BEFORE THE BOARD OF MEDICAL EXAMINERS
STATE OF MONTANA

IN THE MATTER OF THE DISCIPLINARY TREATMENT OF THE LICENSE OF ROBERT M. MICHAUD, DO, License No. 9917 (Temporary).	)	**Docket No. CC-03-0067-MED**
	)	**Hearings Bureau Case No. 616-2003**
	)	**PROPOSED FINDINGS OF FACT; CONCLUSIONS OF LAW; AND ORDER**

I. INTRODUCTION

The Screening Panel of the Board of Medical Examiners issued a complaint against Dr. Robert Michaud (licensee) after finding that probable cause existed to believe the licensee had engaged in unprofessional conduct in violation of Mont. Code Ann. § 37-1-316(18) and Admin. R. Mont. 24.156.625. This matter proceeded to contested case hearing before Hearing Examiner Gregory L. Hanchett on January 21, 2003. M. Gene Allison, agency legal counsel, represented the licensing bureau of the Department of Labor and Industry. The licensee appeared *pro se.*

Department Exhibits A, B, C, D, E, F, and G were admitted into evidence without objection. The licensee's Exhibit 1 was admitted for the sole purpose of determining aggravation/mitigation in the event that imposition of sanctions was found to be merited.

Dr. Jeffrey Hinz, M.D., Davilynn Stevens, certified medical assistant, Jeannie Guderjahn, LPN, and Mary Francis Frieling, RN, testified on behalf of the Department. The licensee and the licensee's spouse, Rae Michaud, testified on behalf of the licensee. Based on the evidence adduced at the hearing, the following findings of fact, conclusions of law, and recommended decision are made.

II. FINDINGS OF FACT

1. The Montana Board of Medical Examiners granted the licensee a temporary license in December 2001.

2. The licensee's temporary license expired in December 2002.

3. The licensee is a doctor of osteopathy (DO) who specializes in dermatology. In December 2001, Dr. Jeffrey Hinz, M.D., hired the licensee to work as a dermatologist for the Great Falls Physician Clinic located in Great Falls, Montana.

4. The licensee began his work for the clinic on December 10, 2001. Davilynn Stevens, a certified medical assistant, worked as the licensee's assistant.

5. During the first three or four days of working at the clinic, the licensee performed various procedures including skin biopsies. Some of these skin biopsies consisted of "single punch" biopsies which require only one suture to close. Another one of the biopsies, performed on the chest of a male patient, required the use of four sutures to close.

6. For the first two or three days of working at the clinic, the licensee did not use sterile gloves in order to perform the biopsies. In addition, when completing the biopsy that required the use of the four sutures, the licensee did not use sterile draping around the biopsy area to ensure that the suture remained sterile during the procedure. As a result, the suture was dragged through the patient's chest hair, compromising the suture's sterility.

7. The licensee's failure to use sterile gloves during his first few days of employment was not in keeping with his standard practice and amounted to unprofessional conduct. Furthermore, where four sutures are necessary in order to close a biopsy wound, proper sterile technique requires the use of sterile drapes.

8. Shortly after beginning work at the clinic, the licensee had a box of old medical supplies and old prescriptions delivered to the clinic. Some of these prescriptions included controlled substances such as narcotics. The licensee told Stevens that she should use only those things in the box that were "appropriate" to use. Neither the licensee nor Stevens attempted to provide any of the prescription medications to patients or otherwise attempted to use the prescriptions.

9. The licensee also requested that Stevens "pre-draw" hypodermic needles (shots) containing zylocaine with epinephrine, and place them in certain areas in the operation room for use as the injections became necessary. This is a common practice for dermatologists. There was very little danger that the pre-drawn syringes might be used on a patient after the medication had expired since the licensee used a significant number of these syringes each day and would use any given syringe long before the medication in the syringe expired.

10. Stevens quit working for the licensee within four days because of her concerns about the licensee's sterile technique.

11. The licensee maintained a log book to track the results of laboratory tests upon the biopsy specimens that he had obtained. He did this to ensure proper follow-up of the test results so that patients would be timely informed if the laboratory tests revealed malignancies or other abnormalities in the biopsy specimens.

12. Jeannie Guderjahn spent one day, December 19, 2001, assisting the licensee. She set up the equipment that the licensee requested, but was not present in the procedure room while the licensee performed skin biopsies on patients that day. Guderjahn stated that she cleaned up after the licensee had exited the room. She reported finding portions of "skin tags" on the floor and in the sink. The licensee disputed her testimony, stating unequivocally that he did not leave skin tags or biopsies in inappropriate places nor did he discard them improperly.

13. In 1998, the state of Utah sanctioned the licensee for failure to use proper sterile technique. Exhibit E, Summary of Reported Actions of the National Practitioner's Data Bank.

III. CONCLUSIONS OF LAW

A. The Licensee committed unprofessional conduct

1. Mont. Code Ann. § 37-1-316 provides in pertinent part:

> The following is unprofessional conduct for a licensee . . . governed by this chapter:
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> *
> *
> *
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> (18) conduct that does not meet the generally accepted standards of practice.

2. Admin. R. Mont. 24.156.625(22) provides that unprofessional conduct includes any act, whether specifically enumerated or not, that in fact constitutes unprofessional conduct.

3. The Department bears the burden of proof in this matter to demonstrate by a preponderance of the evidence that the licensee committed an act of unprofessional conduct. Mont. Code Ann. § 37-3-311; *Ulrich v. State ex rel. Board of Funeral Service* (1998), 289 Mt. 407, 961 P.2d 126.

4. To establish that the licensee's sterile technique did not meet professional standards, the agency must demonstrate both the proper standard of care with respect to the sterile technique and the manner in which the licensee deviated from that standard of care. Mont. Code Ann. § 37-1-316(18). *See also, Webb v. Board of Medical Examiners*, 202 Ariz. 555, 48 P.3d 505 (App. 2002) (holding that due process in an administrative licensing proceeding requires that both the standard of care and the deviation from that standard must be established in the record).[(1)]

5. The Board has met its burden of proof in this case with respect to the conduct of failing to use sterile gloves and to use the sterile drapes when closing the four suture biopsy. Both the testimony of Dr. Hinz and the testimony of the licensee established the proper standard for sterile technique and the manner in which the licensee deviated from that standard. The licensee conceded that the proper sterile technique requires the use of sterile gloves prior to undertaking a skin biopsy. He admitted that during those first few days of employment at the Great Falls Clinic, he did not use sterile gloves even though he should have. Moreover, the licensee admitted that with respect to the "four suture" biopsy, proper sterile technique required the use of sterile drapes around the incision to prevent contamination which could result from the suture coming into contact with uncovered hair or skin. By failing to use sterile gloves and by failing to use sterile drapes around the four suture biopsy, the licensee deviated from the proper sterile technique and committed unprofessional conduct.

6. The evidence fails to demonstrate that the licensee committed unprofessional conduct by bringing the box containing the medical supplies and prescriptions into the office. There was no evidence to suggest that merely having the old prescriptions in his possession violated any standard of care. Furthermore, neither the licensee nor his medical assistant attempted to provide any of the prescription medications to patients or to otherwise use the prescriptions. His admonition to his medical assistant that she should use only those things that were appropriate to use, under the circumstances in this case, was not unreasonable or insufficient and does not demonstrate unprofessional conduct.

7. The evidence is insufficient to find that the licensee engaged in improper disposal techniques of the various skin tags and skin biopsies. The licensee's testimony that he did not leave skin tags lying about on the floor or by the sink is found to be credible. The licensee readily conceded that he fell below professional standards with respect to using sterile gloves. His candor with respect to that issue establishes the credibility of his testimony with respect to the issue of the disposal of the skin tags. Having already admitted his culpability with respect to the failure to use sterile gloves, the licensee had nothing to gain by lying about the skin tags. Had the licensee not properly disposed of the skin tags, he would have admitted as much.

Guderjahn's testimony, on the other hand, is not compelling. She was not in the procedure room with the licensee at the time the procedures were being completed and her testimony was entirely circumstantial. Under the circumstances, the evidence fails to show that the licensee's disposal of the skin tags was improper. Because the hearing examiner has not found that the skin tags and biopsy samples were disposed of improperly, there is no factual predicate for Dr. Hinz's opinion testimony that the licensee violated the applicable standard of care with respect to the disposal of those tissue samples. Accordingly, no weight can be accorded to Dr. Hinz's opinion on the issue of the disposal of the tissue samples.

8. The evidence fails to show that the licensee did not maintain a proper protocol for follow up on laboratory tests performed on biopsy specimens.

9. The use of pre-drawn syringes did not violate the standard of care. The only witness competent to testify on the question of the proper standard of care on this issue was the licensee, the only dermatologist who testified at the hearing. His testimony that it is common practice to pre-draw syringes was not rebutted. Therefore, with respect to this issue, there has been no demonstration that the licensee deviated from the standard of practice.

B. The Appropriate Sanction

1. The fact that the licensee's temporary license expired before the conclusion of this matter does not divest the Board of the power to impose sanctions upon the licensee. *Gilpin v. Board of Nursing* (1992), 254 Mont. 308, 837 P.2d 1342, *overruled on other grounds, Erickson v. Board of Medical Examiners* (1997), 282 Mont. 367, 938 P.2d 625.

2. Upon a finding that a licensee has committed unprofessional conduct, the regulatory board may impose any or all of a wide variety of sanctions including imposition of a fine and satisfactory completion of remedial education. Mont. Code Ann. § 37-1-312. To determine

which sanctions are appropriate, a regulatory board must first consider sanctions that are necessary to protect the public, and only after that determination has been made can the board then consider remedies designed to rehabilitate the licensee. Mont. Code Ann. § 37-1-312(2).

3. A temporary license, such as the one at issue in this case, may only be issued for a period not to exceed one year. The license may be renewed, but such renewal is at the discretion of the Board of Medical Examiners. Mont. Code. Ann. § 37-3-304. Because the licensee's temporary certificate has expired, he cannot presently practice medicine in this state. Neither can he begin practicing again unless first approved by the Board of Medical Examiners on terms and conditions that the Board in its proper discretion may dictate. The primary consideration prescribed by Mont. Code Ann. § 37-1-312(2) in imposing sanctionsthe protection of the public-has already been met since the licensee cannot now practice medicine in Montana nor can he return to practice without first being screened by the Board. Thus, no further sanctions are required in this matter in order to protect the public.

4. What remains is consideration of remedies designed to rehabilitate the licensee. As demonstrated by the findings of fact in the matter before this hearing examiner, the licensee continues to have issues with implementation of proper sterile technique. Imposition of a requirement that the licensee complete remedial education of a type and duration to be determined by the Board is certainly appropriate in this matter. In addition, to impress upon the licensee the importance of following proper sterile technique, imposition of a fine in the amount of $250.00 is appropriate.

IV. RECOMMENDED ORDER

Based on the foregoing, the hearing examiner recommends that the Board enter its order (1)requiring the licensee to enroll at his own expense in remedial medical education, the type and duration to be determined by the Board, (2) that the licensee be ordered to pay a fine in the amount of $250.00 within thirty days of the issuance of the final order in this matter, and (3) that the licensee not be permitted to apply for any certificate to practice medicine in the State of Montana until he has paid in full the $250.00 fine and presents proof to the Board to demonstrate that he has satisfactorily completed any remedial education imposed by the Board.

DATED this 11th day of February, 2003.

DEPARTMENT OF LABOR & INDUSTRY
HEARINGS BUREAU

By: /s/ GREGORY L. HANCHETT
GREGORY L. HANCHETT Hearing Examiner

NOTICE

Mont. Code Ann. § 2-4-621 provides that the proposed order in this matter, being adverse to the

licensee, may not be made final by the regulatory board until this proposed order is served upon each of the parties and the party adversely affected by the proposed order is given an opportunity to file exceptions and present briefs and oral argument to the regulatory board.

1. In light of the statutory language in Mont. Code Ann. § 37-1-316(18), *Webb's* applicability to this case is plainly evident. The rule in *Webb* derives from the requirement in medical malpractice cases that a plaintiff establish both the standard of care and that the physician deviated from that standard of care. *Webb, supra*, 202 Ariz. at 510, 48 P.3d at 560, citing, *Croft v. Arizona Board of Dental Examiners*, 157 Ariz. 203, 755 P.2d 1191 (App. 1988) (recognizing that a doctor is not liable in negligence for mere mistakes in judgment, but is liable only where the treatment falls below the recognized standard of care for good medical practice). The terms of Mont. Code Ann. §37-1-316(18) require a showing that the licensee "has not met the generally accepted standards of practice" in order to prove unprofessional conduct. Obviously, in order to make a case under this statute, the agency must demonstrate both the standard of care and the licensee's deviation from that standard, the very requirements set out in *Webb*.