

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 732
ADMINISTRATIVE ACTION NO. 00-KBML-0132

FILED OF RECORD
AUG 12 2003
K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF
KENTUCKY HELD BY KIRK D. MORGAN, M.D., LICENSE NO. 16289,
2708 FRANKFORT AVENUE, LOUISVILLE, KENTUCKY 40206

ORDER OF INDEFINITE RESTRICTION

At its July 24, 2003 meeting, the Board's Hearing Panel B took up this case for final resolution. The Panel reviewed a July 2, 2003 memorandum by the Board's General Counsel; the Complaint filed March 16, 2000; the hearing officer's recommended Findings of Fact, Conclusions of Law and Recommended Order issued May 12, 2003; the Board's Exceptions to the recommended order; the licensee's Exceptions to the recommended order; Colorado Personalized Education for Physicians (CPEP) Assessment Report of licensee of May 2001; and, the Board's *Order Amending Agreed Order of Probation* filed of record September 14, 1999. The Panel also heard argument by counsel for both parties.

Having considered all of the information available to it and being sufficiently advised, Hearing Panel B ACCEPTS and ADOPTS recommended Findings of Fact 1-14, 16-20, 21-26, 27-32, 33, 35-36, 37-42, and 43-48 and INCORPORATES those delineated Findings of Fact, in whole, into this Order of Indefinite Restriction by reference. Hearing Panel B ACCEPTS and ADOPTS recommended Conclusions of Law 49, 51-53, 54, 60-73, and 76-77 and INCORPORATES those Conclusions of Law into this Order of Indefinite Restriction by reference.

Hearing Panel B expressly REJECTS that portion of Findings of Fact 15 and 34 and Conclusion of Law 55, in which the hearing officer erroneously defined "gross

negligence". KRS 311.595(9), as illustrated by KRS 311.597(3) authorizes the Panel to impose sanctions upon proof of:

A serious act, or a pattern of acts committed during the course of his medical practice which, under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice.

The Board has construed each of these terms to define a flagrant form of a deviation from the standard of care, through ignorance, negligence, incompetence or malpractice. The hearing officer erroneously superimposed the requirements of "malice and willfulness" or "wanton and utter disregard" onto the Board's definition of "gross ignorance."

Hearing Panel B modifies the recommended Conclusion of Law 50 by concluding that the stated violations also constituted violations of KRS 311.595(9), as illustrated by KRS 311.597(4) as deviations from the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky.

Hearing Panel B modifies the recommended Conclusion of Law 57 by deleting the first sentence which incorrectly states the definition of gross negligence. Conclusion of Law 57 shall read:

The licensee was concerned about and attentive to the problems of patients A, B, C, E, G, and K. but dealt with them less aggressively and thoroughly than Barnes thought was proper. Noel and VonderHaar agreed that Morgan's treatment was acceptable. Barnes' allegation that Morgan failed to document his patients' office visits and ignored his office staff's fabrication of vital signs was simply not supported by the documentary evidence in the record. There was no substantial evidence in the record to prove that the laboratory work was incompetent or fabricated. Barnes herself admitted that her allegations in regard to the laboratory work was only a guess.

Hearing Panel B modifies the recommended Conclusion of Law 59 by limiting it to the first two sentences and shall read as follows:

The problems of Patient A, Patient B, Patient C, Patient E, Patient G and Patient K were also termed "malpractice" by Barnes. Black's Law Dictionary, 971, (7th ed.),

defines "malpractice" as "An instance of negligence or incompetence on the part of a professional."

Hearing Panel B modifies the recommended Conclusion of Law 78 by adding the following additional reasons for the licensee's inability to enroll in a residency program:

1) past disciplinary actions, 2) the findings and conclusions of the Emergency Order of Suspension and/or 3) his three (3) year absence from the practice of medicine.

Hearing Panel B makes the following additional Findings of Fact as it relates to the Board's prior attempts to rehabilitate the licensee.

- 1.) Complaint # 363 was filed against Dr. Morgan's license on September 22, 1989. Dr. Morgan proposed an Agreed Order which would permit him to resume the use of chelation therapy if his protocol was approved by the Academy of Family Physicians. Three proposed protocols were rejected. In May 1992, the Board received additional grievances about Dr. Morgan's use of chelation therapy, hydrogen peroxide, and hair analysis. Dr. Morgan was advised that, if he did not enter into a proposed Agreed Order, the original Complaint would be amended. On August 26, 1994, Dr. Morgan entered into an Agreed Order of Restriction which prohibited his use of: EDTA or chelation therapy; intravenous hydrogen peroxide; and/or, intravenous germanium;
- 2.) Complaint # 558 involved allegations that Dr. Morgan had violated the Agreed Order of Restriction by: advising a patient to surreptitiously add hydrogen peroxide to her family's drinking water; and, sending patients to Indiana for EDTA/Chelation Therapy treatments. On April 18, 1996, Dr. Morgan entered into an Agreed Order of Probation, reinforcing his original restrictions;
- 3.) On September 14, 1999, Panel B issued an Order Amending Agreed Order of Probation, very particularly specifying practice requirements for Dr. Morgan.

Hearing Panel B specifically INCORPORATES the Colorado Personalized Education for Physicians (CPEP) Assessment Report of the licensee of May 2001 in its entirety as an additional Finding of Fact.

Hearing Panel B FINDS that the licensee agreed to delays in the proceedings on the Complaint of approximately 23 months. The Hearing Panel FINDS that approximately 12 months of the delay was attributable to the licensee's failure to comply

with the discovery orders. Additionally, delays in the proceedings caused by or agreed to by the licensee SHALL not in themselves affect the appropriate disciplinary determination.

Hearing Panel B CONCLUDES as a matter of law that KRS 311.604 authorizes the Board to require a clinical skills assessment at a Board approved facility after a physician has been absent from the active practice of medicine for more than two (2) years.

Hearing Panel B CONCLUDES as a matter of law that the health, welfare and safety of patients and the public requires that the licensee demonstrate his current ability to safely practice medicine in a Family Practice setting, without undue risk to patients or the public, before he is permitted to resume the active practice of medicine.

Hearing Panel B FINDS that based upon the violations found in the hearing officer's Findings of Fact and Conclusions of Law, the prior actions by the Board to rehabilitate the licensee, the violations of the terms of the September 14, 1999 Order Amending Agreed Order of Probation, the CPEP Assessment Report of May 2001, and that the licensee's absence from the practice of medicine since March 16, 2000, it is not necessary to remand this matter to the hearing officer to make additional findings based upon the correct definition of "gross negligence".

Hearing Panel B CONCLUDES that the licensee has violated the provisions of KRS 311.595(13) and KRS 311.595(9) as illustrated by KRS 311.597(3) and (4). Having considered all the of the information available, including the nature of the violations, the nature of the previous disciplinary actions against the licensee's Kentucky medical license, the Board's previous attempts to rehabilitate the licensee, the CPEP Assessment

and Recommendations and the licensee's absence from the practice of medicine for more than two (2) years, it is hereby ORDERED that the license to practice medicine in the Commonwealth of Kentucky held by Kirk D. Morgan, M.D., is INDEFINITELY RESTRICTED under the following terms and conditions:

1. The licensee SHALL NOT engage in the practice of medicine as defined by KRS 311.550(10) until approved to do so by the Panel. KRS 311.550(10) defines the practice of medicine as "the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities."
2. The licensee shall only request to resume the active practice of medicine and enter into a subsequent Order of Indefinite Restriction or Order of Probation, upon SATISFYING THE FOLLOWING TERMS AND CONDITIONS:
 - a. The licensee SHALL provide proof to the Panel that:
 - i. He has successfully completed an approved residency training program in Family Practice;
 - ii. He has successfully completed a CPEP Education Course and Post Education Evaluation which attests to his competency that he is competent to resume the practice of medicine; or
 - iii. He has successfully passed the American Board of Family Practice exam for Board Certification in Family Practice. Proof of passing the recognized exam for Board certification by the American Board of Family Practice shall provide prima

facie evidence that the licensee has regained competency to practice medicine.

- b. The burden shall be upon the licensee to satisfy the Panel that he is presently of good moral character and is qualified both physically and mentally to resume the practice of medicine, under appropriate restrictions, without undue risk or danger to his patients or the public. It shall be within the Board's discretion to review available evaluations and reports from either a residency training program successfully completed by the licensee or a CPEP Post Education Evaluation to determine if the licensee is competent to safely resume the practice of medicine.

3. The licensee SHALL pay the cost of the proceedings in the amount of \$9,942.28.
4. If the licensee makes a request to resume the practice of medicine and the Panel approves his request, then a separate Order of Indefinite Restriction or Order of Probation shall be entered with those terms and conditions deemed appropriate at the time the licensee's request is granted and based upon the information available to the Panel at that time.

SO ORDERED this 12th day of August, 2003.



PRESTON P. NUNNELLEY, M.D.
CHAIR, HEARING PANEL B

Certificate of Service

I certify that the original of this Order of Indefinite Restriction was delivered to C. William Schmidt, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222 and a copy was mailed to Susan S. Durant, Esq., Division of Administrative Hearings, 1024 Capital Center Drive, Suite 200, Frankfort, Kentucky 40601-8204; and via certified mail return-receipt requested to Jason Segeleon, Esq., 125 South 7th Street, Louisville, Kentucky 40202 and Kirk D. Morgan, M.D., 2708 Frankfort Avenue, Louisville, Kentucky 40206 on this 12th day of August, 2003.



L. CHAD ELDER
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EFFECTIVE DATE AND APPEAL RIGHTS

Pursuant to KRS 311.593(1) and 13B.120, the effective date of this Order will be thirty (30) days after this Order of Indefinite Restriction is received by the licensee or the licensee's attorney, whichever shall occur first.

The licensee may appeal from this Order, pursuant to KRS 311.593 and 13B.140-.150, by filing a Petition for Judicial Review in Jefferson Circuit Court within thirty (30) days after this Order is mailed or delivered by personal service. Copies of the petition shall be served by the licensee upon the Board and its General Counsel or Assistant General Counsel. The Petition shall include the names and addresses of all parties to the proceeding and the agency involved, and

a statement of the grounds on which the review is requested, along with a copy of this Order.

MAY 12 2003

COMMONWEALTH OF KENTUCKY
KENTUCKY BOARD OF MEDICAL LICENSURE
AGENCY CASE NO. 732
ADMINISTRATIVE ACTION NO. 00-KBML-0132

K.B.M.L. 3

KENTUCKY BOARD OF MEDICAL LICENSURE

COMPLAINANT

FINDINGS OF FACT, CONCLUSIONS OF LAW
v. and RECOMMENDED ORDER
NOTICE OF EXCEPTION AND APPEAL RIGHTS

KIRK D. MORGAN, M.D.
License No. 16289

RESPONDENT

* * * * *

An Administrative Hearing was held in this case on February 27-28, 2003, at the Kentucky Board of Medical Licensure, 310 Whittington Parkway, Louisville, Kentucky. Closing arguments were held at the Board on April 14, 2003. C. Lloyd Vest, General Counsel, represented the Board at the Hearing. The Respondent, Kirk D. Morgan, M.D., was represented by Jason Segeleon, Attorney at Law, and Mark L. Morgan, Attorney at Law.

The Complainant introduced the record compiled in *Morgan v. Kentucky Board of Medical Licensure*, Administrative Action No. 00-KBML-0197, which was heard on April 18, 2000, pursuant to KRS 311.592 and KRS 13B.125. At that Emergency Suspension Hearing, Mary Ann Barnes, M.D., testified as an expert in family practice. The videotape of the testimony was introduced as part of the testimony in this action. The Board also introduced the deposition testimony of Martha Illige, M.D., who is a faculty member at the University of Colorado Health Science Center, Family Medical Residency, and Medical Director for the Colorado Personalized Education for Physicians. In addition Betty Leonhardt, the daughter of Patient A, testified in person at the Hearing. Betty Prater, Medical Investigator for the Board, was called as a rebuttal witness by the Board. Morgan called Robert A. Noel, M.D., and William VonderHaar, M.D., in

person as experts in family practice. The deposition testimony of both Noel and VonderHaar was also admitted as part of the evidence in the Hearing. In addition Morgan, himself, testified in person.

It is herein recommended that Kirk Morgan be placed on probation on such terms as are acceptable to Kentucky Board of Medical Licensure.

FINDINGS OF FACT

1. The Complaint issued on March 16, 2000, was based upon the complaint of Patient A's daughter and the review of the Board's expert of the office records of 11 of Kirk Morgan's patients which included Patient A. The Complaint charged that Morgan had violated the following statutes:

KRS 311.595 (13): Violated any agreed order, letter of agreement, order of suspension, or the terms or conditions of any order of probation, issued by the board;

KRS 311.595 (9): Engaged in dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud, or harm the public or any member thereof; [as illustrated by]

KRS 311.597 (2): Issues, publishes, or makes oral or written, representations in which grossly improbable or extravagant statements are made which have a tendency to deceive or defraud the public, or a member thereof....

KRS 311.597 (3): A serious act, or a pattern of acts committed during the course of his medical practice which, under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice.

KRS 311.597 (4): Conduct which is calculated or has the effect of bringing the medical profession into disrepute, including, but not limited to, any departure from, or failure to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky.... For the purposes of this subsection, actual injury to a

patient need not be established.

2. The medical records of 11 of Morgan's patients were subsequently introduced into evidence at the hearing. The file of Patient A was under consideration because a complaint had been filed concerning Morgan's treatment of that patient. Ex. 3. The other 10 files of Patient B through Patient K were chosen at random because the Board's medical expert had questions about Morgan's general care of his patients. The ages of the patients to whom the records belonged ranged from 65 to 88. Although Morgan engaged in family practice, his clientele appeared to be primarily geriatric.

3. According to Morgan, the patients in the files had generally been patients that he inherited when he took over his father's medical practice. Kirk Morgan formally took over the practice on January 1, 1997, although he had seen some of the patients before that date. Some of the files were incomplete because the Board was not concerned about the care provided by Morgan's father. Betty Prater, Medical Investigator for the Board, testified that the files were chosen at random with the cooperation of Morgan's office staff.

4. The Board relied primarily upon the expert testimony of Mary Ann Barnes, M.D. Barnes graduated from the University of Louisville School of Medicine in 1981. In 1984 she was board certified in family practice and has remained certified since that date. Barnes engaged in private practice for 5 years. For the past 11 years prior to her testimony, Barnes had been on the faculty of St. Elizabeth Hospital teaching in the family practice residency program.

5. In addition the Board introduced the deposition testimony of Martha Illige, M.D., who is a faculty member at the University of Colorado Health Science Center, Family Medical Residency, and Medical Director for the Colorado Personalized Education for Physicians (CPEP). CPEP is a private nonprofit organization that assesses physicians' competencies and

skills and develops remedial programs to improve or enhance those skills. CPEP's clients are generally state licensing boards and privileging institutions such as hospitals who refer physicians for assessment. Morgan voluntarily agreed to be assessed at CPEP in order to improve his skills with the aim of reaching an agreement regarding the charges against him. Illige testified that although the CPEP staff did review some of Morgan's office files, they were not supposed to be the same files as were involved in this action. Illige's deposition included, as an exhibit, a 21-page Executive Summary of the assessments performed on May 14-16, 2001. Thus the CPEP report evaluated the medical knowledge and clinical skills necessary for a family practitioner, but made no judgment as to the specific facts alleged in the instance action.

6. Robert A. Noel, M.D., testified as an expert in family practice for Morgan. Noel graduated from the University of Louisville School of Medicine in 1965. Noel was board certified in family practice until several years ago when he decided that the certification was too expensive and was unnecessary. Noel has been in private practice since 1965 in Louisville.

7. William VonderHaar, M.D., also testified as an expert in family practice for Morgan. VonderHaar graduated from the University of Louisville School of Medicine in 1956. He taught in the family practice residence program at Louisville and eventually became Associate Vice-President for Health Affairs at the School of Medicine. VonderHaar was certified in family practice until 1998 when he retired from active practice.

RECORD KEEPING

8. The order of probation that Morgan is charged with violating is entitled "Order Amending Agreed Order of Probation," which was issued on September 14, 1999. The provisions of that Order that appear relevant to the current charges are found in numerical paragraph 2. sub paragraphs (f)(j)(k)(n)(o)(p)(q)and(t). The first seven subparagraphs listed

required Morgan to conform to a standard of record keeping which in turn affected the care of his patients because it required notations that certain basic procedures were followed and because it formed a reference for future treatment. Subparagraph (t) requires Morgan to "fully comply with the Kentucky Medical Practices Act." Ex.2.

9. With the exception of Patient A, and one other patient, the first entries in the medical records were made in 1996. With the exception of Patient A, the most recent entries in the records copied by the Board's investigator were made in October, November, or December, 1999. Thus at a maximum only the last 3½ months of entries were made after the Amended Order of Probation was issued. The Emergency Order of Suspension contained only one specific reference to poor record keeping after September 14, 1999, the date of the Amended Order, and that was in reference to the treatment of Patient I on December 1, 1999. Ex. 3. In that the Amended Order meted out the discipline for record keeping deficiencies prior to September 14, 1999, the Hearing was concerned only with violations of the Amended Order in regard to record keeping-- and with new charges concerning other issues.

10. The Board's medical expert, Barnes, testified that the record keeping was substandard in the 11 records that she reviewed. She also conceded that it had improved in the past two years, but was still not generally up to an acceptable standard. She testified only as to one entry, that on December 1, 1999, as demonstrating incomplete record keeping after the Amended Order became effective. In that entry for Patient I, Morgan noted "Dyspneic on exertion" but there is no indication that he listened to Patient I's lungs. Also the entry is unclear as to whether the prescription noted was a new prescription or a refill prescription of previous treatment. Ex. 14. In short, the standard "Subjective, Objective, Assessment, Plan" (SOAP) format was not followed as required in the Amended Order, 2(f).

11. The Simulated Patient Chart Notes portion of the CPEP Executive Summary stated that "The three notes were legible. Each was organized in the SOAP format, and all notes contained all four components." The assessor concluded, "Thus Dr. Morgan's performance in this area was good, indicating that Dr. Morgan knows how to document well." Ex. 19 at ex.A, p.14.

12. Noel and VonderHaar both felt that Morgan's office notes met the standard of care. VonderHaar pointed out that a solo practitioner had no need to write as detailed and voluminous notes as would be required in an academic setting where many individuals, such as Barnes, reviewed the same notes. Noel observed that the SOAP method was just one method of record notation; there were other acceptable methods.

13. Regardless of the divergent opinions regarding Morgan's method and skills in keeping his office notes, the standard required for Morgan's office notes was that set out in numerical paragraph 2. sub paragraphs (f)(j)(k)(n)(o)(p)(q) of the "Order Amending Agreed Order of Probation."

14. A review of the latest entries in the medical records entered into the record at the Hearing indicated that some of Morgan's record keeping did not meet the requirements of the Amended Order. Numerical paragraph 2 of the Amended Order required:

- f. The licensee shall maintain concise and legible patient charts which reflect the "Subjective, Objective, Assessment, Plan" format....
- p. The licensee must formulate and include a plan of treatment for each patient. This plan shall be formulated upon the initial visit and be updated in the progress notes for each visit.....

Ex. 2. The entry for Patient D for December 31, 1999, contains only vital signs. Ex. 9. The entry for Patient F on October 19, 1999, Ex. 11; for Patient G on October 15, 1999, Ex.12; for Patient H on October 15, 1999, Ex.13; for Patient J on November 18, 1999, Ex. 15; and for Patient K on October 7, 1999, Ex. 16, were brief, such as one word subjective descriptions, or a test to be run. Some entries were prescription refills.

15. The charges against Morgan contain a statement from Barnes that "Failure to document his patients' office visits is gross negligence." *Cooper v. Barth*, 464 S.W.2d 233, 234 (Ky. 1971), provides the following definition of gross negligence:

We have further defined gross negligence as being something more than the failure to exercise slight care. We have stated that there must be an element either of malice or willfulness or such an utter and wanton disregard of the rights of others as from which it may be assumed the act was malicious of [*sic*] willful.

Hoke v. Cullinan, 914 S.W.2d 335, 337, (Ky., 1995) states:

To summarize, conduct that evidences a reckless disregard for the safety of other persons is gross negligence.

There was no evidence that any office visits were totally undocumented. Thorough office notes are a convenience and help to other practitioners and to insurance companies but there was no evidence that Morgan's office notes demonstrated malice, willfulness, utter and wanton disregard for the rights of others, or recklessness.

FAILURE TO WORK-UP ILLNESSES

16. According to Barnes, Morgan failed to work up life-threatening illnesses in 5 out of the 11 patients whose records she reviewed.

Patient A:

- a. Patient A came into Morgan's office on July 28, 1998, complaining that she was throwing up old blood. Her hematocrit was 22% which was considerably below the normal level of 33-36%. Morgan diagnosed a bleeding gastric ulcer and told her to discontinue Daypro and take over-the-counter Cimetidine and Pepto-Bismol. On the next day, July 29, 1998, Morgan noted that Patient A was taking Tagamet and Pepto-Bismol and diagnosed blood loss iron deficiency anemia. On July 31, Morgan noted that Patient A's "pallor is dissipating a bit." On August 4, Moore noted that Patient A's hematocrit was 25% which was a "marked improvement." On August 8, Patient A was taken to the hospital because she was vomiting blood and had bloody stools. She died almost immediately. In his file Morgan listed acute myocardial infarction as the first cause of death with gastrointestinal blood loss anemia as second. Ex. 6.
- b. Barnes testified that the standard of care in such a situation was to hospitalize the patient immediately, give her a transfusion, and perform an urgent esophago-gastroduodenoscopy. The risk of not transfusing Patient A was much greater than any risks from transfusion. The urgency of such treatment was increased by the "very significant risk factors for heart disease" such as hypertension, diabetes, hypercholesterolemia, post-menopausal state, possible obesity, and treatment with DHEA. Ex. 3.
- c. Noel and VonderHaar both testified that the improvement in Patient A's hematocrit was a good sign indicating that Morgan's course of treatment was working. Neither doctor thought that hospitalization was necessary.

Morgan testified that Patient A's hematocrit at 22% was still above the Medicare guidelines for hospitalization. VonderHaar was firm that an endoscopy would have been incorrect and risky because Patient A would have had to have been put to sleep for the procedure. VonderHaar conceded, however, that it would have been safer to have hospitalized Patient A to stabilize her.

- d. Barnes was convincing that Morgan's care fell below the standard of care. Barnes's explanation was detailed and took into account the whole range of Patient A's physical condition.

Patient B:

- e. Patient B came to Morgan on May 1, 1997, complaining of chest discomfort. Morgan noted ASCV on the file and ordered an ECG and x-ray. Patient B's ECG was abnormal. Morgan wrote in the file that he could not rule out the possibility of a heart attack. Ex. 7.
- f. Barnes testified that the standard of care is to admit the patient to the hospital so that tests can be performed and the heart can be monitored.
- g. Noel and VonderHaar pointed out that Patient B was already under the care of a cardiologist. In February, 1997, Patient B had bypass surgery and was following up with the surgeon. Furthermore, Patient B returned to Morgan's office the next day, reporting that he was feeling better. Noel testified that Patient B's history and test results did not suggest hospitalization. Noel also noted that Patient B's lab results showed no cardiac damage.

Patient E:

- h. Patient E had an EKG run on June 4, 1999. Ex. 10.
- i. Barnes noted that the EKG was suspicious for ischemia. There was a biphasic T wave in V2, as well as persistence of T wave inversion laterally. The standard of care, according to Barnes, is to admit the patient to the hospital so that tests can be run and the heart can be monitored.
- j. Morgan's office records included documents generated by Baptist Hospital East on April 3, 1999, after Patient E had been in an automobile accident. Patient E was seen by cardiologist at the hospital and was placed on Coumadin.
- k. Noel pointed out that Patient E typically had a flutter and that the ischemia may have been from a digitalis effect. Hospitalization was not necessary.
- l. Morgan testified that he compared EKGs from 1994, 1995, and 1998 to the one run on June 4, 1999. He thought he detected some digoxine effect. On the basis of the test and the comparison, he considered ischemia and ruled it out.

Patient G:

- m. Patient G came to Morgan on September 5, 1996, complaining that she tired easily and had some chest discomfort which felt like pressure or a need to belch frequently. Morgan had an EKG run. Ex. 12. Barnes testified that Morgan failed to make an assessment or plan concerning her complaint. She was concerned that Patient G had angina or possibly a heart attack. The record showed that Patient G had been prescribed

nitroglycerine in 1996 prior to Morgan's taking over the practice. Kirk Morgan prescribed nitroglycerine on January 8, 1997, 100 on February 28, 1997, again on April 21, 1997, and June 10, 1997. Ex. 12. Barnes testified the heavy use of nitroglycerine could indicate significant coronary artery disease, but only relieved the symptoms. On October 22, 1997, Morgan noted simply "stroke" in Patient G's records, because the patient requested something for her memory, but Morgan again did no work-up. Ex. 12. Barnes felt that the standard of care for such symptoms as Patient G demonstrated is to hospitalize the patient to run tests and monitor the heart.

- n. Noel testified that Patient F's records were obviously incomplete. Her care was begun under Edmund Morgan and continued under Kirk Morgan. Noel stated that the EKG run in September, 1996, was normal compared to her previous EKG in 1994. There were no significant changes and no need for a hospital work-up.
- o. Morgan stated that he had not hospitalized Patient F because the EKG was within normal limits and there was little change since 1994.

Patient K:

- p. Patient K came to Morgan's office on September 4, 1997. One of Morgan's notations was "s-angina- Rx NTG." On December 9, 1997, Patient K had a four vessel bypass. Ex. 16. Barnes testified that the standard of care was to refer the patient to a cardiologist before he had a myocardial infarction and urgent need for a bypass. Prescribing

nitroglycerine only relieved the symptoms; Morgan made no effort to find the cause.

- q. Noel and VonderHaar both pointed out that Patient K was already under the care of a cardiologist. And, Patient K was already taking warfarin as a blood thinner. VonderHaar stressed that every report of chest pain did not require hospitalization.
- r. Morgan's records and testimony indicated that Patient K had had a myocardial infarction 10 years ago. He had had a stroke in 1992 and had had multiple transient ischemic attacks since that time. Patient K was under the care of a cardiologist.

17. In general, Barnes thought that Morgan was not sufficiently aggressive in referring his patients to cardiologists and admitting them to hospitals for tests and monitoring.

VonderHaar and Noel testified, and Morgan's testimony paralleled their opinion, that Morgan was aware of the problems suffered by his patients, he was cognizant of their past medical history, he considered the possibilities of the current complaint, and rejected hospitalization. Patient B, Patient E, and Patient K were under the care of cardiologists for heart problems. The record was not complete for Patient G. Noel and VonderHaar were convincing that Morgan provided safe, effective, and acceptable treatment as prevailed in the Commonwealth for the heart conditions that Barnes was concerned about.

18. Related to Morgan's failure to provide proper care to his patients was his failure to give Patient D a tetanus shot after he sewed up a cut 3cm in length that the patient had received from a hacksaw. Morgan did not note that he gave a tetanus shot or that he inquired as to when Patient D last had such a shot. Ex. 9. The standard of care according to Barnes is to

assure that a patient is protected against tetanus after a severe laceration.

19. Morgan testified that he did give Patient D a tetanus booster and his routing slips indicated that it was given. Ex. 17. Morgan elaborated that he realized that Patient D needed a shot as the patient was leaving the office, so he called him back. Because the shot was given out of the normal procedure, Morgan failed to note it in his chart.

20. Morgan's description of the events surrounding the cut and tetanus shot for Patient D was convincing. It is found that Morgan's oversight was in regard to chart notation rather than medical care.

FAILURE TO MONITOR SIDE EFFECTS

21. Barnes testified that Morgan was negligent, but not grossly negligent, regarding Patient C by his failure to monitor the adverse side effects of Prandin. On September 2, 1998, Bruce S. Chang, M.D., sent Morgan a report on Patient C in which he noted "Recent onset of hypoglycemic episodes possibly related to addition of Prandin." Yet Morgan failed to monitor Patient C regarding the Prandin at the next office visit on September 28, 1998; and, on November 6, 1998, and June 25, 1999, Morgan wrote refills of Prandin and instructed Patient C to continue taking it. On June 28, 1999, Patient C decreased his dosage himself because he had "been experiencing some hypoglycemic episodes which caused consumption of cookies late at night." Ex. 8. According to Barnes, Morgan's records give no indication that the doctor routinely discussed the side effects of medicines with his patient or monitored him for harmful side effects. Barnes testified that the hypoglycemic episodes could cause harm. She stated that the standard of care is to educate and monitor patients in regard to the harmful side effects of medicines.

22. At the time of Chang's letter to Morgan on September 2, 1998, Patient C was taking 1 mg Prandin TID. On September 28, 1998, when Patient C next saw Morgan the office

notes state "urine run" and "(Glycohb- 5.9) drew blood SMA-Hb & Hemat." A Chemstrip Urinalysis Report Form and a LabCorp report for blood collected on September 28, 1998, are included in the file. There are Chemstrips in the file almost monthly during the period cited by Barnes-- from September, 1998, until June, 1999. There is another LabCorp report in January, 1999. There is a 24 hour urine test result performed by Jewish Hospital for Chang on September 28, 1999. There are glycosylated hemoglobin results reported in the notes, *see e.g.* May 24, 1999.

23. On January 7, 1999, Chang sent Morgan a report to continue Patient C's medications which included 1 mg Prandin TID

24. On February 15, 1999, Morgan notes "I tried to leave him with the impression that I consider him very knowledgeable regarding his own care and he needs to use that information and take proper liberty to modify his control as necessary." The office chart appears to indicate that Morgan kept a close eye on Patient C and discussed his treatment with the patient.

25. Noel stated that there may have been other causes for Patient C's hypoglycemia and that his blood sugar was normal in September, 1998. He observed that Morgan met the standard of care in regard to Patient C's treatment, education, and documentation. Morgan and VonderHaar both testified that it was not necessary to chart the possible side effects of medication or that a patient had been counseled as to the possible side effects.

26. Patient C's record did not seem to be logically organized-- test results were out of order. Barnes appeared to have overlooked some relevant test results. Her opinion that Morgan fell beneath the standard of care was not persuasive.

FAILURE TO FOLLOW UP ABNORMAL LABORATORY VALUES

27. Barnes testified that Morgan endangered the life of Patient E by his failure to

follow-up on abnormal laboratory values. On June 1, 1998, Morgan noted that a urine test was run on Patient E. The laboratory results issued on June 3, 1998, reported that Patient E's potassium, phosphorus, and LDH were abnormally high. The laboratory report cautioned that the high values "may be caused by specimen mixing in transit, or prolonged time of serum remaining in contact with cells before centrifugation." Ex. 10. Barnes testified that the standard of care is to repeat a test with questionable outcomes because these elevated levels could be signs of serious illnesses.

28. Noel testified that the results from Patient E's test on June 1, 1998, were obviously in error and that they were to be accepted as such. Morgan testified that the explanation on the test results seemed to properly identify the problem, but he was unable to get Patient E to return to his office to be retested.

29. Patient E's next office visit was on September 1, 1998. She returned again on November 30, 1998 and on March 4, 1999, but it was not until June 4, 1999, that Morgan ordered a similar panel of tests for Patient E.

30. Likewise, Morgan did not follow up on Patient C's high white blood cell count on August 17, 1998, Ex. 8. Barnes termed the test results a minor deviation. Patient H's elevated leukocytes on September 10, 1999, Ex. 13, and Patient I's high values of globulin and AST on March 4, 1997, Ex. 14, were not followed up by Morgan. According to Barnes, this repeated failure to note and address such abnormalities placed patients at risk because the abnormalities could be signals of serious latent or developing illnesses.

31. Barnes considered Patient C's and Patient H's elevated test results as minor deviations from the standard of care. Barnes testified that the high values on Patient I's globulin and AST indicated a potential risk. VonderHaar observed that some test results were not

followed up but they were not a significant problem. Noel considered Patient C's and Patient H's elevated results of not much significance. He conceded that Patient I's results were high but he did not think that the failure to deal with the high values was a breach of the standard of care.

32. Barnes was convincing that Morgan's failure to deal with the abnormal laboratory values of Patient E, Patient C, Patient H, and Patient I was a deviation from the standard of care. Barnes argued persuasively that Morgan should have retested, conducted further tests, or dealt with the potential problem in some way other than ignoring the abnormality.

USE OF OUTDATED THERAPIES

33. Barnes testified that the use of out-dated therapies such as Lincomycin, Serapes, and Protimes (PTs) demonstrated ignorance of current, more effective therapies.

Lincomycin:

- a. Lincomycin, an antibiotic, was prescribed for Patient B, Patient D, Patient H, and Patient J. According to Barnes, the drug is effective in only a narrow range and has the unfortunate side effect of causing diarrhea. It has been replaced by Rocephin that treats a wider range and that is superior enough that the use of a relatively ineffective drug such as Lincomycin is below the standard of care. The low cost of Lincomycin does not outweigh the greater efficacy of a more modern drug.
- b. VonderHaar testified that lincomycin was an acceptable antibiotic. Noel more thoroughly evaluated its merits. Noel testified that the drug is useful for individuals who are allergic to penicillin. It covers a sufficiently broad spectrum. It is injectable. It has low side effects. VonderHaar and Noel were convincing that lincomycin was beneficial, safe, and effective.

Serapes:

- c. Serapes, which is a diuretic, can place patients in a position of risk, according to Barnes, because it can cause low sodium and low potassium. It has generally been replaced by hydrochlorothiazide or, in the case of diabetes and hypertension by an ACE inhibitor. Serapes was used extensively with Patient F.
- d. Morgan testified that serapes is effective and inexpensive. It can cause depression as a side-effect, but Patient F had suffered no adverse effects. Serapes was better for that specific patient.
- e. Noel stated that there was nothing wrong with using serapes. All drugs have some side effects. Noel was convincing that the use of serapes was not below the standard of care.

Protimes:

- f. According to Barnes, the use of PTs has been outdated by the use of INR. Patient E and Patient K regularly had PTs run. The problem with using PTs to measure blood coagulation is that one test cannot be readily translated in order to compare it with other similar tests because of variability and lack of consistency.
- g. Neither Noel nor VonderHaar were convincing that PTs were still validly useful.

34. Barnes categorized Morgan's use of Lincomycin, serapes, and PTs as gross ignorance. Noel and VonderHaar described the medicines as still useful although the pharmaceutical industry has now passed them by. Morgan was cognizant of the limitations of the

medicines but stressed the economical aspect of their use and their familiarity to his patients. Nothing in Barnes' testimony about the use of the medicines or PTs rose to the level of such wanton and utter disregard of newer modalities as to rise to the level of gross ignorance. VonderHaar's testimony concerning the preferable use of INR supported Barnes' criticism of the PTs as below the standard of care.

USE OF COMPLIMENTARY THERAPIES

35. Barnes testified that the standard of care was to use complimentary therapies along with more traditional therapies. She said that complementary therapies have an appropriate place in medical treatment, but they should not be substituted completely for more traditional and proven methods of treatment.

- a. On February 10, 1998, Morgan noted, in regard to Patient I's chronic heart failure, that "She plans to walk more and take more vinegar." Ex. 14. On September 30, 1999, Morgan mentions "vinegar" as part of the "Plan" for Patient J to treat paroxysmal leg spasm. Ex. 15. On October 1, 1999, Morgan notes that Patient B "is going to try using vinegar, a teaspoon to a tablespoon every day" as part of the treatment for hypercholesterolemia. Patient B was also self-prescribing Lethosin and Lipex. Ex. 7.
- b. Barnes testified that vinegar *per se* is not harmful. Nor did Barnes provide any evidence that other more traditional therapies were not being used. Patient B's use of vinegar, Lethosin, and Lipex are listed under "S" as subjective. Patient B's chart indicated that the patient himself was determined to manage his hypercholesterolemia without pharmaceutical aids if possible. He tried garlic pills as advertised on television prior to

trying vinegar. In the interim Morgan had prescribed Simvastatin. Patient I also self-prescribed vinegar. Two months previously on December 9, 1997, Morgan noted that the plan for CHF was, "Continue digoxin. We are going to get a serum level and diuretic." Morgan included potassium and magnesium as well as vinegar as part of the Plan for Patient J.

- c. On April 23, 1998, Morgan suggested that Patient K use "hydrotherapy" for his chronic heart failure. Barnes testified that she did not know what "hydrotherapy" was.
- d. Morgan explained that hydrotherapy was walking in a wading pool in order to increase the flexibility of the ankles.

36. Although the use of non-traditional medicine was included as part of the factual basis of the complaint, even Barnes conceded, "Because I am unfamiliar with any studies on these particular therapies, however, I cannot determine if they are incompetence, ignorance, negligence or malpractice." It is found that the therapies, as used by Morgan, fell into none of Barnes' categories of wrong-doing. Noel pointed out that generally the complimentary therapies appear to have been self-prescribed by the patient.

QUALITY CONTROL IN THE OFFICE

37. The quality control problem in Morgan's office that is most specifically dealt with by Barnes was that the temperatures of his patients were overwhelmingly recorded as 98.6°. Barnes stated that she saw only one deviation from 98.6°. She stressed that all people were not made with the same temperature and that such uniformity was the result of "obvious fabrication."

38. A closer look at the temperatures in the files selected at random indicates that 30 out of 221, or 14%, were above or below the "normal" temperature, ranging from 97.0° to 99.4°

Barnes, however, gave no testimony as to the variation that could be expected..

39. Likewise Barnes wrote, "All the blood pressure reading [*sic*] are within the range of 120-48/75-86, except for one that is written in his handwriting at 180/100. This was after his assistant wrote 148/86 (Patient C, 11-14-97)!"

40. As with the temperatures, Barnes exaggerated. In about the same number of blood pressure readings as temperatures, 40 readings were outside Barnes' range. Only one patient (Patient E) had no abnormal readings. Patient G had 9 readings outside the range. There were several instances in which blood pressure had obviously been rechecked.

41. Relying on her inaccurate assessment of the uniformity of the temperature and blood pressure readings, Barnes also stated that Morgan's office laboratory possibly had poor quality control. However, Barnes presented no evidence of improper laboratory work--except her contention that protimes were outdated.

42. Neither Noel nor VonderHaar found anything amiss about the quality control in Morgan's office procedures or laboratory. It is found that Barnes' factual allegations were not correct, thus the charge of fabrication of vital signs and poor laboratory quality control were not supported by substantial evidence.

HEALTH MAINTENANCE CARE

43. Finally, Barnes testified that Morgan practiced no real preventive medicine. She conceded that some standard preventive measures were no longer as necessary for older patients. Some health maintenance, however, was dictated by the standard of care and the failure to oversee such preventive care as influenza shots, pneumovax, tetanus shots, and aspirin put the health of his patients at risk. Barnes testified that the standard of care was the health maintenance recommendations of the United States Preventative Services Task Force and other national

groups.

44. Noel and VonderHaar pointed out that Morgan's charts were not devoid of such care. Although a couple of charts were marked "patient refuses annual physical," most of the patients received a scheduled annual physical examination. Noel and VonderHaar both testified that because Morgan's clientele was fairly stable, the doctor would have checked out the patients piecemeal at follow-up visits in between annual examinations. The charts indicated that Morgan discussed weight and exercise with his patients. There was some preventive medicine. In October, 1998, Patient B and Patient E had flu shots and Patient J received a tetanus shot in November, 1997.

45. Barnes' evaluation was accurate, however, that the charts contained no consistent or even general preventive care. There were no regular flu shots or mammograms or suggestions that aspirin be taken to prevent heart attacks. Noel and VonderHaar were correct that Morgan's practice was strongly problem oriented. Barnes was convincing in terming the lack of preventive medicine protocols as placing Morgan's patients at risk by deviating below the standard of care.

46. Barnes testified about other matters of concern to her but findings are made only in regard to those items that are specifically delineated as the factual basis of the Complaint.

47. Barnes testified that the standards of care that she enunciated were for the Commonwealth as a whole and that no distinction was made in regard to the standard of care as to whether the doctor had a solo practice, a multi-physician practice, or was associated with an institution. She stated that the standard of care is based upon medical literature and studies, lectures, association with professional colleagues, published guidelines and other recognized medical sources.

48. Noel agreed to the same sources of the standard of care as Barnes delineated, but

Noel emphasized that the standard of care rested ultimately upon the actual practice of the physicians in the Commonwealth. It not based on an ideal but the reality of everyday practice. VonderHaar and Noel agreed that the standard of care varied according to sex, gender, age, and other factors. VonderHaar elaborated that, for instance, individuals in the 18-30 age range do not come in for annual examinations, women are more apt to schedule physicals than men are, and such. Thus in a sense the standard of care varies according to the factors relevant to each patient's situation.

CONCLUSIONS OF LAW

49. The initial allegation is that Morgan violated KRS 311.595 (13). That statute provides:

KRS 311.595 (13). Violated any agreed order, letter of agreement, order of suspension, or the terms or conditions of any order of probation, issued by the board.

50. The agreed order cited in the complaint is the Order Amending Agreed Order of Probation of September 14, 1999. Barnes criticized Morgan's failure to regularly adhere to the SOAP format which was stated in paragraph 2(f) of the Agreed Order. Included in the SOAP format is a plan of treatment, "P," which is required in paragraph 2(p). The only faulty record mentioned by Barnes after the Agreed Order of September 14, 1999, was in regard to Patient I. There were other post-Agreed Order entries that violated the required format. It is concluded that Morgan violated paragraphs 2(f) and 2(p) of the Order Amending Agreed Order of Probation. These failures are violations of KRS 311.595(13).

51. There was no testimony concerning violations of paragraphs 2(g), (h), (i), (j), (k), (l), (m), (n), (o) and (q) of the Agreed Order. A review of the records indicates that most patients only saw Morgan once or twice after September 14, 1999, so some of the Agreed Order

requirements were not relevant--such as requiring a physical on the initial visit, because none of the subject charts belonged to new patients; or coordination with the primary care physician, because Morgan *was* the primary care physician. The records revealed that patients were identified by social security number and date of birth; each entry was dated; vital signs were recorded at each office visit; follow-up status was generally noted. The general quality of Morgan's record keeping was improving. Because only two and one-half months of records had been compiled since the issuance of the Amended Order and because there was no testimony as to what would have been considered adequate compliance, no accurate evaluation could be made concerning many of the Order's requirements. There was not sufficient proof to find a violation of KRS 311.595(13) in regard to paragraph 2(g), (h), (i), (j), (k), (l), (m), (n), (o) and (q) in the Order Amending Agreed Order of Probation.

52. The second allegation contained in the Complaint stated that Morgan had violated KRS 311.595(9) as illustrated by KRS 311.597(2). Those statutory provisions state:

KRS 311.595 (9): Engaged in dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud, or harm the public or any member thereof; [as illustrated by]:

KRS 311.597 (2): Issues, publishes, or makes oral or written, representations in which grossly improbable or extravagant statements are made which have a tendency to deceive or defraud the public, or a member thereof....

53. It is concluded on the basis of the facts that were found above that there was no violation of KRS 311.595(9) as illustrated by KRS 311.597(2). There was no testimony nor documentary evidence to support the allegation.

54. The third allegation contained in the Complaint stated that Morgan had violated KRS 311.595(9) as illustrated by KRS 311.597(3). Those statutory provisions state:

KRS 311.595 (9): Engaged in dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud, or harm the public or any member thereof; [as illustrated by]:

KRS 311.597 (3): A serious act, or a pattern of acts committed during the course of his medical practice which, under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice.

55. As quoted above "gross negligence" includes "malice or willfulness" or "utter and wanton disregard of the rights of others," *Cooper v. Barth*, 464 S.W.2d 233, 234 (Ky. 1971), or "reckless disregard for the safety of other persons." *Hoke v. Cullinan*, 914 S.W.2d 335, 337, (Ky., 1995).

56. The charges under the heading "Failure to Work-up Illnesses," the failure to monitor the side-effects of Prandin in regard to Patient C, the failure to document office visits, and the charges under "Quality Control in the Office" were described by Barnes as gross negligence. These charges did not rise to the level of gross negligence.

57. As described in the facts above, Morgan was not malicious, willful, wanton or reckless in regard to the problems of Patient A, Patient B, Patient C, Patient E, Patient G, and Patient K. He was concerned about and attentive to their problems but dealt with them less aggressively and thoroughly than Barnes thought was proper. Noel and VonderHaar agreed that Morgan's treatment was acceptable. Barnes' allegation that Morgan failed to document his patients' office visits and ignored his office staff's fabrication of vital signs was simply not supported by the documentary evidence in the record. There was no substantial evidence in the record to prove that the laboratory work was incompetent or fabricated. Barnes herself admitted that her allegations in regard to the laboratory work was only a guess.

58. Barnes described the use of Lincomycin, Serapes, and protimes as "gross

ignorance." Barnes apparently considered "out-of-date" as equivalent to gross ignorance and that is not a valid equivalent. Morgan, Noel, and VonderHaar all testified convincingly about the benefits of Lincomycin and Serapes, pointing out that they still had useful and curative purposes although pharmaceutical producers had moved to other drugs. Morgan testified as to his knowledge about the drugs' limitations and side-effects--which is a problem with all drugs. VonderHaar agreed that a more accurate and universal test has been developed to test blood coagulation, but he not think that the use of protimes was egregious.

59. The problems of Patient A, Patient B, Patient C, Patient E, Patient G, and Patient K were also termed "malpractice" by Barnes. Black's Law Dictionary, 971, (7th ed.), defines "malpractice" as "An instance of negligence or incompetence on the part of a professional." "Negligence" is defined as: "A tort grounded in this failure, usu. expressed in terms of the following elements; duty, breach of duty, causation, and damages." *Id.* at 1056. KRS 311.597(4) provides discipline for "a failure to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky," *i.e.*, a breach of the duty to conform to a standard of care. Thus, by juxtaposition, malpractice in KRS 311.597(3) is impliedly a misstep less serious than "gross negligence" but more serious than "a failure to conform to the standard of care."

60. Based on Morgan's reluctance to transfuse or hospitalize Patient A despite the gravity of her condition and despite the general aggravating factors enumerated by Barnes as well as the dire consequences suffered by the patient, it is concluded that Morgan's treatment of Patient A was malpractice. It is concluded, on the basis of the expert testimony of Noel and VonderHaar, that Morgan's treatment of Patient B, Patient C, Patient E, Patient G, and Patient K was not malpractice.

61. The third allegation contained in the Complaint stated that Morgan had violated KRS 311.595(9) as illustrated by KRS 311.597(3). Those statutory provisions state:

KRS 311.595 (9): Engaged in dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud, or harm the public or any member thereof; [as illustrated by]:

KRS 311.597 (4): Conduct which is calculated or has the effect of bringing the medical profession into disrepute, including, but not limited to, any departure from, or failure to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky.... For the purposes of this subsection, actual injury to a patient need not be established.

62. Barnes, Noel, and VonderHaar were in fundamental agreement that the standards of acceptable and prevailing medical practice stem from a variety of sources, both formal and informal, such as conversations with fellow physicians, service on credentialing committees, learned treatises. Barnes placed more emphasis on published standards while Noel relied more on informal sources. Noel and VonderHaar agreed that the standards of practice vary according to the factors governing the situation. There was agreement in the legal arguments of the parties that the standard is the minimum safe, effective, and acceptable treatment prevailing in the Commonwealth.

63. The factual statements in the Complaint lists 12 deviations from the standard of care based on Barnes' review of the charts of 11 of Morgan's patients. The same situations were also termed gross ignorance, gross negligence, or malpractice by Barnes.

64. Based on the testimony of Noel and VonderHaar, it is concluded as a matter of law that Morgan's failure to use the SOAP format to document the majority of his patients' visits was not a departure from, or failure to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky.

65. Based on the testimony of Noel and VonderHaar, it is concluded as a matter of law that Morgan did not depart from, or fail to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky in failing to work up, hospitalize, or refer to a specialist Patient B, Patient E, Patient G, or Patient K.

66. Based on the factual evidence in the record, it is concluded as a matter of law that Morgan did not depart from, or fail to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky in regard to his treatment of Patient D. Morgan did give Patient D a tetanus booster.

67. Based on the evidence in the record, it is concluded as a matter of law that Morgan did not depart from, or fail to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky in regard to Morgan's follow-up on Patient C's use of Prandin.

68. Based on the testimony of Barnes, it is concluded as a matter of law that Morgan departed from, or failed to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky in regard to Morgan's failure to follow-up on the abnormal laboratory results of Patient C, Patient E, Patient H, and Patient I.

69. Based on the testimony of Noel and VonderHaar, it is concluded as a matter of law that Morgan's use of Lincomycin was not a departure from, or failure to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky.

70. Based on the testimony of Noel and Morgan, and the uncertainty of Barnes as well as the documentary evidence, it is concluded as a matter of law that Morgan did not depart from, or fail to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky in his use of vinegar and hydrotherapy.

71. Based on the testimony of Noel and VonderHaar, as well as the office charts introduced into the record it is concluded as a matter of law that Morgan did not depart from, or fail to conform, to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky in regard to the quality control in Morgan's office and laboratory.

72. Based on the testimony of Barnes and the office charts introduced into the record, it is concluded as a matter of law that Morgan departed from, or failed to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky concerning health maintenance care or preventative medicine.

73. Having found that Morgan violated KRS 311.595(9) as illustrated by KRS 311.597(3) in regard to his malpractice concerning Patient A and that he violated KRS 311.595(9) as illustrated by KRS 311.597(4) in regard to his breach of the standard of care concerning his failure to follow up on abnormal laboratory values, his continued use of Protimes rather than INR, and his lack of health maintenance care, it is concluded that Morgan violated KRS 311.595(13) in regard to paragraph 2(t) of the Agreed Order.

74. The recommended discipline in this matter takes into account the fact that Kirk Morgan's license has been suspended since March 16, 2000. Thus Morgan has been punished for three years. Morgan has served sufficient time in suspension. He should be reinstated into the profession--but in such a manner that will rehabilitate his skills and protect the public. He should be placed on probation on rehabilitative terms.

75. In formulating the terms of Morgan's reinstatement, the CPEP Executive Summary should be considered. In her deposition which explained the goals and purposes of CPEP and the evaluative process that Morgan underwent, Illige was asked by the attorney for the Board: "Did you see any of the same concerns raised by Dr. Barnes that were raised during the

assessment by CPAP [*sic.*]?" Illige responded: "The issues seemed similar in terms of unacceptable patient care documentation and evidence of problems with both medical knowledge and clinical judgment, yes." Ex. 19 at pp. 54-55. The issues, however, translate only generally across the different formats--standardized and personalized testing versus an administrative hearing. Also CPEP was judging Morgan against the best that he should be while the statutes of the Commonwealth only demand an adherence to the lowest standard of acceptable care.

76. The bottom line conclusion of CPEP was "Because of the extent of the deficiencies identified and concerns that his care may put patients at risk, Dr. Morgan should retrain in a residency setting. Dr. Morgan did not demonstrate the ability to remain in independent practice while attempting to remediate his clinical skills." Ex. 19, ex. A at 21.

77. VonderHaar, Noel, and Morgan himself pointed out that there were significant reservations and qualifications to accepting CPEP's harsh recommendation. Morgan had been out of practice for over a year at the time of the evaluation. Morgan was naturally tense and stressed about the possible effect of the assessment on his future. The computerization of much of the testing was an unfamiliar mode for Morgan.

78. It also is to be recognized that Morgan went to CPEP in good faith in order to work to get his license back. He accepted the outcome in good grace and contacted over 50 residency programs in order to retrain. Because he had been out of school for many years, because of Medicare payment limitations, because he could not obtain medical malpractice insurance, no one would accept Morgan as a resident.

79. There should be some way to remediate and relicense Kirk Morgan.

RECOMMENDED ORDER

Being sufficiently advised, IT IS HEREIN RECOMMENDED that Kirk Morgan be placed on PROBATION on such terms as are acceptable to Kentucky Board of Medical Licensure.

Exhibits 3-17 are SEALED in order to protect the privacy of the patients.

NOTICE OF EXCEPTION AND APPEAL RIGHTS

Pursuant to KRS 13B.110 (4) you have the right to file exceptions to this recommended decision:

(4) A copy of the hearing officer's recommended order shall also be sent to each party in the hearing and each party shall have fifteen (15) days from the date the recommended order is mailed within which to file exceptions to the recommendations with the agency head.

You have a right to appeal the Final Order of the agency pursuant to KRS 13B.140 which reads in part:

(1) All final orders of an agency shall be subject to judicial review in accordance with the provisions of this chapter. A party shall institute an appeal by filing a petition in the Circuit Court of venue, as provided in the agency's enabling statutes, within thirty (30) days after the final order of the agency is mailed or delivered by personal service. If venue for appeal is not stated in the enabling statutes, a party may appeal to Franklin Circuit Court or the Circuit Court of the county in which the appealing party resides or operates a place of business. Copies of the petition shall be served by the petitioner upon the agency and all parties of record. The petition shall include the names and addresses of all parties to the proceeding and the agency involved, and a statement of the grounds on which the review is requested. The petition shall be accompanied by a copy of the final order.

Pursuant to KRS 23A.010(4), "Such review [by the Circuit Court] shall not constitute an appeal but an original action." Some courts have interpreted this language to mean that summons must be served upon filing an appeal in Circuit Court.

SO RECOMMENDED this 12th day of May, 2003.

Susan S. Durant

SUSAN S. DURANT
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CERTIFICATE OF SERVICE

I hereby certify that the original of this ORDER was mailed this 12th day of May, 2003,
by ~~first class mail, postage prepaid~~, to:

Hand Delivered
JILL LUN
KY BOARD OF MEDICAL LICENSURE
HURSTBOURNE OFFICE PARK SUITE 1B
310 WHITTINGTON PKWY
LOUISVILLE KY 40222

for filing; and a true copy was mailed, postage prepaid, to:

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Executive Summary

Kirk Deeb Morgan, M.D.

May 14 – 16, 2001

This is a condensed summary of findings detailed fully in the accompanying report for Kirk Deeb Morgan, M.D.

REASONS FOR ASSESSMENT: Kirk Deeb Morgan, M.D. is a 55 year-old family physician who presented voluntarily for an Assessment with Colorado Personalized Education for Physicians (CPEP) while in the process of an investigation by the Kentucky Board of Medical Licensure (Board). A Board investigation found that Dr. Morgan failed to conform to a standard of record keeping, work-up life-threatening conditions, provide complete care, monitor a patient adequately for side effects of medication, follow-up abnormal laboratory values, and provide preventive care; he also was found to use outdated, less effective therapies. The Board placed an Emergency Order of Suspension on Dr. Morgan's Kentucky license on March 16, 2000. He has a reciprocal suspension in Indiana.

BACKGROUND: Dr. Morgan is a graduate of University of Louisville School of Medicine in Kentucky. After a rotating internship at University of Louisville, he joined a family practice residency at Valley Medical Center in Fresno, California. He then returned to the University of Louisville to complete his family practice training. Dr. Morgan was board certified but failed the recertification exam in his fourth seven-year cycle, chose not to retake the exam, and is therefore no longer certified. Dr. Morgan is currently employed in automotive sales.

OVERVIEW OF ASSESSMENT MODALITIES	
<i>Standardized Testing</i>	<i>Personalized Testing</i>
Cognitive Function Screen	Two Structured Clinical Interviews (SCI)
Primum Computer Case Simulations	Transaction Stimulated Recall Interview (TSR)
Mechanisms of Disease MCQ Exam	Physician-Patient Communication Evaluation
	Family Practice Multiple Choice Exam
	Simulated Patient Chart Review
	Electrocardiogram Interpretation
	Personal Preference Inventory
<i>Additional Assessments</i>	
Review of Health Information	CPEP Staff Observations of Participant Behavior

Note: CPEP cannot resolve the issue of the proper place of alternative and complementary medicine in practice in the United States.

IMPRESSIONS: As detailed fully in the body of this Report, Dr. Morgan demonstrated significant deficiencies in several areas during this Assessment. Dr. Morgan's medical knowledge was limited and showed specific weaknesses in several areas. An analysis of Dr. Morgan's cognitive function screen suggests possible difficulties in the areas of learning and memory requiring further evaluation. In addition, questions about Dr. Morgan's cognition arose throughout the Assessment process. Dr. Morgan demonstrated an overall disorganized approach and inattention to detail, and showed no structured, evidence-based approach to diagnosis and treatment. His communication skills were marginal.

Regarding documentation, Dr. Morgan was able to generate progress notes at CPEP that were effective in conveying what transpired during simulated patient encounters. However, a review of records from Dr. Morgan's former practice did not demonstrate this and lacked critical information. Dr. Morgan's office charts were found to be disorganized and lacking detail in critical areas. Demonstrated abilities were not sufficient to support Dr. Morgan returning to the practice of medicine independently without first engaging in extensive re-education.

RECOMMENDATIONS: Dr. Morgan needs to obtain a diagnostic neuropsychological evaluation. In light of his overall poor performance, he deserves a comprehensive work-up to identify any conditions which might interfere with his ability to function at the high level required for medical practice as well as his ability to participate in an intensive, remedial education program. If further testing does not demonstrate any impairment, CPEP recommends that Dr. Morgan engage in a fully supervised education program, such as a residency, because of the extent of his problem solving difficulties.

Assessment Report

Kirk Deeb Morgan, M.D.
May 14 - 16, 2001

I. Reasons for Assessment

[The CPEP Medical Education Director (MED) obtained this information from conversations with Dr. Morgan and from documents submitted by Dr. Morgan and the Kentucky Board of Medical Licensure.]

Kirk Deeb Morgan, M.D. was subject to an Emergency Order of Suspension by the Kentucky Board of Medical Licensure (Board) on March 16, 2000 and has not practiced in Kentucky since that time. He discontinued practice in Indiana shortly thereafter. The investigation that prompted the suspension began following a grievance submitted to the Board by the daughter of a patient who died while under the care of Dr. Morgan. The daughter alleged that Dr. Morgan provided inappropriate care to her mother related to monitoring for and treatment of side effects of anti-inflammatory pain medication. The patient developed a bleeding ulcer and eventually died.

Dr. Morgan had been subject to previous investigations and actions of the Board. An Agreed Order was placed upon his medical license in 1991, implementing restrictions regarding his use of chelation and intravenous (IV) hydrogen peroxide therapy. Subsequently, the Board issued another Agreed Order in 1994, stating that Dr. Morgan would not utilize chelation therapy or ethylene diamine tetra acetic acid (EDTA), IV hydrogen peroxide, or IV Germanium. In 1996, after two complaints alleging that Dr. Morgan had recommended oral hydrogen peroxide therapy and was referring patients to another physician located out of state to receive chelation therapy, the board issued an Agreed Order of Probation of five years duration. At the request of Dr. Morgan, an Amendment was issued on September 14, 1999, removing chelation therapy from the terms and conditions of probation; this occurred after the Board considered material submitted by Dr. Morgan, including protocols and patient charts for review. In addition, this Amended Order of Probation detailed conditions of the probation which required Dr. Morgan to adhere to various standards of record keeping, including keeping legible records, maintaining charts in the "SOAP" format, obtaining informed consent before procedures, including an accurate and current history of the medical problem being treated, validating diagnoses by objective means, formulating a plan of treatment for each patient, indicating if a patient has allergies and clearly noting such allergies, taking vital signs on all patients, keeping detailed logs of patients administered EDTA, among other items.

During the most recent investigation, the Board determined that Dr. Morgan violated the Order of Probation issued in September of 1999. Specifically, that Dr. Morgan had failed to conform

to a standard of record keeping. The Board was also concerned about patient safety after considering a report submitted by a physician consultant based on chart reviews of eleven of Dr. Morgan's patients. The consultant detailed cases where Dr. Morgan may have failed to recognize a potentially life threatening situation or failed to treat such a situation appropriately: an elderly patient with an acute gastrointestinal (GI) bleed and a hematocrit of 22% who was not immediately hospitalized and subsequently died; a patient whose electrocardiogram (ECG) was recognized as a possible myocardial infarction (MI) by Dr. Morgan, but for whom there was no documentation that admission was recommended; and a patient whose ECG was suspicious for ischemia with no indication in the chart that these changes were recognized or acknowledged by Dr. Morgan.

In one case outlined in the report, the consultant states that, despite a letter from a consultant indicating a patient was experiencing side effects of a medication, Dr. Morgan did not document any subsequent education of the patient regarding this or change in management to avoid such side effects. There were a number of cases described by the consultant where she noted that there was no apparent follow-up of abnormal laboratory values.

The consultant noted indications that Dr. Morgan, in several instances, used out-dated, less effective therapies, such as the use of older antibiotics, for instance intramuscular (IM) Lincomycin; use of older, centrally acting antihypertensives with high side-effect profiles; and failure to choose an ACE inhibitor in a patient with diabetes and hypertension. In addition, the consultant reported Dr. Morgan's use of therapy of questionable or unproven benefit: use of Lecithin and Lipex to treat hyperlipidemia in a patient with known coronary artery disease and vinegar for a treatment of congestive heart failure. The report also documented use of outdated or unconventional laboratory testing; for example, the use of prothrombin time (PT), rather than International Normalized Ratio (INR), to monitor patients on coumadin therapy, and the use of T4, rather than thyroid stimulating hormone (TSH), to monitor a patient on thyroid replacement.

These findings led the Board to proceed with the suspension of Dr. Morgan's medical license. Dr. Morgan's objectives of participating in the Assessment with Colorado Personalized Education for Physicians (CPEP) were two-fold. He hoped to provide the Board with additional information to support reinstatement of his license. In addition, he stated he hoped "to gain awareness of current private medical practice standards in office and hospital settings." Dr. Morgan desires to return to practice, perhaps in association with another physician interested in chelation therapy.

II. Education and Practice History

[The CPEP MED obtained this information from verbal and written information submitted by Dr. Morgan.]

Dr. Morgan is a 55 year-old family physician from Louisville, Kentucky. He received a B.S. from Murray State University in 1967. He then attended University of Louisville School of Medicine, KY, graduating in 1971. At this point in time there were very few residency programs

available in family practice. After a rotating internship at University of Louisville, since the family practice program in Louisville was still in development, Dr. Morgan spent his second year of residency at Valley Medical Center in Fresno, CA. He then returned to the University of Louisville as chief resident in family practice. Dr. Morgan noted that he was the first family physician in Kentucky to be both residency-trained and board-certified.

Dr. Morgan initially certified in family practice in 1974, and recertified in 1980 and 1986. His subsequent attempt to recertify was unsuccessful, and Dr. Morgan felt that it would be difficult to devote the time necessary to prepare; therefore, he did not attempt to recertify again. He is, however, certified by the American Board of Chelation Therapy since 1987 with recertification in 1993 and 1999. The American Board of Chelation Therapy is not recognized by the American Board of Medical Specialties.

Dr. Morgan's licenses in Kentucky and Indiana are suspended, pending the outcome of the Kentucky Board's current investigation. Dr. Morgan was licensed in California from 1972 until 1977.

Following residency, Dr. Morgan continued a relationship with the University of Louisville as the Director of the Family Medicine Residency Program, 1977 until 1978. He remained a clinical instructor with the University for the following year and served as a clinical advisor to the residents in 1979, 1980, and 1983. Dr. Morgan was a preceptor from 1983 until 1987.

Dr. Morgan also held locum tenens positions during his first three years of practice. In addition to continuing locum tenens work until 1985, Dr. Morgan began a solo medical practice in a suburb of Louisville in 1977 where he practiced until March 2000. After his father retired, Dr. Morgan managed his father's solo medical practice from January 1997 through March 2000. Dr. Morgan also reported practicing during the Spring of 2000 in Clarksville, Indiana in a two-physician practice. Dr. Morgan stated that during his last twelve months of practice, he saw 20 patients per day. He estimated that 50% of his patients were older than 65 years of age and only 5% were pediatric patients. Dr. Morgan did not provide obstetric care. He saw approximately 40 patients per month at local long-term care facilities or in their homes.

In his former practice, Dr. Morgan performed ECGs and X-rays; neither of these tests were routinely over-read, but he had means to have this done electively. Other procedures routinely performed by Dr. Morgan included arthrocentesis, treatment of fractures, flexible sigmoidoscopy, Holter monitoring, and minor surgeries, such as vasectomies and removal of skin lesions. His office was equipped with a "crash cart" and defibrillator. He has not participated in inpatient care for the past five to six years, having resigned hospital privileges while under investigation by the Board.

Dr. Morgan is currently employed as an automobile salesman. While out of practice, he continues to read articles from *American Family Physician*, *Family Practice Management*, *Journal of the Kentucky Academy of Family Physicians*, *Journal of the Kentucky Medical Association*, and *Journal of Advancement in Medicine*. Texts that Dr. Morgan referred to while in practice included Conn's Current Therapy, Physician's Desk Reference, The Merck Manual,

Textbook of Family Practice (Rakel), The Principles and Practice of Internal Medicine (Harvey), and others. The most recent CME attended was the Kentucky Academy of Family Practice Scientific Assembly in May 2000.

Dr Morgan has had three malpractice suits filed against him. The first, in 1982, was dismissed. The remaining two cases were in 1994. One concerned allegations of harm from IV hydrogen peroxide and was settled. The basis of the other suit was a claim of harm from IV hydrogen peroxide and Germanium; this case went to trial and resulted in a judgment in the plaintiff's favor.

III. Evaluation of Medical Knowledge and Clinical Performance

This section consists of the following content: Two clinical interviews, a transaction stimulated recall interview, two multiple choice examinations covering topics in family practice and basic mechanisms of disease, electrocardiogram interpretation, and simulated patient encounter chart notes.

A. Structured Clinical Interview (SCI) #1:

The first consultant was a board certified family physician and faculty member of a community-based family medicine residency program. The consultant conducted an interview based on two hypothetical cases. He also reviewed seven charts submitted by Dr. Morgan.

The majority of charts were from patients that Dr. Morgan followed for long-term primary care. Appropriately, each chart was divided into progress notes, lab results, and a section for other results such as ECGs and chest X-rays (CXR). In addition, all of the charts had a problem list of both acute and chronic conditions. The consultant noted that most of the progress notes were legibly written or transcribed in a brief "SOAP" format.

However, the consultant expressed many concerns about Dr. Morgan's documentation. The progress notes were brief and often did not include any physical exam findings. Many visits did not have sufficient documentation to substantiate the diagnosis. There were cases where there was inadequate demonstration of the reason certain laboratory studies were ordered, and one case where it appeared that lab studies that the chart note indicated were to be done were never obtained. Lab results had no documentation indicating that the results were communicated to the patient. The only indication that the lab results were reviewed was a single check mark on the lab sheet. In addition, the consultant found numerous examples in which there was no documentation that abnormal lab findings were addressed.

In one chart reviewed, Dr. Morgan ordered an AMAS (Anti-Malignin Antibody in Serum), as he did for several other patients. The consultant had two concerns with this intervention. The consultant questioned the validity of this test as a screening tool for neoplasia; it is not a generally accepted method of cancer screening. Dr. Morgan did not document adequate rationale for obtaining this test. There was no notation as to why the test was obtained, nor was

there documentation that the test results (above normal in this case) were addressed when they became available.

The consultant questioned the appropriateness of Dr. Morgan's use and choice of antibiotics. There were several examples where Dr. Morgan addressed patient complaints of upper respiratory symptoms with both intramuscular injections of antibiotics and oral antibiotics. The consultant noted that Dr. Morgan's physical exam documentation to support such intervention was most often scant or completely absent.

The consultant noted that, based on review of documentation, Dr. Morgan did not utilize appropriate and accepted strategies in screening and managing diabetes and thyroid disease. The consultant observed that Dr. Morgan routinely screened patients for diabetes with a Hemoglobin A1C in his office. He also routinely screened patients for thyroid disease with a T4 assay. In addition, it appeared that Dr. Morgan monitored patients on thyroid medication with T4 assays rather than TSH.

One of the charts reviewed by the consultant raised concern regarding Dr. Morgan's management of patients on cholesterol-lowering therapy. The patient was treated over a long period of time with statins for hyperlipidemia (Pravachol and, later, Zocor), but there was no evidence that Dr. Morgan routinely checked the patient's liver function tests to monitor for adverse effects of the medication.

Based on the charts reviewed, the consultant noted that Dr. Morgan did not apply accepted principles of the treatment of hypertension. For example, in one encounter, Dr. Morgan documented dispensing samples for five different antihypertensives (two calcium channel blockers, one angiotensin II receptor blocker, and two ACE inhibitors) in response to the patient reporting that he was unable to obtain insurance coverage for his current antihypertensive. Dr. Morgan did not clearly document a plan or direction for these new medications. On a follow-up visit three months later, Dr. Morgan documented giving the patient a prescription for spironolactone 25 mg., with directions to take "1 or 2 BID to TID" in combination with the lisinopril. The consultant noted that there was no note referring to the disposition of the previously dispensed medications or how the patient was to manage this broad dosage-range prescribed.

During the interview, the first hypothetical case described to Dr. Morgan was that of a 68 year-old female; the consultant asked Dr. Morgan to describe how he would manage this patient if she presented with the intention of transferring her primary care needs to him from a previous physician. The consultant noted that Dr. Morgan was disorganized in his approach. The consultant redirected Dr. Morgan to specifically describe his review of systems. Although Dr. Morgan organized his review in the traditional order of "head-to-toe," the consultant observed that it lacked sufficient thoroughness.

This first case generated several focused discussions about thyroid disease, urinary incontinence, lipid disorders, and diabetes. The consultant thought that Dr. Morgan demonstrated a significant lack of knowledge about these basic primary care concerns. For example, he was unable to list

the basic forms of urinary incontinence commonly experienced by post-menopausal females. Dr. Morgan incorrectly described the rationale and protocol for monitoring thyroid function. Although Dr. Morgan discussed the combined use of TSH and T4 assays to screen and monitor thyroid function, the consultant commented that there was no evidence in the charts that Dr. Morgan ever uses TSH.

Dr. Morgan could not adequately list the components and roles of a standard lipid profile. In addition, Dr. Morgan listed only three interventions for hyperlipidemia: calcium channel blockers, dietary changes, and chelation therapy. The consultant noted that calcium channel blockers are not an indicated therapy for hyperlipidemia. The consultant reported that Dr. Morgan's suggestion to use chelation as a treatment for hyperlipidemia has no substantiation in the medical literature. Finally, the consultant thought it was significant that Dr. Morgan omitted exercise, statins, niacin, and sequestering agents from the list of possible interventions.

The consultant noted a similar lack of basic understanding of diabetes. Dr. Morgan could not describe standard screening protocols for diabetes, nor could he explain the diagnostic criteria for diabetes. He could not state why ACE inhibitors are indicated for diabetic nephropathy and was unaware of the use of microalbuminuria in the screening for nephropathy. Finally, Dr. Morgan could not name any medicines that could potentially impair renal function.

The consultant next asked Dr. Morgan about a 40 year-old male with a one-week history of cough and tactile fever. The consultant noted that Dr. Morgan was again disorganized in his approach to this patient. During the discussion, the consultant noted that Dr. Morgan made unsubstantiated assumptions about the patient's smoking and alcohol history. Dr. Morgan described an overly limited physical exam and never asked for vital signs.

The consultant also observed that Dr. Morgan prematurely intervened with antibiotic therapy before having all the necessary information to formulate an appropriate therapeutic plan. In addition, the consultant thought that Dr. Morgan's choice of medicine, intramuscular penicillin, was an inappropriate route of administration for the patient and did not provide adequate coverage for community-acquired pneumonia.

The consultant thought that Dr. Morgan demonstrated significant deficits in his understanding of this common primary care presentation. When asked about the indication for hospitalization, Dr. Morgan did not list any objective criteria, but instead stated that he could determine if the patient needs to be hospitalized by the "glaze in his eyes" and the history of fever. Dr. Morgan presented inadequate justification for obtaining a CXR in this patient, stating that he would want to get one for "baseline purposes." Finally, when asked about the possibility of viral etiologies, Dr. Morgan agreed that this was a possibility, but then incorrectly identified Mycoplasma as a virus.

SCI #1 Summary: The consultant thought that Dr. Morgan's medical knowledge was inadequate with many deficits regarding common primary care issues. Dr. Morgan demonstrated a lack of understanding of disease processes and a failure to utilize accepted medical practices. The consultant was concerned about Dr. Morgan's clinical judgment, noting that Dr. Morgan

made inappropriate patient care decisions in both the charts and in the case discussions. His patterns of reasoning were disorganized and undisciplined, often based on inadequate or incorrect information. He did not attempt to gather the appropriate information and he often made assumptions about the patient's complaints. Regarding Dr. Morgan's patient care documentation, the consultant noted the components of appropriate documentation, such as problem lists, and section dividers; however he found that actual documentation was disorganized and ineffective.

B. Structured Clinical Interview #2:

The second consultant is a board-certified family physician, in private practice, with a particular interest in geriatrics. Prior to the interview, this consultant reviewed six charts that Dr. Morgan had submitted and then used three of these for the basis of the interview.

The consultant noted that the charts were disorganized, overall. While Dr. Morgan attempted to provide structure using problem lists, the notes were incomplete and usually missing important data. For example, there was no consistent allergy marker, the medication lists were incomplete and not updated, and the problem lists were disorganized and confusing. Additionally, there was no periodic screening flow sheet, diabetic or hypertensive flow sheets, or a structured format for documentation of immunizations. There was little attention to periodic health screening and preventative care noted.

The consultant first asked Dr. Morgan about a 73 year-old woman with multiple medical problems including chronic renal failure, diabetes mellitus, atherosclerotic coronary artery disease, and congestive heart failure. This patient was seeing several other physicians for her medical problems and was followed by Dr. Morgan on an intermittent basis. Dr. Morgan thought he was aware of the other treating physicians interventions, but the consultant found little documentation regarding the patient's concurrent medical care in the chart.

An ECG was available in the chart and Dr. Morgan was asked to interpret this tracing. Dr. Morgan identified a 'bundle branch block' but was unable to decipher if this was right or left. When directed, Dr. Morgan appreciated ST-T abnormalities; he was unable to identify if these were related to the bundle branch block or if these were ischemic changes. When discussing ischemic blood markers, Dr. Morgan mentioned creatine phosphokinase (CPK), but did not mention troponin.

Using this patient as an example, this consultant described a hypothetical scenario in which this patient presented with increased volume overload, possibly congestive heart failure, and this ECG. Dr. Morgan was asked how he would evaluate and treat this patient. In his response, Dr. Morgan was disorganized, however eventually described an evaluation that would include a digoxin level, potassium level, complete blood count, and chest X-ray. The plans Dr. Morgan considered as potentially appropriate for this situation ranged from sending the patient home, checking an ECG every 15 minutes, rechecking the patient in a month, or writing a note to her cardiologist. Last, Dr. Morgan added that he could have called her cardiologist and discussed this ECG and clinical findings. The consultant commented that the differential in this scenario

would have included inadequate volume reduction during dialysis as well as an ischemic event leading to increased cardiac decompensation. The appropriate care would have been to hospitalize her, or at least request immediate specialty evaluation. The consultant was disturbed with the disorganization of Dr. Morgan's response, and was not confident that Dr. Morgan would have made a decision that was appropriately aggressive.

It was unclear from the chart review if this patient was receiving any form of anticoagulation therapy. When asked about anticoagulation, Dr. Morgan decided that anticoagulation would be dangerous. The consultant noted that for this patient, current practices would include anticoagulation.

Last, this patient was seen on June 22, 1999 with "severe abdominal pain and left leg pain." A chart entry for this evaluation was made following the next visit on July 22, 1999. This late entry did not mention the abdominal pain and lacked any patient instructions, follow-up directions, or treatment rendered.

Discussing this severe abdominal pain, the consultant asked for a diagnostic differential. Dr. Morgan's differential included arthritis, myocardial infarction, constipation and lastly "possibly ischemia." The consultant was concerned with Dr. Morgan's disorganized response, especially with the most serious concern being last on his differential. The consultant was concerned that Dr. Morgan would fail to recognize and appropriately evaluate this patient's complaint.

The consultant then asked Dr. Morgan about an 80 year-old female with multiple medical problems. The patient had been admitted to the hospital in 1993 following an acute episode of confusion and disorientation. Documentation of Dr. Morgan's admission history and physical was again disorganized, but did primarily address this neurologic event. During this admission, Dr. Morgan provided supportive care, routine laboratory testing and intravenous fluids, but did not pursue any further diagnostic testing. The patient was discharged the next day without a head computed tomography (CT) scan, anticoagulation, or documentation regarding his thoughts, treatments, patient education, or follow-up instructions.

The consultant asked how Dr. Morgan would approach this patient today, approximately nine years later. Dr. Morgan, instead, defended his previous decisions, stating that further testing was not done because the patient was indigent and unable to afford the diagnostic tests. This evaluator disagreed with this reasoning but noted that if a standard evaluation was not performed, then the chart should document a conversation with the patient where the risks of future neurologic events are clearly described and witnessed by family members or someone else close to the patient. This was not done.

Without financial considerations, Dr. Morgan stated that a head CT scan would be indicated and other work-up could include a "heart ultrasound" looking for "thrombus, ejection fraction and valvular disease." Dr. Morgan indicated that he would order an ultrasound of the carotid arteries as well. Dr. Morgan was aware of different types of strokes and different treatment for different types of strokes. He discussed Coumadin, but in this case, was reluctant to use this treatment. He was in favor of low dose aspirin. The consultant noted the appropriate aspects of Dr.

Morgan's proposed work-up and treatment for ischemic cerebrovascular accidents, although noting that usually a full aspirin dose is used.

The consultant next presented a 61 year-old female with multiple problems including hypertension, diabetes mellitus, and atherosclerotic vascular disease. This woman was receiving Dilantin and when asked about the indication for Dilantin in this particular patient, Dr. Morgan was unable to explain the reason this patient was taking this medication. Despite a review of the chart by Dr. Morgan, the indication for Dilantin was not identified.

Dr. Morgan was asked about his management of diabetes mellitus. He stated that he regularly monitored glycosylated hemoglobin and advised this patient on diet and exercise. No physical examination documentation was found. For example, there was no documentation of eye or foot examinations. There was no documentation of preventative discussion regarding shoes, nail care, etc. There were no referrals for eye exams or notes in the chart regarding ophthalmologic visits. As previously noted, the medication list was incomplete. The consultant was not certain what diabetic medications the patient was taking.

Last, the consultant presented a case from his practice, an elderly, chronic renal failure patient with decreased TSH and decreased T4. Dr. Morgan, after reviewing these lab results, thought of T3 thyrotoxicosis, and abruptly began discussing an old professor's preference to save serum on his thyroid cases. Dr. Morgan failed to mention pituitary failure as a possible explanation.

SCI #2 Summary: Although Dr. Morgan's medical knowledge demonstrated some areas of average performance, the consultant noted areas of significant deficit. In the discussion, with direction provided by the consultant, Dr. Morgan, with effort, was generally able to develop a limited differential, able to recognize most medical problems, and utilize specialists appropriately. Areas in which Dr. Morgan showed deficits during this interview included recognition and management of serious medical conditions, endocrinology, and utilization of appropriate laboratory studies in acute and chronic conditions. The consultant expressed concern regarding Dr. Morgan's clinical judgment. During this evaluation, Dr. Morgan's approach to clinical problem solving was without structure. He had difficulty formulating and prioritizing a reasonable differential. The consultant was unsure if Dr. Morgan had the ability to apply his knowledge in a reasonable and systematic fashion. Documentation was poor and generally disorganized. The consultant also indicated that Dr. Morgan's verbal communication skills were not effective; Dr. Morgan was disorganized and tangential. His apparent difficulty with focus and attention concerned the consultant.

C. Transaction Stimulated Recall (TSR) Interview:

Dr. Morgan told the consultant that he has used a computer but not for patient care or simulations. He was a bit frustrated with the program and found it difficult to enter orders that the computer would accept. He stated that he was unsure if he was to enter a diagnosis as soon as it became clear to him, or if he was to continue caring for the patient. The computerized setting did not allow Dr. Morgan to ask patients how they were doing, as he would have preferred.

When asked to rate himself in this exercise, he was unsure. He thought his care would have been reasonable had these been office patients. In one case, however, he was not satisfied. The consultant noted that the review of the transcripts revealed poor performance. Dr. Morgan's self-assessment overestimated his actual management.

Dr. Morgan answered questions regarding all eight cases in the review. He recorded the correct diagnosis in three of the eight cases. In the interview, Dr. Morgan demonstrated that he knew two additional patients' diagnoses. He came to the wrong conclusion in the remaining three patients. When the consultant reviewed those three cases, she asked about key findings in two and as a result, Dr. Morgan deduced the correct diagnoses during the interview. In the one remaining case, Dr. Morgan listed the actual condition in his differential and a physical finding supported this; however, his workup failed to address the possibility. In this case, Dr. Morgan stayed with his initial, incorrect, impression. The consultant concluded Dr. Morgan displayed a tendency to overlook important data and may be inflexible in his thinking.

During the discussion, the consultant read brief descriptions of three cases. She then asked for a differential diagnosis. When the symptoms were in a physical location, Dr. Morgan listed the potential major and some minor causes. When the symptoms were general, he considered most, but not all, major and few minor possibilities. Dr. Morgan did not describe his organizational approach to differential diagnosis when asked. Although Dr. Morgan was hesitant in his responses, the consultant thought that Dr. Morgan displayed the ability to use anatomy as a guide.

Dr. Morgan demonstrated some limited breadth and depth of medical knowledge during the interview. He described the origin and mechanisms of symptoms and body responses. He understood the principles of certain laboratory tests. In each case simulation, Dr. Morgan obtained the history and physical exam first. He then ordered a set panel of laboratory tests. During the review, he interpreted most studies correctly. However, he did not demonstrate current knowledge of laboratory findings and diagnosis in endocrinology. He failed to note complete health-screening recommendations for cancer. He stated incorrect choices for antibiotics and hormones. He did not display knowledge of indications for discrete testing. One study modality he described in cardiovascular medicine was outmoded.

Dr. Morgan's management strategy appeared to be aimed to prepare patients for consultants and avoid poor outcomes that he had experienced in the past. During the simulation, he provided timely workup and appropriate treatment in two of eight cases. In these, he displayed good knowledge and a suitable approach, missing only a few particulars. However, during the simulation, he failed to address important data and/or was slow to respond to findings in multiple cases. For example, in a pediatric case simulation Dr. Morgan obtained a significantly abnormal vital sign and laboratory test result, yet did not act on these findings. In the same case, he responded to an abnormal situation only after repeated prompts about the circumstance. In the discussion, Dr. Morgan advised the consultant of steps he would take but had not recorded in the other six cases. However, he still described workups and regimens in some that were incomplete or not in keeping with the current literature. For example, Dr. Morgan placed one urgent

problem into the wrong organ system; in another acute situation, he suggested possibly ineffective treatment. In a semi-urgent case, he knew the diagnosis but provided only partial therapy. His actions could have resulted in poor outcomes in more than half the cases.

TSR Summary: The consultant thought that Dr. Morgan demonstrated limited breadth and depth of medical knowledge; however he needed updating, specifically in the areas of cardiology, endocrinology, health screening, pediatrics, and pharmacology. He displayed the ability to reason logically but not flexibly. He did not demonstrate the ability to recognize important complaints, to address significant laboratory findings, and/or to provide appropriate treatment in six of the eight cases during the simulation. During the interview, Dr. Morgan demonstrated knowledge about areas he overlooked in the test. However, he did not consistently act on that knowledge. He showed an organized initial approach to patient care during the simulations, but did not display a structured, analytical, evidence based plan to pursue diagnoses and treatments. This is poor performance.

D. Multiple Choice Question (MCQ) Knowledge Test

Dr. Morgan completed a 105-item family practice exam as well as a 120-item test covering mechanisms of disease.

On review of the family practice exam, it was noted that several of the questions that Dr. Morgan answered incorrectly were in the areas of infections disease and pediatric development. Thus, the results indicated a need for review in those areas.

In the test covering mechanisms of disease Dr. Morgan achieved a score of 63% correct. This represents the 20th percentile of performance of a group of 761 physicians who took this test. This is poor performance and suggests a need for better understanding of the basic mechanisms of disease.

E. Electrocardiogram Interpretation

Dr. Morgan was presented with ten electrocardiogram tracings and asked to provide an interpretation and course of action for each. The CPEP Medical Director reviewed Dr. Morgan's performance in this area.

Dr. Morgan identified many of the important findings on the ECG tracings. He correctly identified changes as ischemic in four cases; however the location he specified was inaccurate in two of these instances. He misidentified the primary abnormality in three cases, however in none of these particular cases would the patient have been adversely affected by these errors. In three cases the treatment plan was questionable. Two of these plans included consideration of a medication that was not indicated; in the other case the plan was not adequately aggressive.

Dr. Morgan's overall performance on the ECG test was poor; the results indicate the need for further review.

F. Simulated Patient Chart Notes

Dr. Morgan participated in three simulated patient encounters. (*See Section IV for details.*) Dr. Morgan was asked to document each encounter in a chart note. The CPEP Medical Education Director reviewed these notes.

The three notes were legible. Each was organized in the SOAP format, and all notes contained all four components. The history of present illness sections documented the current concern, exacerbating factors, and in some cases, social and family history. Exams were directed to the chief complaint. For each patient, Dr. Morgan provided only one working diagnosis without offering a differential diagnosis. In all three cases, the plan was well detailed, including the time frame for a return visit. There was no documentation of patient education. In general, the notes adequately conveyed what had transpired and would enable subsequent care providers to assume care of these patients. Thus, Dr. Morgan's performance in this area was good, indicating that Dr. Morgan knows how to document well.

IV. Physician Communication Skills

General Overview:

Dr. Morgan met with three Simulated Patients (SPs), presenting with abdominal pain, numbness of the hand, and irritability. Dr. Morgan's skills ranged from substandard to excellent. He focused more on the clinical complaint than the interactions with the SPs. Dr. Morgan demonstrated most of the requisite skills. Areas of concern were primarily due to a lack of application of skills, not an absence of skills. Overall, his skills were marginal.

Strengths:

Dr. Morgan effectively used language to facilitate the interactions. He used the SPs' names throughout the interviews, provided adequate summaries, and used transitional statements to direct the flow of questioning. He was conversational in tone and used the terms "we" and "us" to convey a partnership.

Dr. Morgan's interactions leading into and during the physical exams were excellent. He summarized the history and his clinical thinking before initiating the exams. During the exams, Dr. Morgan fully engaged the SPs and told them exactly what he was doing and why. When discussing treatment options, he worked to get verbal commitment from the SPs and provided them with timeframes.

Areas of Weakness:

The consultant focused on three areas of weakness: note taking, self-defeating statements, and some of Dr. Morgan's explanations. Dr. Morgan took so many notes at the beginning of the interviews that they interfered with the development of rapport. They precluded eye contact and slowed the pace by which the SPs were able to tell their story. Dr. Morgan commented that he was simply completing the form provided by CPEP and that he does not let notes interfere with his patient relationships. Midway through the histories he put the notes down and the interactions became more personable.

Dr. Morgan made an excessive number of self-doubting statements (i.e., "I don't know exactly what would be best for you.") throughout the interactions. During the feedback session, he stated his belief that patients should know when the physician is not certain. However, the number and timing of these statements made it difficult for the SPs to have confidence in Dr. Morgan's abilities since it appeared that he was unsure of everything.

Dr. Morgan did a good job of explaining several points of confusion but he failed to address many others. He explained the importance of a brace when the second SP expressed concern but he did not explain carpal tunnel syndrome, nerve conduction tests, or why he thought these were relevant. Adding to the confusion was his use of technical language such as "anatomical area." Dr. Morgan stated an example of how he had used a suggested medication in the past with one of the SPs. However, the example had no relevance at all to this SP's situation.

Professional Observations:

Dr. Morgan's self-assessments correctly identified which interactions were viewed best by the SPs. During the feedback session, the consultant noted that Dr. Morgan disputed essentially all issues brought up by the consultant.

Recommendations:

Based on the interviews, the consultant had significant concerns about a variety of issues. It was recommended that Dr. Morgan seek individualized coaching. Prior to such an intervention, Dr. Morgan should work on presenting himself in a more confident manner. Because he demonstrated flashes of excellent behaviors, the consultant thought that, with greater confidence, Dr. Morgan could make significant improvements with a few sessions of structured practice and immediate feedback.

V. Interpersonal Style and Cognitive Function Screen

A. Personality Preference Inventory

The consultant found that Dr. Morgan is an ENTJ personality type based on the Myers Briggs Type Indicator questionnaire administered. Dr. Morgan's scores showed a strong preference for Extraversion, and iNtuition, and a mild preference for Thinking, and Judging.

The consultant commented that this type's energy is outer-directed and people-oriented (E), perceiving events with possibilities and connections (N), viewing the big picture and being oriented toward the future. People with this profile may make decisions objectively looking at the facts and principles (T). A lifestyle of structure and organization (J) is preferred.

This type is described as "life's natural leader." The strengths of an ENTJ are an ability to be a strategist that sees possibilities in everything and acts on those ideas instantly with a penchant for handling complexities. An ENTJ would pride himself on his independence and he has a passion for learning. An ENTJ prefers a job with problems to be solved. Leadership qualities of the

ENTJ personality type include an ability to take charge, to be commanding and confrontative, and to be gregarious.

B. Cognitive Function Screen

Dr. Morgan's overall scores on the cognitive function screen were within normal limits. However, some of his summary scores were below average and he had difficulty on tests of memory ability. His immediate recall for verbal information was below average, and he forgot more than an expected amount of the material over a brief delay. The consultant commented that this may suggest some memory difficulties in Dr. Morgan, in the absence of more generalized impairment. He had some attentional difficulty at times, but this was less than the memory difficulty.

Although the result of this screen did not suggest generalized impairment in Dr. Morgan, the difficulty he had with tests of learning and memory was concerning to the consultant. Without an obvious explanation for his difficulty, it would be prudent for Dr. Morgan to obtain further neuropsychological assessment with a special focus on assessing multiple memory functions.

C. Observations of Participant Behavior

Dr. Morgan was pleasant and cooperative throughout the Assessment. He was punctual and professional. Several consultants questioned Dr. Morgan's thought processes.

VI. Review of Health Function

Dr. Morgan submitted a note from his physician certifying a normal physical exam dated March 30, 2000.

VII. Assessment Summary

[CPEP's Assessment conclusions about the participant physicians are based solely upon our review of initial documents provided by the participant, the referring agency or institution, assessment findings, reports, interviews and meetings with the physicians in question. Our findings are not based upon the determinations or conclusions of peer review, judicial or state licensing bodies. In addition, this assessment is of general medicine.]

Note: CPEP cannot resolve the issue of the proper place of alternative and complementary medicine in practice in the United States.

Dr. Morgan is a 55 year-old family physician from Louisville, Kentucky. He voluntarily requested an evaluation by CPEP while being evaluated by the Kentucky Board of Medical Licensure. A Board investigation alleged that Dr. Morgan had failed to work up life-threatening conditions, provide complete care, monitor a patient adequately for side effects of medication,

follow-up abnormal laboratory values, and provide preventive care; the board also alleged that he used outdated, less effective therapies. Dr. Morgan's licenses, in Kentucky and Indiana, are currently suspended.

During this Assessment, Dr. Morgan's *medical knowledge* was significantly lacking. In some instances, he proposed a spectrum of choices of treatment plans for a given circumstance that were strikingly varied in degree of urgency; it was unclear if Dr. Morgan understood the actual degree of acuity of the described situation. He demonstrated specific deficits in knowledge in the following areas: routine health maintenance; infectious disease; cardiovascular disease; endocrinology; hyperlipidemia; pediatric development; ECG interpretation; and recognition of acute, life threatening medical conditions; and basic mechanisms of disease.

Dr. Morgan's *clinical judgment and reasoning*, as demonstrated in the charts and cases reviewed, was an area of concern. Dr. Morgan was, with direction, able to describe reasonable patient work-ups in some cases; however, in general, he had a disorganized approach to history taking and physical exams, and showed no structured, evidence-based approach to pursue diagnosis and treatment. At times, Dr. Morgan appeared to jump to inaccurate conclusions about the hypothetical patients, and used these faulty conclusions to formulate proposed plans for the situations. Dr. Morgan did not demonstrate appropriate management of acute, life threatening medical conditions. Dr. Morgan's stated management during the interviews was at times inconsistent with his patient care documentation.

Dr. Morgan's *physician-patient communication* skills were, overall, marginal. He effectively used language to facilitate the interactions and did an excellent job transitioning to the physical exams. The three areas of concern were note-taking that interfered with patient rapport, excessive self-defeating statements, and inadequate explanations to patients.

A review of *documentation* from Dr. Morgan's former practice found that chart notes were overly brief and often lacking an adequate history or physical exam, disorganized, lacked sufficient detail to convey what had transpired during the visit, and often did not justify diagnostic or treatment interventions offered by Dr. Morgan. In addition, there were instances where there was no documentation that abnormal lab results were addressed. In contrast, patient care documentation in the notes for the standardized patients at CPEP was reasonably good, suggesting that Dr. Morgan did not apply principles that he understands when writing notes in his former practice.

Dr. Morgan's *cognitive screen* demonstrated some difficulty with tests of learning and memory. During the Assessment, Dr. Morgan demonstrated a disorganized approach and displayed a tendency to overlook data, potentially validating the concerns raised by the cognitive screen. Further neuropsychological testing is recommended.

Dr. Morgan submitted a brief note from his physician certifying a normal physical exam.

An Assessment such as that done by CPEP does not involve direct observation of the client physician at work. Our conclusions, therefore, can address only whether the physician possesses

the knowledge and judgment necessary to perform. We cannot predict actual behavior. Overall, Dr. Morgan's performance showed poor breadth and depth of medical knowledge, poorly organized clinical reasoning, questionable clinical judgment, inattention to detail, incomplete office charts, marginal communication skills, and problems processing important information that could be related to difficulties with learning and memory.

Demonstrated abilities were not sufficient to support Dr. Morgan returning to the practice of medicine independently without first engaging in extensive re-education.

VIII. Prognosis, Implications for Education, and Other Interventions

In order to improve or enhance practice, physicians as adult learners need ability, attitude, motivation and insight. Dr. Morgan's curriculum vitae showed that his early career was one of respectable accomplishments; this likely reflects his overall ability. Additional neuropsychological testing may be helpful in identifying any cognitive problems that might interfere with successful participation in an education plan. Dr. Morgan expressed an openness to improve his clinical skills, however it is unclear if he has true insight into the extent of his deficiencies or an awareness of the time and effort that an education plan will require. Dr. Morgan expressed altruistic goals and a strong motivation to return to clinical medicine.

➤ *Neuropsychological testing:*

Based upon Dr. Morgan's neuropsychological screening test results, he may have some problems processing information that could affect his practice of medicine. Because of this, more extensive evaluation involving a comprehensive neuropsychological examination is recommended to rule out any underlying medical or neurological disease. The testing is designed to measure skills and abilities related to higher-level brain functioning, i.e., cognition, language, and memory.

This more comprehensive testing often requires ½ to one full day of testing and examines a variety of cognitive functions in detail. The testing should be performed by a neuropsychologist who has experience working with physicians or other individuals who need a high level of cognitive functioning to perform their jobs. While evaluation by a neurologist may also be helpful, it should not be substituted for the neuropsychological evaluation. Given Dr. Morgan's education and occupational background, CPEP recommends a selection of tests that take into account the high level of function necessary for a practicing physician.

This testing should be completed prior to his participation in an educational plan. If Dr. Morgan has difficulty finding a qualified neuropsychologist to perform this testing, CPEP can assist him in locating one.

Dr. Morgan cannot participate in an education program until his cognitive health concerns are assessed and any impact on his practice is ascertained.

Areas of Demonstrated Need in Medicine (including but not limited to):

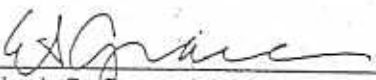
- Knowledge of:
 - Preventive care and cancer screening;
 - Infectious disease, especially use and choice of antibiotics;
 - Treatment of hypertension;
 - Screening, diagnosis and management of thyroid disease;
 - Screening, diagnosis and management of diabetes;
 - Diagnosis and treatment of hyperlipidemia;
 - Indications and use of hormones in gynecology;
 - ECG interpretation;
 - Basic mechanisms of disease;
 - Clinical testing; increased understanding and appropriate use of laboratory and other tests;
- Judgment and patterns of reasoning;
- Management of complex medical situations;
- Recognition and response to life-threatening problems;
- Patient data formulation; the collection of histories and the creation of differential diagnoses;
- Patient care documentation, including management of chart components and creating documents that appropriately convey that which transpired during a visit and the thought process supporting the course taken;
- Physician-patient communication skills.

Specific Educational Recommendations:

[The following recommendations provide the foundation for practice enhancement. Further detailed educational planning may include additional interventions.]

Because of the extent of the deficiencies identified and concerns that his care may put patients at risk, Dr. Morgan should retrain in a residency setting. Dr. Morgan did not demonstrate the ability to remain in independent practice while attempting to remediate his clinical skills.

IX. Signatures


Elizabeth S. Grace, M.D.
Medical Education Director
Colorado Personalized Education for Physicians

6-26-01
Date

My signature below indicates that I have had the opportunity to review the Assessment report. It does not necessarily mean agreement with or approval of the report.

Kirk Deeb Morgan M.D.
Kirk Deeb Morgan, M.D.

6/20/2001
Date

PARTICIPANT RESPONSE TO CPEP ASSESSMENT REPORT
(Optional)

Please type or write your response. You may attach additional pages. Only comments received by the identified due date will be attached. Articles, charts, research papers and expert opinions will not be accepted.

The therapies referred to by the Kentucky License Board as being out of date & limited in knowledge, were established in the practice & patients I inherited, and they were the preference of the patients involved, rather than change in therapy. The patient who died continued to receive NSAID's from her forgetful daughter against my specific orders. Many incorrect statements originating from the Ky Board are included in your report. When the Ky. Board evaluated my records previously, they found no problems with the records & many patients testified they were only helped. The Kentucky Board lost all of those records. Patients chose to go wherever they wanted & required no referral from me to find treatment I was not allowed to give.

What you have referred to from the Ky Board's consultant as ischemia or possible acute changes on ECG's, were actually only chronic changes consistently present, & known to me as such upon review at the old ECG's & Cardiology reports. On consultation, documented in those records, not picked up by the Ky Board's consultant, those ECG's were demonstrating only consistent patterns, & my comments were made in the process of finding that out in that practice.

There was no complaint of hypoglycemia from my consultant. The Ky Board witness took the consultant's comments out of context. He complimented me on indicating only occasional hypoglycemia occurred. ACEI & ARB drugs were used in diabetics standardly, & the failure to do so when the consultant recommended so is another in correction.

In many patients the therapy was already established for decades & to change risked destabilization of stable happy healthy patients with good outcomes.

(Please continue to the end of my response
for signature & date)

Signature

Date

I am aware of the superiority of TST over T4,
but consideration of reasonable effectiveness + expense in
a private paying practice should be considered too for
frequent spot checks

Laboratory findings were all reviewed by me if
abnormal before being placed in charts; so for you to
refer to that in an evaluation, again has to be based on the
one sided hearsay you received from the Ky Board, +
no evidence from my consultants provided to the Board.
It was unfair of the Ky Board to provide any prejudicing
information to you whatsoever, if they did not include
all the testimony of my five medical expert witnesses,
+ they included none of that testimony whatsoever.

Therefore, I would have to feel that although
I agree my skills regarding overall medical
practice certainly require updating + honing, your
prejudice was influenced by the KMB's
information + apparently occurred without consideration
of the overall outcome of my patients + my
practice for years.

Laboratory results were often mailed to and
discussed with patients on return to the office.
Patients received a copy along with my note to
return for review.

I may not have expressed myself well, but I
know, + know proteinuria is an indication of potentially
impaired renal function. I am again surprised that you
report here, I do not.

My patients have not really seemed to love the type of outcomes you refused to form the foundation you must have received from the Ky Board. In fact, the case has been made, by other physicians in my behalf, that my patients tend to have good results + do well with longevity + decreased morbidity. So that statement is repetition of hearsay on CPEP's part. Liper is a brand name for a lithaerine. Some patients tell me what they will do so I record that as added liper or vinegar to their diet, but it was wrong for you to be convinced that those are recommended treatments, when in fact they are recorded statements of some of my patients who tell me what they are doing on their own.

The use of the Prothrombin Time was available + expected from the practice it inherited. INR is thus not relevant as long as all tests used for comparison are done on the same equipment in the same lab. There are thus not 2 techniques to standardize, just the one in-office ProTime tests. Again you have repeated in your evaluation of me the accusations made by the Ky Board, when it was assured that would not happen, that you would be objective. You have reacted to the Kentucky Board's information, when in fact the hearing on my issue was deferred for your evaluation only after the Board's single witness was heard. None of my four witnesses were heard out side of interrogatory or deposition, + I believe you would have been much influenced by their testimonies at hearing had they occurred. I thus cannot actually honestly endorse your report as unprejudiced by having been unenfluenced by the one side of the information you received + responded too.

In Paragraph 5 on page 12 of 2 you have apparently assumed that results I have had with patients previously was "poor". Again I cannot help but feel that because I have lost two cases in court & the Kentucky Board has responded as they have, that my results were poor. In fact, my information is that there are great numbers of people who have, & would ~~do~~ conforth, to contradict these impressions, with their first hand experience with treatment such as some which has caused ^{some} other physicians to not endorse it here in Kentucky.

The evidence regarding Anti-Malignon Antibody Serum levels was listed right on every report including 2 (two) references from Lancet, the most prestigious medical journal in the world, many believe. Patients, contrary to the statement you made in your report, always received a copy of this report preferentially in person in my office, but always at least by mail if nothing else would occur quickly, if it was abnormal.

I accept all criticisms that are objective. I would give credit for being accurate that I certainly would benefit from updating medical education. I feel like Dr. Elizabeth S. Groce tried to be very objective, but was interfered with by being provided only the accusations, in full, & none of the defence; I do believe it influenced the approach taken.

On the other hand, I am actually grateful for the recommendation toward updating my medical knowledge on general & specific areas, & welcome the opportunity to do so, if it is

available. I do feel that any opportunity to improve my medical knowledge & skills would be just as welcomed & appreciated by me as it always has been. As always, the opportunity must be available. I appreciate the recommendation and, if asked to & if it is available, would follow it. I recognize my limitations & weaknesses, and have no problem doing what ever I can to strengthen them. I do appreciate the favorable comments regarding my strengths. I am somewhat disturbed that the CPEP evaluation occurred without the benefit of the testimony of my four witnesses to correct the record, & without any time for me to prepare, after being prohibited from medicine to the point I feared for the reinstatement of my Kentucky Medical License, if I even so much as associated with any continuing medical education for over a year before being required to be evaluated by CPEP. I had only two weeks notice before I arrived at CPEP, at the time they specified. I now feel that the hearing on this matter should be completed simply for the correction of the impression generated by the KBML's single witness, which stood alone as the history provided to CPEP, & now as the recorded causes for Licensing issues. I believe not only is the record still standing incomplete, but it created some bias on the part of CPEP, so they could not fairly know all the circumstances leading me to them, and the limitations which had been placed

interfered with any and all long term preparation for an evaluation.

Nonetheless, I appreciate the effort of CPEP to attempt to remain objective; but, I regret that the information provided to them were accusations only with absolutely none of the refutation included what so ever. If an attitude of bias did not result, then at least CPEP's expectations of me were already heavily influenced before my arrival. A Simple Summary of the refutation of these charges, in my defence, was expected, but not provided, & this leaves me with concern about a biasing influence which may have been an intentional "inadvertent" oversight, similar to the prolongation of KBML's single witness for a whole day such that all of my witnesses were prevented from testifying, & never have yet, on any record I am seeing, but I know dispositions exist.

In Summary: ① I believe the testimony of my four witnesses should be made part of KBML's official record, & should be taken completely, to avoid any further & future perpetuation of bias.

② Cognitive ability can also vary with expectations, attitudes, bias, and stress in anyone; so the neuropsychological testing will be completely which CPEP recommends.

③ Just as we all do, I have my weaknesses; but, if allowed to I recognize them and both do the best I can to not only responsibly compensate, but also build on my strengths.

④ The type of practice I was in did not require all of the immediate evaluation

you my ...

(5) I appreciate & welcome constructive criticism. I appreciate any opportunity to act on it, preferentially with out further distracting stress which always interferes with concentration in anyone.

(6) After over a year of being prevented from association with medicine, I welcome the opportunity to do so, including education, in whatever form it may take, including both any regular Continuing Medical Education, and/or residency, if, & as, available.

I would like to think that I have always welcomed opportunities to improve myself as a human being, & as a physician. I truly do enjoy being of real aid to my fellow man.

Two final comments: first this handwritten response was necessary in order to comply with the time restraints placed upon me.

And lastly, I wish to genuinely thank Dr. Grace & her associates, & staff of CPER, for their work & efforts in my behalf. If given the opportunities, I intend to follow the recommendations and, if at all possible, return to the practice of medicine.

I have already placed your list of recommendations in my continuing medical education file, & have started taking actions in several different ways to follow them. Dr. Grace is, & will continue to be, a fine Medical Director at CPER.

Kim Deeb Morgan MD 6/20/2001

See references enclosed on Dr. David (phonetic) [unclear]

The Broad Range of Clinical Use of Phenytoin

Bioelectrical Modulator

BIBLIOGRAPHY AND REVIEW

Barry H. Smith, M.D., Ph.D.
Jack Dreyfus

*These references are provided regarding your
consultant's question of the use of
Dilantin®, phenytoin (PHT), as appropriate
for abdominal pain in a nervous, otherwise
unimpressively, evaluated patient.*

Karl Deeb Morgan 6/16/2001

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Library of Congress Catalog Card Number: 92-081737

4 • CLINICAL USES

behavior in epileptic children, even when seizures were not the major problem.

IN NON-EPILEPTICS

LENDLEY AND HENRY, *Psychosomatic Medicine* (1942),²² in an early study, observed that problem children given PHT showed behavioral improvement.

BROWN AND SOLOMON, *American Journal of Psychiatry* (1942),²³ reported that delinquent boys committed to a state training school showed important behavioral improvement on PHT therapy.

Improvement was seen in a reduction in extreme hyperactivity, excitability and temper "flare-ups" and in attention span and more efficient work patterns.

SILVERMAN, *Criminal Psychopathology* (1944),²⁴ in what appears to be the first reported study on the use of PHT in prisoners, found PHT to be superior to all other agents tested. The study was done with sixty-four prisoners at the Medical Center for Federal Prisoners, Springfield, Missouri.

Improvements were noted in sleep, sense of well-being and cooperativeness. These observations were made in a double-blind crossover study with placebo.

BODKIN, *American Journal of Digestive Diseases* (1945),²⁵ reporting on his ten years of successful treatment of pruritus ani with PHT, noted that all the patients had one thing in common—they were highly nervous. (See p. 59.)

GOODWIN, *Journal of the National Proctologic Association* (1946),²⁶ reporting the successful treatment of patients with pruritus ani with PHT, agreed with BODKIN²⁵ that

nervousness was a factor common in the vast majority of these patients. (See p. 59.)

WALKER AND KIRKPATRICK, *American Journal of Psychiatry* (1947),²⁷ treated ten behavior problem children with abnormal EEG findings with PHT. None of the children had clinical evidence of seizures, and physical and neurological examinations were all negative.

All of these children showed definite clinical improvement under PHT treatment.

FABRYKANT AND PACELLA, *Annals of Internal Medicine* (1948),²⁸ in discussing the effects of PHT in labile diabetes, noted that PHT alleviated anxiety, nervous tension and irritability. In addition, the ability to concentrate and to work increased and the patients exhibited a general feeling of well-being.

ZIMMERMAN, *New York State Journal of Medicine* (1956),²⁹ gave PHT to a group of two hundred children having severe behavior disorders. Improvement was seen in 70% of the cases.

The use of PHT resulted in reduced excitability, less severe and less frequent temper tantrums, reduced hyperactivity and distractibility, fewer fears, and less tendency to go out of contact.

CHAO, SEXTON AND DAVIS, *Journal of Pediatrics* (1964),³¹ conducted an extensive study of 535 children classified as having convulsive equivalent syndrome characterized by autonomic disturbances and dysfunction in behavior and communication. A majority of these patients had 14- and 6-EEG patterns. PHT was used alone with 296 of these children and in combination with other drugs in 117 children.

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The symptoms benefited included headache, abdominal pain, vasomotor disturbances, nausea, dizziness or syncope, fever and/or chills, shortness of breath, eye pain, photophobia, sweating, weakness, pain in extremities and chest pain.

Behavioral and emotional problems, retardation, school problems in non-retarded, sleep disturbances, speech problems and neurological deficits also responded to treatment. The response was rapid and often striking.

JONAS (1965),³²² in his book *Ictal and Subictal Neurosis*, based on observations of 162 patients over a twelve-year period, found PHT of benefit in a wide range of nonconvulsive disorders.

Among the symptoms which the author noted were helped by PHT were anxiety, depression, agitation, irritability, violence, headache, sleep disturbances, abdominal symptoms, sexual disturbances, hypochondria, visual and auditory phenomena and body image distortion.

LYNK AND AMIDON, *Michigan Medicine* (1965),³⁷⁶ studied the effect of medication with severely disturbed delinquents under court jurisdiction. The number of patients who received PHT (out of a total of 125) was not given.

They found that some of the children with borderline EEGs but no epilepsy had markedly aggressive behavior. These children responded to PHT when no other drug seemed to help.

DREYFUS (1966)⁷⁰⁷ reported on "The Beneficial Effects of PHT on the Nervous System of Nonepileptics—As Experienced and Observed in Others by a Layman."

The author observed that multiple simultaneous thoughts as well as obsessive

and preoccupied thinking were relieved by PHT. Coincident with this, marked improvements were noted in symptoms of anger and related conditions of impatience, irritability, agitation and impulsiveness. Also, there was marked improvement in symptoms of fear and the related emotions such as worry, pessimism, anxiety, apprehensiveness and depression.

He noted that the ability to fall asleep more promptly and to sleep more soundly, without nightmares, occurred in the majority of cases. However, with a minority who slept excessively (so-called avoidance sleep) duration of sleep tended to be beneficially reduced.

Based on his observations, the author formed the impression that excessive bioelectrical activity in the nervous system causes unfavorable emotional responses, anger and fear being chief among them. PHT corrects this excessive bioelectrical activity, causing excessive anger and fear to be eliminated.

ROSSI, *New York State Journal of Medicine* (1967),³¹⁴ stated that PHT is clinically effective in impulsivity and behavior in hyperactive children and particularly effective in controlling nightmares.

RESNICK, *International Journal of Neuropsychiatry* (1967),²⁰⁷ reported a double-blind controlled study with crossover and placebo involving eleven inmates at a prison, selected from a group of forty-two volunteers. The entire study (RESNICK AND DREYFUS, 1966)⁷⁰⁴ was recorded on tape. The beneficial effects of PHT were reported in connection with overthinking, anger and fear, tension, irritability and hostility. There was marked improvement in ability to concentrate and in sleep problems. Improvement was also observed in

headaches, gastrointestinal disturbances and, in one case, phantom limb pain.

Subsequently similar observations were made at a reformatory in six juvenile delinquents ranging in age from twelve to fifteen. With the administration of 100 mg PHT daily, prompt relief in anger and fear was noted and clearly expressed in marked diminution in fighting by five of the boys. The sixth boy, who was withdrawn and passive, became more outgoing, talkative and had an occasional fight. General improvements in overthinking, tension, impatience, impulsiveness, irritability, anger, fear, sleep difficulties and headaches were also observed.

TURNER, *International Journal of Neuropsychiatry* (1967),³⁶⁴ studied the effect of PHT on patients seen in psychiatric practice during an eighteen-month period. They suffered from a wide variety of emotional and behavioral disorders. Forty-six of fifty-six neurotic patients improved. Improvement was observed in relation to anger, irritability, tension, sleep disturbances, ruminations, anxiety, depression, feelings of guilt and withdrawal, regardless of diagnostic category or EEG findings.

Because of the lack of sedation or stimulation, the author suggested that PHT might be called a normalizer.

JONAS, *International Journal of Neuropsychiatry* (1967),¹⁸⁵ found that over half of 211 patients seen in general psychiatric practice had a therapeutic response to PHT, ranging from reduction to complete reversal of symptoms in the following conditions: anxiety and tension states, reactive depressions, certain cognitive disturbances, obsessive-compulsive manifestations, hypochondria, psychopathy, obesity, and addiction to alcohol and to cigarette smoking.

Many patients reported favorable reactions within one hour after intake of PHT.

The author suggested that the action of PHT placed it in a category separate from the tranquilizers or stimulants and agreed with TURNER³⁶⁴ that the term normalizer seemed appropriate.

AYD, *International Drug Therapy Newsletter* (1967),⁷⁸ in a summary of the clinical psychopharmacological value of PHT entitled "New Uses for an Old Drug," pointed out the effectiveness of PHT for psychic overactivity, distractibility, short attention span, irritability, impulsiveness, insomnia and behavioral disorders in children.

ITIL, RIZZO AND SHAPIRO, *Diseases of the Nervous System* (1967),¹⁷⁸ studied the effect of PHT, combined with thioridazine, on twenty behaviorally disturbed children and adolescents. Eleven patients had personality disorders: five schizophrenic reactions; and four chronic brain syndrome, two with convulsions.

These patients showed low frustration tolerance, hyperactivity and restlessness, aggressive destructive behavior, impulsiveness, poor school or work performance, antisocial acts, sexual acting out, irritability and stubbornness.

After three months of treatment, fifteen of the twenty patients showed moderate to marked improvement and fourteen of them were discharged.

TEC, *American Journal of Psychiatry* (1968),³⁵⁷ reviewed his fifteen years' experience with PHT in the treatment of behavior disorders in children.

The author reported that PHT improved disruptive behavior in the large majority of the children seen during that period and emphasized that PHT often helped when

the phenobarbital failed.

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sion and sometimes severe depression. The author notes that after cerebrovascular accident the patient often has paresthesias and tingling. He states that PHT not only frequently gives relief from the paresthesias, but that mental symptoms also improve.

* This discussion of PHT by Daniel is part of a larger study of other substances entitled, "Psychiatric drug use and abuse in the aged." For other work on the effect of PHT in cerebral blood flow and hypoxia, see Refs. 790, 1216, 1560, 2142, 2768. See also Anti-Anoxic Effects of PHT, p. 131-137.

Bozza, in a detailed paper presented at the Fourth Italian National Congress of Child Neuropsychiatry (1971),²⁶⁷ reports on an individual basis on twenty-one slightly brain damaged retarded children who were observed for periods of from twelve to thirty-six months. In most of the cases PHT was tried. The author concludes that PHT and vitamins materially improved the expected intellectual growth rate of these retarded children. (See also Refs. 8, 355, 373, 1626.)

ALVAREZ, in a book titled "Nerves in Collision" (1972),⁷⁶¹ reviews his twenty-five years' experience in the use of PHT for a wide variety of disorders.

In his book, Alvarez reports on the successful use of PHT in the treatment of anxiety, nervousness, tension, fear, nightmares, depression, rage, violent outbursts, confusion, fatigue (extreme), abdominal pain, alcoholism, anorexia nervosa, bed wetting, blackouts, dizzy spells, head pain, involuntary movements, migraine-like headaches. (See also Ref. 4.)

STEPHENS AND SHAFFER, *The Journal of Clinical Pharmacology* (1973),¹⁵⁹² In an earlier paper⁷⁰⁰ the authors had reported on the successful treatment with PHT of thirty private psychiatric outpatients. This study had

been done on a double-blind crossover basis.

About two years later, ten of this group of patients participated in a double-blind study of PHT for four consecutive two-week periods.

Consistent with the previous study, 100 mg t.i.d. of PHT proved significantly more effective than placebo in relieving symptoms of anxiety, anger and irritability as assessed both by self-ratings and physicians' ratings of change.

BRODSKY, ZUNIGA, CASENAS, ERNSTOFF AND SACHDEV, *Psychiatric Journal of the University of Ottawa* (1983),²⁴³⁷ describe a group of ten patients with recurrent anxiety. Eight responded to PHT alone. The ninth responded to a combination of PHT and clonazepam, and the tenth to carbamazepine. All patients had normal routine EEGs, but abnormal twenty-four-hour sleep-deprived EEGs. (See also Ref. 2356.)

DE LA TORRE, NAVARRO AND ALDRETE, *Current Therapeutic Research* (1985),²⁴³⁷ reported a controlled study of eighty patients with irritable bowel syndrome. Forty patients received PHT (100 mg t.i.d.) and forty received conventional treatment which included either a tranquilizer or an antidepressant.

In addition to greater relief of abdominal pain, diarrhea, constipation, nausea, vomiting and pyrosis, patients receiving PHT had a statistically significant greater number of complete remissions of depression, insomnia and anxiety than patients receiving conventional therapy.

Violent Behavior

Many of the preceding studies have reported PHT useful for anger and related symptoms. Expressions used are aggressive

ment of these types of recurring head and facial pain.

RASKIN, LEVINSON, PICKETT, HOFFMAN AND FIELDS, *American Journal of Surgery* (1974),¹⁴⁴⁴ as part of a larger study, reported that two of the patients with post-sympathectomy neuralgia, unresponsive to meperidine, had immediate relief with intravenous PHT.

TAGUCHI, WATANABE AND IOKU, *Neurologia Medico Chirurgical (Tokyo)* (1981),²⁹⁴⁸ reported a patient with bulbar syringomyelia who developed severe, intractable pain and paresthesias in her legs, abdomen and chest after cervical laminectomy. She also developed muscle spasms of her upper body. PHT, 250 mg/day, stopped both the pain and muscle spasms.

SWERDLOW, *Clinical Neuropharmacology* (1984),²⁹⁶⁷ reviewed a series of 200 patients with various types of refractory chronic lancinating or paroxysmal pain. The etiologies of the pain included post-laminectomy, post-traumatic, post-herpetic, post-operative, and post-amputation neuralgias, as well as pain secondary to nerve or plexus injury or operation, atypical facial pain, and central pain syndromes. Of fifty-two patients who received PHT as their first drug, twenty-four found it effective. This success rate was higher than that achieved with carbamazepine, clonazepam, and valproate.

PAIN IN MULTIPLE SCLEROSIS

MATTHEWS, *Brain* (1958),¹³⁴² reported the effectiveness of PHT in the treatment of painful spasms in a patient with multiple sclerosis. When PHT, 100 mg t.i.d., was prescribed, the attacks stopped within two days.

KUROIWA AND SHIBASAKI, *Folia Psychiatrica et Neurologica Japonica* (1965),¹²³³ found that PHT and/or carbamazepine were useful in suppressing the painful tonic spasms in four patients with multiple sclerosis. In a further study, SHIBASAKI AND KUROIWA, *Archives of Neurology* (1974),¹⁵⁰ reported the successful treatment of five of seven patients with PHT alone or in combination with carbamazepine.

SKILLRUD AND GOLDSTEIN, *Journal of the American Medical Association* (1983),²⁵⁰³ reported in detail the case of a twenty-seven-year-old male physician with multiple sclerosis and paroxysmal limb hemiataxia and crossed facial paresthesias who became symptom free on 500 mg of PHT per day.

CLIFFORD AND TROTTER, *Archives of Neurology* (1984),²⁵⁹⁵ reviewing the records of 317 multiple sclerosis patients with a wide variety of painful syndromes and therapies, reported PHT's usefulness in the treatment of limb, facial, head, and thoracic pain.

ABDOMINAL PAIN

KELLAWAY, CRAWLEY AND KAGAWA, *Epilepsia* (1959-1960),³⁵¹ in a review of experience with a group of 459 children who had consistent 14- and 6-per-second spike patterns on the EEG and whose primary complaints were headache and abdominal pain, found the most effective treatments were PHT and Diamox, alone or in combination.

✓ PEPPERCORN, HERZOG, DICHTER AND MAYMAN, *JAMA* (1978),²³⁹⁸ found PHT useful in the treatment of three patients with paroxysmal abdominal pain. When two of the patients stopped their medication the symptoms returned. With the resumption of the medication symptoms disappeared.

SCHAFER, *Medische Medizin* (1978),¹²³³ reported that pain occurs in the severe form of PHT, in which carbamazepine

The top of skin is reviewed. The importance of prompt relief.

CHIKHA, *Neurologiques* (1981),¹²³³ patients, with the beneficial pain.

LUDWIG, *Neurologie und Neurochirurgie* (1981),¹²³³ controlled study of gingivitis, (1% gel) of sensitivity. No group.

RODRIGUEZ, MADA, AND

SCHAFFLER AND KARBOWSKI, *Schweizerische Medizinische Wochenschrift* (1981),²⁹¹²⁴ reported six cases of paroxysmal abdominal pain occurring in association with cerebral dysrhythmias. PHT controlled or reduced the severity of the attacks in the four cases in which it was used alone. In one case, PHT, in combination with carbamazepine, was used successfully and, in another case, carbamazepine was used alone.

AND CHAPA-ALVAREZ, *Investigacion Médica Internacional* (1983),²⁹¹¹ reported a group of twenty patients with venous stasis or diabetic ulcers treated with topical PHT powder. All patients experienced rapid improvement in local pain. In the control group, pain persisted until the lesion was completely healed.

WOUNDS, ULCERS, BURNS

The topical use of PHT to promote healing of skin ulcers, burns and other wounds is reviewed in the Clinical Healing section. The important benefit of topical PHT, prompt relief of pain, is discussed here.

CHIKHANI, *Actualités Odonto-Stomatologiques* (1972),⁸⁹⁴ in a study of fifty-eight patients, with periodontal disease, reported the beneficial effects of topical PHT on gingival pain as well as bleeding.

LUDWIG AND OTTO, *Russian Pharmacology and Toxicology* (1982),²⁷³⁰ in a controlled study of sixty patients with atrophic gingivitis, found topical application of PHT (1% gel) controlled gum pain and heat sensitivity. Edema and gum bleeding disappeared. No effects were seen in the control group.

RODRIGUEZ-NORIEGA, ESPARZA-AHUMADA, ANDRADE-PEREZ, ESPEJO-PLASCENCIA

✓ MENDIOLA-GONZALES, ESPEJO-PLASCENCIA, CHAPA-ALVAREZ AND RODRIGUEZ-NORIEGA, *Investigacion Médica Internacional* (1983),²⁷³⁸ reported a group of eighty patients with second-degree burns. Twenty patients were treated topically with PHT powder, ten with oral PHT, and ten with both topical and oral PHT. Bilateral burns provided control and treatment sites for the topical applications. Pain improved in five to twenty-five minutes at the treated sites, compared to twelve to fifteen hours at control sites.

Other clinical reviews and studies on the use of PHT in pain: facial pain including trigeminal neuralgia, glossopharyngeal neuralgia, and temporomandibular joint syndrome, Refs. 2470, 2472, 2492, 2523, 2593, 2619, 2801, 2847, 2943; headache including migraine, Refs. 2317, 2492; post-herpetic neuralgia, Refs. 2474, 2657; reflex sympathetic dystrophy and post-sympathectomy pain, Refs. 2492, 3040; pain in multiple sclerosis, Refs. 2601, 2929; central and other chronic pain syndromes, Refs. 2452, 2460, 2492, 2756, 2784, 2997.



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REPORT ATTACHMENT

ASSESSMENT PROGRAM DESIGN

The Assessment is designed to evaluate the physician-participant through use of standardized testing, specialty-specific and individualized testing tools (*Please refer to Testing Materials*). A Medical Education Director (MED) oversees the Assessment and attends clinical interviews to ensure that the process is reflective of the physician-participant's practice specialty and also takes into account any noted reason for referral. The MED incorporates results from the physician-participant's performance in each assessment modality into a written Report.

DESCRIPTION OF EVALUATION TOOLS

The use of the testing modalities varies with each Assessment. Please refer to the Executive Summary to determine which tests were used.

Structured Clinical Interviews

Structured Clinical Interviews (SCI) are oral evaluations of the physician-participant conducted by physician-consultants in the same specialty field. Each consultant is board certified. The interview is conducted in the presence of the MED. The consultant asks about patient care management based on charts submitted by the participant, hypothetical case scenarios, and the consultant's own case material. X-ray films or videotapes of surgical procedures may also be used in the interview process. These ninety-minute oral interviews are used to evaluate the physician-participant's medical knowledge, clinical judgment, documentation, and peer communication skills.

Note: On occasion, physician-participants are unable to provide charts from their practice, either because they have not been in practice for a number of years or because the facility at which they work is unable or unwilling to release them. In these situations, hypothetical case scenarios are used as the basis for the interviews.

Computer Case Simulations

Generalist physicians take a computerized patient management test developed by the National Board of Medical Examiners (NBME). The test uses a spectrum of patient cases to cover emergency situations, acute illness, and chronic illness with additional diagnoses. Areas of medicine covered by the cases include infectious diseases, rheumatology, gynecology, obstetrics, oncology, hematology, and endocrinology. The simulation provides the kind of information that is present on a patient chart before a visit. The physician-participant must manage the case through the computer program, asking for history, physical exam and test information, or ordering treatment. No cues are provided about what should be included or what diagnoses should be considered.

Because this test requires familiarity with computers, the way in which the physician-participant manages the computer format is important. The physician-participant has the opportunity to complete five practice cases. An administrative proctor is present to assist the physician-participant. The proctor may only serve as a scribe on the keyboard or to answer questions about how to move from one part of the program to another. The proctor does not provide any clinical information.

Transaction Stimulated Recall (TSR) Interview

A record of the physician-participant's actions, the transaction list, is produced at the completion of the computer case simulations described above. A board-certified physician conducts an interview with the physician-participant based on the transaction list from the standardized cases. The consultant reviews all of the cases and then conducts an in-depth interview focusing on selected cases. The physician-participant's performance and management choices are used as the basis for a discussion of thinking about the cases. Medical knowledge down to the basic science level, clinical reasoning, and flexibility and creativity in managing problems are evaluated in this experience.

Multiple-Choice Question (MCQ) Knowledge Test

Multiple-choice testing is used to identify possible deficiencies regarding knowledge in clinical areas and in basic mechanisms of disease.

Specialty Specific Testing: These instruments are targeted to the physician-participant's specialty and practice. Analysis of the physician-participant's performance identifies areas of strength as well as areas for new learning. These specialty-specific MCQs are not standardized and do not provide normative data.

Mechanisms of Disease: Primary care physician-participants complete a standardized Mechanisms of Disease test. It provides insight into the physician-participant's understanding of the basic mechanisms of disease. This test is normed and compares the physician-participant's performance to a group of 1800 physicians.

Electrocardiogram Interpretation (ECGs)

Physician-participants whose practice includes reading electrocardiogram tracings are presented with ten electrocardiogram tracings and asked to provide an interpretation and course of action for each. The Medical Education Director reviews the performance in this area.

Fetal Monitor Strips

Physician-participants providing obstetric care in their practice are asked to read 15 fetal monitor strips and provide an interpretation and course of action for each strip. The Medical Education Director reviews the performance in this area.

Physician Communication Skills

Effective communication and formation of therapeutic physician-patient relationships are assessed through the use of Simulated Patient (SP) encounters. The physician-participant conducts a patient interview in an exam-room setting. The patient cases are selected based on

the physician-participant's specialty area. Both the SPs and the physician-participant evaluate the interaction. The patient encounters are videotaped and analyzed by a communication consultant. The consultant provides the physician-participant with feedback.

Simulated Patient Chart Notes

Following each Simulated Patient (SP) encounter, the physician-participant is asked to document each encounter in a chart note. The Medical Education Director reviews these notes.

Personality Preference Inventory

The Myers-Briggs Type Indicator (MBTI) is a self-assessment instrument used to indicate basic personal preferences. It is a personality profile, not a test with right or wrong answers. The physician-participant completes the MBTI questionnaire prior to the Assessment. A trained consultant meets with the physician-participant and shares feedback about the individual scores and personality profile.

Cognitive Function Screen

Microcog™, a computer-based assessment of cognitive skills, is a screening test to help determine which physician-participants should be given a complete neuropsychological workup. The test is viewed as a *screening instrument only* and is not diagnostic.

This screening test does not require proficiency with computers; a proctor is available to answer questions about test instructions. Test performance or expected test performance can be impacted by a number of factors, including normal aging and background. A neuropsychologist analyzes the test results, taking these factors into account.

Review of Health Information

The physician-participant is asked to submit the findings from a recent physical examination including a hearing and vision screen. If indicated, program staff requests information related to specific health concerns. The Medical Education Director reviews this information.

COMMONWEALTH OF KENTUCKY
KENTUCKY BOARD OF MEDICAL LICENSURE
AGENCY CASE NO. 732
ADMINISTRATIVE ACTION NO. 00-KBML-0197

FILED OF RECORD

APR 25 2000

K.B.M.L.

KIRK D. MORGAN, M.D.
License No. 16289 (Emergency Suspension)

PETITIONER

v. **DECISION AFFIRMING EMERGENCY ORDER
OF SUSPENSION AND NOTICE OF APPEAL RIGHTS**

KENTUCKY BOARD OF MEDICAL LICENSURE

RESPONDENT

* * * * *

The above styled-case concerns an Emergency Order of Suspension issued to Kirk D. Morgan, M.D. suspending his license to practice medicine in Kentucky. The Order was issued by the Kentucky Board of Medical Licensure under the authority of KRS 311.592 which states in relevant part: "At any time when an inquiry panel has probable cause to believe that a physician has violated the terms of an order placing him on probation, or a physician's practice constitutes a danger to the health, welfare, and safety of his patients or the general public, the inquiry panel may issue an emergency order, in accordance with KRS 13B.125, suspending, limiting, or restricting the physician's license." A Hearing was held pursuant to KRS 13B.125. C. Lloyd Vest, General Counsel, represented the Board at the Hearing. The Board's only witness was [REDACTED] M.D. Morgan was represented by Henry J. Novak, Attorney at Law; Mark L. Morgan, Attorney at Law; and Jason Segeleon, Attorney at Law. The Petitioner was present but did not testify.

FINDINGS OF FACT

1. The Emergency Order of Suspension issued on March 16, 2000, charged that Morgan had violated the following statutes:

KRS 311.595 (13): Violated any agreed order, letter of agreement, order of suspension, or the terms or conditions of any order of probation, issued by the board;

KRS 311.595 (9): Engaged in dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud, or harm the public or any member thereof; [as illustrated by]

KRS 311.597 (2): Issues, publishes, or makes oral or written, representations in which grossly improbable or extravagant statements are made which have a tendency to deceive or defraud the public, or a member thereof, including, but not limited to:

(a) Any representation in which the licensee claims that he can cure or treat diseases, ailments, or infirmities by any method, procedure, treatment, or medicine which the licensee knows or has reason to know has little or no therapeutic value;

KRS 311.597 (3): A serious act, or a pattern of acts committed during the course of his medical practice which, under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice.

KRS 311.597 (4): Conduct which is calculated or has the effect of bringing the medical profession into disrepute, including, but not limited to, any departure from, or failure to conform to the standards or acceptable and prevailing medical practice within the Commonwealth of Kentucky.... For the purposes of this subsection, actual injury to a patient need not be established.

2. The order of probation that Morgan is charged with violating is entitled "Order Amending Agreed Order of Probation," which was issued on September 14, 1999. The provisions of that Order that appear relevant to the current charges are found in numerical paragraph 2. sub paragraphs (f)(j)(k)(n)(o)(p)(q)and(t). The first seven subparagraphs listed required Morgan to conform to a standard of record keeping which in turn affects the care of his patients because it requires notations that certain basic procedures were followed and because it forms a reference

for future treatment. Subparagraph (t) requires Morgan to "fully comply with the Kentucky Medical Practices Act." Ex.2.

3. The medical records of 11 of Morgan's patients were introduced into evidence at the hearing. The file of Patient A was under consideration because a complaint had been filed concerning Morgan's treatment of that patient. Ex. 3. The other 10 files of Patient B through Patient K were chosen at random because the Board's medical expert had questions about Morgan's general care of his patients. The ages of the patients to whom the records belonged ranged from 65 to 88. Although Morgan engages in family practice, his clientele appears to be primarily geriatric.

4. With the exception of Patient A, and one other patient, the first entries in the medical records were made in 1996. With the exception of Patient A, the latest entries in the records copied by the Board's investigator were made in October, November, or December, 1999. Thus at a maximum only the last 3½ months of record entries were made after the Amended Order of Probation was issued. The Emergency Order of Suspension contained only one specific reference to poor record keeping after September 14, 1999, the date of the Amended Order and that was in reference to treatment of Patient I on December 1, 1999. Ex. 3. In that the Amended Order meted out the discipline for record keeping deficiencies prior to September 14, 1999, the Hearing on the Emergency Order of Suspension was concerned with violations of the Amended Order in regard to record keeping and with new charges concerning other issues.

5. The Board's medical expert, [REDACTED] M.D., who qualified as an expert in family practice, testified that the record keeping was substandard in the 11 records that she reviewed. She also conceded that it had improved in the past two years, but was still not generally up to an acceptable standard. She testified only as to one entry, that on December 1, 1999, as

demonstrating incomplete record keeping after the Amended Order became effective. In that entry for Patient I, Morgan noted "Dyspneic on exertion" but there is no indication that he listened to Patient I's lungs. Also the entry is unclear as to whether the prescription noted was a new prescription or a refill prescription of previous treatment. Ex. 14. In short, the standard "Subjective, Objective, Assessment, Plan" format was not followed as required in the Amended Order, 2(f).

6. A review of the latest entries in the medical records entered into the record at the Hearing indicated that Morgan's record keeping did not meet the standard described by [REDACTED] nor did it meet the requirements of the Amended Order. Numerical paragraph 2 of the Amended Order required:

- p. The licensee must formulate and include a plan of treatment for each patient. This plan shall be formulated upon the initial visit and be updated in the progress notes for each visit.....
- q. There must be a follow-up of the medical status for each patient upon each visit.

Ex. 2. The entry for Patient D for December 31, 1999, contains only vital signs. Ex. 9. The entry for Patient F on October 19, 1999, Ex. 11; for Patient G on October 15, 1999, Ex. 12; for Patient H on October 15, 1999, Ex. 13; for Patient J on November 18, 1999, Ex. 15; and for Patient K on October 7, 1999, Ex. 16, were all sketchy and incomplete such as one word subjective descriptions, a test to be run, or a prescription.

7. The charges against Morgan contain a statement from Barnes that "Failure to document his patients office visits is gross negligence." If that statement means that patients made office visits and there was no record at all of their visits, there was no substantial evidence that this occurred.

8. According to [REDACTED] Morgan failed to work up life-threatening illnesses in 5 out of the 11 patients whose records she reviewed.

- a. Patient A came into Morgan's office on July 28, 1998, complaining that she was throwing up old blood. Her hematocrit was 22% which was considerably below the normal level of 33-36. Morgan diagnosed a bleeding gastric ulcer and told her to discontinue Daypro and take over-the-counter Cimetidine and Pepto-Bismol. On the next day, July 29, 1998, Morgan noted that Patient A was taking Tagamet and Pepto-Bismol and diagnosed blood loss iron deficiency anemia. On July 31, Morgan noted that Patient A's "pallor is dissipating a bit." On August 4, Moore noted that Patient A's hematocrit was 25 which was a "marked improvement." On August 8, Patient A was taken to the hospital because she was vomiting blood and had bloody stools. She died almost immediately. In his file Morgan listed acute myocardial infarction as the first cause of death with gastrointestinal blood loss anemia as second. Ex. 6. [REDACTED] testified that the standard of care in such a situation was to hospitalize the patient immediately, give her a transfusion, and perform an urgent esophago-gastroduodenscopy. The risk of not transfusing Patient A was much greater than any risks from transfusion. The urgency of such treatment was increased by the "very significant risk factors for heart disease" such as hypertension, diabetes, hypercholesterolemia, post-menopausal state, possible obesity, and treatment with DHEA. Ex. 3.
- b. Patient B came to Morgan on May 1, 1997, complaining of chest

discomfort. Morgan noted ASCV on the file and ordered a ECG and x-ray. Patient B's ECG was abnormal. Morgan wrote in the file that he could not rule out the possibility of a heart attack. Ex. 7. [REDACTED] testified that the standard of care is to admit the patient to the hospital so that tests can be performed and the heart can be monitored.

- c. Patient E had an EKG run on June 4, 1999. Ex. 10. Barnes noted that the EKG was suspicious for ischemia. There was a biphasic T wave in V2, as well as persistence of T wave inversion laterally. The standard of care, according to [REDACTED] is to admit the patient to the hospital so that tests can be run and the heart can be monitored.

- d. Patient G came to Morgan on September 5, 1996, complaining that she tired easily and had some chest discomfort which felt like pressure or a need to belch frequently. Morgan had an EKG run. Ex. 12. He failed to make an assessment or plan concerning her complaint. [REDACTED] testified that she was concerned that Patient G had angina or possibly a heart attack. The record showed that Patient G had been prescribed 100 nitroglycerine on October 2, 1996; 100 on November 20, 1996; again on December 20, 1996, 100 on January 8, 1997, 100 on February 2, 1997, again on April 21, 1997, and June 10, 1997. Ex. 12. [REDACTED] testified the heavy use of nitroglycerine could also indicate significant coronary artery disease, but only relieved the symptoms. On October 22, 1997, Morgan noted simply STROKE in Patient G's records but again did no work-up. Ex. 12. The standard of care for such symptoms as Patient G demonstrated is to

hospitalize the patient to run tests and monitor the heart.

- e. Patient K came to Morgan's office on September 4, 1997. One of Morgan's notations was "s-angina- Rx NTG." On December 9, 1997, Patient K had a four vessel bypass. Ex. 16. [REDACTED] testified that the standard of care was to refer the patient to a cardiologist before he had a myocardial infarction and urgent need for a bypass. Prescribing nitroglycerine only relieved the symptoms; Morgan made no effort to find the cause.

9. Related to Morgan's failure to provide proper care to his patients was his failure to give Patient D a tetanus shot after he sewed up a cut 3cm in length that the patient had received from a hacksaw. Morgan did not note that he gave a tetanus shot or that he inquired as to when Patient D last had such a shot. Ex. 9. The standard of care according to [REDACTED] is to assure that a patient is protected against tetanus after a severe laceration.

10. [REDACTED] testified that Morgan endangered Patient C by his failure to monitor the adverse side effects of Prandin. On September 2, 1998, Bruce S. Chang, M.D., sent Morgan a report on Patient C in which he noted "Recent onset of hypoglycemic episodes possibly related to addition of Prandin." Yet Morgan failed to monitor Patient C regarding the Prandin at the next office visit on November 28, 1998; and, on November 6, 1998, and June 25, 1999, Morgan wrote refills of Prandin and instructed Patient C to continue taking it. On June 28, 1999, Patient C decreased his dosage himself because he had "been experiencing some hypoglycemic episodes which caused consumption of cookies late at night." Ex. 8. Morgan's records give no indication that the doctor routinely discussed the side effect of medicines with his patient or monitored him for harmful side effect. [REDACTED] testified that the hypoglycemic episodes could case harm. She

stated that the standard of care is to educate and monitor patients in regard to the harmful side effects of medicines.

11. [REDACTED] testified that Morgan endangered the life of Patient E by his failure to follow-up on abnormal laboratory values. On June 1, 1998, Morgan noted that a urine test was run on Patient E. The laboratory results issued on June 3, 1998, reported that Patient E's potassium, phosphorus, and LDH were abnormally high. The laboratory report cautioned that the high values "may be caused by specimen mixing in transit, or prolonged time of serum remaining in contact with cells before centrifugation." Ex. 10. [REDACTED] testified that the standard of care is to repeat a test with questionable outcomes because these elevated levels could be signs of serious illnesses. Morgan risked his patient's health by not following up on test results that facially suggested grave problems. Likewise, Morgan did not follow up on Patient C's high white blood cell count on August 17, 1998, Ex. 8, nor on Patient H's elevated leukocytes on September 10, 1999, Ex. 13, nor on Patient I's high values of globulin and AST. Ex. 14. This repeated failure to note and address such abnormalities placed patients at risk because the abnormalities could be signals of serious latent or developing illnesses.

12. [REDACTED] testified that the use of out-dated therapies such as Lincomycin, Serapes, and Pro Times (PTs) demonstrated ignorance of current, more effective therapies.

- a. Lincomycin, an antibiotic, was prescribed for Patient B, Patient D, Patient H, and Patient J. The drug is effective in only a narrow range and has the unfortunate side effect of causing bad diarrhea. It has been replaced by other more effective drugs that treat a wider range and that are superior enough that the use of a relatively ineffective drug such as Lincomycin is below the standard of care. The low cost of Lincomycin does not outweigh

the greater efficacy of more modern drugs.

- b. Serapes, which is a diuretic, can place patients in a position of risk because it can cause low sodium and low potassium. It has generally been replaced by hydrochlorothiazide or, in the case of diabetes and hypertension by an ACE inhibitor. Serapes was used extensively with Patient F.
- c. The use of PTs has been outdated by the use of INR. Patient E and Patient K regularly had PTs run. The problem with using PTs to measure blood coagulation is that one test cannot be readily translated in order to compare it with other similar tests because of variability and lack of consistency.

13. [REDACTED] also testified that the standard of care was to use complementary therapies along with more traditional therapies. She said that complementary therapies have an appropriate place in medical treatment, but they should not be substituted completely for more traditional and proven methods of treatment.

- a. On February 10, 1998, Morgan noted, in regard to Patient I's chronic heart failure, that "She plans to walk more and take more vinegar." Ex. 14. On September 30, 1999, Morgan mentions "vinegar" as part of the "Plan" for Patient J to treat paroxysmal leg spasm. Ex. 15. On October 1, 1999, Morgan notes that Patient B "is going to try using vinegar, a teaspoon to a tablespoon every day" as part of the treatment for hypercholesterolemia. Ex. 7. These suggestions of vinegar, however, do not seem to be exclusive of other more traditional therapies. [REDACTED] testified that vinegar *per se* is not harmful.
- b. On April 23, 1998, Morgan suggested that Patient K use "hydrotherapy"

for his chronic heart failure. [REDACTED] testified that she did not know what "hydrotherapy" was.

14. A general problem with Morgan's patients' files that was described by [REDACTED] is that the temperatures of his patients were overwhelmingly recorded as 98.6°. [REDACTED] stated that she saw only one deviation from 98.6°. A closer look at the temperatures of the files selected at random indicates that 30 out of 221, or 14%, were above or below the "normal" temperature, ranging from 97.0° to 99.4°. [REDACTED] was adamant in her testimony that all people were not made with the same temperature and that such uniformity was the result of "obvious fabrication." She urged that Morgan needed to assess whether his employees were accurately taking and recording temperatures. [REDACTED] however, gave no testimony as to the variation that could be expected.

15. Finally [REDACTED] testified that Morgan practiced no real preventive medicine. She conceded that some standard preventive measures were no longer as necessary for older patients. Some health maintenance, however, was dictated by the standard of care and the failure to oversee such preventive care as influenza shots, pneumovax, tetanus shots, and aspirin put the health of his patient at risk. Morgan's charts were not totally devoid of such care. In October, 1998, Patient B and Patient E had a flu shot and Patient J received a tetanus shot in November, 1997, but there is certainly no consistent or even general preventive care.

16. There were other deviations from good practice that [REDACTED] was concerned about and discussed in her testimony but findings are made only in regard to those items that are specifically delineated as the factual basis of the Emergency Order of Suspension.

17. [REDACTED] testified that the standards of care that she enunciated were for the Commonwealth as a whole and that no distinction was made in regard to the standard of care as to whether the doctor had a solo practice, a multi-physician practice, or was associated with an

institution. She stated that the standard of care is based upon medical literature and studies, lectures, association with professional colleagues, published guidelines and other recognized medical sources.

CONCLUSIONS OF LAW

18. The standard used in rendering a decision concerning emergency action by an agency is that "The emergency order shall be affirmed if there is substantial evidence of a violation of law which constitutes an immediate danger to the public health, safety, or welfare." KRS 13B.135(3). In Kentucky State Racing Commission v. Fuller, Ky., 481 S.W.2d 298, 302 (1972), the Court defined "substantial evidence" as "being evidence of substance and relevant consequence, having the fitness to induce conviction in the minds of reasonable men." The Court elaborated, that substantial evidence "is something less than the weight of the evidence, and the possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's finding from being supported by substantial evidence." A further elaboration upon reviewing the decision of an Agency is found in Haste v. Kentucky Unemployment Insurance Commission, Ky. App., 673 S.W.2d 740, 740 (1984), "[F]indings of an administrative agency will be upheld despite its partial reliance upon incompetent evidence if it also had before it competent evidence which by itself would have been legally sufficient to support the findings."

19. It is concluded that Morgan violated paragraph 2(p) and (q) of the Order Amending Agreed Order of Probation by his failure to keep adequate medical records as required in the Order. Paragraph 2(f) was violated in regard to Patient I. These failures are violations of KRS 311.595(13). The general quality of Morgan's record keeping was substandard, but improving. Because only two and one-half months of records had been compiled since the

issuance of the Amended Order, no accurate evaluation could be made concerning most of the Order's requirements. Additionally [REDACTED] offered little specific guidance as to the omissions in the post-Amended Order entries.

20. It is to be noted that the Board's medical expert was not willing to draw conclusions concerning Morgan's practice until she had seen enough randomly selected records to conclude that his treatment of Patient A was not a single mistake of gross negligence or a lone deviation from the standard of care. [REDACTED] presented substantial evidence that Morgan had pervasive problems in his practice that categorically and as a whole endangered his patients.

21. It is concluded on the basis of the facts that were found above that Morgan failed to conform to prevailing medical practice thus violating KRS 311.597(4) and endangered the health, safety, and welfare of his patients by his failure to provide work-ups on life threatening diseases, by his failure to provide complete care in regard to Patient D's laceration, by his failure to monitor the adverse side effects of Prandin, by his failure to follow-up on abnormal laboratory values, by his use of outdated, less effective therapies, and by his failure to use preventive medicine for his clients.

22. It is concluded on the basis of the facts that were found above that Morgan demonstrated gross incompetence, gross negligence, or malpractice thus violating KRS 311.597(3) and endangered the health, safety, and welfare of his patients by his failure to provide work-ups on life threatening diseases.

23. The violations of KRS 311.597(3) and (4) are also violations of the Amended Order and thus violate KRS 311.595(13). They are also violations under KRS 311.595(9).

24. It is concluded that there was not sufficient substantial evidence to conclude that Morgan failed to properly supervise his staff in assessing vital signs because [REDACTED] testimony

was not completely accurate and there was no standard to judge what the range of temperatures should be.

25. It is concluded that there was not sufficient substantial evidence to demonstrate that Morgan's use of vinegar and hydrotherapy deviated from the standard of care or endangered the patients.

FINAL ORDER

Being sufficiently advised, IT IS HEREIN ORDERED that the EMERGENCY ORDER OF SUSPENSION is **AFFIRMED**.

Exhibits 3-17 are SEALED in order to protect the privacy of the patients.

NOTICE OF APPEAL RIGHTS

Pursuant to KRS 13B.135(4), this Order is a final order of the Kentucky Board of Medical Licensure and any party aggrieved by the decision may appeal to the Circuit Court in the same manner as provided in KRS 13B.140. KRS 13B.140 reads in part:

(1) All final orders of an agency shall be subject to judicial review in accordance with the provisions of this chapter. A party shall institute an appeal by filing a petition in the Circuit Court of venue, as provided in the agency's enabling statutes, within thirty (30) days after the final order of the agency is mailed or delivered by personal service. If venue for appeal is not stated in the enabling statutes, a party may appeal to Franklin Circuit Court or the Circuit Court of the county in which the appealing party resides or operates a place of business. Copies of the petition shall be served by the petitioner upon the agency and all parties of record. The petition shall include the names and addresses of all parties to the proceeding and the agency involved, and a statement of the grounds on which the review is requested. The petition shall be accompanied by a copy of the final order.

Pursuant to KRS 23A.010(4), "Such review [by the Circuit Court] shall not constitute an appeal but an original action." Some courts have interpreted this language to mean that summons must be served upon filing an appeal in Circuit Court.

SO ORDERED this 25th day of April, 2000.



SUSAN S. DURANT
HEARING OFFICER
DIV. OF ADMINISTRATIVE HEARINGS
OFFICE OF THE ATTORNEY GENERAL
1024 CAPITAL CENTER DRIVE, STE. 200
FRANKFORT, KY 40601-8204
(502) 696-5442
(502) 573-8315 - FAX

CERTIFICATE OF SERVICE

I hereby certify that the original of this ORDER was mailed this 25th day of April, 2000, by first class mail, postage prepaid, to:

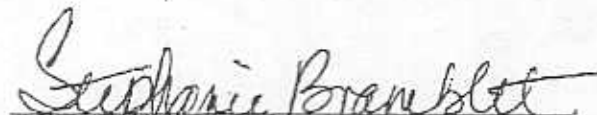
JILL LUN
KY BOARD OF MEDICAL LICENSURE
HURSTBOURNE OFFICE PARK SUITE 1B
310 WHITTINGTON PKWY
LOUISVILLE KY 40222

for filing; and a true copy was mailed, postage prepaid, to:

HENRY J NOVAK
ATTORNEY AT LAW
4412 SPICEWOOD SPRINGS RD STE 402
PO BOX 26162
AUSTIN TX 78755-0162

MARK L MORGAN
ATTORNEY AT LAW
105 W MAIN ST
LEBANON KY 40033

C LLOYD VEST II
GENERAL COUNSEL
KY BOARD OF MEDICAL LICENSURE
HURSTBOURNE OFFICE PARK SUITE 1B
310 WHITTINGTON PKWY
LOUISVILLE KY 40222


STEPHANIE BRANBLATT
DOCKET COORDINATOR

COMMONWEALTH OF KENTUCKY
STATE BOARD OF MEDICAL LICENSURE
CASE NO. 732

FILED OF RECORD
MAR 16 2000
K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF
KENTUCKY HELD BY, KIRK D. MORGAN, M.D., LICENSE NO. 16289,
2708 FRANKFORT AVENUE, LOUISVILLE, KENTUCKY 40206

EMERGENCY ORDER OF SUSPENSION

The Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel A, considered this matter at its February 17, 2000 meeting. At that meeting, Inquiry Panel A considered a Memorandum from Betty A. Prater, Medical Investigator, dated January 25, 2000; a grievance dated July 14, 1999 from Betty F. Leonhardt; a response dated November 11, 1999 from the licensee Kirk D. Morgan, M.D.; and December 8 and January 17, 2000 reports from a Board consultant. Having considered all of this information and being sufficiently advised, Inquiry Panel A ENTERS the following EMERGENCY ORDER OF SUSPENSION, in accordance with KRS 311.592(1) and 13B.125(1):

FINDINGS OF FACT

Pursuant to KRS 13B.125(2) and based upon the information available to it, Inquiry Panel A concludes there is probable cause to make the following Findings of Fact, which support its Emergency Order of Suspension:

1. At all relevant times, Kirk D. Morgan, M.D. (hereafter "the licensee"), was licensed by the Kentucky Board of Medical Licensure (hereafter "the Board") to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is Family Practice.

3. On July 14, 1999, Patient A's daughter filed a grievance with the Board against the licensee's Kentucky medical license, alleging in part:

My mother has always been healthy and active throughout her whole life. She has not been in the hospital since I was 15 years old (now 62). Her illness started with a prescription from Kirk D. Morgan for daypro. Two a day after a full meal. She took one after breakfast and one after dinner. This lead to a bleeding ulcer. Kirk Morgan failed to give her any medical assistance to save her life. Keep in mind she's 81 years old. My internist told me you don't fool with a young person or an old person with a bleeding ulcer. My mother died from lack of blood, which lead to heart failure. She never had a heart problem. This was told to me by the doctor at Baptist East. I asked Kirk Morgan twice to put her in the hospital, his EXACT words were your doing as good as any hospital. Had he turned her over to another doctor, she would be alive today. I asked him twice to give her blood (transfusion) his EXACT words were she could get hepatitis or aids. Make that three times I asked him at the funeral home why didn't you give her a blood transfusion, his exact words were she could get hepatitis or aids.

Patient A's mother died during her professional relationship with the licensee.

4. During its interview, the Board obtained the licensee's medical records regarding Patient A and provided the licensee with the opportunity to submit a written response. This information was provided to a Board consultant, whose medical specialty is Family Practice, for review. The Board consultant concluded, in part,

...
[Patient A's] medical care prior to July 28, 1998 was fragmented at best. Record keeping is poor, handwriting fairly illegible, with little history, only rare physical findings documented and poor follow up. ...

...I am concerned:

- 1) that the documentation of the patient's physical exam is absent;
- 2) that there are no real review of systems which may have picked up ulcer or anginal symptoms before they become life threatening, and
- 3) no mention of prevention, including flu shots and pneumovax. ...In general, I feel that Dr. Morgan's lack of organization (as reflected in his medical record) and lack of documentation of more history and physical exams is sloppy medicine at best, and is worrisome for having important issues fall through the cracks in both healthy and complicated patients.

....
...when the patient presented with an obvious GI bleed and the hematocrit was 22%, the standard of care was hospitalization and urgent esophogastro-duodenoscopy to prevent life threatening hemorrhage. Also, I agree with the patient's daughter that the

standard of care would be transfusion in this elderly patient. This patient has a number of risk factors for heart disease. Including hypertension, diabetes, hypercholesterolemia, post-menopausal state, possibly obesity (I do not find mention of height) and treatment with DHEA.

In light of the patient's age and presence of very significant risk factors for heart disease, I feel that Dr. Morgan's failure to hospitalize Mrs. Franklin on 7-28-98 is gross negligence. I feel his general medical care of [Patient A] before the morbid event in July to be substandard and unacceptable. Whether this is from incompetence or ignorance, I can not know without review of other records to determine if he does not follow published guidelines for treatment of diabetes, hypertension, hypercholesterolemia, and recommended health maintenance issues. Further chart review could also help determine if this was an isolated event of malpractice or if he indeed is a danger to his patients as a whole.

5. In order to fully assess the quality of the licensee's medical practice, the Board obtained his medical records for Patients B-K and provided those records to the Board consultant for review. The consultant provided individual opinions regarding each patient and provided the following general conclusions:
 1. Most of the notes contain little if any subjective and objective assessment and plan. Over the past two years the notes are a little better, however, this problem persists into the present. Without a record of these visits, patient care is compromised because there is no continuity of thought or integration of material.
 2. Any recently transcribed visit is not back from the typist. ...there are missing dictations from as far back as October 4th. Again, I feel strongly that the medical record needs to be complete as soon as possible, and this wait on dictation is unacceptable.
 3. Every temperature recorded (except one, which was 98.8) is 98.6, which makes one suspect that all the values were fabricated. With this evidence, it causes one to wonder whether the same thing is happening with the blood pressures. All the blood pressure reading are within the range of 120-148/75-86, except for one that is written in his handwriting at 180/100. This was after his assistant wrote 148/86 (Patient C, 11-14-97)! As common as hypertension appears to be diagnosed in his office, I am concerned that some hypertension is undertreated or underdiagnosed. If this is substantiated, I am very concerned because it appears that he performs many labs in his practice and these laboratory values may be fabricated also.
 4. It appears that he is doing anticoagulation studies in his office. All the follow-up after coumadinization is monitored as PTs. This practice was stopped several years ago because of variability and lack of consistency between labs. INR's are now used to achieve standardization. Dr. Morgan is still using PTs. In addition, twice the control values are too high and suggest potential problems in the analysis (Patient K, 8-13-98 and 9-28-98). However, no mention was made of why the controls were so high, or that the values obtained on Patient K may be inaccurate.

This again reflects that Dr. Morgan is out-of-date, and that his laboratory has poor quality control. It also implicates him as failing in the supervisory role in the assurance that his patients receive appropriate treatment.

5. ... There is not much variation in the lab values obtained, which makes me suspect that the values may be inaccurate.
6. Dr. Morgan still gives frequent injections of Lincomycin, which is an old antibiotic. I am not aware of any [sic] still using this drug after the introduction of Rocephin onto the market about 10 years ago. Again, this is a marker of being out-of-date.

....

After reviewing these 10 charts, I feel that Dr. Morgan's medical practice is substandard as follows:

Deviations from standard of care:

1. Failure to perform subjective, objective, assessment and plans on the majority of his patients office visits. Because this was not a rare occurrence, but a pervasive finding, it reflects a laissez-faire attitude that can compromise patient care.
2. Lack of health maintenance, despite some documented 'yearly physicals' that included CXR, EKG, and labs but no real history, review of systems, or physical. There was also no preventative medicine.
3. Continued use of Lincomycin.
4. Failure to work-up Patient E on 6-10-99 when she had the EKG suggestive of ischemia.
5. Failure to to give Patient D a dT when he presented with a laceration.
6. Failure to admit Patient B to the hospital on 5-1-97 when he presented with chest pain.
7. Failure to work-up Patient G for chest pain.
8. Use of vinegar for congestive heart failure on 2-10-98.
9. Use of hydrotherapy for congestive heart failure on Patient K on 4-23-98.
10. Failure to work-up angina on Patient K on 12-8-97.
11. Failure to follow-up on abnormal labs on Patient E on 6-1-98.
12. Failure to monitor for side effects from Prandin on Patient C on 9-2-98 and again on his refills.

The use of out-dated therapies, e.g. Lincomycin, Serapes, PT's, are probably best categorized as gross ignorance.

Failure to work-up life-threatening illness in his patients is gross negligence or malpractice (#4, 6, 7, 10 and 12 above).

Failure to document his patients office visits is gross negligence.

Use of hydrotherapy, vinegar and Lipex and Lecithin are outside of traditional medicine. I find these therapies disturbing because they are being used to treat serious medical illnesses. I feel that complimentary therapies should be used *in conjunction* with traditional therapies when the patient is at risk for life-threatening disease. Because I am unfamiliar with any studies on these particular therapies, however, I cannot determine if they are incompetence, ignorance, negligence or malpractice.

Failure to address the obvious fabrication of vital signs by his office staff, and

possibly failure to ensure quality control in his laboratory are gross negligence. I feel that Dr. Morgan does put his patients lives at risk because of his failure to address life-threatening symptoms, failure to follow-up on abnormal labs, failure to maintain quality control in his office, and failure to follow health maintenance as delineated by the United States Preventative Services Task Force and other national groups.

6. The Board filed an administrative Complaint against the licensee's Kentucky medical license on September 22, 1989. That Complaint was resolved informally by an agreement dated May 20, 1991. A second Complaint was filed against the licensee's Kentucky medical license on August 30, 1993. That Complaint was resolved informally by an Agreed Order dated August 18, 1994. The Board filed Administrative Complaint 558 against the licensee's Kentucky medical license on August 17, 1995. Complaint 558 was resolved informally by the parties on April 18, 1996 by the filing of an Agreed Order of Probation. On September 14, 1999, the Board entered an Order Amending Agreed Order of Probation, modifying the terms and conditions of the Agreed Order of Probation. At all times relevant to the present allegations, the licensee was subject to the terms and conditions of either the Agreed Order of Probation or the Order Amending Agreed Order of Probation; accordingly, the terms and conditions of those Orders are incorporated by reference into this pleading.

CONCLUSIONS OF LAW

Pursuant to KRS 13B.125(2) and based upon the information available to it, Inquiry Panel A finds there is probable cause to support the following Conclusions of Law, which serve as the legal basis for this Emergency Order of Suspension:

1. The licensee's Kentucky medical license is subject to regulation and discipline by this Board.

2. KRS 311.592(1) provides that the Board may issue an emergency order suspending, limiting, or restricting a physician's license at any time an inquiry panel has probable cause to believe that a) the physician has violated the terms of an order placing him on probation; or b) a physician's practice constitutes a danger to the health, welfare and safety of his patients or the general public.
3. There is probable cause to believe that the licensee has violated KRS 311.595(13) and KRS 311.595(9), as illustrated by KRS 311.597(2), 311.597(3) and 311.597(4).
4. The Board may draw logical and reasonable inferences about a physician's practice by considering certain facts about a physician's practice. If there is proof that a physician has violated a provision of the Kentucky Medical Practice Act in one set of circumstances, the Board may infer that the physician will similarly violate the Medical Practice Act when presented with a similar set of circumstances. Similarly, the Board concludes that proof of a set of facts about a physician's practice presents representative proof of the nature of that physician's practice in general. Accordingly, probable cause to believe that the physician has committed certain violations in the recent past presents probable cause to believe that the physician will commit similar violations in the near future, during the course of the physician's medical practice.
5. The Board concludes that there is probable cause to believe that the licensee's practice constitutes a danger to the health, safety and welfare of his patients and of the general public.
6. The United States Supreme Court has ruled that it is no violation of the federal Due Process Clause for a state agency to temporarily suspend a license, without a prior

evidentiary hearing, so long as 1) the immediate action is based upon a probable cause finding that there is a present danger to the public safety; and, 2) the statute provides for a prompt post-deprivation hearing. Barry v. Barchi, 443 U.S. 55, 61 L.Ed.2d 365, 99 S.Ct. 2642 (1979); FDIC v. Mallen, 486 U.S. 230, 100 L.Ed.2d 265, 108 S.Ct. 1780 (1988) and Gilbert v. Homar, 117 S.Ct. 1807 (1997). Cf. KRS 13B.125(1).


KRS 13B.125(3) provides that the Board shall conduct an emergency hearing on this emergency order within ten (10) working days of a request for such a hearing by the licensee. The licensee has been advised of his right to a prompt post-deprivation hearing under this statute.

EMERGENCY ORDER OF SUSPENSION

Based upon the foregoing Findings of Fact and Conclusions of Law, Inquiry Panel A hereby ORDERS that the license to practice medicine in the Commonwealth of Kentucky held by Kirk D. Morgan, M.D., is SUSPENDED and Dr. Morgan is prohibited from practicing medicine in the Commonwealth of Kentucky until the resolution of the Complaint setting forth the allegations discussed in this pleading or until such further Order of the Board.

Inquiry Panel A further declares that this is an EMERGENCY ORDER, effective upon receipt by the licensee.

SO ORDERED this 16th day of March, 2000.



DONALD J. SWIKERT, M.D.
ACTING CHAIR, INQUIRY PANEL A

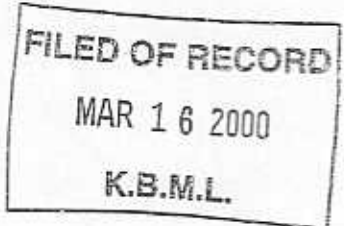
CERTIFICATE OF SERVICE

I certify that the original of this Emergency Order of Suspension was delivered to Mr. C. William Schmidt, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and a copy was mailed to Kirk D. Morgan, M.D., 2708 Frankfort Avenue, Louisville, Kentucky 40206 via certified mail return-receipt requested on this 16th day of March, 2000.

C. Lloyd Vest II

C. LLOYD VEST II
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-8046

COMMONWEALTH OF KENTUCKY
STATE BOARD OF MEDICAL LICENSURE
CASE NO. 732



IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF
KENTUCKY HELD BY KIRK D. MORGAN, M.D., LICENSE NO. 16289,
2708 FRANKFORT AVENUE, LOUISVILLE, KENTUCKY 40206

COMPLAINT

Comes now the Complainant Donald J. Swikert, M.D., Acting Chair of the
Kentucky Board of Medical Licensure's Inquiry Panel A, and on behalf of the Panel
which met on February 17, 2000, states for its Complaint against Licensee, Kirk D.
Morgan, M.D., as follows:

1. At all relevant times, Kirk D. Morgan, M.D. (hereafter "the licensee"), was licensed
by the Kentucky Board of Medical Licensure (hereafter "the Board") to practice
medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is Family Practice.
3. On July 14, 1999, Patient A's daughter filed a grievance with the Board against the
licensee's Kentucky medical license, alleging in part:

My mother has always been healthy and active throughout her whole life. She has
not been in the hospital since I was 15 years old (now 62). Her illness started with a
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This information was provided to a Board consultant, whose medical specialty is Family Practice, for review. The Board consultant concluded, in part,

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...I am concerned:

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...when the patient presented with an obvious GI bleed and the hematocrit was 22%, the standard of care was hospitalization and urgent esophago-gastro-duodenoscopy to prevent life threatening hemorrhage. Also, I agree with the patient's daughter that the standard of care would be transfusion in this elderly patient. This patient has a number of risk factors for heart disease. Including hypertension, diabetes, hypercholesterolemia, post-menopausal state, possibly obesity (I do not find mention of height) and treatment with DHEA.

In light of the patient's age and presence of very significant risk factors for heart disease, I feel that Dr. Morgan's failure to hospitalize Mrs. Franklin on 7-28-98 is gross negligence. I feel his general medical care of [Patient A] before the morbid event in July to be substandard and unacceptable. Whether this is from incompetence or ignorance, I can not know without review of other records to determine if he does not follow published guidelines for treatment of diabetes, hypertension, hypercholesterolemia, and recommended health maintenance issues. Further chart review could also help determine if this was an isolated event of malpractice or if he indeed is a danger to his patients as a whole.

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After reviewing these 10 charts, I feel that Dr. Morgan's medical practice is substandard as follows:

Deviations from standard of care:

1. Failure to perform subjective, objective, assessment and plans on the majority of his patients office visits. Because this was not a rare occurrence, but a pervasive finding, it reflects a laissez-faire attitude that can compromise patient care.

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3. Continued use of Lincomycin.
4. Failure to work-up Patient E on 6-10-99 when she had the EKG suggestive of ischemia.
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The use of out-dated therapies, e.g. Lincomycin, Serapes, PT's, are probably best categorized as gross ignorance.

Failure to work-up life-threatening illness in his patients is gross negligence or malpractice (#4, 6, 7, 10 and 12 above).

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Use of hydrotherapy, vinegar and Lipex and Lecithin are outside of traditional medicine. I find these therapies disturbing because they are being used to treat serious medical illnesses. I feel that complimentary therapies should be used *in conjunction* with traditional therapies when the patient is at risk for life-threatening disease. Because I am unfamiliar with any studies on these particular therapies, however, I cannot determine if they are incompetence, ignorance, negligence or malpractice.

Failure to address the obvious fabrication of vital signs by his office staff, and possibly failure to ensure quality control in his laboratory are gross negligence. I feel that Dr. Morgan does put his patients lives at risk because of his failure to address life-threatening symptoms, failure to follow-up on abnormal labs, failure to maintain quality control in his office, and failure to follow health maintenance as delineated by the United States Preventative Services Task Force and other national groups.

6. The Board filed an administrative Complaint against the licensee's Kentucky medical license on September 22, 1989. That Complaint was resolved informally by an agreement dated May 20, 1991. A second Complaint was filed against the licensee's Kentucky medical license on August 30, 1993. That Complaint was resolved informally by an Agreed Order dated August 18, 1994. The Board filed

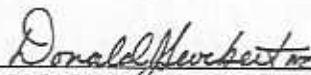
Administrative Complaint 558 against the licensee's Kentucky medical license on August 17, 1995. Complaint 558 was resolved informally by the parties on April 18, 1996 by the filing of an Agreed Order of Probation. On September 14, 1999, the Board entered an Order Amending Agreed Order of Probation, modifying the terms and conditions of the Agreed Order of Probation. At all times relevant to the present allegations, the licensee was subject to the terms and conditions of either the Agreed Order of Probation or the Order Amending Agreed Order of Probation; accordingly, the terms and conditions of those Orders are incorporated by reference into this pleading.

7. By his conduct, the licensee has violated KRS 311.595(13) and KRS 311.595(9), as illustrated by KRS 311.597(2), 311.597(3) and 311.597(4). Accordingly, there are legal grounds for the Board to impose disciplinary sanctions against the licensee's Kentucky medical license.
8. Respondent is directed to respond to the allegations delineated in the Complaint within thirty (30) days of service thereof and is further given notice that:
 - (a) His failure to respond may be taken as an admission of the charges;
 - (b) He may appear alone or with counsel, may cross-examine all prosecution witnesses and offer evidence in his defense.
9. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for July 25 & 26, 2000, at 9:00 a.m., Eastern Standard Time, at the Kentucky Board of Medical Licensure, Hurstbourne Office Park, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222. Said hearing shall be held pursuant to the Rules and Regulations of the Kentucky Board of Medical Licensure. This hearing shall

proceed as scheduled and the hearing date shall only be modified by leave of the Hearing Officer upon a showing of good cause.

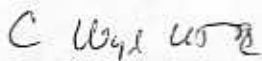
WHEREFORE, Complainant prays that appropriate disciplinary action be taken against the license to practice medicine held by Kirk D. Morgan, M.D.

This 16th day of March, 2000.


DONALD J. SWIKERT, M.D.
ACTING CHAIR, INQUIRY PANEL A

CERTIFICATE OF SERVICE

I certify that the original of this Complaint was delivered to Mr. C. William Schmidt, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222 and a copy was mailed, postage prepaid to, Division of Administrative Hearings, 1024 Capital Center Drive, Frankfort, Kentucky 40601-8204 and a copy was mailed via certified mail to Kirk D. Morgan, M.D., 2708 Frankfort Avenue, Louisville, Kentucky 40206 on this the 16th day of March, 2000.


C. LLOYD VEST, II
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
502/429-8046

COMMONWEALTH OF KENTUCKY
STATE BOARD OF MEDICAL LICENSURE
CASE NO. 558
ADMINISTRATIVE ACTION NO. 95-KBM L-1578

FILED OF RECORD
SEP 14 1999
K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF
KENTUCKY HELD BY KIRK D. MORGAN, M.D., LICENSE NO. 16289,
9105 U.S. 42, PROSPECT, KENTUCKY 40059

ORDER AMENDING
AGREED ORDER OF PROBATION

At its October 15, 1998 meeting, the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Hearing Panel B, considered a request by the licensee to modify the terms and conditions of his Agreed Order of Probation so that they were similar to the terms and conditions found in informal resolutions of other cases involving the use of chelation therapy. Panel B had originally considered this request at its July 1998 meeting, but deferred further discussion until the full Board had an opportunity at its September 1998 meeting to discuss alternative therapies generally. In addition to the licensee's request, the Panel reviewed a September 28, 1998 memorandum by the Board's General Counsel; the April 18, 1996 Agreed Order of Probation; a December 15, 1997 letter from the licensee's attorney; an April 1998 position paper by Terence R. Collins, M.D., entitled, "Review of Efficacy of Chelation Therapy;" a June 23, 1998 letter from Dr. Collins to the Board's General Counsel, with attachment; and, a draft of the Board's Policy Statement, Complementary and Alternative Therapies. The Panel also heard oral comments from the licensee and his attorney.

Having considered all of that information and being sufficiently advised, Hearing Panel B ORDERED that the Panel Chair be vested with the discretion of the Panel to approve the requested modifications to the Agreed Order of Probation, upon the

favorable recommendation of the Dean, University of Kentucky College of Medicine, after his review of protocols submitted by the licensee addressing the following issues:

1. information concerning what medical conditions chelation therapy will be used to treat;
2. criteria utilized to determine if a patient is an appropriate candidate for chelation therapy; and,
3. information detailing how the therapy is administered.

On November 30, 1998, the Board received a report by the Dean of the College of Medicine, in which he concluded that the materials originally provided by the licensee for review did not warrant a favorable recommendation; the Dean specified the materials that would be needed to comply with the Panel's specifications and for a favorable recommendation. On July 6, 1999, the licensee submitted protocols, along with patient charts for review; these materials were forwarded to the Dean for review on July 30, 1999. On August 4, 1999, the Dean submitted a favorable recommendation, concluding that the materials provided represent appropriate patient information and approval forms, outlining the benefits and risk of such therapy and adhering to the written protocols requested by Panel B. This recommendation was forwarded to the Panel Chair on August 5, 1999.

Having considered all of the information available to it and being sufficiently advised, Hearing Panel B ORDERS that the licensee's request to modify the terms and conditions of his April 18, 1996 Agreed Order of Probation is GRANTED. Hearing Panel B further ORDERS that, effective upon its filing, the license to practice medicine in the Commonwealth of Kentucky held by Kirk D. Morgan, M.D., SHALL BE SUBJECT TO THE FOLLOWING AMENDED ORDER OF PROBATION:

AMENDED ORDER OF PROBATION

Hearing Panel B ORDERS that, effective upon its filing, the following AMENDED ORDER OF PROBATION shall supercede and replace the AGREED ORDER OF PROBATION entered by the parties on April 18, 1996:

1. The license to practice medicine in the Commonwealth of Kentucky held by Kirk D. Morgan, M.D., is PLACED ON PROBATION THROUGH, AND INCLUDING, APRIL 17, 2001.
2. During that period of probation, the licensee's Kentucky medical license SHALL BE SUBJECT to the following TERMS AND CONDITIONS:
 - a. the licensee shall not, in any form, fashion, or manner, utilize, discuss or recommend the use of Germanium;
 - b. the licensee shall not, in any form, fashion, or manner utilize, discuss or recommend the internal use of hydrogen peroxide;
 - c. the licensee shall post and maintain a sign in his office which details conditions a and b of this Amended Order of Probation and his commitment to complying with the terms of this Probation, throughout the course of his probation. The sign shall state:

As the result of various discussions with the Kentucky Board of Medical Licensure, I have adopted the following policy for my practice:

I will not utilize, discuss or recommend in any shape, form or fashion a) the use of Germanium for any condition; or, b) the internal use of hydrogen peroxide for any condition.

I appreciate your understanding and your cooperation in ensuring that I can comply with this agreement that I have reached with the Kentucky Board of Medical Licensure.


- d. If, during the course of this probationary period, Germanium or the internal use of hydrogen peroxide become an acceptable and prevailing standard of care for any condition, the licensee may request a modification in the terms of his probation;
- e. If, during the course of this probationary period, a statute is enacted which permits the use of Germanium or the internal use of hydrogen peroxide for any condition, that statute shall serve as a basis for a modification in the terms of his probation;
- f. The licensee shall maintain concise and legible patient charts which reflect the "Subjective, Objective, Assessment, Plan" format;
- g. Each of the licensee's patient charts shall contain medical record number(s);
- h. Each of the licensee's patient charts shall consist of dated and numbered pages;
- i. The licensee shall obtain an informed consent for treatment for each patient, for each procedure performed, which shall follow an explanation of the various procedures available and the relative length, costs and potential effects of each procedure. The licensee shall utilize the informed consent format reviewed and approved by the Board's representatives;
- j. Each of the licensee's patient charts shall include an accurate and current history of the problem being treated;
- k. Each of the licensee's diagnoses must be validated by objective means, either by medical record, letter from another physician, lab results, physical findings, etc.;
- l. The licensee shall coordinate his medical treatment of each patient with that patient's primary care physician. When the licensee provides medical treatment

to a patient, the licensee shall notify the patient's primary care physician that such treatment has been provided;

- m. Each of the licensee's patient charts must indicate whether the patient has allergies and, if so, must clearly identify those allergies;
- n. The licensee or his staff shall take and record each patient's vital signs on each visit. At a minimum, these would include the patient's blood pressure and pulse;
- o. The licensee must include some notation of physical examination(s) for each patient, at least upon the initial visit and as needed thereafter;
- p. The licensee must formulate and include a plan of treatment for each patient. This plan shall be formulated upon the initial visit and be updated in the progress notes for each visit. The licensee must follow the protocols reviewed and approved by the Board's representatives;
- q. There must be a follow-up of the medical status for each patient upon each visit;
- r. The licensee shall maintain a log of all patients administered EDTA chelation therapy, which shall include: the date of the visit; the reason for administration of EDTA chelation therapy; the method of billing for such treatment; the nature of the treatment; and, the date of the last administration.
- s. The licensee shall make that log and any/all patient charts available to the Board's agents, upon request, for review and/or submission to a Board consultant for review;
- t. The licensee shall fully comply with the Kentucky Medical Practice Act, KRS 311.530 *et seq.*

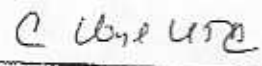
u. A violation of any condition of probation may result in revocation of the licensee's Kentucky medical license, or any lesser sanction authorized by the Kentucky Medical Practice Act.

SO ORDERED this 14th day of September, 1999.


PRESTON P. NUNNELLEY, M.D.
CHAIR, HEARING PANEL B

Certificate of Service

I certify that the original of this Amended Order of Probation was delivered to Mr. C. William Schmidt, Executive Director, Kentucky Board of Medical Licensure 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222 and a copy was mailed to Henry J. Novak, Esq., Suite 402, Spicewood Business Center, 4412 Spicewood Springs Road, P.O. Box 26162, Austin, Texas 78788 on this 14th day of September, 1999.


C. Lloyd Vest II
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-8046

FILED OF RECORD

APR 18 1996

K.B.M.L.

COMMONWEALTH OF KENTUCKY
STATE BOARD OF MEDICAL LICENSURE
AGENCY CASE NO. 558
ADMINISTRATIVE ACTION NO. 95-KBML-1578

KENTUCKY BOARD OF MEDICAL LICENSURE

PLAINTIFF

V.

KIRK D. MORGAN, M.D.

DEFENDANT

AGREED ORDER OF PROBATION

Come now the Kentucky Board of Medical Licensure (hereinafter "the Board"), by and through its Hearing Panel B, and Kirk D. Morgan, M.D., with their respective counsel, and in the interest of finally resolving this Administrative Complaint, hereby enter into the following Agreed Order of Probation:

STIPULATIONS OF FACT

Pursuant to 201 KAR 9:082, the parties enter the following Stipulations of Fact concerning the Administrative Complaint:

1. A prior Administrative Complaint was filed against Dr. Morgan's Kentucky medical license on September 22, 1989. That Complaint alleged that Dr. Morgan was utilizing Chelation therapy and intravenous hydrogen peroxide treatments.
2. That initial Administrative Complaint was resolved by an agreement of May 20, 1991, whereby counsel for the parties agreed that the Complaint would be dismissed based upon Dr. Morgan's

written assurance that he would neither use Chelation therapy nor intravenous hydrogen peroxide therapy unless: a) such treatment became the accepted and prevailing standard of care within the Commonwealth; b) he received approval by the Board to perform such treatments; or, c) he used such treatments pursuant to a protocol accepted by an Institutional Review Board.

3. That, on June 20, 1991, the Great Lakes Association of Clinical Medicine Institutional Review Board approved Dr. Morgan's project and established a protocol for Dr. Morgan's use of EDTA and oxidative therapies.

4. That, on August 30, 1993, the Board filed a second Administrative Complaint against Dr. Morgan's Kentucky medical license. This second Complaint alleged that Dr. Morgan had improperly continued to utilize EDTA, Germanium and hydrogen peroxide.

5. That this second Complaint did not acknowledge that Dr. Morgan was utilizing EDTA, Germanium and/or hydrogen peroxide under the protocol established by the Great Lakes Institutional Review Board.

6. That the second Complaint was resolved by an Agreed Order, dated August 18, 1994, whereby Dr. Morgan agreed that he would not utilize a) Chelation therapy or EDTA; b) hydrogen peroxide (intravenously); or, c) Germanium (intravenously).

7. That the present Administrative Complaint was filed against Dr. Morgan's Kentucky medical license on August 17, 1995 by the

Board's Inquiry Panel A. The present Complaint alleges that Dr. Morgan treated Patient A through the ^{oral MM CV} internal use of hydrogen peroxide and recommended that she obtain Germanium for internal use. When the Complaint was filed, Patient B was not originally included.

8. That, during a deposition conducted on January 26, 1996, the Board produced evidence that, during his treatment of Patient A, Dr. Morgan had advised her that the best treatment for her condition was intravenous hydrogen peroxide. However, Dr. Morgan advised Patient A that "special interest" groups had gotten a restraining order to prevent him from utilizing intravenous hydrogen peroxide. Accordingly, Dr. Morgan advised Patient A to take hydrogen peroxide internally through an oral application. He suggested Patient A add certain quantities of hydrogen peroxide to the family's drinking water, without telling the other family members, so they she would receive the sufficient amount of hydrogen peroxide internally.

9. That, during that deposition, the Board presented additional evidence that, while she was under Dr. Morgan's care, Patient B went to Indiana and received EDTA or Chelation therapy from Dr. Wolverton. The Board presented additional evidence that Dr. Wolverton had told the Board's investigator that Dr. Morgan was

referring all of his Chelation patients to Dr. Wolverton during that time period. Dr. Morgan contests the information provided by the Board's investigator concerning Dr. Wolverton.

10. That, on the day subsequent to this deposition, Dr. Morgan voluntarily posted a sign in his waiting room which advised his patients,

Your cooperation and understanding of my compliance with the known policy of the Kentucky Board of Medical Licensure that no Kentucky physician may consider, nor use, nor recommend Chelation, hydrogen peroxide, nor Germanium, in either oral or intravenous form, is appreciated, so long as that remains the policy of the Kentucky Board of Medical Licensure under Kentucky law.

11. That Dr. Morgan posted this sign as a show of good faith and in an attempt to effectuate this Agreed Order of Probation between the parties, in resolution of the pending Administrative Complaint.

12. That Dr. Morgan has indicated, through counsel, that he is willing to forego totally the use of EDTA or Chelation therapy, hydrogen peroxide and/or Germanium in any form or fashion so long as required by the Board or until Kentucky law allows the use of said therapies.

13. That, at all relevant times, Dr. Morgan was licensed to practice medicine in the Commonwealth of Kentucky and is thereby subject to review and discipline by the Board pursuant to the Kentucky Medical Practice Act.

CONCLUSIONS OF LAW

Pursuant to 201 KAR 9:082, the parties agree to the following Conclusions of Law:

1. That, while they are contested by Dr. Morgan, the facts adduced by the Board at the January 26, 1996 deposition could provide a factual basis for a finding by Hearing Panel B of proof that Dr. Morgan violated the Agreed Order of August 18, 1994.
2. That such conduct by Dr. Morgan provides a basis for Hearing Panel B to take disciplinary action against Dr. Morgan's Kentucky medical license pursuant to KRS 311.595(13).
3. That, while they are contested by Dr. Morgan, the facts adduced by the Board at the January 26, 1996 deposition could provide a factual basis for a finding by Hearing Panel B of proof that Dr. Morgan's treatment of Patients A and B could have the effect of bringing the medical profession into disrepute because it was a departure from or failure to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky.
4. That such conduct by Dr. Morgan provides a basis for Hearing Panel B to take disciplinary action against Dr. Morgan's Kentucky medical license pursuant to KRS 311.595(9) and 311.597(4).
5. That the range of permissible sanctions which could be imposed against Dr. Morgan's Kentucky medical license are set forth in KRS 311.565 and 311.595.

AGREED ORDER OF PROBATION

Based upon the foregoing Stipulations of Fact and Conclusions of Law, and as a means of finally resolving this Administrative Complaint, the parties enter into the following Agreed Order of Probation:

1. The license to practice medicine in the Commonwealth of Kentucky held by Kirk D. Morgan, M.D., is hereby placed on probation for a period of five (5) years, subject to the following conditions:

a. Dr. Morgan may utilize EDTA or Chelation therapy for the treatment of heavy metal poisoning;

b. Dr. Morgan shall not, in any form, fashion or manner, utilize, discuss or recommend the use of EDTA or Chelation therapy for any condition other than heavy metal poisoning;

c. Dr. Morgan shall not, in any form, fashion or manner, utilize, discuss or recommend the use of Germanium;

d. Dr. Morgan shall not, in any form, fashion or manner, utilize, discuss or recommend the internal use of hydrogen peroxide;

e. Dr. Morgan shall post and maintain a sign in his office which details conditions a-d of this Agreed Order of Probation and his commitment to complying with the terms of this Probation, throughout the course of his probation. The sign shall state:

As the result of various discussions with the Kentucky Board of Medical Licensure, I have adopted the following policies for my practice:

At present, the use of EDTA or Chelation therapy is only appropriate for the treatment of heavy metal poisoning. I will utilize such treatment for that condition and that condition only.

Pursuant to an agreement between me and the Kentucky Board of Medical Licensure, I will not utilize, discuss or recommend in any shape, form or fashion the use of EDTA or Chelation therapy for any condition other than heavy metal poisoning.

Also pursuant to that agreement, I will not utilize, discuss or recommend in any shape, form or fashion the use of Germanium or hydrogen peroxide for any condition.

I appreciate your understanding and your cooperation in ensuring that I can comply with this agreement that I have reached with the Kentucky Board of Medical Licensure.

f. If, during the course of the probationary period, EDTA or Chelation therapy becomes an acceptable and prevailing standard of care for condition(s) other than heavy metal poisoning, Dr. Morgan may request a modification in the terms of his probation;

g. If, during the course of the probationary period, Germanium or hydrogen peroxide become an acceptable and prevailing standard of care for any condition, Dr. Morgan may request a modification in the terms of his probation;

h. If, during the course of the probationary period, a statute is enacted which permits the use of EDTA or Chelation therapy for conditions(s) other than heavy metal poisoning and/or permits the use of Germanium or hydrogen peroxide for any condition, that statute shall serve as a basis for a modification in the terms of his

probation;

i. During the course of this probation, Dr. Morgan shall permit agents of the Board to visit his offices at random times and to conduct random reviews of patient files, to ensure that he is complying with the terms of probation.

j. Within 30 days of the entry of this Agreed Order of Probation, Dr. Morgan will reimburse the Board for the costs of this proceeding, \$768.16 in investigative costs and \$200.00 as the consultant's fee, for a total payment of \$968.16.


k. Throughout the term of probation, Dr. Morgan shall comply with the provisions of the Kentucky Medical Practice Act.

l. A violation of any condition of probation may result in revocation of Dr. Morgan's Kentucky medical license, or any lesser sanction authorized by the Kentucky Medical Practice Act.

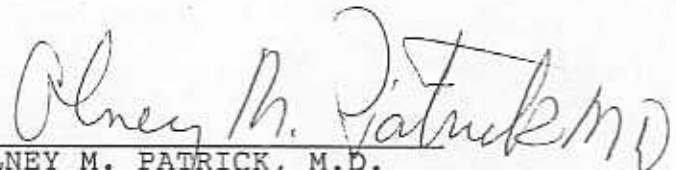
SO AGREED on this 18th day of April, 1996.

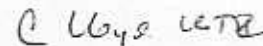
FOR DR. MORGAN:


KIRK D. MORGAN, M.D.

 4/18/96
MARK L. MORGAN, ESQ.
COUNSEL FOR DR. MORGAN

FOR THE BOARD:


OLNEY M. PATRICK, M.D.
CHAIRMAN, HEARING PANEL B


C. LLOYD VEST II, ESQ.
GENERAL COUNSEL

ENTERED:

4-18-96

COMMONWEALTH OF KENTUCKY
STATE BOARD OF MEDICAL LICENSURE
CASE NO. 558

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF
KENTUCKY HELD BY KIRK D. MORGAN, M.D., LICENSE NO. 16289,
9105 U.S. 42, PROSPECT, KENTUCKY 40059

WAIVER OF RIGHTS

Comes now Kirk D. Morgan, M.D., with counsel, and pursuant to 201 KAR 9:082 and in hopes of resolving this Administrative Complaint through informal proceedings, waives his right to raise any constitutional, statutory or common law objection should the Board reject the informal proposal submitted by Dr. Morgan and the Board's General Counsel, or if informal proceedings are curtailed by the General Counsel.

If the informal proposal is accepted and adopted by the Board, Dr. Morgan waives his right to an administrative hearing under KRS 311.591. Obviously, if the Board should not accept and adopt the informal proposal, the proceedings shall continue and Dr. Morgan will have the right to raise any objection(s) normally available to a licensee in proceedings brought pursuant to the Kentucky Medical Practice Act, KRS 311.530 et seq .


KIRK D. MORGAN, M.D.


MARK L. MORGAN, ESQ.
COUNSEL FOR DR. MORGAN

DATE:

4/18/96

FILED OF RECORD

APR 18 1996

K.B.M.L.

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STATE BOARD OF MEDICAL LICENSURE
AGENCY CASE NO. 558
ADMINISTRATIVE ACTION NO. 95-KBML-1578

KENTUCKY BOARD OF MEDICAL LICENSURE

PLAINTIFF

V.

KIRK D. MORGAN, M.D.

DEFENDANT

AGREED ORDER OF PROBATION

Come now the Kentucky Board of Medical Licensure (hereinafter "the Board"), by and through its Hearing Panel B, and Kirk D. Morgan, M.D., with their respective counsel, and in the interest of finally resolving this Administrative Complaint, hereby enter into the following Agreed Order of Probation:

STIPULATIONS OF FACT

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2. That initial Administrative Complaint was resolved by an agreement of May 20, 1991, whereby counsel for the parties agreed that the Complaint would be dismissed based upon Dr. Morgan's

written assurance that he would neither use Chelation therapy nor intravenous hydrogen peroxide therapy unless: a) such treatment became the accepted and prevailing standard of care within the Commonwealth; b) he received approval by the Board to perform such treatments; or, c) he used such treatments pursuant to a protocol accepted by an Institutional Review Board.

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7. That the present Administrative Complaint was filed against Dr. Morgan's Kentucky medical license on August 17, 1995 by the

Board's Inquiry Panel A. The present Complaint alleges that Dr. Morgan treated Patient A through the ^{oral} ^{MM} ^{CLV} ^{XPR} ^{ENG} internal use of hydrogen peroxide and recommended that she obtain Germanium for internal use. When the Complaint was filed, Patient B was not originally included.

8. That, during a deposition conducted on January 26, 1996, the Board produced evidence that, during his treatment of Patient A, Dr. Morgan had advised her that the best treatment for her condition was intravenous hydrogen peroxide. However, Dr. Morgan advised Patient A that "special interest" groups had gotten a restraining order to prevent him from utilizing intravenous hydrogen peroxide. Accordingly, Dr. Morgan advised Patient A to take hydrogen peroxide internally through an oral application. He suggested Patient A add certain quantities of hydrogen peroxide to the family's drinking water, without telling the other family members, so they she would receive the sufficient amount of hydrogen peroxide internally.

9. That, during that deposition, the Board presented additional evidence that, while she was under Dr. Morgan's care, Patient B went to Indiana and received EDTA or Chelation therapy from Dr. Wolverton. The Board presented additional evidence that Dr. Wolverton had told the Board's investigator that Dr. Morgan was

referring all of his Chelation patients to Dr. Wolverton during that time period. Dr. Morgan contests the information provided by the Board's investigator concerning Dr. Wolverton.

10. That, on the day subsequent to this deposition, Dr. Morgan voluntarily posted a sign in his waiting room which advised his patients,

Your cooperation and understanding of my compliance with the known policy of the Kentucky Board of Medical Licensure that no Kentucky physician may consider, nor use, nor recommend Chelation, hydrogen peroxide, nor Germanium, in either oral or intravenous form, is appreciated, so long as that remains the policy of the Kentucky Board of Medical Licensure under Kentucky law.

11. That Dr. Morgan posted this sign as a show of good faith and in an attempt to effectuate this Agreed Order of Probation between the parties, in resolution of the pending Administrative Complaint.

12. That Dr. Morgan has indicated, through counsel, that he is willing to forego totally the use of EDTA or Chelation therapy, hydrogen peroxide and/or Germanium in any form or fashion so long as required by the Board or until Kentucky law allows the use of said therapies.

13. That, at all relevant times, Dr. Morgan was licensed to practice medicine in the Commonwealth of Kentucky and is thereby subject to review and discipline by the Board pursuant to the Kentucky Medical Practice Act.

CONCLUSIONS OF LAW

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1. That, while they are contested by Dr. Morgan, the facts adduced by the Board at the January 26, 1996 deposition could provide a factual basis for a finding by Hearing Panel B of proof that Dr. Morgan violated the Agreed Order of August 18, 1994.
2. That such conduct by Dr. Morgan provides a basis for Hearing Panel B to take disciplinary action against Dr. Morgan's Kentucky medical license pursuant to KRS 311.595(13).
3. That, while they are contested by Dr. Morgan, the facts adduced by the Board at the January 26, 1996 deposition could provide a factual basis for a finding by Hearing Panel B of proof that Dr. Morgan's treatment of Patients A and B could have the effect of bringing the medical profession into disrepute because it was a departure from or failure to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky.
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5. That the range of permissible sanctions which could be imposed against Dr. Morgan's Kentucky medical license are set forth in KRS 311.565 and 311.595.

AGREED ORDER OF PROBATION

Based upon the foregoing Stipulations of Fact and Conclusions of Law, and as a means of finally resolving this Administrative Complaint, the parties enter into the following Agreed Order of Probation:

1. The license to practice medicine in the Commonwealth of Kentucky held by Kirk D. Morgan, M.D., is hereby placed on probation for a period of five (5) years, subject to the following conditions:

a. Dr. Morgan may utilize EDTA or Chelation therapy for the treatment of heavy metal poisoning;

b. Dr. Morgan shall not, in any form, fashion or manner, utilize, discuss or recommend the use of EDTA or Chelation therapy for any condition other than heavy metal poisoning;

c. Dr. Morgan shall not, in any form, fashion or manner, utilize, discuss or recommend the use of Germanium;

d. Dr. Morgan shall not, in any form, fashion or manner, utilize, discuss or recommend the internal use of hydrogen peroxide;

e. Dr. Morgan shall post and maintain a sign in his office which details conditions a-d of this Agreed Order of Probation and his commitment to complying with the terms of this Probation, throughout the course of his probation. The sign shall state:

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I appreciate your understanding and your cooperation in ensuring that I can comply with this agreement that I have reached with the Kentucky Board of Medical Licensure.

f. If, during the course of the probationary period, EDTA or Chelation therapy becomes an acceptable and prevailing standard of care for condition(s) other than heavy metal poisoning, Dr. Morgan may request a modification in the terms of his probation;

g. If, during the course of the probationary period, Germanium or hydrogen peroxide become an acceptable and prevailing standard of care for any condition, Dr. Morgan may request a modification in the terms of his probation;

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i. During the course of this probation, Dr. Morgan shall permit agents of the Board to visit his offices at random times and to conduct random reviews of patient files, to ensure that he is complying with the terms of probation.

j. Within 30 days of the entry of this Agreed Order of Probation, Dr. Morgan will reimburse the Board for the costs of this proceeding, \$768.16 in investigative costs and \$200.00 as the consultant's fee, for a total payment of \$968.16.


k. Throughout the term of probation, Dr. Morgan shall comply with the provisions of the Kentucky Medical Practice Act.

l. A violation of any condition of probation may result in revocation of Dr. Morgan's Kentucky medical license, or any lesser sanction authorized by the Kentucky Medical Practice Act.

SO AGREED on this 18th day of April, 1996.

FOR DR. MORGAN:


KIRK D. MORGAN, M.D.

 4/18/96
MARK L. MORGAN, ESQ.
COUNSEL FOR DR. MORGAN

FOR THE BOARD:


OLNEY M. PATRICK, M.D.
CHAIRMAN, HEARING PANEL B

C Lloyd Vest II
C. LLOYD VEST II, ESQ.
GENERAL COUNSEL

ENTERED: 4-18-96

COMMONWEALTH OF KENTUCKY
STATE BOARD OF MEDICAL LICENSURE
CASE NO. 558

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF
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9105 U.S. 42, PROSPECT, KENTUCKY 40059

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Comes now Kirk D. Morgan, M.D., with counsel, and pursuant to 201 KAR 9:082 and in hopes of resolving this Administrative Complaint through informal proceedings, waives his right to raise any constitutional, statutory or common law objection should the Board reject the informal proposal submitted by Dr. Morgan and the Board's General Counsel, or if informal proceedings are curtailed by the General Counsel.

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KIRK D. MORGAN, M.D.


MARK L. MORGAN, ESQ.
COUNSEL FOR DR. MORGAN

DATE: 4/18/96