IN THE MATTER OF	*	**BEFORE THE MARYLAND**
GIDEON M. KIOKO, M.D.	*	**STATE BOARD OF PHYSICIANS**
Respondent.	*	**Case Number 2005-0499**
License Number D08283	*	

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FINAL DECISION AND ORDER

INTRODUCTION

In November, 2005, the Maryland State Board of Physicians (the "Board") summarily suspended the license of Gideon M. Kioko, M.D., ("Dr. Kioko") to practice medicine in the State of Maryland under Md. Code Ann., State Gov't ("SG") § 10-226(c)(2)(2004). The Board's summary suspension was based on complaints about the medical and surgical care provided by Dr. Kioko during his unsuccessful attempts to perform late second trimester therapeutic abortions on two female patients[1] in his office in Takoma Park, Maryland.

Following an incomplete abortion procedure performed by Dr. Kioko, Patient A required an emergency hospital admission for disseminated intravascular coagulopathy ("DIC")[2], hemorrhagic shock, a perforated uterus, cervical and vaginal lacerations, retained fetal skull and vertebral column. Ambulance personnel arriving at Dr. Kioko's office found Patient A covered in blood, her legs bathed in blood, and a heavy constant stream of blood spurting from her vagina. The procedure table, numerous equipment tools on tables, suction units and an IV bag were also covered in blood. Patient B also

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1 For purposes of confidentiality, the patients involved in this case are referred to as Patient A and Patient B throughout this Final Decision and Order.

2 Dissiminated intravascular coagulopathy ("DIC") is a life-threatening condition caused by the patient's blood loss and depletion of the body's clotting factors, so that there is no way to stop further bleeding.

required an emergency hospital admission because Dr. Kioko perforated her uterus and bladder, transected and extensively lacerated her colon, and extensively lacerated her upper rectum, injuries that entailed the performance of a left colectomy with colostomy on Patient B. Dr. Kioko failed to call an ambulance to transport Patient B to the nearest hospital, but drove her in his own car to Prince George's Hospital Center ("Prince George's") where he had privileges.

INVESTIGATIVE AND PROCEDURAL HISTORY

1. 1989-1997: Dr. Kioko's Prior Disciplinary History

a. Hillview Clinic

This case marks the second time that Dr. Kioko has come before the Board in connection with his medical and surgical treatment of patients. In 1989, two female patients suffered cardiac arrests as a result of anesthesia complications during therapeutic abortion procedures performed by Dr. Kioko at Hillview Clinic in Suitland, Maryland. Dr. Kioko was at that time the sole physician employed at Hillview. One patient, aged 34, died three days after her procedure. The other patient, aged 26, suffered massive, permanent neurological damage and died in a nursing home three years later. Prior to and during the abortion procedures performed by Dr. Kioko, unqualified, unlicensed individuals administered general anesthesia in the form of IV Brevital to these patients.

b. CYGMA Health Center

Subsequent to these two incidents, Dr. Kioko also performed therapeutic abortions under local and general anesthesia from February 1990 through November, 1991 at CYGMA Health Center in Kensington, Maryland. Dr. Kioko became CYGMA's

Medical Director in November, 1990, and performed abortions under general anesthesia in conjunction with a Certified Registered Nurse Anesthetist ("CRNA") who administered the anesthesia. The relevant regulations required that an anesthesiologist or licensed physician with knowledge and experience in resuscitation, anesthetic drugs and their reactions be physically available for consultation to the CRNA at all times during the administration and recovery from anesthesia. Throughout this time at CYGMA, however, no anesthesiologist or qualified licensed physician was physically available for consultation with the CRNA while Dr. Kioko performed the abortion procedures.

c. Investigation; surrender; denial of reinstatement; reinstatement

In October, 1991, after investigating these events, the Board charged Dr. Kioko with unprofessional conduct in the practice of medicine, practicing medicine with an unauthorized person, and failing to meet appropriate standards of quality medical and surgical care, in violation of Md. Health Occ. Code Ann. § 14-404(a)(3), (18) and (22). To avoid prosecution of these charges, Dr. Kioko surrendered his medical license. Dr. Kioko later petitioned the Board for reinstatement of his license, and the Board issued a Notice of Intent to Deny Reinstatement in January, 1993. After an evidentiary hearing, an administrative law judge issued a proposed decision recommending that Dr. Kioko's petition be denied. In a Final Order issued in July, 1995, the Board denied Dr. Kioko's petition for reinstatement.

On appeal by Dr. Kioko, the Circuit Court for Prince George's County reversed the Board's decision and remanded the case back to the Board to consider the allegations stemming from the incidents at Hillview because Dr. Kioko had not admitted to or litigated those incidents. In May, 1997, following an appearance by Dr. Kioko and

the Administrative Prosecutor for the State before the Board with a proposed stipulation of fact, the Board issued a Final Opinion and Order reinstating Dr. Kioko's medical license. The Board's Order incorporated the parties' stipulation of fact regarding the deaths of the two female patients on whom Dr. Kioko performed abortions at Hillview, and included findings that Dr. Kioko:

(1) practiced medicine with unauthorized persons;

(2) engaged in unprofessional conduct in the practice of medicine by performing surgical procedures under the circumstances listed in (3) and (4) below;

(3) failed to meet appropriate standards of medical and surgical care, in part because anesthesia was not administered by or under direct supervision of qualified medical personnel;

(4) failed to perform a complete physical examination on the patients and performed the abortion procedures under conditions that failed to meet standards for the delivery of quality medical and surgical care by not ensuring:

a) that the patients were appropriate candidates to receive IV Brevital;
b) that the patients were appropriately monitored before and during the surgical procedures he performed;
c) that their vital signs were appropriately monitored;
d) that proper medical equipment or resuscitative drugs were available, or that qualified medical personnel were present to monitor patients and participate in resuscitative efforts if so required.

With respect to Dr. Kioko's role as medical director and his performance of therapeutic abortions at CYGMA, the Board found that Dr. Kioko failed to meet the appropriate standard of medical and surgical care because he did not ensure that an anesthesiologist or qualified physician was physically available to the CRNA for consultation at all times during the administration of and recovery from anesthesia. The Board expressed concern about Dr. Kioko's assumption that his role was limited to performing technical procedures on anesthesized patients, leaving the overall management of the patients to others.

In this respect, the Board found that Dr. Kioko demonstrated a serious lack of judgment regarding the administration of anesthesia and his obligation as a physician to ensure the safety of patients undergoing surgical procedures. He failed to recognize either the potential for emergency situations that might arise in that surgical setting or that he lacked the training and experience to respond appropriately. The Board also noted that Dr. Kioko initially did not seem cognizant of his own role and responsibility in the deaths of these two patients.

The Board reinstated Dr. Kioko's medical license based in part on Dr. Kioko's assurance that: (1) over time, he had gained a better understanding of his responsibility for the tragic events leading to the deaths of the two patients; (2) he had taken appropriate rehabilitative steps to make certain that similar events would never recur; (3) he had ensured that the clinic where he practiced had appropriate drugs and resuscitative equipment; (4) he became certified in Advanced Cardiac Life Support Resuscitation and maintained his certification; (5) he understood that his role as a surgeon goes beyond merely performing a technical procedure and that he is responsible for overseeing the wellbeing of the patient.

The Board placed Dr. Kioko on probation for three years, during which he was required to submit to annual peer review and perform community service. In addition, Dr. Kioko was prohibited from performing surgical procedures requiring general anesthesia or IV sedation unless performed in a hospital with an anesthesiologist present, and prohibited from performing outpatient abortions after twelve (12) weeks gestation. The Board later modified its Final Order to state that Dr. Kioko shall not

perform outpatient abortions after eighteen (18) weeks gestation. In 1999, the Board terminated Dr. Kioko's probation.

2. 1996-1999: Dr. Kioko's Disciplinary History in the District of Columbia

In 1996, the District of Columbia ("D.C") Board of Medicine also concluded that Dr. Kioko's surgical care of one of the patients who died at Hillview was professionally incompetent, that Dr. Kioko had willfully practiced medicine with an unauthorized person, disregarded the health, welfare and safety of a patient, and failed to conform to prevailing standards of acceptable medical care. The D.C. Board placed Dr. Kioko's medical license on probation for sixty (60) months, with conditions including a $5,000 fine and community service, and a prohibition on performing any abortions in D.C. At Dr. Kioko's request, the D.C. Board later amended its prior Order to remove the prohibition against performing abortions, and added practice monitoring and a malpractice insurance requirement. In 1999, the D.C. Board granted Dr. Kioko's request for early termination of his probation.

3. 2005-2006: The Current Investigation, Summary Suspension, Charges, and Proposed Decision

Patient A

In January, 2005, the Board received a complaint from the Risk Manager at Washington Adventist Hospital alleging that Patient A, a 26 year old female patient, was admitted to its emergency room by ambulance on December 1, 2004, following an incomplete abortion performed by Dr. Kioko in his office. Based on Patient A's medical records, the Board's investigation revealed that:

(1) The ambulance crew responded to a 911 call made by Dr. Kioko from his office at 3:50 p.m, and found Patient A:

covered in blood, legs bathed in blood, heavy constant stream of blood spurting from the patient's vagina, table covered in blood, numerous equipment tools on tables covered in blood. . .. Suction unit on table also covered in blood . . .. IV bag also covered in blood.

(2) The emergency crew transported the patient to the closest emergency room at Washington Adventist. On arrival, Patient A had a blood hematocrit of 12.5, her hemoglobin was 4.2,[3] and she was in hemorrhagic shock with DIC. She received three to four units of blood in the emergency department. Patient A required an emergency laparotomy by the on-call GYN surgeon for a perforated uterus, cervical and vaginal lacerations, and a retained fetal head and vertebral column. The patient's estimated blood loss was 4,000 ml., and she also required eight (8) units of packed red blood cells and 4 units of fresh frozen plasma intraoperatively.

(3) Patient A was taken to the recovery room in guarded condition and then to the intensive care unit, where she was further massively transfused for correction of her coagulopathy.

(4) The patient's last menstrual period was on July 1, 2004, and the final pathology report indicated a fetal skull measurement of 17.5 cm in circumference, both of which were consistent with a gestational age of between 20 and 22 weeks.

(5) To prepare the patient's cervix for the procedure, Dr. Kioko administered Cytotech 200 mg intra-cervically, and did not use serial dilators.

(6) A female assistant took Patient A's vital signs before the procedure. Dr. Kioko did not document that he performed a physical or pelvic examination on Patient A. Nor was there documentation of the patient's blood type, her baseline hematocrit, or fetal measurements by sonogram.

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[3] Normal blood hematocrit levels range from 35.3 to 44.4. Normal hemoglobin levels range from 12.0 to 15.3.

(7) According to the patient's office medical record compiled by Dr. Kioko, he began the procedure at about 11:30 a.m., using a #16 cannula to aspirate the products of conception. The electrical power went out in the office between 11:43 a.m. and 12:25 p.m. Dr. Kioko resumed the procedure at approximately 2 p.m. During the two-hour time frame between the power outage and 2 p.m., there was no indication that Dr. Kioko monitored the patient's blood pressure, pulse, or bleeding. Dr. Kioko also refused to allow her to make a phone call to her emergency contact.

(8) During this second attempt to complete the procedure, the patient was bleeding profusely. Dr. Kioko informed Patient A that he would have to "cut the baby up" to get it out, but he was unable to remove the fetal head. Patient A continued to bleed profusely, was semi-conscious, and Dr. Kioko became concerned about imminent DIC. He did not call 911 until 3:50 p.m., however.

Patient B

After receipt of an anonymous complaint in April, 2005, regarding Dr. Kioko's care of Patient B, a 30 year old female, the Board's investigation revealed that:

(1) Patient B, who was 19½ weeks pregnant, was referred to Dr. Kioko for a therapeutic abortion procedure on January 29, 2005.

(2) Dr. Kioko documented a pelvic examination in Patient B's medical record, but did not document her gynecological history, fetal measurements, or performance of a sonogram.

(3) According to Patient B, she arrived at Dr. Kioko's office around 2:00 p.m., saw Dr. Kioko for consultation around 2;30 p.m., was given a "white pill" by Dr. Kioko's female assistant, and sat in the waiting room until Dr. Kioko had seen all his other patients.

(4) Dr. Kioko began the procedure around 5:00 p.m. with his female assistant present. Patient B felt Dr. Kioko insert an instrument inside her, experienced a lot of pressure and then excruciating pain. She then observed a lot of blood hit Dr. Kioko and the wall and felt very faint. Dr. Kioko said that they had to get to a hospital.

(5) In Patient B's medical record, Dr. Kioko indicated that he administered Cytotech 200 mg by mouth at 1:45 p.m., began the procedure at 2:42 p.m., grasped and dilated the cervix, and tried to aspirate the uterine contents "with difficulty" using a 16 mm suction tip. Dr. Kioko stopped the procedure "at about 3:00 p.m." because he suspected uterine perforation and bowel injury to Patient B.

(6) Dr. Kioko did not call 911 but transported Patient B in the back seat of his own car with his assistant to Prince George's Hospital Center where he had admitting privileges.

(7) Hospital records showed that Patient B arrived at the emergency department at 6:35 p.m.

(8) Patient B had a perforated uterus and bladder, as well as a transection of the rectosigmoid colon and extensive lacerations of the left colon and upper rectum. Dr. Kioko performed an exploratory laparotomy, hysterotomy, myomectomy, removal of the fetus and placenta, and surgical repair of the patient's perforated uterus. Another surgeon repaired her perforated bladder, and performed a left colectomy with colostomy.

(9) Since her emergency surgery, Patient B has been unable to have the colostomy reversed due to a lack of medical insurance.

Dr. Kioko's Office, Procedures and Employees

In October, 2005, during two site visits to Dr. Kioko's office, Board staff and Donald Chambers, M.D., an OB/GYN medical consultant to the Board, observed that:

(1) The office had a sonogram machine, an aspiration machine with tubing, a standard GYN examination table, sterile specula, a sink, and Sharps container;
(2) The office had no crash cart, oxygen equipment, pulse oximeters, or ambu bags;
(3) The entire resuscitative equipment consisted of a glove taped to a wall that contained an empty capped syringe and two vials of epinephrine;
(4) The printer on the sonogram machine had not worked in a while and no hard copies were obtained;
(5) There were no Center for Disease Control ("CDC") guidelines posted in the office;
(6) The carpeting in the procedure room was stained and dirty;
(7) The single refrigerator contained medication, food, open soda and condiment bottles;
(8) A full Sharps box was on the floor of the procedure room, not attached to the wall;
(9) There were no policy or procedure manuals for instrument sterilization techniques, or care following post-operative abortions, and Dr. Kioko had no policy for emergencies such as significant bleeding;

In terms of his office procedures, Board staff learned that:

(1) Dr. Kioko did not use a new sterile aspiration tube for each patient. Instead, aspiration tubing contaminated with each patient's blood was washed out between procedures on different patients until it became opaque, then it was discarded;
(2) Dr. Kioko had no contract for the removal of biohazardous material, especially the aspirated contents of the uterus or bloody table sheets. Dr. Kioko did not send this tissue to the lab, but placed it in a red bag and removed it from the office himself;
(3) Dr. Kioko did not routinely perform physical examinations, or document the patient's medical history, biparietal diameter or crown length;
(4) Patients got one initial blood pressure check, and were placed on the examination table with a paper drape across the abdomen and legs;
(5) No I.V. was started on the patient prior to a procedure. Dr. Kioko prepped the perineum with Betadine, inserted a speculum coated with KY jelly from an unsterile tube to expose the cervix, cleaned the cervix with a cotton swab dipped in Betadine, and performed a paracervical block;
(6) Patients were not sedated, and did not receive intravenous or general anesthesia, or conscious sedation;

(7) At the end of an abortion procedure, patients were walked to another recovery room, and one more blood pressure was taken;
(8) Dr. Kioko checked patients after an hour for adequate hemostasis, and the patients were discharged with pain medication and a prescription for antibiotics;
(9) Since June, 2005, Dr. Kioko had not held any hospital privileges and was without emergency back up for any outpatient abortion procedures he performed.

Dr. Kioko's three employees at times consisted of his wife who is a registered nurse, his niece who was reportedly a nursing student, and a medical assistant/office secretary (who worked part time only from April, 2005 until October, 2005). This individual obtained patients' vital signs, performed finger sticks for hematocrit levels, sterilized equipment, and assisted Dr. Kioko in procedures by handing him KY jelly and applying Betadine, and cleaned the office after procedures. Dr. Kioko's wife and his niece both denied that they were involved in or present during the abortion procedures he performed on Patients A and B. Dr. Kioko provided no credible evidence of the identity of his "assistant" on the dates of those procedures.

Cease and Desist, Summary Suspension, Charges and Hearing

On October 13, 2005, based on its investigation, the Board advised Dr. Kioko by hand-delivered correspondence to immediately cease and desist from performing any abortion procedures until the Board's investigation was resolved. On November 1, 2005, the Board summarily suspended Dr. Kioko's medical license, immediately prohibiting him from engaging in the practice of medicine and requiring that he surrender his license to the Board. Dr. Kioko appeared before the Board on November 16, 2005, for a post-deprivation hearing on the summary suspension. After hearing arguments from Dr. Kioko and the Administrative Prosecutor, the Board voted to continue the summary suspension.

On December 9, 2005, the Board issued charges against Dr. Kioko under the Maryland Medical Practice Act, Md. Health Occ. Code Ann. §§ 14-401 *et seq.* (2005 Repl. Vol.) The pertinent provisions under § 14-404(a) provide as follows:

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (3) Is guilty of immoral or unprofessional conduct in the practice of medicine;
>
> (4) Is professionally, physically, or mentally incompetent;
>
> (31) Except in an emergency life-threatening situation where it is not feasible or practicable, fails to comply with the Centers for Disease Control's guideline on universal precautions;
>
> (32) Fails to display the notice required under § 14-415 of this title.

Section 14-415 states:

> If a physician is engaged in the private practice of medicine in the State, the physician shall display the notice developed under § 1-207[4] of this article conspicuously in each office where the physician is engaged in practice.

Md. Health Occ. Code Ann. § 14-415 (2005 Repl. Vol.).

The charging document notified Dr. Kioko that (1) an evidentiary hearing was scheduled for March 8 and 9, 2006 at the Office of Administrative Hearings ("OAH"); and (2) a pre-hearing conference was scheduled at OAH for February 9, 2006. On December 28, 2005, the OAH sent another notice to Dr. Kioko of the hearing scheduled for March 8 and 9, and the in-person pre-hearing conference scheduled for February 9, 2006. The notice included instructions advising Dr. Kioko of the requirement to complete

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[4] Section 1-207 requires the development of a notice written in layman's language that explains the CDC guidelines. Md. Health Occ. Code Ann. § 1-207 (2005 Repl. Vol.)

and exchange a Pre-Hearing Conference Statement with opposing counsel, including a list of witnesses to be called and the name and curriculum vitae of any expert witness

Dr. Kioko, however, failed to complete a Pre-Hearing Conference Statement, and failed to appear at the pre-hearing conference on February 9. The Administrative Law Judge ("ALJ"), J. Bernard McClellan, conducted the pre-hearing conference in Dr. Kioko's absence, issued a Pre-Hearing Conference Report on February 13, 2006, and mailed a copy to Dr. Kioko. The report reiterated the hearing dates of March 8 and 9, 2006.

On February 27, 2006, the OAH received a request to postpone the hearing from Dr. Kioko, who stated that he needed more time to obtain legal counsel and retain an expert witness. The ALJ denied the request based on Dr. Kioko's failure to establish good cause for a postponement.

An evidentiary hearing was held at OAH on March 8 and 9, 2006 before the ALJ. Dr. Kioko was present and represented himself. He again requested a postponement and the ALJ denied Dr. Kioko's request for the same reason – failure to establish good cause. Dr. Kioko elected not to testify and did not present any witnesses. He did, however, cross-examine the State's fact witnesses, including Carol Palmer, Patient A and Patient B. He also cross-examined Dr. Chambers and Michelle Fox, M.D., who testified as expert witnesses for the State.

On June 6, 2006, the ALJ issued a Proposed Decision upholding the Board's charges and summary suspension, and recommending revocation of Dr. Kioko's medical license. Dr. Kioko and the State filed written Exceptions to the ALJ's Proposed

Decision, and both parties filed responses to each other's Exceptions. The parties then appeared before the Board for an oral Exceptions Hearing.

After considering the entire record in this case, including the record made before the ALJ and the written and oral exceptions by both parties, the Board now issues this Final Decision and Order.

FINDINGS OF FACT

The Board adopts the ALJ's Findings of Fact numbers 1-42 as set forth in the ALJ's Proposed Decision. (The ALJ's Proposed Decision of June 6, 2006, is incorporated by reference into this Final Decision and Order and is appended to this Order as Attachment A.) These facts have been proven by a preponderance of the evidence.

DISCUSSION

The Board adopts the ALJ's analysis on pages 14-28 of the ALJ's Proposed Decision. Dr. Kioko provided professionally incompetent care by: performing late second trimester abortion procedures with only a sketchy medical history and an inadequate physical examination; failing to assess and document fetal gestational age and to obtain a hematocrit and blood type; insufficiently preparing and dilating the cervix, thereby increasing the risk of cervical laceration and uterine perforation, and the probability of being unable to remove the fetus or complete abortion procedures; attempting these procedures on patients with advanced gestational ages using suction equipment; failing to use a dilatation and evacuation technique with special forceps or ultrasound guidance to direct removal of fetal parts; failing to monitor patients during and after abortions by checking their blood pressure, pulse, and respiration every 15 minutes; continuing to

perform the procedure during a power outage; failing to regularly monitor Patient A, including her blood pressure and bleeding during the two-hour time frame between the power outage and the second attempt to complete the procedure; and waiting for almost two hours to call for an ambulance as Patient A bled profusely instead of immediately arranging for her emergency transportation to the nearest hospital. Dr. Kioko's mismanagement of Patient A's complications greatly endangered her life.

Dr. Kioko was also professionally incompetent when he: performed outpatient abortions without emergency resuscitative equipment or sufficiently qualified medical personnel to assist with the procedures or monitor the patients; failed to notify paramedics about Patient B when he suspected bowel injury; failed to arrange for her immediate transportation to the nearest hospital; transported her to another hospital in his personal car without adequate monitoring or qualified personnel to respond to her worsening critical condition; failed to use proper medical judgment in responding to the complications and medical crises triggered by his professional incompetence; and risked further bleeding by performing an elective myomectomy on Patient B; Dr. Kioko's mismanagement of Patient B's complications also greatly jeopardized her life.

In addition, Dr. Kioko engaged in unprofessional conduct in the practice of medicine when he refused to allow Patient A to call her emergency contact and did not honor her request to call 911 or an ambulance; performed outpatient abortions with no hospital privileges and no contract with another physician with privileges; and had no arrangement for emergency back-up to accommodate possible inpatient admissions.

Dr. Kioko's multiple infringements of CDC and OSHA guidelines created numerous safety hazards and violated the Medical Practice Act. Dr. Kioko failed to

properly dispose of aspirated uterine contents and other biohazard materials, such as bloody table sheets; failed to ensure the sharps box was attached and locked to the wall; failed to maintain medications separate from food; failed to maintain policies for instrument sterilization techniques; and failed to maintain a clean office. Dr. Kioko also failed to post the CDC guidelines in his office.

Patient A's medical record contains no documentation of the patient's vital signs during or after the power outage. Significantly, the record also does not contain a written explanation by Dr. Kioko of what occurred from 2:00 p.m. to 3:50 p.m., or why he delayed calling 911 during that critical time period. In addition, Patient B's account of the time she arrived at Dr. Kioko's office and the time Dr. Kioko began her procedure at 5:00 p.m. are consistent with the time she was actually admitted to the emergency department at Prince George's – 6:35 p.m. Dr. Kioko's written medical record is not. He documented 2:42 p.m. as the time he began the procedure and 3:00 p.m. as the time he terminated it after he perforated her colon. Moreover, Dr. Kioko declined to testify about this or any other issue at the hearing before the ALJ. The Board, therefore, finds that Dr. Kioko's medical documentation is not credible in reflecting the reality of what transpired during his care of Patients A and B.

On two separate occasions, Dr. Kioko flirted with medical catastrophe in his surgical management of Patients A and B. Dr. Kioko demonstrated the same troubling patterns of flawed medical judgment as in his previous disciplinary cases before the Board. Fortunately, the patients survived due to hospitalization and subsequent surgical intervention, but only after exposure to the unnecessary risks caused by Dr. Kioko's professional incompetence and unprofessional conduct in the practice of medicine.

CONCLUSIONS OF LAW

The Board adopts the conclusions of law proposed by the Administrative Law Judge on page 28 of the Proposed Decision.

SANCTION

The Board previously charged Dr. Kioko with violations of the Medical Practice Act and publicly disciplined him severely. The Board found that Dr. Kioko failed to meet appropriate standards for the delivery of quality medical and surgical care and engaged in unprofessional conduct in the practice of medicine. The Board also found that Dr. Kioko failed to ensure that anesthetized patients undergoing therapeutic abortions were properly monitored and that proper medical equipment, resuscitative drugs and qualified medical personnel were available in the operative setting. The Board expressed concern about Dr. Kioko's serious lack of judgment regarding the safety of patients having surgical procedures and his inability to recognize the potential for emergency situations that might arise during his performance of therapeutic abortion procedures.

Now, more than nine years later, Dr. Kioko has again shown similar serious errors in medical judgment. This time, Dr Kioko endangered the lives of two female patients by attempting to perform late second trimester abortion procedures without ensuring adequate cervical preparation, the availability of proper medical and resuscitative equipment and the presence of adequately trained medical personnel. It is obvious that the Board's previous sanctions did not substantially alter Dr. Kioko's conduct or improve his deficient professional judgment.

As the surgeon for Patients A and B, Dr. Kioko had the primary responsibility for competently managing their abortion procedures. His incompetent management led to

their grave operative complications. It was also incumbent on Dr. Kioko to comply with CDC guidelines. Instead, Dr. Kioko ran a shoestring office operation and ignored his obligation to observe universal precautions. Dr. Kioko's multiple violations of these guidelines jeopardized the health and safety of all of his patients.

A physician who enjoys the benefits of medical licensure in the State of Maryland must also shoulder all of the resulting responsibilities, one of which is the obligation to provide professionally competent medical and surgical care. As a licensee, Dr. Kioko had such an obligation. Dr. Kioko, however, set the scene for two medical catastrophes by attempting to perform late second trimester abortions using inadequate cervical dilation and suction techniques. Dr. Kioko demonstrated extreme incompetence.

Moreover, Dr. Kioko's refusal to allow Patient A to make a phone call and his delay in calling appropriate emergency personnel to get her to the nearest hospital were inexplicable and callous actions. Dr. Kioko's failure to call 911 to transport Patient B to the nearest hospital and his insistence on taking her in his own car to another hospital was unprofessional and self-serving. His decision further endangered Patient B's life and deprived her of ambulance equipment and trained medical personnel able to appropriately respond to her serious condition. Dr. Kioko's incompetence, his unprofessional conduct, and his inadequate response to the plight of his patients were truly egregious. Dr. Kioko poses too great a risk to the public for the grant of medical licensure ever again in this State. To safeguard patients in the State of Maryland, the Board will permanently revoke Dr. Kioko's medical license.

ORDER

It is therefore:

ORDERED that the medical license of Gideon M. Kioko, M.D., License No. D08283, be **REVOKED PERMANENTLY**; and it is further

ORDERED that the Board will not accept any applications for reinstatement from Dr. Kioko in the future; and it is further

ORDERED that this Final Decision and Order is a public document under Md. State Gov't Code Ann. § 10-611 *et seq.*

SO ORDERED this 20th day of December, 2006.

12/20/06
Date

C. Irving Pinder, Jr., Executive Director
Maryland State Board of Physicians

NOTICE OF RIGHT TO APPEAL

Pursuant to Md. Code Ann., HO § 14-408(b), Dr. Kioko has the right to take a direct judicial appeal. Any appeal shall be filed within thirty (30) days from the receipt of this Final Order and shall be made as provided for judicial review of a final decision in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Dr. Kioko files an appeal, the Board is a party and should be served with the court's process. In addition, Dr. Kioko should send a copy to the Board's counsel, Thomas W. Keech, Esq., at the Office of the Attorney General, 300 W. Preston Street, Suite 302, Baltimore, Maryland 21201.

ATTACHMENT A

STATE BOARD OF PHYSICIANS	* **BEFORE J. BERNARD McCLELLAN,**
v.	* **AN ADMINISTRATIVE LAW JUDGE**
GIDEON M. KIOKO, M.D.,	* **OF THE MARYLAND OFFICE**
RESPONDENT	* **OF ADMINISTRATIVE HEARINGS**
License No. D08283	* **OAH NOS.: DHMH-SBP-71-05-62900 and**
	* **DHMH-SBP-72-05-62894**

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PROPOSED DECISION

STATEMENT OF THE CASE
ISSUES
SUMMARY OF THE EVIDENCE
FINDINGS OF FACT
DISCUSSION
CONCLUSIONS OF LAW
PROPOSED DISPOSITION

STATEMENT OF THE CASE

On November 1, 2005, the State Board of Physicians ("Board") issued an Order of Summary Suspension of the license of Gideon M. Kioko, M.D. ("Respondent") after concluding that the public health, safety or welfare imperatively required emergency action. Md. Code Ann., State Gov't § 10-226(c)(2) (2004). It further ordered that a post-deprivation hearing on the Summary Suspension take place on November 16, 2004 before the Board in accordance with Code of Maryland Regulations ("COMAR") 32.02.05(B)(7).

On December 9, 2005, the Board issued charges against the Respondent for immoral or unprofessional conduct in the practice of medicine; professional, physical, or mental incompetence; failure to comply with Centers for Disease Control ("CDC") guidelines on universal precautions

except where it is not feasible or practicable; and failure to display notice required under § 14-415, in violation of the Medical Practice Act. Md. Code Ann., Health Occ. § 14-404(a) (3), (4), (31) and (32) (2005).

By Notice dated December 28, 2005, the Respondent was notified that a Pre-Hearing Conference would take place on February 9, 2006 at the Office of Administrative Hearings ("OAH"), 11101 Gilroy Road, Hunt Valley, Maryland and that the Evidentiary Hearing was scheduled for March 8 and 9, 2006, at the OAH. Said Notice also included Pre-Hearing Conference Instructions that advised the Respondent of the requirement to complete, and exchange with opposing Counsel, a Pre-Hearing Conference Statement.

The Respondent failed to complete a Pre-Hearing Conference Statement as instructed and failed to appear at the Pre-Hearing Conference on February 9, 2006. The Pre-Hearing Conference was conducted in his absence and a Pre-Hearing Conference Report was issued on February 13, 2006, and a copy was mailed to the Respondent, which Report reiterated the Evidentiary Hearing dates of March 8 and 9, 2006.

On February 27, 2006, the Respondent, by fax, requested a postponement to obtain legal counsel and retain an expert witness. The request for postponement was denied for failure to establish good cause for a postponement.

An evidentiary hearing was held on March 8 and 9, 2006, at the Office of Administrative Hearings ("OAH"), 11101 Gilroy Road, Hunt Valley, Maryland, before J. Bernard McClellan, Administrative Law Judge ("ALJ"). Md. Code Ann., Health Occ. § 14-405(a) (2005). The Respondent was present and represented himself. Janet Klein Brown, Assistant Attorney General, represented the Board.

At the beginning of the hearing, the Respondent again requested a postponement because he could not afford to obtain legal counsel. As the same request had previously been made for the same reason, it was again denied.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules of Procedure of the State Board of Physicians, and the Rules of Procedure of the Office of Administrative Hearings. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2004 & Supp. 2005); COMAR 10.32.02; COMAR 28.02.01.

The hearing record closed on March 9, 2006.

ISSUES

1. Did the public health, safety or welfare imperatively require emergency action in the form of a Summary Suspension?
2. Did the Respondent engage in immoral or unprofessional conduct in the practice of medicine?
3. Was the Respondent professionally, physically, or mentally incompetent?
4. Did the Respondent fail to comply with Centers for Disease Control guidelines on universal precautions except where it is not feasible or practicable?
5. Did the Respondent fail to display notice required under § 14-415?
6. If the Respondent is guilty of any of the violations listed above, what is the appropriate sanction?

SUMMARY OF THE EVIDENCE

Exhibits

The Board submitted the following exhibits that were admitted into evidence:

State Ex. #1 - Complaint Form, 1/13/05
State Ex. #2 - Complaint Form
State Ex. #3 - Transcript of interview with the Respondent, 9/9/05
State Ex. #4 - Memorandum re: Service of Subpoenas from Carol Palmer and Maureen Sammons, 10/5/05
State Ex. #5 - Memorandum of Interview of Shura Murphy by Carol Palmer and Maureen Sammons, 10/7/05
State Ex. #6 - Memorandum of Telephone Interview of Johnette Anderson-Kioko by Carol Palmer and Maureen Sammons, 10/7/05
State Ex. #7 - Letter to Carol Palmer from the Respondent, 10/6/05 enclosing Anshura Murphy's Application for Employment
State Ex. #8 - Memorandum of Telephone Interview of Patient A by Carol Palmer, 10/12/05
State Ex. #9 - Memorandum of Office Visit and Office Inspection transcribed by Maureen Sammons, 10/14/05 with printed digital photographs
State Ex. #10 - Letter to the Respondent from the Board, 10/13/05
State Ex. #11 - Memorandum of Telephone Call from the Respondent by Carol Palmer, 10/13/05
State Ex. #12 - Fax to the Board from the Respondent, 10/16/05
State Ex. #13 - Letter to Michelle C. Fox., M.D., from the Board, 10/17/05
State Ex. #14 - Investigative Report, 10/27/05
State Ex. #15 - Review by Michelle C. Fox., M.D., 10/28/05
State Ex. #16 - Memo to File by Maureen Sammons, 11/1/05 with Affidavit of Service
State Ex. #17 - Memorandum by Carol Palmer of interview of Tim Silk, 11/2/05
State Ex. #18 - Transcript of interview with Julia Kioko, 11/7/05
State Ex. #19 – Two Memos to File by Vic Tolentino, 11/17/05
State Ex. #20 – Transcript of interview with Patient B, 11/23/05
State Ex. #21 - Curriculum Vitae of Michelle Candice Fox, M.D., M.P.H., F.A.C.O.G.
State Ex. #22 - Curriculum Vitae of Donald C. Chambers, M.D., F.A.C.O.G., F.A.C.S.
State Ex. #23 - Letter to the Department from C. Lamont Reddon, Pepco, 2/1/06
State Ex. #24 - Letter of Surrender, 12/3/91 with attached Charges, 10/17/91; Final Order of the Board, 7/21/95 with attached Recommended Decision, 12/19/94; Final Opinion and Order of the Board, 5/28/97; Modified Final Opinion and Order of the Board, 10/29/97; Termination of Probation, 3/24/99
State Ex. #25 - Final Decision and Order of the District of Columbia Board of Medicine, 3/6/96; Recommended Decision to the District of Columbia Board of Medicine, 8/8/95; Order of the District of Columbia Board of Medicine, 6/30/99
State Ex. #26 - A - Respondent's Explanation of Events that led to Hospital Admission for Patient A
B - Respondent's letter to the Board re: Patient B
State Ex. #27 -A-D - Office and medical records for Patient A
E-G - Office and medical records for Patient B
State Ex. #28 - Resume of Carol A. Palmer
State Ex. #29 - Transcript of show cause hearing before the Board, 11/16/05
State Ex. #30 - Prince George's Hospital Patient Information Form for Patient B

The Respondent submitted the following exhibit that was admitted into evidence:

Resp. Ex. #1 - Infectious and Chemotherapeutic Waste Manifest, 7/7/05; Statements from Bio-Haz Solutions, Inc., 7/31/05 and 8/31/05

Testimony

The following witnesses testified on behalf of the Board:

- Carol Palmer, Supervisor, Intake Unit
- Donald Clive Chambers, M.D., who was accepted as an expert in obstetrics and gynecology
- Michelle Candice Fox, M.D., who was accepted as an expert in obstetrics, gynecology, family planning and abortion services
- Patient A, who testified via telephone
- Patient B, who testified via telephone
- Sarah Rarick, Office Manager, Bio-Haz, Inc., who testified by telephone

The Respondent elected not to testify and did not present any witnesses.

FINDINGS OF FACT

Having considered all of the evidence presented, I find the following facts by a preponderance of the evidence:

1. At all times relevant to this proceeding, the Respondent was a licensed physician in the State of Maryland, practicing under license number D08283. The Respondent was also licensed to practice in Washington, D.C.

2. On January 13, 2005, the Board received a complaint from the Risk Manager at Washington Adventist Hospital, advising the Board that on December 1, 2004, a 26-year-old patient (Patient A) had been admitted to the Emergency Room by ambulance after an incomplete abortion performed by the Respondent.

3. Patient A hemorrhaged during her procedure and developed disseminating intravascular coagulopathy ("DIC").[1] At the hospital, she underwent an exploratory laparotomy, repair of uterine perforation, bilateral uterine artery ligation, right utero-ovarian artery ligation, repair of cervical laceration and repair of vaginal vault laceration. The final pathology diagnosis of Patient A's uterine contents included the fetal head and upper vertebral column.

4. During Patient A's procedure, the power in the Respondent's office went out for approximately an hour. The Respondent resumed the procedure once power was restored. During the outage, the Respondent did not arrange for Patient A to be transported to a hospital where a Dilation and Evacuation could be performed.

5. Patient A experienced significant blood loss during her procedure. The Respondent did not monitor Patient A, including her blood pressure and the amount of blood loss, during a two hour time frame between the power outage and a second attempt to complete the abortion. Patient A developed DIC, a critical condition that can be fatal if not treated.

6. During the procedure, Patient A requested to call her emergency contact or have the Respondent call, but the Respondent refused.

7. The Respondent eventually called 911. Emergency personnel arrived within five minutes. The Respondent requested that Patient A be transported to Prince George's Hospital so that he could treat her, but emergency personnel informed the Respondent that they had to take Patient A to the closest hospital. Emergency personnel transported Patient A by ambulance to Washington Adventist Hospital.

[1] This is a condition in which a patient has depleted their body of all clotting factors such that their blood will no longer clot. (Test. of Dr. Fox, pg. 221)

8. The Board asked Dr. Donald Chambers to review the complaint regarding Patient A.

9. In April 2005, the Board received an anonymous complaint regarding a "botched abortion" performed by the Respondent.

10. On January 29, 2005, Patient B, a 30-year-old female, was referred to the Respondent by Potomac Family Planning ("Potomac"). Patient B had gone to Potomac earlier in the day for a termination of pregnancy and with problems of "bleeding."

11. During Patient B's procedure, the Respondent suspected uterine perforation and possible bowel injury. The procedure was terminated. The Respondent did not call emergency personnel; instead, he drove Patient B to Prince George's Hospital in his car. At this time, the Respondent had privileges at Prince George's Hospital.

12. Patient B had a "perforated uterus, with transaction of rectosigmoid colon and extensive lacerations of the left colon and upper rectum and perforated urinary bladder." A surgeon who was working with the Respondent performed a left colectomy with colostomy and repair of urinary bladder perforation. The Respondent performed exploratory laporotomy, hystecomy, myomectomy, removal of fetus and placenta and repairs to the uterus.

13. A myomectomy is an elective gynecological procedure. The procedure should not be performed on a pregnant uterus, as it creates a risk of bleeding

14. On September 9, 2005, Carol Palmer, an Intake Supervisor, and Dr. Yemisi Koya interviewed the Respondent.

15. Ms. Palmer and Maureen Sammons, a Compliance Analyst, visited the Respondent's office on October 5, 2005. During that visit, they interviewed Shura Murphy.[2] Ms.

[2] Ms. Murphy's complete first name is Anshura.

Murphy worked as a receptionist and assistant. Her duties included cleaning the office after procedures, sterilizing equipment and assisting in exam rooms. She took patients' vital signs and performed finger sticks for Hematocrit if a patient did not provide previous blood work. She also assisted the Respondent with procedures by handing him KY jelly, taking blood pressures and applying Betadine. Ms. Murphy told investigators that no one has had any problems since she started working in the office.

16. On October 5, 2005, Ms. Palmer and Ms. Sammons also interviewed Johnette Anderson-Kioko. She is the Respondent's wife. Mrs. Anderson-Kioko does not work for the Respondent, but occasionally helps him out with filing, phone coverage and office duties. She is a licensed registered nurse, but was unable to provide her license number to Ms. Palmer. In addition, she occasionally prepared a patient, counseled a patient, set up the room, cleaned the patient, obtained vital signs and gave discharge instructions, charting the information in the medical record and signing her name as the assistant. She denied ever assisting with a patient who had problems with bleeding after a procedure.

17. Ms. Palmer conducted a telephone interview with Patient A on October 12, 2005. Patient A came to the Respondent's office in December 2004 for a termination of pregnancy procedure. She arrived around 9:00 a.m. She asked the Respondent if there would be any problems since she believed she was four months pregnant. The Respondent said there would be no problems. The Respondent performed a sonogram and stated that Patient A looked bigger than four months. An assistant took Patient A's vital signs and blood pressure before the procedure. Her procedure began around 10:00 a. m. During the procedure, the electricity in the office began going on and off. The Respondent was having problems with the procedure. He told Patient A he would have to "cut

the baby up" to get it out. Patient A was losing blood. She asked for her cell phone to call her emergency contact, but the Respondent refused and would not call her contact himself. Patient A told the Respondent she couldn't breathe and she kept passing out. She did not recall what time the Respondent called 911. No blood work was performed. She recalled that her blood pressure was only taken when she arrived. The "assistant" did not monitor Patient A.

18. Ms. Palmer and Dr. Chambers visited the Respondent's office on October 13, 2005. Shura Murphy was present during the visit. During that visit, Ms. Palmer and Dr. Chambers made the following observations:

- the waiting area was small and relatively clean.
- the carpeting in the procedure room was stained and unclean
- a full sharps box [3] was sitting on the floor in the procedure room and not attached to the wall
- Ms. Murphy stated that they do not use a new aspiration tube for each patient
- a glove was taped to the wall which contained an empty capped syringe and two vials of epinephrine
- there was no evidence of oxygen cylinders, pulse ox, or ambu bag
- Ms. Murphy stated that a patient get one initial blood pressure prior to her procedure, the patient is placed on the table with a paper drape across her abdomen and legs, the Respondent prepares the perineum with betadine, then he inserts a speculum upon which KY jelly from an unsterile tube has been applied then exposes the cervix. The Respondent uses a cotton swab dipped in betadine to clean the cervix. This is followed by a paracervical block.
- the printer on the ultrasound machine had not worked. Ms. Murphy stated that biparietal diameter and crown length are generally, but not always, recorded on the patient's physical form.
- patients in the recovery room have their blood pressure taken once and the Respondent checks on them an hour after their procedure. They are given antibiotics and Motrin when they are discharged.
- there is a small lab where finger sticks are done for hematrocrits and an Rh is done. No blood typing is done.
- a refrigerator in the receptionist area contained medication, food, opened bottles of soda, and open bottles of condiments

[3] This is a lockable box for disposal of needles and sharp instruments.

- there were no policy or procedure manuals for sterilization techniques for instruments. There was no policy for emergencies. There are, at times, only two people in the office.
- there was no hospital backup for the Respondent
- Ms. Murphy did not know what happens to biohazard material. No tissue is sent to a lab. There was no information available about disposal of biohazard material.

19. On October 13, 2005, the Board sent the Respondent an order instructing him to cease and desist performing abortions

20. On October 17, 2005, the Board asked Dr. Fox to review the medical records and documents in the case. Her review was received on October 31, 2005.

21. On November 1, 2005, the Board summarily suspended the Respondent's license to practice medicine in Maryland. The Order of Summary Suspension was delivered to the Respondent at his home by Ms. Sammons and Pamela Cromer the same day.

22. Ms. Palmer contacted Tim Silk of the Prince George's County Public Safety Communications regarding calls received by the Prince George's County Fire Department for an ambulance at the Respondent's office on January 29, 2005. Mr. Silk checked three databases and police records, and found that no calls were received from the Respondent's address on that date.

23. Patricia Bramlet interviewed Julia Kioko, the Respondent's niece, on November 7, 2005.

24. Ms. Palmer and Ms. Sammons interviewed Patient B on November 23, 2005. Patient B was referred to the Respondent by Potomac Family because she was having problems with bleeding. She was scheduled for an abortion the same day. She arrived around 2:00 p.m. and her procedure began around 5:00 p.m.. The Respondent gave her a pill to take, but he did not numb any part of her body. The Respondent did explain the procedure to her. Patient B's blood pressure

was not taken and no blood work was done. She did not bring a sonogram from Potomac with her. Patient B advised the Respondent that she could feel what he was doing, but he told her just to be calm. The Respondent and his assistant were watching a screen, but Patient B could not see it. She felt excruciating pain and began to feel faint. Patient B began to bleed and the Respondent told her she had to go to a hospital. The assistant helped Patient B get dressed. The Respondent told her that there was not time to wait for an ambulance; he had to take her to the hospital himself. He drove Patient B to Prince George's Hospital while his assistant sat with her in the rear of the vehicle. She was taken in for emergency surgery.

25. The Respondent performs outpatient abortions without an adequate number of qualified personnel available to assist him while he is performing the procedure, to monitor the patients at the conclusion of the procedure, and assist in an emergency. Usually there is only one staff member present with the Respondent.

26. The Respondent performs abortions without obtaining a patient's medical history or conducting an adequate physical examination. He fails to sufficiently document preoperative assessments of patients undergoing abortions. Additionally, he fails to adequately assess and document fetal gestational age.

27. The Respondent performs abortions under local anesthetic without knowing whether the procedure may safely be performed by documenting the size of the fetus.

28. Emergency resuscitative equipment, including an ambu bag, IV set-up, epinephrine, benedryl, and oxygen cylinders is not available while the Respondent performs outpatient abortions.

29. No office policy or procedure manual exists for emergencies, such as significant bleeding.

30. Patients' respirations, pulse and blood pressure are not monitored every 15 minutes following an abortion.

31. The Respondent does not meet Centers for Disease Control guidelines for the:

- disposal of the aspirated contents of the uterus and other biohazard materials, such as bloody table sheets;
- maintenance of the sharps box;
- maintenance of medication;
- posting of CDC guidelines;
- maintenance of policies for sterilization techniques for instruments;
- maintenance of a clean office

32. The Respondent performed late second trimester abortions on Patient A and Patient B without adequate cervical preparation resulting in an increased risk of complications. The Respondent administered Cytotec intracervically. He did not use serial dilators. The procedures were performed using suction alone, instead of by Dilation and Evacuation using special forceps.

33. A hematocrit was not performed on Patient A prior to performing a late second trimester abortion.

34. On December 3, 1991, the Respondent executed a Letter of Surrender in which he irrevocably surrendered his license to practice medicine in Maryland. This resulted from Charges issued on October 17, 1991. These charges involved the Respondent's failure to ensure that qualified individuals administered anesthesia to patients. Two patients suffered cardiac arrests as a result of anesthesia complications during abortions performed by the Respondent. One patient died three days after her procedure on July 12, 1989. The other patient was left with massive, permanent brain damage after her procedure on September 9, 1989. She lived in a nursing home until her death three years later.

35. The Respondent later applied for reinstatement of his license to practice medicine in Maryland. On December 19, 1994, Administrative Law Judge Jana Corn Burch issued a Recommended Order in which she recommended that the Board deny the Respondent's application for reinstatement.

36. On July 21, 1995, the Board issued a Final Order denying the Respondent's application for reinstatement.

37. By Order dated May 28, 1997, the Respondent's license was reinstated with the following conditions:

- Respondent's practice be subject to peer review in 12 months
- Respondent shall not perform any medical or surgical procedure requiring general anesthesia or IV sedation unless it is performed in a hospital with an anesthesiologist present
- Respondent shall not perform outpatient abortions after 12 weeks gestation
- Respondent shall perform 300 hours community service
- Respondent shall practice medicine in compliance with the Order and Maryland Medical Practice Act

38. On October 29, 1997, the Board modified its order of May 28, 1997. The only change was that the Respondent was prohibited from performing abortions after 18 weeks gestation instead of 12.

39. The Respondent's probation was terminated on March 24, 1999.

40. On August 8, 1995, the District of Columbia Board of Medicine issued a decision to revoke the Respondent's license.

41. By Final Order dated March 6, 1996, the District of Columbia Board of Medicine found the Respondent to have acted in a professionally incompetent manner; to have willfully practiced medicine with an unauthorized person; to have disregarded the health, welfare and safety

of a patient; and to have failed to conform to the prevailing standards of acceptable practice. The Order included the following conditions:

- Respondent pay $5,000.00 fine
- Respondent be placed on five years probation
- Respondent perform no abortions during probation
- Respondent perform 300 hours of Board approved community service in first three years of probation
- Respondent provide notarized statements that he has performed no abortions

42. On June 30, 1999, the Respondent's District of Columbia probation was terminated.

DISCUSSION

Applicable Law

Section 14-404(a) of the Health Occupations provides, in pertinent part:

> (a) In general.--Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (3) Is guilty of immoral or unprofessional conduct in the practice of medicine;
>
> (4) Is professionally, physically, or mentally incompetent;
>
> (31) Except in an emergency life-threatening situation where it is not feasible or practicable, fails to comply with the Centers for Disease Control's guidelines on universal precautions;
>
> (32) Fails to display the notice required under § 14-415 of this title;
>
> Md. Code Ann., Health Occ. § 14-404(a) (2004). [4]

Section 14-415 provides, in pertinent part:

[4] As the investigation involved treatment of patients that occurred in November of 2004 and January 2005, the 2004 Supplement is cited.

If a physician is engaged in the private practice of medicine in the State, the physician shall display the notice developed under § 1-207 [5] of this article conspicuously in each office where the physician is engaged in practice.

The Burden and Standard of Proof

In a physician disciplinary proceeding, the Board bears the burden of proof by the preponderance of the evidence. Md. Code Ann., Health Occ. § 14-405(b)(2); Md. Code Ann., State Gov't § 10-217 (2004).

The Evidence

The Board received a complaint in January 2005 regarding an incomplete abortion procedure performed by the Respondent on Patient A. Carol Palmer, Intake Supervisor, investigated the complaint.

The office and hospital records for Patient A, along with the Respondent's response to the complaint, were sent to Dr. Donald Chambers for review. While Dr. Chambers was reviewing that complaint, an anonymous complaint was received regarding Patient B. The Board notified the Respondent of the second complaint and asked for a response. The Respondent provided his response. Ms. Palmer continued to investigate both complaints. Both cases were taken to the investigative review panel, which recommended a full investigation be opened on both complaints.

The Respondent came to the Board for an interview on September 9, 2005. (State Ex. #3). There were concerns about who may have been working in the Respondent's office, so the Board subpoenaed his personnel records. On October 5, 2005, Ms. Palmer and Maureen Sammons visited the Respondent's office. During that visit, Ms. Palmer and Ms. Sammons interviewed Shura Murphy. (State Ex. #5). Ms. Palmer also interviewed the Respondent's wife, Johnette Anderson-

[5] Section 1-207 requires the development of a written notice in layman's language that explains the CDC guidelines.

Kioko, by telephone on October 5, 2005. (State Ex. #6). On October 13, 2005, the Board sent the Respondent an order instructing him to cease and desist performing abortions. (State Ex. #10). Also on that date, Ms. Palmer conducted a telephone interview with Patient A (State Ex. #8), and conducted a site visit of the Respondent's office with Dr. Chambers. (State Ex. #9). On October 17, 2005, the Board requested that Dr. Michelle Fox review the records of the two complaints. Her report was received on October 28, 2005. An interview was conducted with Julia Kioko, the Respondent's niece, on November 7, 2005. (State Ex. #18). Patient B was interviewed by telephone on November 23, 2005. (State Ex. #20). The Respondent received the Board's Order of Summary Suspension on November 1, 2005. (State Ex. #16).

Additionally, Ms. Palmer contacted the Potomac Electric Power Company ("PEPCO") to document the power outage that occurred during Patient A's procedure. A response from PEPCO was received on February 1, 2006. (State Ex. #23). Ms. Palmer also subpoenaed records from the ambulance call for Patient A. (State Ex. #27-B, C). She also obtained Patient B's records from Potomac Family Planning .(State Ex. #27-G). Hospital records were obtained for both patients (State Ex. #27-D to F).

Ms. Palmer also obtained copies of previous disciplinary decisions against the Respondent from Maryland and Washington D.C. (State Exs. 24 and 25).

The Board presented the testimony of Dr. Donald Chambers, who testified as expert in obstetrics and gynecology. He reviewed the complaint regarding Patient A, the Respondent's office records for Patient A and the records from Washington Adventist for Patient A. He also accompanied Maureen Sammons on a visit to the Respondent's office on October 13, 2005.

Dr. Chambers observed that the waiting area of the Respondent's office was neat and properly furnished. He instructed Ms. Sammons to photograph various equipment, the layout of the rooms, the floor and instruments. Dr. Chambers testified that the floor in the procedure room was carpeted, and he noted that carpeting is inappropriate as it would become contaminated by bodily fluids. He stated that the floor should be impervious, either vinyl or tile that can be washed easily and easily sanitized. (p. 156). Dr. Chambers testified that office staff reported that tubing was reused and not sterilized; it was just washed out and rinsed out between procedures. He noted that "in my experience in both ambulatory surgical centers and free-standing centers that I've worked in, the tubing was discarded after each procedure." (p. 158).

A filled sharps box was on the floor; however, it is an Occupational Safety and Health Administration requirement that the box be locked to the wall. Sharp boxes, and other biohazard material, should be disposed of by a biohazard company. There were no red biohazard bags available, and Ms. Murphy did not know what happened to the sharp boxes when the Respondent took them out.

Dr. Chambers explained that a sonogram is taken to determine gestational age because, "It is important to be sure that ... you're not going beyond 23 weeks gestation...The new paranatal-neonatal guidelines say that 23 weeks [or] above- there is significant chance of viability of this fetus, and it's no longer an abortion – an elective termination of pregnancy. In Maryland, you can do an elective termination of pregnancy to 24 weeks if there is documented fetal abnormality that's not compatible with life." (p. 166). He also explained that "The more advanced gestational age, the higher the degree of difficulty in performing the procedure, primarily removing the fetal head. The fetal head is the largest part of the baby at this point, and throughout most of the pregnancy. So one

of the measurements that you would get is what they call the biparietal diameter. This is the distance between just above your ears on either side. This gives you a good idea of how large the fetal head is, and it correlates with the gestational age." (pp. 166-67). Dr. Chambers testified that Ms. Murphy told him sonograms were not used all the time and that the printer was not working. Dr. Chambers stated that, "If you do an ultrasound, then you need to document what you see." (p. 169).

Dr. Chambers observed a glove attached to the wall containing a syringe and epinephrine. In his memo regarding the visit, Dr. Chambers wrote that this "was the entire resuscitative equipment that was in the office." (State's Ex. #9, pg. 2).

With regard to patient monitoring after a procedure, Dr. Chambers felt that, "...blood pressure should be taken every 15 minutes, minimally, along with the pulse. A temperature should be done and the fundus of the uterus, the top part of the uterus, should be checked very 15 minutes to be sure that it is not filling up with blood...also, the amount of bleeding that she's doing should be checked every 15 minutes...to be sure that you're not having post-operative hemorrhage from the uterus." (pp. 173-74). Dr. Chambers testified that the Respondent did not comply with these monitoring requirements.

Dr. Chambers observed that medications were stored in the same refrigerator as food. He stated that this is a violation of OSHA and CDC guidelines.

The Respondent's current license and DEA certificate were not displayed in his office. Additionally, CDC guidelines were not posted.

Dr. Chambers found the Respondent's use of personnel inadequate. He saw no indication of procedure manuals for emergency situations, sterilization of equipment and care of the post-

abortion patient. In his opinion, the Respondent did not have sufficient emergency backup because he has no hospital privileges and no arrangements with a back-up physician who could handle complications at a hospital in the vicinity.

The Board also presented the testimony of Dr. Michelle Fox, who was admitted as an expert in obstetrics, gynecology, family planning and abortion services. In October 2005, the Board had requested that Dr. Fox review the records related to the case. She described the management of the cases as "unprofessional, and in some cases incompetent." (p. 205).

Dr. Fox was concerned that there was no physical examination and no pelvic examination documented for Patient A. She found no explanation of how fetal sizing of 19 to 20 weeks was obtained. Patient A's medical record says a sonogram was necessary, but there was no documentation it was performed, which was a special concern because by last menstrual period Patient A was 21 to 22 weeks pregnant. (pp. 206-207).

Patient A's blood type & Rh were not obtained through office testing. It was unclear to Dr. Fox if Patient A's medical history was taken and/or reviewed by the Respondent, because the history was completed by Patient A. (pp.207-08).

According to Dr. Fox, the only means of cervical preparation used by the Respondent was Cytotec 200 milligrams given intracervically, which is "not a proven method for late second trimester abortion." (p. 208). She testified that the standard of care is to use serial dilators, which are often placed overnight to further dilate the cervix and minimize risk of injury to cervix and uterus. (p. 208). There was no indication that dilators were used. Dr. Fox believed it was incompetent for the Respondent not to have done an ultrasound.

Additionally, Dr. Fox was concerned with complete lack of documentation between the

initial attempt of Patient A's procedure and the second attempt. She testified that nowhere was it stated that Patient A was being monitored. (p. 210-11).

Dr. Fox asserted that Patient A's fetus was too big to be removed by suction alone. (p. 211). She testified that "the procedure is a dilation and evacuation procedure, specialized forceps instruments are used to collapse the fetal structure such that they can be removed from a cervix that is not dilated that far." (p. 212). Dr. Fox described the Respondent's failure to use D&E as professionally incompetent. She noted that there were almost two hours that they were attempting to remove the fetal head the second time, which she testified is far too long in a bleeding patient. (p. 217). According to Dr. Fox., "after 15 minutes, 20 minutes of trying, if it's not working, then this patient should have been transported to a hospital to have the procedure completed." (p. 218).

Dr. Fox testified that no hematocrit was done for Patient A, even though "standard practice is that if you're going to be doing an outpatient procedure that entails blood loss, that you should make sure that the patient is not already anemic before you start...If they're starting at a lower level, they're more likely to run into complications. We don't know what [Patient A]'s baseline is at all." (p. 219).

The Respondent's failure to allow Patient A to make a phone call was very unprofessional, according to Dr. Fox.

With regard to monitoring Patient A, Dr. Fox testified that "By definition of the fact that her procedure was incomplete and she was at risk of hemorrhage qualifies somebody who needs more intensive monitoring, which standardly would be done every 15 minutes at the very minimum...taking her blood pressure, pulse, respirations, and checking her pad and documenting

what was on the pad." (p. 226).

Dr. Fox felt that the Respondent's comment to Patient A that he had to "cut up the baby" was not an appropriate way to explain to a patient that the fetus will not be removed intact.

Patient A was taken by ambulance to Washington Adventist Hospital. She had emergency surgery, during which a uterine perforation was repaired, including injury to vessels inside the abdomen as well as in the cervix and vagina.

With respect to Patient B, Dr. Fox considered it important that Patient B had had no children. Patient B recorded that she had two previous abortions, but Dr. Fox found that there was not enough detail to know if this would have changed Patient B's cervix. Patient B completed her medical history, but Dr. Fox noted that there were no comments, so "I don't know if that means there are no comments or they weren't reviewed. It's usually standard to at least write something so you can show you've reviewed them." (p. 232). Patient B had not provided the date of her last menstrual period so determining gestational age would be based on her pelvic examination and an ultrasound.[6] Patient B did not have any cervical dilaters placed, she just had Cytotec which is unproven for late second trimester procedures. Dr. Fox explained that "...because the cervix was not prepared adequately, it could not be dilated adequately. And because of that, there had to be increased force used during the procedure, and that increases the risk of cervical lacerations and uterine perforation." (p. 233).

Dr. Fox noted that an ultrasound was not done on Patient B, which is important to ensure

[6] Potomac Family Planning had determined Patient B's gestational age to be 19 weeks and four days, while the Respondent recorded that the gestational age was 18+ weeks.

that you don't have a 24-week fetus since "it is illegal to be doing that." (p. 235). Although there were labs written in the medical record, Dr. Fox testified that Patient B stated that she did not have her blood drawn; therefore, Dr. Fox did not know where the labs came from.

The Respondent performed Patient B's procedure using suction, but Dr. Fox testified that "The safer method to do this procedure would be to use forceps and collapse the fetus and remove it rather than trying to remove it all with suction, because it is not going to fit into a 16 millimeter suction cannula." (p. 238). She went on to testify that "Textbooks state that while you can attempt a procedure up to 14 to 16 weeks, beyond 16 weeks...you cannot complete the procedure under suction. You're going to need to use some type of evacuative measure besides the suction" (p. 239).

Patient B sustained a uterine perforation and bowel injury during the attempted procedure. She was driven by the Respondent to the hospital. Dr. Fox considered it unprofessional that the Respondent drove Patient B to the hospital, noting that he could not have attended to Patient B's medical care if he were driving and he would not have any emergency equipment available. The hospital was not aware that Patient B was en route; therefore, the hospital could not minimize Patient B's delay in receiving care. Although a medical assistant was with Patient B during the ride, Dr. Fox pointed out that a medical assistant does not have the training to assist a patient who has a critical injury. She also noted that an ambulance responded in five minutes when called regarding Patient A.

On cross-examination, Dr. Fox stated that "calling EMS would have actually speeded [Patient B]'s care; that she would have gotten to the hospital faster because EMS doesn't have to deal with traffic, red lights and all those other things. I believe that she could have arrived at the

hospital with two large IVs and been taken directly to the operating room rather than walking into an emergency department and trying to command attention with just somebody walking in with a patient. I really believe that not using EMS actually delayed the patient's care." (p. 256).

The Respondent and another surgeon performed emergency surgery for Patient B. While performing this emergency surgery, the Respondent also performed a myomectomy. Dr. Fox explained that a myomectomy is an elective procedure to remove a fibroid from the uterus. She testified that "...a myomectomy entails a risk of blood loss. And especially in a pregnant uterus where the vasculature to the uterine fibroid is increased, it is standard to not perform a myomectomy on a pregnant uterus." (p. 244).

The Board also presented, by telephone, the testimony of both Patient A and Patient B.

Patient A stated that the power went out during her procedure. She testified that the Respondent told her he was having difficulty removing the baby's head. She was bleeding heavily. She began to worry, and asked to have her cell phone to call an emergency contact and work. The Respondent and the assistant would not give her the phone, so she got off of the table and got it herself while she was alone in the room. Although the Respondent initially said he did not need to call for help, he later called paramedics. Patient A woke up in the ICU of Washington Adventist with a tube down her throat.

Patient B testified that she was referred to the Respondent by Potomac Planning. During her procedure, Patient B told the Respondent that he was hurting her. He told her to relax. She began to bleed, and the Respondent told his assistant "Oh wow, this is a disaster." He then told Patient B that they had to go to the hospital. The assistant helped Patient B dress. The Respondent drove Patient B to the hospital as the assistant sat with her. She was hospitalized for

a week as she recovered. Patient B has been unable to work, and has not been able to have her colostomy reversed due to a lack of insurance.

Finally, in response to the manifest submitted by the Respondent as Resp. Ex. #1, the Board presented the testimony of Sarah Rarick, an office manager for Bio-Haz Solutions. She testified that prior to May 9, 2005, the company did not have any current agreement with the Respondent. She stated that the company performed four pick-ups for the Respondent from May through August 2005. After that, pick-ups were suspended for nonpayment. The balance of the account was paid in January 2006.

Analysis

As noted above, the Board bears the burden of proof by a preponderance of the evidence. In this case, the Respondent failed to present any testimony, electing both not to testify and not to present testimony from any witnesses. Therefore, the Board's case is entirely unrebutted, including the opinions expressed by its expert witnesses, Dr. Chambers and Dr. Fox. As such, I find that the Board has clearly met its burden to establish that the Respondent violated each of the provisions with which he has been charged. I will address each violation separately.

First, I am persuaded that the Respondent engaged in unprofessional conduct in the practice of medicine. The Respondent's office conditions and his policies and practice reveled that: he performed outpatient abortions without adequate number of qualified personnel available to assist while he is performing the procedure, to monitor the patients at the conclusion of the procedure and to assist in an emergency; he performed abortions without obtaining a medical history and without an adequate physical examination; he failed to sufficiently document preoperative assessments of patients undergoing abortions; he failed to assess and document fetal

gestational age; he performed outpatient abortions under local anesthetic without knowing whether the procedure may safely be performed by documenting the size of the fetus; he performed outpatient abortions without emergency resuscitative equipment, including an ambu bag, IV set-up, epinephrine, benydryl, and oxygen cylinders; he performed outpatient abortions without having an office policy or manual for emergencies; he performed outpatient abortions without emergency back-up by having privileges at a nearby hospital or having a contract with another physician who has privileges at a nearby hospital; he failed to monitor patients after abortions by checking the patients' respiration, pulse and blood pressure every 15 minutes; he failed to dispose of the aspirated contents of the uterus and other biohazard materials in compliance with CDC guidelines; he failed to maintain a sharps box in accordance with CDC guidelines; he failed to maintain medicine in compliance with CDC guidelines; he failed to post CDC guidelines; he failed to maintain policies for sterilization techniques for instruments; and he failed to maintain a clean office, including the consultation room, waiting room, procedure and recovery rooms, and laboratory area. Each and every one of the above recited deficiencies were testified to by those individuals who either observed, first hand, the Respondent's office or who reviewed the medical records, and statements, of the Respondent's patients.

Next, I am also persuaded that the Respondent's treatment of both Patient A and Patient B was professionally incompetent. Based upon the testimony presented from Dr. Chambers, Dr. Fox, Patient A and Patient B, I find that the Respondent: performed late second trimester abortions on Patient A and Patient B without adequate cervical preparation resulting in an increased risk of complications; performed abortions on Patient A and B using suction alone instead of by Dilation and Evacuation, using special forceps; failed to obtain a hematocrit on Patient A prior to performing

a late second trimester abortion; failed to respond to Patient A's repeated requests to call her emergency contact person; failed to immediately arrange for Patient A's transportation to a hospital when it became apparent that he would be unable to complete the abortion in a timely manner due to a power outage; failed to regularly monitor Patient A, including blood pressure and amount of blood loss, during a power outage; failed to contact paramedics and arrange for Patient B's transportation to a hospital when he suspected a bowel injury instead of personally transporting Patient B in his vehicle; failed to exercise sound medical judgment in regard to both Patient A and Patient B during known complications of abortion; performed an elective procedure (myomectomy) on Patient B while performing emergency surgery to repair the uterus, possibly leading to further bleeding.

Finally, I am persuaded that the Respondent did not follow CDC guidelines on universal precautions. Specifically, the Respondent: failed to post CDC guidelines in his office; the office carpet, in rooms where procedures were performed, were stained and unclean; washed and reused aspiration machine tubing; did not have the sharps container attached and locked to the wall; did not have a contract for removal of biohazard material; did not maintain a log for when and how much biohazard material is picked up; and kept medication in the same refrigerator as food, opened soda bottles and open condiment containers. These deficiencies were documented by photographs taken during a Board visit to the Respondent's office on October 13, 2005 as well as direct observation on Board visits to Respondent's office.

Sanctions

As noted above, the Board "may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee . . ." violates any of the enumerated provisions of Md.

Code Ann., Health Occ., § 14-404. In addition to, or in lieu of, action against a licensee's license, the Board may impose a monetary penalty for such violations. Md. Code Ann., Health Occ., § 14-405.1.

In determining the appropriate sanctions that should be imposed against the Respondent for the violations committed, it is important to consider that the purpose of a physician disciplinary proceeding is not "to punish the offender but rather ... a catharsis for the profession and a prophylactic for the public." *McDonnell v. Comm'n Medical Discipline*, 301 Md. 426, 436 (1984). Since there is a punitive aspect to the proceeding, however, "statutes authorizing sanctions against the physician should be strictly construed against the disciplinary agency." *Id.* at 436. The Court of Appeals has reaffirmed the principal set forth in the *McDonnell* case in holding that:

> It ought to be made clear ... that the primary purpose of professional disciplinary proceedings is to protect the public. The punishment of an offending member of the profession is indeed a serious matter, but it is incidental to the protection of the public.

Attorney Grievance Commission v. Goldsborough, 330 Md. 342, 356-357 (1992).

With this legal framework in mind, and having considered all of the evidence presented at the hearing, including the evidence of prior disciplinary proceedings presented by the Board, I find that the appropriate sanction to be imposed is the revocation of the Respondent's license.

Having been guided by the Court of Appeals to address, as my primary concern, the protection of the public, I am of the opinion that the level of incompetent and unprofessional conduct shown by the Respondent regarding the care of Patients A and B to warrant only the most severe and extreme sanction of revocation. Any lesser sanction would not only do a disservice to the citizens of Maryland but would place in serious jeopardy the health, safety and

welfare of any potential patient of the Respondent. The two patients that were the subject of this proceeding were not only injured, but they were unquestionably exposed to further injury as a result of the Respondent's callous conduct. Both patients were scarred physically and mentally by the Respondent's lack of proper care and concern for their welfare. In addition, the Respondent has a history of being disciplined in both Maryland and the District of Columbia for extremely serious violations.

Taking all of these factors into consideration, I conclude that the only proper sanction is the revocation of the Respondent's license.

Emergency Suspension

Having upheld all of the charges filed by the Board on December 9, 2005, the issue of the Respondent's Summary Suspension of November 1, 2005, is moot. However, it is quite apparent that my findings that the Respondent's unprofessional and incompetent conduct, as well as his violation of CDC guidelines, placed the general public's health, safety or welfare in such serious jeopardy that revocation of the Respondent's license was the only possible sanction to be imposed, would have supported a finding that the conduct of the respondent imperatively required emergency action in the form of a Summary Suspension.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact and Discussion, I conclude, as a matter of law, that the Respondent did violate section 14-404(a)(3), (4), (31) and (32). I further conclude that, as a result, the Board may discipline the Respondent. Md. Code Ann., Health Occ. § 14-404(a).

PROPOSED DISPOSITION

I **PROPOSE** that the charges filed by the Board on December 9, 2005 against the Respondent be **UPHELD**. I further **PROPOSE** that the Respondent's license to practice medicine be **REVOKED**.

June 6, 2006
Date

J. Bernard McClellan
Administrative Law Judge

JBMC
81139

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party may file exceptions, in writing, to this Proposed Decision with the State Board of Physicians within fifteen (15) days of receipt of the decision. Md. Code Ann., State Gov't § 10-216 (2004) and COMAR 10.32.02.03F. The Office of Administrative Hearings is not a party to any review process.

Copies to:
Gideon M. Kioko, MD
8301 Osage Terrace
Adelphi, Maryland 20783

Janet Klein Brown, Assistant Attorney General
Office of the Attorney General
300 West Preston Street
Baltimore, Maryland 21201

Sylvia Morgan, Paralegal
Office of the Attorney General
300 West Preston Street
Suite 207
Baltimore, Maryland 21201

Barbara K. Vona
Chief of Compliance
State Board of Physicians
4201 Patterson Avenue
Baltimore, Maryland 21215

Irving Pinder, Executive Director
State Board of Physicians
4201 Patterson Avenue, 3rd Floor
Baltimore, Maryland 21215

Harry C. Knipp, M.D., FACR, Chairman
State Board of Physicians
Metro Executive Plaza
4201 Patterson Avenue, 3rd Floor
Baltimore, Maryland 21215

Timothy J. Paulus, Deputy Counsel
Department of Health and Mental Hygiene
Office of the Attorney General
300 West Preston Street, 3rd Floor
Baltimore, Maryland 21201