COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2010

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY GERALD W. THORPE, M.D., LICENSE NO. 48842, 3420 IMPERATOR LANE, #202, LOUISVILLE, KENTUCKY 40245

AGREED ORDER

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Hearing Panel B, and Gerald W. Thorpe, M.D. ("the licensee"), and, based upon their mutual desire to fully and finally resolve the Complaint, hereby enter into the following **AGREED ORDER**:

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Agreed Order:

1. At all relevant times, Gerald Thorpe, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is obstetrics/gynecology.
3. In or around 2015, the licensee applied for a license to practice medicine in the Commonwealth of Kentucky with a history of eight malpractice suits, two of which were pending at the time of application.
4. In or around December 2015, the licensee was granted a license to practice medicine in the Commonwealth of Kentucky, after he completed a clinical skills assessment which found that he had limited educational needs that were able to be addressed without a formal education plan.

5. On or about October 28, 2020, John Craddock, M.D., submitted a grievance to the Board in which he relayed the following:

> On September 13, 2020, I received a phone call from Labor & Delivery at 4:02 p.m. I was told there was a cord prolapse of a patient of Dr. Thorpe. At the time of the call, I was almost to the hospital. I pulled into the parking lot and immediately presented to room #311. Dr. Thorpe was in the room with the patient. When he saw me, he began breaking the bed down. He approached me and said "I need you to do this C-section, I have to leave for vacation." I went to the OR and got ready for the emergency C-section. A few minutes later, the patient rolled into the room. No one is on the bed relieving pressure from the cord. As the nurse starts prepping her, Dr. Thorpe presents and then starts pushing the cord and fetal head up. I draped the patient and Dr. Thorpe left the room. The patient was placed under general anesthesia and soon after, a very unresponsive infant was delivered and was handed off to the Pediatric hospitalist. The baby was coded for 4-1/2 minutes before being taken to the NICU. I finished the closure and went to talk with the husband of the patient. He said Dr. Thorpe had come into the room and prayed with him. Dr. Thorpe had told him that this was all God's will. I went to the NICU to check on the infant. His head was extremely bruised and the infant was a pale gray. I asked if I did that to his head. The NP said, "no, the three forceps and one vacuum application was the cause." I immediately called the Chief of Staff to see this infant. As I was waiting for him, I talked to the patient's nurse. She informed me that Dr. Thorpe had walked in the room and said "if I don't put a vacuum or forceps on, I will miss my flight." The nurse had been pushing with the patient and the strip had been normal category 1. She reviewed the strip with me. He walked in the room and applied forceps, and the cord prolapsed at that time with a loop of cord outside the vagina. He then took off the forceps and applied two more times and then attempted vacuum twice until I was present. He also blamed the nurse for pushing with a cord prolapse. His documentation does not correspond to the events that actually took place. The documentation of the Labor & Delivery nurse and pediatric hospitalist do not correspond to his documentation either.
>
> This is one example of several cases in the last couple of months where Dr. Thorpe has displayed a significant deviation from the standard of care. I strongly believe there is a significant risk to patient safety.

6. On or about September 14, 2020, TJ Regional Health terminated the licensee's Physician Services Agreement with TJ Sampson Community Hospital.

7. The grievance was supported by a statement from Neil C. Thornbury, CEO of TJ Regional Health, who stated

... I believe that the severity of this particular incidence along with a trend of patient safety concerns warrants your attention. At TJ Regional Health, quality and patient safety is at the forefront of everything we do. Our patients deserve the best care available, and we strive to make sure each healthcare experience meets and exceeds their expectations.

8. On or about November 15, 2020, Stephanie Austin, RN, stated as follows:

On September 3, 2020, I assumed care of a G1P0 patient of Dr. Thorpe. This patient was receiving Pitocin. Throughout the day the Pitocin was titrated per protocol and baby/mom was evaluated per Protocol. All was proceeding well until early afternoon. I would have to look back at my charting to know exact times but in the early afternoon the patient was complete and we started pushing. After almost an hour of pushing I ask Allison Tackett RN (my labor and delivery coworker for the day) to call Dr. Thorpe and let him know we had been pushing for almost an hour and we were making progress but it was slow and that I would like him to come for a bedside evaluation of the progress after he was finished at the office. Allison came into the room and states that he was on his way he was already done at the office. I continue to push with the patient during this time. Baby and mother was tolerating pushing well and baby showed no signs of fetal distress on monitor. A short time later Dr. Thorpe came to bedside to evaluate patient. After a vaginal exam by him he tells the mother and father that a couple of things can happen: 1) he can pass her care off to Dr. Craddock who would be covering for him or 2) he could assist her in the delivery with forceps because he has a plane to catch (he said this directly to the mother and father). The mother and father look at each other and I can't remember what was said but something to the extent of whatever he thought was best. Dr. Thorpe ask me for forceps. I had a nursing student that was in the room with me to ask Allison to grab those for me and to call for nursery staff to come for a forcep assisted delivery. Allison brings the forceps in and Natalie Bruce RN, Natashia Gaskin RN, and Vicki Herman APRN from nursery come in to set up supplies for delivery. Dr. Thorpe applies forceps and pulls three different times. After the third pull Dr. Thorpe said we have a prolapsed cord. Nursery staff leaves the room to get the OR ready for delivery and alert Allison to call Dr. Craddock and OR staff for an emergency C/section for prolapsed cord. At this point I turn the Pitocin off and start to move stuff out of the way so the bed can be put back together and we can head to the OR. Dr. Thorpe states he wants the Kiwi vacuum. I ask him what he is doing and he ask for it again. I hand him the Kiwi and ask another nursing student in the room to get nursery staff back at bedside because we are pushing with a prolapsed cord and Kiwi vacuum. Nursery staff returns to bedside. Dr. Thorpe applies Kiwi and pulls while patient is pushing. After 3 popoffs Dr. Thorpe throws the kiwi in the delivery bag and gets the forceps off the delivery table again. As he is applying the forceps again Dr. Craddock and Allison walk in the room. Dr. Craddock states "let's go." Dr. Thorpe removes the forceps. Nursery staff again head to the OR. Allison

places the bed in trendelenburg position. Pt is removed from monitors and rushed out of the room to the OR. Allison pushed from the head of the bed and Dr. Thorpe pulled from the foot of the bed. Noone was applying transvaginal pressure when patient left the room. I talked to the father for a few minutes and then proceeded to the nursery so I could enter my code and help nursery staff bring infant in quicker from the OR.

9. On or about November 15, 2020, Allison Tackett, RN, stated as follows:

> I do not know the exact times or exact quotes. Stephanie Austin, RN, asked me to call Dr. Thorpe and ask him if he was done in the office to come evaluate the patient or if he wasn't to come by the hospital after office to evaluate the patient. I then called and told Dr.Thorpe what Stephanie had asked me to.
>
> After Dr. Thorpe had been the patient's room the student that was with Stephanie came to the desk and asked me to get forceps for Dr. Thorpe. I obtained the forceps told the nursery to go to the room and a brief report given, and took the forceps to Dr. Thorpe. I returned to desk.
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> Natashia Gaskin, RN, exited the room and told me to call Dr. Craddock for a stat c/s for a prolapsed cord. I called Dr. Craddock and told him. I then called the OR and told them. I went to the OR to set up for the stat c/s when the student told me she was a scrub tech here at our hospital. I called the OR to ask them to approve her to be clocked in, then returned to L&D unit. As I was walking to the desk to obtain c/s consents I heard Vicki Herman, APRN, on the phone discussing that Dr. Thorpe was pushing with a prolapsed cord and applying forceps with a prolapsed cord. As I was entering the room Dr. Craddock arrived, he asked me why the patient was not in the OR, I told him what I heard Vicki Herman, APRN, say as we entered the room. The patient was up in stirrups. I said the patient needed to be in T-burg and needed transvaginal pressure as I put the bed in T-burg. I handed the consents to Stephanie Austin, RN, and started unhooking the bed. When Dr. Craddock entered the room he said something about going to the OR. As soon as the bed was unhooked we started pushing the patient in the bed to the OR. I assisted transferring the patient to the OR table. After the patient was transferred to the OR table Dr. Thorpe applied transvaginal pressure.

10. On or about November 17, 2020, Natashia Gaskin, RN, stated as follows:

> The labor and delivery nurses alerted the nursery staff that Dr. Thorpe was going to use forceps for a delivery happening now. I was the secondary nurse that attended this delivery. Upon entry into the room, Dr. Thorpe was attempting the forceps delivery. During the attempt, the cord visibly prolapsed. Dr. Thorpe asked for someone to call Dr. Craddock for a C-section at this time. I alerted the other labor nurse that was at the nurses desk to call

Dr. Craddock and the surgery team for a STAT C-section for a prolapsed cord. I also notified Vickie Herman, APRN, NNP (on call nursery provider for the shift) of the situation. Briefly after I came back to the nursery to gather things for the C-section, a labor nurse came to the nursery doors requesting myself and Vickie Herman, APRN, to return to the delivery room with the primary nursery nurse, as Dr. Thorpe was going to try to deliver the baby vaginally. Upon entry to the room, Dr. Thorpe was placing a kiwi on the baby's head and instructing the mother to push as hard as she could. The cord was still visibly prolapsed at this time. After the kiwi popped off, Dr. Thorpe proceeded to use forceps again in attempt to deliver the baby. Dr. Craddock walked into the room upon his arrival to the unit and stated "get her to the OR now and reduce the pressure on the cord." Dr. Thorpe stops forceps attempt at this time. Dr. Craddock states that he will go scrub in to help deliver the baby. Dr. Thorpe then states "Can you do this section? I have a flight to catch." At this point, Dr. Craddock emergently goes into the OR to get ready for the section. Myself, Natalie Bruce, RN and Vickie Herman, APRN, NNP, go into the OR and begin to get Dr. Karmo, the on call neonatologist, on TeleHealth for this delivery. The infant was born with no tone, heart rate or respiratory effort. NRP protocol was followed for full resuscitation of neonate.

11. On or about November 20, 2020, Natalie Bruce, RN, stated as follows:

I was sitting in nursery when Labor nurse stuck head in door and said we were having a delivery in 312 and Dr. Thorpe was going to use forceps. I enter the room and he is getting out forceps to use. N. Gaskin, RN followed behind me per NNP order due to the use of forceps. Forceps were used during pushing at which time the infant's heart rate when into the 60s. Forceps were pulled out without successful delivery of the infant and the umbilical cord come out with them. At this point there was no longer a heartbeat detected on the monitor. Nursery staff leaves to tell other Labor nurse to call OR for emergency sections and to get ready for section. I went into nursery to notify NNP. Come out of nursery and labor nurse states he is going to try and delivery baby in the labor room. I went back into labor room and Dr. Thorpe then cuts an episiotomy and places a kiwi (vacuum) on infant's head and pulls. Infant does not come out. Forceps are then used again without success. I leave room and meet Dr. Craddock at the door. Thorpe states to him they have to get to OR there is a prolapsed cord. Myself and nursery staff (RN and NNP) go into OR to wait on baby. Dr. Thorpe enters OR with patient, gets patient onto the OR table and leaves. Dr. Craddock performs C-section. Hands nursery staff a non-responsive infant, no heartbeat or respirations. Infant taken immediately to the warmer where resuscitation of infant began. After approx. 4.5 min a heartbeat was detected. Infant was "stabilized" and transported via warmer to NICU. Before entering NICU doors infant began having seizure like activity. Infant placed on ventilator, given numerous medications, and later transported to Norton's Children's Hospital.

12. On or about March 21, 2021, a Board consultant completed a review of the incident which was the subject of the grievance (including the grievance, correspondence from the licensee's counsel and medical records), and found that the licensee failed to conform to or departed from acceptable and prevailing medical practices in the Commonwealth of Kentucky due to the licensee's repeated sequential use of forceps and vacuum during attempted operative vaginal delivery, especially in the face of prolapsed umbilical cord, and due to the licensee's failure to stay with the patient the entire time to elevate the fetal head off of the prolapsed cord or to designate someone else to perform the maneuver.

13. In addition, the Board consultant found that the licensee demonstrated gross incompetence by attempt of operative vaginal delivery with a prolapsed cord and demonstrated negligence by failing to provide or designate someone else to provide continuous elevation of the fetal head off of the prolapsed cord in the emergent setting.

14. The Board consultant stated

> [I]f this provider fails to retrain or reeducate himself in order to make more wiser and judicious decisions when it comes to employing operative vaginal deliveries in his practice of obstetrics, then I would expect there to be a continued and further increase in potential harm to his patient and/or his patient's newborn.

15. The Board consultant also reviewed charts of eight (8) other obstetrical deliveries by the licensee between May 2020 and September 2020, and noted that five (5) involved use of forceps and/or vacuum. One delivery involved sequential use of forceps followed with vacuum and delivery of infant with subdural hematoma; the infant was subsequently transferred to Norton's Children's Hospital with possible seizures. One infant was delivered with a brachial plexus injury following vacuum assist.

16. The licensee was provided a copy of the Board consultant report and an opportunity to respond.

17. Following review of the licensee's response, the Board consultant stated

> ... I can fully appreciate the acuity and "exigencies" that Dr. Thorpe has faced in his decision making concerning use of forceps and/or vacuum. Many times review of these cases can be fraught with "Monday morning quarterback" criticisms. Nevertheless, my main criticism of this colleague's actions is still the use of forceps after a failed forceps application, followed by failed vacuum extraction AFTER the diagnosis of a prolapsed cord. ...

18. The Board consultant's report is incorporated in its entirety by reference herein.

19. On or about June 24, 2021, the Chair of Inquiry Panel A determined that the licensee's medical practice places the safety and health of his patients at risk and in danger and issued an emergency order of restriction.

20. On August 19, 2021, the licensee and his counsel appeared before and were heard by the Inquiry Panel, and after which the Inquiry Panel chose to ratify the emergency order and issue this Complaint.

21. A hearing on the Complaint in the above-styled action was scheduled for January 25-28, 2022.

22. The licensee disputes that the facts demonstrate a violation of law that would warrant imposition of sanctions and was prepared to put on a vigorous defense thereof. His May 2021 response to the consultant's report is incorporated herein by reference.

23. The licensee chose, after being advised by his counsel, to waive his right to a hearing and to resolve this action by entering into this Agreed Order.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Agreed Order:

1. The licensee's medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee agrees that there is a preponderance of evidence from which the Board may conclude there are violations of the provisions of KRS 311.595(9), as illustrated by KRS 311.597(3) and (4), and KRS 311.595(21). Accordingly, there are legal grounds for the parties to enter into this Agreed Order.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve the Complaint by entering into an informal resolution such as this Agreed Order.

AGREED ORDER

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to fully and finally resolve the Complaint, the parties hereby ENTER INTO the following **AGREED ORDER:**

1. The license to practice medicine within the Commonwealth of Kentucky held by Gerald W. Thorpe, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Agreed Order.
2. During the effective period of this Agreed Order, the licensee's medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS OF RESTRICTION/LIMITATION for an indefinite term:
    a. The licensee SHALL NEITHER perform NOR participate in any obstetrical delivery, including but not limited to vaginal delivery, operative vaginal delivery or delivery by C-section;
    b. Pursuant to KRS 311.565(1)(v), the licensee SHALL REIMBURSE the Board the costs of the proceedings in the amount of $10,318.47, within five (5) years from entry of this Agreed Order; and
    c. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. As an express condition for the entry of this Agreed Order, each party understands and agrees that neither Panel of the Board will ever consider any petition for termination or modification of this Agreed Order. This Agreed Order is expressly designed to serve as the complete and final resolution. Any communication by the licensee and/or his agents to the Board attempting to revive this case or modify or terminate the terms set forth in this Agreed Order will be returned without being provided or forwarded to any Panel or Board member.

4. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that the licensee has violated any term or condition of this Agreed Order, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Agreed Order would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Agreed Order.

5. The licensee understands and agrees that any violation of the terms of this agreed order would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13).

SO AGREED on this 27th day of January, 2022.

FOR THE LICENSEE:

GERALD W. THORPE, M.D.

DANIEL BROWN, ESQ.
COUNSEL FOR LICENSEE

FOR THE BOARD:

DALE E. TONEY, M.D.
CHAIR, HEARING PANEL B

LEANNE K. DIAKOV
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
Tel. (502) 429-7150

WAIVER OF RIGHTS

I, Gerald W. Thorpe, M.D., am presently the Respondent in Kentucky Board of Medical Licensure Case No. 2010. I understand that, under 201 KAR 9:082, I must waive certain rights if I wish to resolve this matter by informal dispensation. Accordingly, I WAIVE my right to raise any constitutional, statutory or common law objection(s) I may have to the Hearing Panel rejecting the proposed informal dispensation or to the curtailment of such a settlement by the Board's General Counsel or Assistant General Counsel.

Furthermore, if the Hearing Panel accepts the proposed Agreed Order as submitted, I WAIVE my right to demand an evidentiary hearing a petition for judicial review, or to raise additional constitutional or statutory objections in this matter. However, if the Hearing Panel should reject the proposed Agreed Order, I understand that further proceedings will be conducted in accordance with KRS 311.530, *et. seq.*, and KRS Chapter 13B and I will have the right to raise any objections normally available in such proceedings.

Executed this 27th day of January, 2022.

GERALD W. THORPE, M.D.
RESPONDENT

DANIEL BROWN, ESQ.
COUNSEL FOR THE RESPONDENT

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2010

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY GERALD W. THORPE, M.D., LICENSE NO. 48842, 3420 IMPERATOR LANE, #202, LOUISVILLE, KENTUCKY 40245

COMPLAINT

Comes now the Complainant Waqar A. Saleem, M.D., Chair of the Kentucky Board of Medical Licensure's Inquiry Panel A, and on behalf of the Panel which met on August 19, 2021, states for its Complaint against the licensee, GERALD W. THORPE, M.D., as follows:

1. At all relevant times, Gerald Thorpe, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is obstetrics/gynecology.
3. In or around 2015, the licensee applied for a license to practice medicine in the Commonwealth of Kentucky with a history of eight malpractice suits, two of which were pending at the time of application.
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went to the OR and got ready for the emergency C-section. A few minutes later, the patient rolled into the room. No one is on the bed relieving pressure from the cord. As the nurse starts prepping her, Dr. Thorpe presents and then starts pushing the cord and fetal head up. I draped the patient and Dr. Thorpe left the room. The patient was placed under general anesthesia and soon after, a very unresponsive infant was delivered and was handed off to the Pediatric hospitalist. The baby was coded for 4-1/2 minutes before being taken to the NICU. I finished the closure and went to talk with the husband of the patient. He said Dr. Thorpe had come into the room and prayed with him. Dr. Thorpe had told him that this was all God's will. I went to the NICU to check on the infant. His head was extremely bruised and the infant was a pale gray. I asked if I did that to his head. The NP said, "no, the three forceps and one vacuum application was the cause." I immediately called the Chief of Staff to see this infant. As I was waiting for him, I talked to the patient's nurse. She informed me that Dr. Thorpe had walked in the room and said "if I don't put a vacuum or forceps on, I will miss my flight." The nurse had been pushing with the patient and the strip had been normal category 1. She reviewed the strip with me. He walked in the room and applied forceps, and the cord prolapsed at that time with a loop of cord outside the vagina. He then took off the forceps and applied two more times and then attempted vacuum twice until I was present. He also blamed the nurse for pushing with a cord prolapse. His documentation does not correspond to the events that actually took place. The documentation of the Labor & Delivery nurse and pediatric hospitalist do not correspond to his documentation either.

This is one example of several cases in the last couple of months where Dr. Thorpe has displayed a significant deviation from the standard of care. I strongly believe there is a significant risk to patient safety.

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> … I believe that the severity of this particular incidence along with a trend of patient safety concerns warrants your attention. At TJ Regional Health, quality and patient safety is at the forefront of everything we do. Our patients deserve the best care available, and we strive to make sure each healthcare experience meets and exceeds their expectations.

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> proceeded to use forceps again in attempt to deliver the baby. Dr. Craddock walked into the room upon his arrival to the unit and stated "get her to the OR now and reduce the pressure on the cord." Dr. Thorpe stops forceps attempt at this time. Dr. Craddock states that he will go scrub in to help deliver the baby. Dr. Thorpe then states "Can you do this section? I have a flight to catch." At this point, Dr. Craddock emergently goes into the OR to get ready for the section. Myself, Natalie Bruce, RN and Vickie Herman, APRN, NNP, go into the OR and begin to get Dr. Karmo, the on call neonatologist, on TeleHealth for this delivery. The infant was born with no tone, heart rate or respiratory effort. NRP protocol was followed for full resuscitation of neonate.

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> I was sitting in nursery when Labor nurse stuck head in door and said we were having a delivery in 312 and Dr. Thorpe was going to use forceps. I enter the room and he is getting out forceps to use. N. Gaskin, RN followed behind me per NNP order due to the use of forceps. Forceps were used during pushing at which time the infant's heart rate when into the 60s. Forceps were pulled out without successful delivery of the infant and the umbilical cord come out with them. At this point there was no longer a heartbeat detected on the monitor. Nursery staff leaves to tell other Labor nurse to call OR for emergency sections and to get ready for section. I went into nursery to notify NNP. Come out of nursery and labor nurse states he is going to try and delivery baby in the labor room. I went back into labor room and Dr. Thorpe then cuts an episiotomy and places a kiwi (vacuum) on infant's head and pulls. Infant does not come out. Forceps are then used again without success. I leave room and meet Dr. Craddock at the door. Thorpe states to him they have to get to OR there is a prolapsed cord. Myself and nursery staff (RN and NNP) go into OR to wait on baby. Dr. Thorpe enters OR with patient, gets patient onto the OR table and leaves. Dr. Craddock performs C-section. Hands nursery staff a non-responsive infant, no heartbeat or respirations. Infant taken immediately to the warmer where resuscitation of infant began. After approx. 4.5 min a heartbeat was detected. Infant was "stabilized" and transported via warmer to NICU. Before entering NICU doors infant began having seizure like activity. Infant placed on ventilator, given numerous medications, and later transported to Norton's Children's Hospital.

12. On or about March 21, 2021, a Board consultant completed a review of the incident which was the subject of the grievance (including the grievance, correspondence from the licensee's counsel and medical records), and found that the licensee failed to conform to or departed from acceptable and prevailing medical practices in the Commonwealth of

Kentucky due to the licensee's repeated sequential use of forceps and vacuum during attempted operative vaginal delivery, especially in the face of prolapsed umbilical cord, and due to the licensee's failure to stay with the patient the entire time to elevate the fetal head off of the prolapsed cord or to designate someone else to perform the maneuver.

13. In addition, the Board consultant found that the licensee demonstrated gross incompetence by attempt of operative vaginal delivery with a prolapsed cord and demonstrated negligence by failing to provide or designate someone else to provide continuous elevation of the fetal head off of the prolapsed cord in the emergent setting.

14. The Board consultant stated

> [I]f this provider fails to retrain or reeducate himself in order to make more wiser and judicious decisions when it comes to employing operative vaginal deliveries in his practice of obstetrics, then I would expect there to be a continued and further increase in potential harm to his patient and/or his patient's newborn.

15. The Board consultant also reviewed charts of eight (8) other obstetrical deliveries by the licensee between May 2020 and September 2020, and noted that five (5) involved use of forceps and/or vacuum. One delivery involved sequential use of forceps followed with vacuum and delivery of infant with subdural hematoma; the infant was subsequently transferred to Norton's Children's Hospital with possible seizures. One infant was delivered with a brachial plexus injury following vacuum assist.

16. The licensee was provided a copy of the Board consultant report and an opportunity to respond.

17. Following review of the licensee's response, the Board consultant stated

> … I can fully appreciate the acuity and "exigencies" that Dr. Thorpe has faced in his decision making concerning use of forceps and/or vacuum. Many times review of these cases can be fraught with "Monday morning quarterback" criticisms. Nevertheless, my main criticism of this colleague's actions is still

> the use of forceps after a failed forceps application, followed by failed vacuum extraction AFTER the diagnosis of a prolapsed cord. ...

18. The Board consultant's report is incorporated in its entirety by reference herein.

19. On or about June 24, 2021, the Chair of Inquiry Panel A determined that the licensee's medical practice places the safety and health of his patients at risk and in danger and issued an emergency order of restriction.

20. On August 19, 2021, the licensee and his counsel appeared before and were heard by the Inquiry Panel, and after which the Inquiry Panel chose to ratify the emergency order and issue this Complaint.

21. By his conduct, the licensee has violated KRS 311.595(9), as illustrated by KRS 311.597(3) and (4), and KRS 311.595(21). Accordingly, legal grounds exist for disciplinary action against his Kentucky medical license.

22. The licensee 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.

23. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for January 4-6, 2022 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 and pursuant to KRS Chapter 13B. 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 GERALD W. THORPE, M.D.

This 23rd day of August, 2021.

W. Saleem.

WAQAR A. SALEEM, M.D.
CHAIR, INQUIRY PANEL A

Certificate of Service

I certify that the original of this Complaint was delivered to Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; a copy was mailed to Keith Hardison, Esq., Hearing Officer, 2616 Bardstown Road, Louisville, Kentucky 40205 and copies were mailed via certified mail, return-receipt requested, to the licensee, Gerald W. Thorpe, M.D., License No. 48842, 3420 Imperator Lane, #202, Louisville, Kentucky 40245 and his counsel, Daniel G. Brown, Esq., Gazak Brown, PSC, 3220 Office Pointe Place, Suite 200, Louisville, Kentucky 40220 on this 23rd day of August, 2021.

Leanne K. Diakov
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

FILED OF RECORD

JUN 24 2021

K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2010

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY GERALD W. THORPE, M.D., LICENSE NO. 48842, 3420 IMPERATOR LANE, #202, LOUISVILLE, KENTUCKY 40245

EMERGENCY ORDER OF RESTRICTION

The Kentucky Board of Medical Licensure ("the Board"), acting by and through the Chair of its Inquiry Panel A, considered a panel memorandum, prepared by Stephen Manley, Medical Investigator, dated June 22, 2021; a grievance from John Craddock, M.D., received October 28, 2020; correspondence from Neil Thornbury, CEO, TJ Regional Health, dated September 14, 2020; correspondence from Neil Thornbury, CEO, TJ Regional Health, undated; correspondence from John Craddock, M.D., dated November 13, 2020; e-mail correspondence from Natalie Gaskin to John Thomas Rogers, dated November 17, 2020; e-mail correspondence from Allison Tackett to John Thomas Rogers, dated November 15, 2020; e-mail correspondence from Natalie Bruce to John Thomas Rogers, dated November 20, 2020; e-mail correspondence from Stephanie Austin to John Thomas Rogers, dated November 15, 2020; correspondence from Daniel G. Brown, Esq., dated February 23, 2021; curriculum vitae of Gerald W. Thorpe, M.D., undated; Board consultant report, dated March 21, 2021; correspondence from Daniel G. Brown, Esq., dated May 4, 2021; and a Board consultant report, dated June 9, 2021.

Having considered this information and being sufficiently advised, the Chair of Inquiry Panel A ENTERS the following EMERGENCY ORDER OF RESTRICTION, 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 him, the Chair of Inquiry Panel A concludes there is probable cause to make the following Findings of Fact, which support its Emergency Order of Restriction:

1. At all relevant times, Gerald Thorpe, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is obstetrics/gynecology.
3. In or around 2015, the licensee applied for a license to practice medicine in the Commonwealth of Kentucky with a history of eight malpractice suits, two of which were pending at the time of application.
4. In or around December 2015, the licensee was granted a license to practice medicine in the Commonwealth of Kentucky, after he completed a clinical skills assessment which found that he had limited educational needs that were able to be addressed without a formal education plan.
5. On or about October 28, 2020, John Craddock, M.D., submitted a grievance to the Board in which he relayed the following:

> On September 13, 2020, I received a phone call from Labor & Delivery at 4:02 p.m. I was told there was a cord prolapse of a patient of Dr. Thorpe. At the time of the call, I was almost to the hospital. I pulled into the parking lot and immediately presented to room #311. Dr. Thorpe was in the room with the patient. When he saw me, he began breaking the bed down. He approached me and said "I need you to do this C-section, I have to leave for vacation." I went to the OR and got ready for the emergency C-section. A few minutes later, the patient rolled into the room. No one is on the bed relieving pressure from the cord. As the nurse starts prepping her, Dr. Thorpe presents and then starts pushing the cord and fetal head up. I draped the patient and Dr. Thorpe left the room. The patient was placed under general anesthesia and soon after, a very unresponsive infant was delivered and was handed off to the Pediatric hospitalist. The baby was coded for 4-1/2 minutes before being taken to the NICU. I finished the closure and went to talk with the husband of the patient.

He said Dr. Thorpe had come into the room and prayed with him. Dr. Thorpe had told him that this was all God's will. I went to the NICU to check on the infant. His head was extremely bruised and the infant was a pale gray. I asked if I did that to his head. The NP said, "no, the three forceps and one vacuum application was the cause." I immediately called the Chief of Staff to see this infant. As I was waiting for him, I talked to the patient's nurse. She informed me that Dr. Thorpe had walked in the room and said "if I don't put a vacuum or forceps on, I will miss my flight." The nurse had been pushing with the patient and the strip had been normal category 1. She reviewed the strip with me. He walked in the room and applied forceps, and the cord prolapsed at that time with a loop of cord outside the vagina. He then took off the forceps and applied two more times and then attempted vacuum twice until I was present. He also blamed the nurse for pushing with a cord prolapse. His documentation does not correspond to the events that actually took place. The documentation of the Labor & Delivery nurse and pediatric hospitalist do not correspond to his documentation either.

This is one example of several cases in the last couple of months where Dr. Thorpe has displayed a significant deviation from the standard of care. I strongly believe there is a significant risk to patient safety.

6. On or about September 14, 2020, TJ Regional Health terminated the licensee's Physician Services Agreement with TJ Sampson Community Hospital.

7. The grievance was supported by a statement from Neil C. Thornbury, CEO of TJ Regional Health, who stated

> … I believe that the severity of this particular incidence along with a trend of patient safety concerns warrants your attention. At TJ Regional Health, quality and patient safety is at the forefront of everything we do. Our patients deserve the best care available, and we strive to make sure each healthcare experience meets and exceeds their expectations.

8. On or about November 15, 2020, Stephanie Austin, RN, stated as follows:

> On September 3, 2020, I assumed care of a G1P0 patient of Dr. Thorpe. This patient was receiving Pitocin. Throughout the day the Pitocin was titrated per protocol and baby/mom was evaluated per Protocol. All was proceeding well until early afternoon. I would have to look back at my charting to know exact times but in the early afternoon the patient was complete and we started pushing. After almost an hour of pushing I ask Allison Tackett RN (my labor and delivery coworker for the day) to call Dr. Thorpe and let him know we had been pushing for almost an hour and we were making progress but it was slow and that I would like him to come for a bedside evaluation of the progress

after he was finished at the office. Allison came into the room and states that he was on his way he was already done at the office. I continue to push with the patient during this time. Baby and mother was tolerating pushing well and baby showed no signs of fetal distress on monitor. A short time later Dr. Thorpe came to bedside to evaluate patient. After a vaginal exam by him he tells the mother and father that a couple of things can happen: 1) he can pass her care off to Dr. Craddock who would be covering for him or 2) he could assist her in the delivery with forceps because he has a plane to catch (he said this directly to the mother and father). The mother and father look at each other and I can't remember what was said but something to the extent of whatever he thought was best. Dr. Thorpe ask me for forceps. I had a nursing student that was in the room with me to ask Allison to grab those for me and to call for nursery staff to come for a forcep assisted delivery. Allison brings the forceps in and Natalie Bruce RN, Natashia Gaskin RN, and Vicki Herman APRN from nursery come in to set up supplies for delivery. Dr. Thorpe applies forceps and pulls three different times. After the third pull Dr. Thorpe said we have a prolapsed cord. Nursery staff leaves the room to get the OR ready for delivery and alert Allison to call Dr. Craddock and OR staff for an emergency C/section for prolapsed cord. At this point I turn the Pitocin off and start to move stuff out of the way so the bed can be put back together and we can head to the OR. Dr. Thorpe states he wants the Kiwi vacuum. I ask him what he is doing and he ask for it again. I hand him the Kiwi and ask another nursing student in the room to get nursery staff back at bedside because we are pushing with a prolapsed cord and Kiwi vacuum. Nursery staff returns to bedside. Dr. Thorpe applies Kiwi and pulls while patient is pushing. After 3 popoffs Dr. Thorpe throws the kiwi in the delivery bag and gets the forceps off the delivery table again. As he is applying the forceps again Dr. Craddock and Allison walk in the room. Dr. Craddock states "let's go." Dr. Thorpe removes the forceps. Nursery staff again head to the OR. Allison places the bed in trendelenburg position. Pt is removed from monitors and rushed out of the room to the OR. Allison pushed from the head of the bed and Dr. Thorpe pulled from the foot of the bed. Noone was applying transvaginal pressure when patient left the room. I talked to the father for a few minutes and then proceeded to the nursery so I could enter my code and help nursery staff bring infant in quicker from the OR.

9. On or about November 15, 2020, Allison Tackett, RN, stated as follows:

> I do not know the exact times or exact quotes. Stephanie Austin, RN, asked me to call Dr. Thorpe and ask him if he was done in the office to come evaluate the patient or if he wasn't to come by the hospital after office to evaluate the patient. I then called and told Dr.Thorpe what Stephanie had asked me to.
>
> After Dr. Thorpe had been the patient's room the student that was with Stephanie came to the desk and asked me to get forceps for Dr. Thorpe. I

obtained the forceps told the nursery to go to the room and a brief report given, and took the forceps to Dr. Thorpe. I returned to desk.

Natashia Gaskin, RN, exited the room and told me to call Dr. Craddock for a stat c/s for a prolapsed cord. I called Dr. Craddock and told him. I then called the OR and told them. I went to the OR to set up for the stat c/s when the student told me she was a scrub tech here at our hospital. I called the OR to ask them to approve her to be clocked in, then returned to L&D unit. As I was walking to the desk to obtain c/s consents I heard Vicki Herman, APRN, on the phone discussing that Dr. Thorpe was pushing with a prolapsed cord and applying forceps with a prolapsed cord. As I was entering the room Dr. Craddock arrived, he asked me why the patient was not in the OR, I told him what I heard Vicki Herman, APRN, say as we entered the room. The patient was up in stirrups. I said the patient needed to be in T-burg and needed transvaginal pressure as I put the bed in T-burg. I handed the consents to Stephanie Austin, RN, and started unhooking the bed. When Dr. Craddock entered the room he said something about going to the OR. As soon as the bed was unhooked we started pushing the patient in the bed to the OR. I assisted transferring the patient to the OR table. After the patient was transferred to the OR table Dr. Thorpe applied transvaginal pressure.

10. On or about November 17, 2020, Natashia Gaskin, RN, stated as follows:

The labor and delivery nurses altered the nursery staff that Dr. Thorpe was going to use forceps for a delivery happening now. I was the secondary nurse that attended this delivery. Upon entry into the room, Dr. Thorpe was attempting the forceps delivery. During the attempt, the cord visibly prolapsed. Dr. Thorpe asked for someone to call Dr. Craddock for a C-section at this time. I alerted the other labor nurse that was at the nurses desk to call Dr. Craddock and the surgery team for a STAT C-section for a prolapsed cord. I also notified Vickie Herman, APRN, NNP (on call nursery provider for the shift) of the situation. Briefly after I came back to the nursery to gather things for the C-section, a labor nurse came to the nursery doors requesting myself and Vickie Herman, APRN, to return to the delivery room with the primary nursery nurse, as Dr. Thorpe was going to try to deliver the baby vaginally. Upon entry to the room, Dr. Thorpe was placing a kiwi on the baby's head and instructing the mother to push as hard as she could. The cord was still visibly prolapsed at this time. After the kiwi popped off, Dr. Thorpe proceeded to use forceps again in attempt to deliver the baby. Dr. Craddock walked into the room upon his arrival to the unit and stated "get her to the OR now and reduce the pressure on the cord." Dr. Thorpe stops forceps attempt at this time. Dr. Craddock states that he will go scrub in to help deliver the baby. Dr. Thorpe then states "Can you do this section? I have a flight to catch." At this point, Dr. Craddock emergently goes into the OR to get ready for the section. Myself, Natalie Bruce, RN and Vickie Herman, APRN, NNP, go into the OR and begin to get Dr. Karmo, the on call neonatologist, on

TeleHealth for this delivery. The infant was born with no tone, heart rate or respiratory effort. NRP protocol was followed for full resuscitation of neonate.

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> I was sitting in nursery when Labor nurse stuck head in door and said we were having a delivery in 312 and Dr. Thorpe was going to use forceps. I enter the room and he is getting out forceps to use. N. Gaskin, RN followed behind me per NNP order due to the use of forceps. Forceps were used during pushing at which time the infant's heart rate when into the 60s. Forceps were pulled out without successful delivery of the infant and the umbilical cord come out with them. At this point there was no longer a heartbeat detected on the monitor. Nursery staff leaves to tell other Labor nurse to call OR for emergency sections and to get ready for section. I went into nursery to notify NNP. Come out of nursery and labor nurse states he is going to try and delivery baby in the labor room. I went back into labor room and Dr. Thorpe then cuts an episiotomy and places a kiwi (vacuum) on infant's head and pulls. Infant does not come out. Forceps are then used again without success. I leave room and meet Dr. Craddock at the door. Thorpe states to him they have to get to OR there is a prolapsed cord. Myself and nursery staff (RN and NNP) go into OR to wait on baby. Dr. Thorpe enters OR with patient, gets patient onto the OR table and leaves. Dr. Craddock performs C-section. Hands nursery staff a non-responsive infant, no heartbeat or respirations. Infant taken immediately to the warmer where resuscitation of infant began. After approx. 4.5 min a heartbeat was detected. Infant was "stabilized" and transported via warmer to NICU. Before entering NICU doors infant began having seizure like activity. Infant placed on ventilator, given numerous medications, and later transported to Norton's Children's Hospital.

12. On or about March 21, 2021, a Board consultant completed a review of the incident which was the subject of the grievance (including the grievance, correspondence from the licensee's counsel and medical records), and found that the licensee failed to conform to or departed from acceptable and prevailing medical practices in the Commonwealth of Kentucky due to the licensee's repeated sequential use of forceps and vacuum during attempted operative vaginal delivery, especially in the face of prolapsed umbilical cord, and due to the licensee's failure to stay with the patient the entire time to elevate the fetal head off of the prolapsed cord or to designate someone else to perform the maneuver.

13. In addition, the Board consultant found that the licensee demonstrated gross incompetence by attempt of operative vaginal delivery with a prolapsed cord and demonstrated negligence by failing to provide or designate someone else to provide continuous elevation of the fetal head off of the prolapsed cord in the emergent setting.

14. The Board consultant stated

> [I]f this provider fails to retrain or reeducate himself in order to make more wiser and judicious decisions when it comes to employing operative vaginal deliveries in his practice of obstetrics, then I would expect there to be a continued and further increase in potential harm to his patient and/or his patient's newborn.

15. The Board consultant also reviewed charts of eight (8) other obstetrical deliveries by the licensee between May 2020 and September 2020, and noted that five (5) involved use of forceps and/or vacuum. One delivery involved sequential use of forceps followed with vacuum and delivery of infant with subdural hematoma; the infant was subsequently transferred to Norton's Children's Hospital with possible seizures. One infant was delivered with a brachial plexus injury following vacuum assist.

16. The licensee was provided a copy of the Board consultant report and an opportunity to respond.

17. Following review of the licensee's response, the Board consultant stated

> … I can fully appreciate the acuity and "exigencies" that Dr. Thorpe has faced in his decision making concerning use of forceps and/or vacuum. Many times review of these cases can be fraught with "Monday morning quarterback" criticisms. Nevertheless, my main criticism of this colleague's actions is still the use of forceps after a failed forceps application, followed by failed vacuum extraction AFTER the diagnosis of a prolapsed cord. …

CONCLUSIONS OF LAW

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

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(9), as illustrated by KRS 311.597(3) and (4), and KRS 311.595(21).
4. 201 KAR 9:240 §1 provides,

   (1) An inquiry panel or the panel's chair, acting on behalf of the inquiry panel, may issue an emergency order restricting or suspending a physician's license to practice medicine or osteopathy within the Commonwealth of Kentucky in accordance with KRS 311.592 and 13B.125.
   (2) ...
   (3) (a) An inquiry panel's chair may act on behalf of the inquiry panel and issue an emergency order restricting or suspending a physician's license to practice medicine or osteopathy within the Commonwealth of Kentucky if the panel chair determines that a basis for an emergency order as established in subsection (1) of this section exists and the circumstances of the specific case warrant emergency action prior to the next regularly scheduled meeting of the inquiry panel.

5. The Inquiry Panel Chair concludes there is probable cause to believe the licensee's practice constitutes a danger to the health, welfare and safety of his patients or the general public.

6. The Board may draw logical and reasonable inferences about a licensee's practice by considering certain facts about a licensee's practice. If there is proof that a licensee has violated a provision of the Kentucky Medical Practice Act in one set of circumstances, the Board may infer that the licensee 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 licensee's practice presents representative proof of the nature of that licensee's practice in general. Accordingly, probable cause to believe that the licensee has committed certain violations in the recent past presents probable cause to believe that the licensee will commit similar violations in the near future, during the course of the licensee's medical practice.

7. 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, 520 U.S. 924 (1997), 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 RESTRICTION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Chair of Inquiry Panel A hereby ORDERS that the license to practice medicine in the Commonwealth of Kentucky held by Gerald W. Thorpe, M.D., is RESTRICTED and Dr. Thorpe is prohibited from performing or participating in any delivery – including but not limited to vaginal delivery, operative vaginal delivery or delivery by C-section – until the resolution of the Complaint setting forth the allegations discussed in this pleading or until such further Order of the Board.

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

SO ORDERED this 24th day of June, 2021.

W. Saleem.

WAQAR A. SALEEM, M.D.
CHAIR, INQUIRY PANEL A

Certificate of Service

I certify that the original of this Emergency Order of Restriction was delivered to Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and copies were mailed via certified mail, return-receipt requested, to the licensee, Gerald W. Thorpe, M.D., License No. 48842, 3420 Imperator Lane, #202, Louisville, Kentucky 40245 and his counsel, Daniel G. Brown, Esq., Gazak Brown, PSC, 3220 Office Pointe Place, Suite 200, Louisville, Kentucky 40220 on this 24th day of June, 2021.

Leanne K. Diakov
General Counsel
Kentucky Board of Medical Licensure
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