unusual for a psychiatrist to give a patient a small token or personal belonging to be used as a transition object. During a psychiatrist's vacation, postcards to a patient or phone calls would also not be considered boundary violations. Often, an intense relationship to the psychiatrist develops.

With this perspective, Dr. H's treatment of Patient X is consistent with the generally accepted standards for this kind of psychiatry. Dr. H's diagnosis was major depression and a dissociative disorder resulting from repeated childhood and adult emotional and physical and sexual trauma. Medication treatment involved prescription of Prozac at 20 mg q am initially, then increased subsequently to 40mg q am. This is appropriate use of an antidepressant and at an appropriate

dosage. There is no evidence in the record that Patient X abused Prozac, or that there were adverse effects from the medication. No other medications were noted to have been prescribed. Specifically, no medications with potential for abuse, such as hypnotics, benzodiazepines, narcotics, appetite suppressants, or stimulants were prescribed. Dr. H particularly cautioned Patient X on several occasions against the use of these medications. Dr. H was well aware of Patient X's history of alcoholism and substance abuse and vigorously supported the patient's participation in NA and Al-Anon.

The goals of psychotherapy appeared to be relief of the symptoms of depression, integration of the self, improved boundary definition and improved self-care. Dr. H's treatment notes do not reflect coercion of the patient. With regard to the husband, Dr. H's concerns were that Patient X maintain her own physical and sexual safety in his presence. Dr. H encouraged Patient X to view her husband as a whole person, instead of fragmenting him into a highly desired partner or a vicious person. Therapy notes do not indicate that Dr. H particularly advocated divorce, although Dr. H did clearly indicate support of Patient X's decision to proceed.

Therapy notes do not directly indicate why more family members were not included in therapy, but narrative statements suggest that the husband had refused involvement in psychotherapy previously. The patient's daughter was included in at least one session, when she had expressed particular concern about her mother's condition.

Dr. H did not appear to actively alienate the patient from other family members, as she also did not coerce Patient X in her relationship with her husband. Rather, it appears that as a result of insight gained in therapy, Patient X became more aware of the need to separate herself from certain family members who had an adverse effect on her.

Some notations indicating alters or multiple personalities are present, but therapy notes do not appear to overly focus on defining these personalities. Rather, encouragement of integration is reflected in the notes. Therapy notes are not clear, but suggest that hypnosis may have been used as a treatment technique. There does not appear to have been misuse of hypnosis, if it was used.

Although the patient expressed hopelessness and suicidal ideation at times through her treatment, Dr. H appeared to have managed the suicide risk appropriately. Hospitalization was considered when indicated, although the patient eventually did not require this. Self-care was emphasized throughout therapy and attention to decreasing self-abusive or self-harming behaviors was frequently given. Patients with major depression and dissociative disorders often have difficulty with suicidal ideation and self-abuse. With treatments available, pharmacologic as well as psychotherapeutic, these symptoms often do not substantially improve except over very long periods of time. That Patient X continued to exhibit these symptoms through years of therapy does not necessarily indicate failure of treatment or poor treatment. At times of stress, even minimal suicidal ideation and self-abuse frequently recurs in this and other such patients with dissociative disorder.

At times, treatment notes describe Patient X as "fragmented," or "spacey". Presumably, these episodes may have appeared to the husband as "memory difficulties". It is symptomatic of patients with dissociative disorder that they may manifest episodic cognitive changes such as these when dissociated and stressed. Presence of these symptoms intermittently during Dr. H's treatment of Patient X does not suggest substandard treatment. These symptoms typically remitted once stressors improved or were understood in therapy. Although the treatment notes do not often provide a clear description of Patient X's job performance, it appears that she continued to function as an employed psychiatric nurse throughout the treatment period.

The husband's allegation of substantial weight gain ("100 pounds") is not addressed in the treatment notes or narrative statements.

Treatment notes and Dr. H's narrative statement do not indicate opposition to obtaining a second opinion evaluation, if that was the wish of the patient. Patient X did not have a desire to seek another evaluation and was satisfied with her treatment with Dr. H. There does not appear to be coercion or undue influence from Dr. H in this preference of the patient.

STATEMENT OF FINDINGS OF MEDICAL FACT AND CONCLUSION:

Dr. H provided appropriate care for the patient. Malpractice and negligence were not present. Although the patient's husband expressed a desire for a greater role in and knowledge of his wife's treatment, the patient did not consent to this. The husband's complaints about Dr. H's treatment of his wife were not substantiated by the narrative statements or the treatment record.

The Committee finds that Dr. H managed this patient with skillful competence.

SPECIALIST STATEMENT:

Dr. L., M.D., a specialist in adult psychiatry with added qualifications in geriatric psychiatry; and Dr. U., D.O., a specialist in adult psychiatry, participated in the review of this case and in formulating the report. Dr. D. has the additional qualification of having trained in a psychoanalytic psychiatry resident training program.

OBJECTIVITY STATEMENT:

Prior to conducting the review, the members of the review committee were questioned in accordance with the objectivity section of the Peer Review Manual. Those physicians who indicated that a conflict of interest might exist were excused from participation in the review of this case,

Submitted by,

_____	_____
Peer Reviewer	Peer Reviewer
_____	_____
Date	Date

Board of Medicine
400 S.W. 8th Street, Ste. C
Des Moines, IA 50309

RE: Dr. Z.

The following is a peer review medical report that was prepared after a detailed review of the charts of patients cared for by Dr. Z. The report is being prepared as per your correspondence dated July 21, 2000. The Board of Medicine of the State of Iowa requested this review because of questions concerning practice patterns of Dr. Z, a general surgeon. Some of the patients had been the subject of a previous review and the results were available to the committee in the form of a letter date 05/16/1996 signed by Drs. H, L and N.

A total of 11 records were reviewed, the charts of the patients were reviewed independently by the members of the committee and then discussed in telephone conversations sometimes with the inclusion of Mr. Nebel. Because of the seriousness of the matter, we have elected to omit discussions that might be considered matters of good practice and not relevant when considering standard of care. The review is based on the standards of care with respect for a physician without residents in a private hospital. Our review was conducted in accordance to the guidelines outlined in the Peer Review Manual, Iowa Board of Medicine, December 2018. None of the committee members know Dr. S personally nor does any conflict of interest exist.

Case #1 Patient 5: This 17 year-old female was admitted with abdominal pain, nausea and vomiting on 01/04/2000. After a short course of observation she was no better so underwent a laparoscopic appendectomy (01/05/2000). The patient sustained a trocar injury to retroperitoneal mesenteric vessels. Eventually the laparoscopic operation was converted to a laparotomy. Bleeding from the mesentery of the terminal ileum was identified and presumably controlled after five unites of transfusion. The operation began at 11:15 am and ended at 2:30 pm. The patient was transferred to the recovery room hypotensive and tachycardic but the bleeding seemed to have stopped. The records reflect that the patient was in shock for two hours but did not receive vigorous treatment. There were some neurological problems in the recovery room. At 6:30 pm, she experienced bloody diarrhea and was transferred to Iowa City. Pathological report showed acute appendicitis. She was re-explored in Iowa City and found to have continued bleeding from mesentery of the terminal ileum. Apparently in a vegetative state afterwards.

Disposition: Technical error that was not satisfactorily corrected, Preventable. Inadequate treatment of shock. Patient was not stable enough to transfer by ambulance to Iowa City. Does not meet standard of care.

Case #2 Patient R: This is an 84 year-old male with a polyp in transverse colon that could not be removed by polypectomy at colonoscopy on 10/08/1999. On 10/15/1999 he underwent a laparoscopic polypectomy using a TA-3D stapler. It is unclear from the operative note if a small segment of the transverse colon was removed or the polyp was removed via a simple colotomy. Regardless the entire right colon was mobilized and brought outside the abdominal cavity in anticipation of performing a right hemicolectomy. At this point the lesion was palpated so the polyp was simply removed and the colon placed back in the abdominal cavity. The patient was febrile throughout his postoperative course. He was given oral medication for pain at first. By 10/18/1999, he began to use large amounts of intravenous morphine sulfate. His white blood cell count rose to 17,700 K/uL with a marked left shift (77segs 10 bands). White count remained elevated on 10/19/1999 and 10/20/1999. On 10/20/1999, the patient was returned to the OR and found to have a necrotic right colon. He underwent a right hemicolectomy with Hartman pouch.

Pathological report showed ischemic colitis. On 10/22/1999, he developed respiratory distress and was transferred to a larger hospital. We are not sure what happened after this.

Disposition: The committee was split whether the colon was devascularized due to a technical error at the first procedure or this was just an unfortunate postoperative event. Regardless the complication was not recognized in a timely fashion. The ensuing respiratory failure was predictable. This case does not meet the standard of care.

Case #3 Patient LS: This was a 77 year-old female who underwent a barium enema on 09/03/1999. It showed a localized perforation of the sigmoid colon presumably from diverticulitis. Abdominal computerized tomographic scan (CT scan) confirmed an abscess. On 09/10/1999, a sigmoid colectomy with primary anastomosis for perforated diverticulitis was performed. The anastomosis was end-to-end using a circular stapler through the rectum. The pathological report confirmed the diagnosis. She was transferred to a skilled nursing facility after unremarkable postoperative course on 09/14/1999. Antibiotics were not continued despite the abscess. On 09/15/1999, she became "restless" in the nursing home. She was transferred back to the hospital on 09/16/1999, at 18:20 hours with sepsis. Admit orders included a clear liquid diet. By the next morning she had increasing free air on abdominal roentgenograms and she was deteriorating rapidly. She became increasingly hypotensive and tachycardic. She expired at 12 noon. No autopsy was performed.

Disposition: Probable preventable death. Window of opportunity lost between 09/15/1999 and 09/17/1999. Pt obviously had leaking anatomizes and needed urgent re-exploration. Antibiotics should have been continued after dismissal with culture proven abscess. Does not meet standard of care.

Case #4 Patient DS: Dr. Z saw this 31 year-old male on 08/23/1996 at 22:53. He noted a 16,600 K/uL WBC and a "very tender McBurney Point". There was muscle guarding and rebound tenderness. On 08/24/1996, at 1:57 a.m., the patient underwent a laparoscopic appendectomy. The pathological report was not included in the record. The patient was sent home febrile but this was documented well in discharge summary. Perhaps he had insurance difficulties. We could not find a record of the patient being given antibiotics on discharge. On 09/03/1996 the patient was readmitted for abdominal pain and constant fever with a WBC of 23,000 K/uL. Two abdominal CT scans showed inflammation but no obvious abscess. On 09/06/1996 the patient was transferred to a larger hospital to another surgeon. The records contain no more follow-up.

Disposition: Probable postoperative abscess. This is a known complication of appendicitis and the patient received normal surgical management unless it is really true that he was sent home without antibiotics and still febrile. Need further information to determine standard of care issue.

Case #5 Patient H: This was a 58 year-old female seen on 09/14/1995, as an outpatient with ascites and a calcified gallbladder. Dr. Z recommends external drainage with an indwelling catheter. On 09/18/1995, he performs the procedure. On 09/25/1995, the patient is admitted with sepsis and finally dies on 10/10/1995, after a protracted septic course.

Disposition: Error in judgment. Sepsis was predictable with external drainage. Standard of care not met.

Case #6 Patient D: This 35 year-old patient was seen in the office on 01/13/1995, for evaluation for biliary dyskinesia. Her sonogram was negative for gallstones. She underwent a radio nucleotide study that showed an 8% ejection action. Dr. Z was satisfied with the diagnosis and performed a laparoscopic cholecystectomy without cholangiogram on 01/20/1995. On 01/23/1995, the patient is seen in office with severe abdominal pain. The diagnosis of a "small" bile leak was made based on an abdominal CT, which showed fluid. He decides to observe the patient hoping the bile leak will subside. On 01/24/1995, she presents to the Genesis east emergency room with an acute abdomen. She underwent exploratory laparoscopy with drainage. Postoperative course was unremarkable and she was discharged 01/26/1995.

Disposition: A series of errors in judgment are evident. The fluid in abdomen was not properly investigated. It could have represented bowel contents from a visceral injury that could have had fatal consequences with this management. Next, a bile duct injury has never been ruled out. A cholangiogram was never done. We feel that long term follow-up of this patient is needed to make sure she does not develop further problems. Finally, most would drain a biloma percutaneously under ultrasound or CT guidance after major bile duct injury is ruled out. The patient did not need the second laparoscopy. Standard of care not met.

Case #7 Patient CS: This 48 year-old patient was admitted on 11/08/1991, with acute cholecystitis. Radio nucleotide study was positive for cystic duct obstruction. The patient was treated conservatively and discharged. WBC was 19,000 K/uL on 11/10/1991, and this was not repeated before discharge. On 12/06/1991, the patient was readmitted for elective cholecystectomy. A laparoscopic procedure had to be converted to open because of inflammation. On 07/25/1994, Dr. Z responds to inquiry from the state of Iowa about a sponge left in. There are no other details.

Disposition: Sponge count correct. Normal surgical judgment and management. Standard of care met.

Case #8 Patient LD: This 39 year-old patient underwent a left inguinal herniorrhaphy on 12/01/1991. The patient eventually sues for testicular atrophy. Dr. Z responds to inquiry from the state of Iowa about testicular atrophy. There are no other details.

Disposition: Known complication. Standard of care met.

Case #9 Patient KD: On 06/16/1992, this 57 year-old patient underwent an elective laparoscopic cholecystectomy. The patient had a history of a previous gastrectomy. We assume that a Billroth 2 reconstruction had been done although this is not explicitly stated in the record. She is brought back to the OR on 06/19/1992, to repair an injured duodenal stump. A primary closure was done without a tube duodenostomy. On 06/29/1992, it is evident that the closure has broken down and the fistula has returned. Conservative treatment is next tried with bowel rest and total parenteral nutrition. By 09/11/2002, the fistula closes. Dr. Z responds to inquiry from the state of Iowa. There are no other details.

Disposition: Technical error but a known complication. Questionable standard of care issue.

Case #10 Patient MR: This is a 31-year-old female who was 12 weeks pregnant. She presents on 08/07/1992, with a ruptured appendix and underwent a conventional appendectomy. On 08/12/1992, the patient was dismissed after a slow postoperative course complicated by a paralytic ileus. She received five days of intravenous antibiotics and this was felt to be enough.

She developed signs of abdominal sepsis after discharge and a magnetic resonance imaging study showed an abdominal abscess. On 08/20/1992, she was transferred to Iowa City for percutaneous drainage. No further follow-up was included with the records.

Disposition: Indeterminate, most surgeons would have continued antibiotics for longer than five days because of the ruptured appendix especially in a pregnant patient. However, this would not be universally held and, therefore, could not be considered an unqualified deviation from acceptable practice. The abscess itself is not a standard of care issue as it is a known complication of a ruptured appendix.

Case #11 Patient SA: This 71-year-old patient underwent an attempted laparoscopic low anterior resection on 07/22/1993, for a carcinoma of the rectum. Cirrhosis and ascites were detected intraoperatively which was not surprising given the abnormal liver-spleen scan and abnormal liver function studies that were determined on 07/21/1993, but not pursued. The operation itself has to be classified as nothing less than a debacle. It took seven hours, there was 2700 cc of blood loss, and a hysterectomy was performed apparently because the uterus was in the way, the right ureter was damaged and finally after five hours the procedure had to be converted to an open abdominal-perineal resection. The patient experiences a cardiac arrest on the way to the recovery room and could not be resuscitated. There was no autopsy performed. A pulmonary embolus or a myocardial infarction would be likely causes of death given the magnitude and length of the operation and the fact that the patient was in stirrups so long.

Disposition: We seriously question Dr. Z's training and credentials to perform a laparoscopic procedure of this magnitude especially in 1993. Very few general surgeons were doing any type of laparoscopic colon surgery in 1993 but especially not for cancer. Even today most experts feel that cancer should not be approached laparoscopically outside of clinical trials. (See attached article by Wexner et al. and the accompanying critiques). The question is, did he actually have privileges to perform this operation? Each specific problem encountered during this operation could be considered a normal complication but the aggregate of all of them in one patient cause us to feel that this case has to be considered substandard.

Conclusion: To summarize, two cases were not felt to represent standard of care issues because the first was a hospital systems problem and the second was a known complication of herniorrhaphy. Three cases were indeterminate; further information is needed. Two other cases were considered indeterminate because the standard of care question was debatable. The remaining six cases were felt to be unequivocally below the standard. The first was the inability to effectively control this bleeding which apparently was not from a major vessel is not consistent with a competent general surgeon. Furthermore, the patient was not adequately resuscitated and was transferred in an unstable condition. The unfortunate result of this is not surprising. The second case was the ischemic right colon. Whether or not the ischemic colitis was caused by a technical error is debatable, regardless, the complication was not recognized in a timely fashion and later deterioration could have been prevented by earlier treatment. In the third case the patient deteriorated suddenly. A physician should rule out a leaking anastomosis after a recent colon surgery. In this elderly patient, a window of opportunity was lost where urgent re-exploration with a colostomy might have saved her. Also it appears she was discharged without antibiotics even though she had a known diverticular abscess. The next patient presents an apparent lack of basic fund of knowledge, as the development of peritonitis is predictable after external drainage. High volume repeated paracentesis or a peritoneal-venous shunt is the preferred management. External drainage is reserved for hospice type interventions only. The fact that this was a scheduled case and not just a snap decision makes it even more distressing. The care given to this patient in the committee's opinion could have easily ended with a mortality and will so in the future if a similar strategy is employed for a patient with severe abdominal pain and free fluid in the abdomen after laparoscopic cholecystectomy. At the

very least intensive in-hospital observation is mandatory. There was no way to know that visceral injury or a major common bile duct disruption caused her symptoms. Quite frankly we remain concerned about this patient and wonder if a stricture might possibly develop later.

Finally the committee seriously questions whether Dr. Z was qualified to perform a laparoscopic colectomy for the last patient and is concerned that perhaps has a problem recognizing his own limitations. Even if he was qualified, laparoscopic colectomy for cancer is questionable even now and would have been more so in 1993.

The committee does not feel that Dr. Z's practice patterns in any way reflect willful malpractice or negligence. However the cases reviewed do suggest a practice harmful and detrimental to the public. The frequency of this occurrence over the last 10 years coupled with the fact that there have been three occurrences in the 1999-2000 time concerns us. With regret, it is our opinion that the cases reviewed are significant enough that a serious threat to patients exists.

Respectfully submitted,

_____	_____
Peer Reviewer	Peer Reviewer
_____	_____
Date	Date

Attachment: Wexner article, "Clinical Status of Laparoscopic Bowel Surgery for GI Malignancy"

APPENDIX C

SAMPLE PAYMENT AGREEMENT

Payment Agreement for Peer Review
Addendum to Iowa Board of Medicine Peer Review Agreement

Date:

Case Name:

Case File:

Physician has agreed to review the above-referenced case. The case is assigned **LEVEL __ ($0),** pursuant to paragraph 10 (a) of the Iowa Board of Medicine's Peer Review Agreement entered into by the physician and the Board. Upon completion of your Peer Review Report, please sign and date below and indicate that you agree to this payment or you are donating your services pro bono.

Payment will be made once the Iowa Board of Medicine receives the signed Peer Review Report, all materials regarding this case, any notes you may have taken, and this form.

Agree to this payment: ☐ **Donating services pro bono:** ☐

Physician

_____

Physician Name

_____

Date

Iowa Board of Medicine

_____

Kent Nebel, Executive Director

_____

Date

NOTE: Should you be asked to participate with hearing preparation and deposition, please submit a separate invoice at a rate of $300 per hour pursuant to paragraph 10(f). Please include your name, case name, file number(s), date(s) of service, hours spent performing service, signature and date submitted.