Jean R. Uranga
URANGA, URANGA & BIETER
714 North 5th Street
P.O. Box 1678
Boise, Idaho 83701
(208) 342-8931

Attorneys for the Board

BEFORE THE BOARD OF PROFESSIONAL DISCIPLINE OF

THE IDAHO STATE BOARD OF MEDICINE

In the Matter of: KENNETH J. WELKER, M.D. License No. M-5630, Respondent.	Case No. 93-016 SECOND AMENDED COMPLAINT

COMES NOW Darleene Thorsted, Executive Director of the Idaho State Board of Medicine, on behalf of the Board of Professional Discipline, hereinafter referred to as the Board, and complains and alleges as follows:

COUNT ONE

I

Kenneth L. Welker, M.D., hereinafter referred to as Respondent, is the holder of an Idaho license to practice medicine and surgery, License No. M-5630, issued by the Idaho State Board of Medicine on January 15, 1990. Said license is subject to the provisions of Title 54, Chapter 18, Idaho Code, commonly referred to as the Medical Practice Act. The purpose of this disciplinary proceeding is to determine whether Respondent's Idaho license to practice medicine and surgery should be suspended, restricted or revoked.

II

On or around July 21, 1994, Patient [redacted], a 66-year-old-female, was admitted to Saint Alphonsus Regional Medical Center with a right upper lobe nodule and history of smoking, shortness of breath with significant exertion, and early COPD. Respondent provided medical care and treatment to Patient [redacted]. prior to and during the hospitalization, including a right anterior thoracotomy with an excision of a right upper lobe lesion and right lower lobectomy. Respondent failed to perform adequate preoperative evaluation; failed to document pulmonary function studies pre-op; failed to clearly document bullous lung disease or other reasons for removing the right lower lobe of the lung; selected and performed surgical procedures which were not indicated; and used enucleation of the upper lobe tumor with purse string closure, which is antiquated or poorly described and documented in the operative report.

III

The acts and practices of Respondent, as alleged in paragraph II above, constitute violations of the Idaho Medical Practice Act in that:

(1) Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7) and IDAPA 22.01.01.101.03.g;

(2) Respondent has performed surgical procedures which were unnecessary and not medically indicated, in violation of Idaho Code §54-1814(14); and

(3) Respondent has engaged in conduct which constitutes

exploitation of a patient, in violation of Idaho Code §54-1814(22) and IDAPA 22.01.01.101.04.a.

COUNT TWO

IV

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

V

On or around March 2, 1994, Patient [redacted], a 66-year-old male, was admitted to Saint Alphonsus Regional Medical Center with a history of intermittent pulmonary problems over a two to three year period prior to admission. Respondent provided medical care and treatment to Patient [redacted] during the hospitalization. The patient underwent right lower and middle lobe resection which was made difficult by adhesions from previous disease. A simple ligation of middle and lower lobe veins was indicated by operative report. The ligation site bled after surgery with a code being called eight minutes after closure and control of the bleeding was not achieved for over 17 minutes. Patient [redacted] died of hypoxic brain damage secondary to prolonged hypotension caused by blood loss. Ligation of these veins with 2-0 silk was inadequate. Further, after bleeding problems were identified, there was a 17 minute delay by Respondent in reopening the chest to access the bleeding site and another ten minute delay in identifying and controlling bleeding.

VI

The acts and practices of Respondent, as alleged in paragraph V above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in

the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT THREE

VII

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

VIII

On or around May 26, 1994, Patient [redacted], a 63-year-old male, was admitted to the Saint Alphonsus Regional Medical Center Emergency Room after being involved in a high speed motor vehicle accident. This patient was alert and oriented at the scene, but required extensive extraction to remove him from the vehicle. Respondent provided medical care and treatment to Patient [redacted] during the hospitalization. Patient had decreased breath sounds in the left lung field and Respondent placed a chest tube, evacuated a hemopneumothorax and placed a central line in the left subclavian vein. The patient showed signs of increasing internal bleeding requiring transfusion to maintain blood pressure, but the Respondent was unavailable. The patient was transferred to St. Luke's via ambulance with CPR initiated en route, and the patient died shortly after arrival with the cause of death being hemorrhage from the aorta. Respondent was the trauma surgeon and improperly left the evaluation and care of a seriously injured patient, who was hemodynamically unstable, to the emergency room MD.

IX

The acts and practices of Respondent, as alleged in paragraph VIII above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the

standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT FOUR

X

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XI

On or around April 13, 1994, Patient [redacted], a 73-year-old male, was admitted to Saint Alphonsus Regional Medical Center for elective cervical disc fusion performed by another physician. Respondent provided care and treatment to this patient, beginning on April 23, 1994, when the patient developed colonic volvulus and necrosis during postoperative recovery from the cervical spine surgery. The surgical correction of the colonic volvulus performed by Respondent lasted three hours and 45 minutes while laparoscopic cholecystectomy and laparoscopy were attempted, and finally a open procedure was pursued. Respondent's care was improper because he failed to order x-rays of the abdomen, he used multiple surgical procedures which were not indicated or necessary and which were too long for a critically ill elderly man, and no surgical assistant was utilized.

XII

The acts and practices of Respondent, as alleged in paragraph XI above, constitute violations of the Idaho Medical Practice Act in that:

(1) Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians

in the same or similar communities, in violation of Idaho Code §54-1814(7) and IDAPA 22.02.02.101.03.g;

(2) Respondent has performed surgical procedures which were unnecessary and not medically indicated, in violation of Idaho Code §54-1814(4); and

(3) Respondent has engaged in conduct which constitutes exploitation of a patient, in violation of Idaho Code §54-1814(22) and IDAPA 22.01.01.101.04.a.

COUNT FIVE

XIII

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XIV

On or around March 25, 1993, Patient [redacted], a 35-year-old male, was admitted to Saint Alphonsus Regional Medical Center for gall bladder disease, with a history of schizophrenia. The Respondent provided mecial care and treatment to Patient [redacted] during the hospitalization. On March 25, 1993, the Respondent performed multiple operative procedures on the patient. The Respondent did not adequately document those procedures performed on March 25, 1993, in any significant detail. The operative sequence of events and surgical reasoning for those events and procedures is missing from the operative report. In the presence of inflammatory disease, Respondent persisted longer than appropriate in his laparoscopic approach before performing a laparotomy. In the presence of duodenal injury and gallbladder fossa abscess and without exploring the common bile duct or complete x-ray evaluation of the duodenum, Respondent performed a choledochoduodenostomy.

The patient required extensive re-exploration two days later for anastomotic leak. The patient also required percutaneous drainage of fluid and later studies showed the drainage tube had been improperly placed by Respondent in the duodenum only.

XV

The acts and practices of Respondent, as alleged in paragraph XVII above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT SIX

XVI

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XVII

On or around May 12, 1994, Patient [redacted], Medical Record #125-787, a 74-year-old female, was admitted to St. Luke's Regional Medical Center by Respondent for probable right breast cancer. The Respondent performed a right breast biopsy, mastectomy and translocation and preservation of the nipple. No informed consent for the translocation and preservation of the nipple is noted in the chart. Respondent had no postoperative progress notes and postoperative care was inappropriately delegated to a resident. Significant postoperative bleeding was documented by hematocrit drop from 38 to 20. Nipple preservation was performed by Respondent without documentation of the rationale for the procedure and in the face of malignant carcinoma in a 74-year-old female.

XVIII

The acts and practices of Respondent, as alleged in paragraph XVII above, constitute violations of the Idaho Medical Practice Act in that:

(1) Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7) and IDAPA 22.01.01.101.03.g;

(2) Respondent has performed surgical procedures which were unnecessary and not medically indicated, in violation of Idaho Code §54-1814(14); and

(3) Respondent has engaged in conduct which constitutes exploitation of a patient, in violation of Idaho Code §54-1814(22) and IDAPA 22.01.01.101.04.a.

COUNT SEVEN

XIX

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XX

On or around November 11, 1991, Patient [redacted], a 69-year-old female, was admitted to St. Alphonsus Regional Medical Center with right lower extremity rest pain, claudication and ankle brachial index 0.5. The arteriogram showed right superficial artery occlusion, right renal artery stenosis stable, and patent aorta with right external iliac artery stenosis.

Respondent provided medical care and treatment to Patient [redacted] prior to and during the hospitalization. Aortal/femoral bypass graft with right femoral popliteal bypass graft was undertaken.

Massive bleeding from the suprarenal aorta led to disseminated intravascular coagulation and massive transfusion. Femoral popliteal bypass graft was abandoned. Patient [redacted] died post-operative day one.

Femoral bypass graft was not indicated for right lower extremity pain and superficial femoral artery occlusion.

Renal artery endarterectomy was not indicated. No renal endarterectomy operative permit was obtained. There is no chart documentation of a discussion with Patient [redacted]. about risks, benefits and alternatives for managing her problems or about renal revascularization.

Respondent's technical abilities were inadequate for this procedure and in controlling proximal bleeding intraoperatively and there was inadequate preparation for an aortic/renal endarterectomy.

XXI

The acts and practices of Respondent, as alleged in paragraph XIX above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT EIGHT

XXII

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XXIII

On or around July 2, 1991, Patient [redacted], a 61-year-old male,

was admitted to St. Alphonsus Regional Medical Center with lower extremity claudication, blue toes and rest pain, ankle brachial index 0.3, reduced right arm blood pressure and right internal carotid artery occlusion.

Respondent provided medical care and treatment to Patient [redacted] prior to and during hospitalization. Aorta bifemoral bypass graft was performed on or around July 3, 1991. A chest x-ray performed one week prior to surgery demonstrated large right lung mass. The chest x-ray was not reviewed by Respondent until pulmonary consultation was obtained postoperatively. Bronchoscopy revealed adenocarcinoma of the right upper lobe, probably unresectable. Right hand ischemia was noted one week postoperatively. An axilla-axillary bypass graft was performed without preoperative arteriogram and the graft thrombosed postoperatively. Multiple thrombectomies, graft revisions, distal bypasses, evacuation of hematomas, etc., were performed, resulting in eight (8) total operations on the right upper extremity for ischemic complications. Eventual right forearm amputation and patient death occurred six (6) weeks after the aortic bifemoral bypass graft.

Respondent's preoperative evaluation of Patient [redacted] was inadequate and he failed to review chest x-rays preoperatively which is mandatory.

Respondent inappropriately performed aortic bifemoral bypass graft in the face of lung cancer. A less invasive procedure could have been done to relieve rest pain.

Respondent inappropriately performed an axilla/axillary bypass graft without arteriographic definition of pathology.

Respondent engaged in inappropriate management of complica-

tions of axilla-axillary graft thromboses and no adequate arteriography was performed at any time during eight operations.

Respondent engaged in inappropriate management of coagulopathy, putting the patient on aspirin, coumadin, and heparin.

Respondent failed to obtain appropriate vascular surgery consultation in the face of numerous complications.

XXIV

The acts and practices of Respondent, as alleged in paragraph XXI above, constitute violations of the Idaho Medical Practice Act in that:

(1) Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7) and IDAPA 22.01.01.101.03.g;

(2) Respondent has performed surgical procedures which were unnecessary and not medically indicated, in violation of Idaho Code §54-1814(14); and

(3) Respondent has engaged in conduct which constitutes exploitation of a patient, in violation of Idaho Code §54-1814(22) and IDAPA 22.01.01.101.04.a.

COUNT NINE

XXV

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XXVI

On or around April 28, 1992, Patient [redacted], a 71-year-old female, was admitted to St. Alphonsus Regional Medical Center with right lower extremity claudication and rest pain, history of right

carotid dissection and strokes in 1991.

Respondent provided medical care and treatment to Patient [redacted] prior to and during hospitalization. Bilateral harsh carotid bruits were noted on the admission physical examination with no mention of preoperative carotid duplex evaluation. A right superficial femoral to tibial saphenous vein bypass was performed on or around April 29, 1992, under epidural anesthesia. Patient [redacted] was unarousable in the recovery room, hypotensive, with postoperative hemoglobin around 5.3. Respondent was not notified of this situation for ninety (90) minutes. Patient [redacted] received four (4) units of blood in the recovery room and two (2) in ICU. Respondent was not in attendance until three (3) hours after the procedure. Patient [redacted] suffered massive right cerebral infarct and postoperative death.

This patient was a poor candidate for surgery and Respondent did an inadequate preoperative evaluation of Patient [redacted] cerebrovascular status following a history of stroke and carotid dissection, including, but not limited to, failure to obtain a conventional contrast cerebral arteriogram. The prolonged operation resulted in excess hemorrhage, produced postoperative anemia and contributed to the patient's stroke. Respondent failed to appropriately and timely evaluate and treat the patient's intraoperative blood loss and post-operative anemia, including, but not limited to, failure to monitor hemoglobin values and transfusing intraoperatively.

XXVII

The acts and practices of Respondent, as alleged in paragraph XXIII above, constitute violations of the Idaho Medical Practice

Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT TEN

XXVIII

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XXIX

On or around July 10, 1992, Patient [redacted], an [redacted]-year-old male, was admitted to St. Alphonsus Regional Medical Center with right lower extremity pain and arterial insufficiency, bilateral superficial femoral artery occlusion, right popliteal and tibial occlusive disease. Heparin and urokinase infusion were attempted. The patient's history of left femoral/tibial saphenous vein bypass in 1991 was complicated by severe postoperative arrhythmias.

Respondent provided medical care and treatment to Patient [redacted] prior to and during hospitalization. Femoral/popliteal bypass with saphenous vein was performed on or around July 13, 1992. Patient [redacted] was stabilized in the Intensive Care Unit. An irregular heart rhythm was noted on the first postoperative day but Patient [redacted] was transferred to the surgical ward before the electrocardiogram was reviewed. Postoperative anemia with hematocrit 25.5% was noted. Transfusion ordered. Patient [redacted] was found dead in his room on the third postoperative day.

Respondent did an inadequate preoperative evaluation. There was no documented history or physical examination by the Respondent and no documentation or evaluation of significant previous

arrhythmias.

Respondent also did an inadequate preoperative preparation, with no preoperative assessment by Respondent. Respondent's first note occurred on the third hospital day.

Respondent exhibited inadequate technical abilities intraoperatively, prolonged the operation and destroyed surgical equipment.

Respondent did an inadequate postoperative follow-up and management, and allowed early transfer from the Intensive Care Unit without adequate cardiac evaluation and inadequate documentation of Respondent in attendance postoperatively.

The operative dictation is disoriented and inaccurate.

XXX

The acts and practices of Respondent, as alleged in paragraph XXV above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT ELEVEN

XXXI

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XXXII

On or around June 8, 1992, Patient [redacted], an 80-year-old female, was admitted to St. Alphonsus Regional Medical Center with left ankle ischemic ulcer, left ankle brachial index 0.63, left superficial femoral and popliteal stenoses on arteriogram.

Respondent provided medical care and treatment to Patient [redacted] prior to and during hospitalization. Left femoral popliteal prosthetic bypass graft was performed on or around June 9, 1992. Patient [redacted] experienced postoperative anemia, hematocrit 23%, requiring transfusion.

Respondent performed a long, overly complex and unnecessary surgical procedure in a patient amenable to balloon angioplasty. Respondent's choice to use Gortex, rather than saphenous vein was improper and inappropriate.

Inadequate postoperative follow-up was done by Respondent. The first progress note was written on the fourth postoperative day. There was inadequate documentation of postoperative hemodynamics.

There were questionable indications for placement of epidural catheter for postoperative pain control, after surgery, after heparin and dextran infusion.

XXXIII

The acts and practices of Respondent, as alleged in paragraph XXVII above, constitute violations of the Idaho Medical Practice Act in that:

(1) Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7) and IDAPA 22.01.01.101.03.g;

(2) Respondent has performed surgical procedures which were unnecessary and not medically indicated, in violation of Idaho Code §54-1814(14); and

(3) Respondent has engaged in conduct which constitutes

exploitation of a patient, in violation of Idaho Code §54-1814(22) and IDAPA 22.01.01.101.04.a.

COUNT TWELVE

XXXIV

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XXXV

On or around May 11, 1996, Patient [redacted], a 40-year-old female, was admitted to St. Alphonsus Regional Medical Center for a laparoscopic cholecystectomy for cholecystitis. Respondent provided medical care and treatment to Patient [redacted] prior to and during the hospitalization. During the laparoscopic cholecystectomy the unprepared transverse colon was inadvertently perforated. The perforation was repaired by an open "mini-laparotomy." The patient's postoperative course was complicated by both liver and pulmonary dysfunction and a severe wound infection. The Respondent failed to adequately document that he informed Patient [redacted] as to the nature, risks, benefits, and alternatives of laparoscopic cholecystectomy. Respondent improperly and inadequately repaired the perforated colon and should have delayed closure. Respondent failed to consult with and discuss the risk of a primary closure of the unprepared colon injury with a responsible member of Patient [redacted] family. Respondent failed to timely detect and treat the wound infection and sepsis. Respondent failed to perform an adequate postoperative physical examination of Patient [redacted] at her two-week postoperative appointment. The Respondent failed to examine her lungs or open wound.

XXXVI

The acts and practices of Respondent, as alleged in paragraph XXIX above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT THIRTEEN

XXXVII

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XXXVIII

On or around June 22, 1995, Patient [redacted] was admitted to St. Alphonsus Regional Medical Center following a motorcycle accident. He suffered blunt trauma to his abdomen, and he sustained a large central, hepatic laceration with extensive intra-abdominal hemorrhage. The Respondent provided medical care and treatment to Patient [redacted] during the hospitalization. On June 24, 1995, the Respondent performed an exploratory laparotomy, hepatorrhaphy, cholecystectomy, retroperitoneal exploration, drainage of intra-peritoneal lavage, and appendectomy. Intrahepatic bile duct injury is commonly associated with blunt trauma of the liver. The Respondent improperly delayed in undertaking operative intervention for the liver laceration and hemorrhaging, failed to properly evaluate and surgically care for the bile duct injury, failed to obtain an operative cholangiogram, failed to place drains, and failed to evaluate or treat the high probability of a biliary tree injury. The postoperative problems suffered by Patient [redacted] are

the result of the undetected intrahepatic bile duct injury and the associated bile leakage. The Respondent's removal of the appendix was unnecessary surgery.

XXXIX

The acts and practices of Respondent, as alleged in paragraph XXXI above, constitute violations of the Idaho Medical Practice Act in that:

(1) Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7) and IDAPA 22.01.01.101.03.g;

(2) Respondent has performed surgical procedures which were unnecessary and not medically indicated, in violation of Idaho Code §54-1814(14); and

(3) Respondent has engaged in conduct which constitutes exploitation of a patient, in violation of Idaho Code §54-1814(22) and IDAPA 22.01.01.101.04.a.

COUNT FOURTEEN

XL

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XLI

On or around December 4, 1995, Patient [redacted] was seen by the Respondent for surgical consultation regarding a mass suspicious for malignancy found in her left breast during a mammogram. On or around December 5, 1995, the Respondent performed a biopsy at St. Alphonsus Regional Medical Center. Respondent improperly operated in the wrong area of the Patient's breast and missed the mass which

had been identified preoperatively and biopsied the wrong area. When the biopsy came back benign, the Respondent should have known or realized his error. The Respondent reported to the patient the lump was benign and recommended a followup mammogram in early February of 1996. The followup mammogram performed on or around February 2, 1996, showed that the mass identified on the previous mammogram of December 1995 had not been removed. On or around February 5, 1996, the Respondent performed a needle biopsy of the mass. The biopsy revealed a cancerous tumor. Patient [redacted] consulted with another physician. On or about February 20, 1996, she underwent a mastectomy which revealed the cancer had spread to the lymph nodes and would require additional treatment.

XLII

The acts and practices of Respondent, as alleged in paragraph XXXIII above, constitute violations of the Idaho Medical Practice Act in that Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7).

COUNT FIFTEEN

XLIII

The Board realleges and incorporates by reference paragraph I of Count One as though fully set forth.

XLIV

On or around September 6, 1996, Patient [redacted] was admitted to St. Luke's Regional Medical Center with an admitting diagnosis of deep venous thrombosis. During the hospitalization, on or around September 8, 1996, Respondent placed a Greenfield filter and did an

exploratory laparotomy. Respondent failed to perform adequate preoperative evaluation, including, but not limited to, failure to perform a venacavogram. Respondent also selected and performed surgical procedures which were not indicated and for which he was not adequately trained and placed the Greenfield filter improperly. Respondent's notes and records further improperly, incorrectly and deceptively reported that procedures were performed which were not performed.

XLV

The acts and practices of Respondent, as alleged in paragraph XLIV above, constitute violations of the Idaho Medical Practice Act in that:

(1) Respondent has provided health care which fails to meet the standard of health care provided by other qualified physicians in the same or similar communities, in violation of Idaho Code §54-1814(7) and IDAPA 22.01.01.101.03.g;

(2) Respondent has performed surgical procedures which were unnecessary and not medically indicated, in violation of Idaho Code §54-1814(14); and

(3) Respondent has engaged in conduct which constitutes exploitation of a patient, in violation of Idaho Code §54-1814(22) and IDAPA 22.01.01.101.04.a.

PRAYER FOR RELIEF

WHEREFORE, Complainant prays that the Board:

1. Appoint a hearing officer and conduct a hearing upon the matters set forth herein;

2. Suspend, revoke or take such action with regard to

Respondent's license as may be deemed just by the Board; and

3. Award the Board its costs and attorney's fees incurred in these matters.

DATED This 10th day of ~~February~~ APRIL, 1998.

BOARD OF PROFESSIONAL DISCIPLINE

Darleene Thorsted

DARLEENE THORSTED
Executive Director