BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL FROM THE ALASKA STATE MEDICAL BOARD

In the Matter of:	)	
	)	
ERIK P. KOHLER, MD	)	
	)	
Respondent.	)	OAH No. 10-0635-MED
	)	Board Case No 2800-08-002

DECISION

I. Introduction

The Division of Corporations, Business and Professional licensing (division) asks this board to revoke the license of Erik P. Kohler, M.D. or to impose other appropriate discipline. In a 31-count accusation, the division alleges that Dr. Kohler has practiced incompetently, negligently, with gross negligence, and unprofessionally. Nearly all of the allegations relate to spinal surgeries or to postoperative care associated with those surgeries.

This decision concludes that the division has proved a single instance of incompetence involving a particular class of surgeries. In all other respects, the division has failed to meet its burden of proving the allegations.

A caution is necessary before proceeding with the merits of the case. This case has been presented in an unusual manner. One of the unusual features is the large number of allegations. Little proof has been offered on most of the allegations, however. The majority of the counts (each of which is equivalent to a full malpractice case regarding an independent surgery and associated treatment) were supported by an average of just over six minutes of testimony per surgery.

The effect of so many allegations can be to create the impression that, to paraphrase one witness, "where there's smoke, there must be fire." The board has authority to impose discipline only for conduct that is actually proven, however. Moreover, some of the allegations were well explored despite the limited case the division presented, and of those all but one proved to be either weak or baseless. It would therefore be illogical to infer, from the number of allegations, that if the evidence had been adequately presented it would have sustained at least some of them.

II. Background

A. Dr. Kohler

Dr. Kohler has been licensed to practice medicine in California since 1986 and in Washington since 1991. His Alaska license, discussed below, is his most recent. He is a

neurosurgeon certified by the American Board of Neurological Surgery. His certification remains active. He completed a residency in neurosurgery in 1991.

Dr. Kohler initially obtained a temporary permit to practice medicine in Alaska on September 4, 2003, and the Alaska State Medical Board subsequently issued him Medical License No. 5237 on December 11, 2003. His license was renewed in 2004, 2006, 2008, and 2010.

In 2006, Mat-Su Regional Medical Center (MSRMC) wished to have a neurosurgeon on its staff, and it recruited Dr. Kohler, who was then practicing at Alaska Native Medical Center.[1] Dr. Kohler practiced neurosurgery at MSRMC from 2006 until 2010, holding provisional clinical privileges throughout that period.[2] In 2010, after a formal proceeding that included an evidentiary hearing before its Judicial Review Committee, MSRMC decided not to grant him permanent privileges.

Because of the pendency of this investigation, Dr. Kohler is not currently a practicing surgeon. His absence is seen by some in the medical community as a loss, because they perceive that he provided good service to a difficult patient population that others were unwilling to treat.[3]

B. Prior Case Against Dr. Kohler

In 2008, this board reprimanded Dr. Kohler and fined him for three incidents.[4] One was a relatively minor paperwork error in which Dr. Kohler did not report a malpractice settlement on the correct form until a year after the report was due.[5] He was fined $500 for that error. The other two incidents involved the failure to disclose on his Alaska licensing applications two investigations by the Washington Medical Quality Assurance Commission. While these Washington investigations did not ultimately find fault with Dr. Kohler, this board was troubled that Dr. Kohler had not reported them. The board's reprimand told Dr. Kohler: "Your failure to truthfully answer questions pertaining to your investigative history on both your initial application and your renewal application detracts from your professionalism."[6] The board fined Dr. Kohler $1000 for each untrue answer.

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1 Cross-exam of Joan Brodie.

2 *See* Ex. 37.

3 This was the gist of Dr. Jaconette's testimony and also, to some extent, Dr. Grissom's.

4 *In re Kohler,* OAH No. 07-0367-MED (Alaska State Medical Board, adopted July 24, 2008).

5 By coincidence, the malpractice action he reported inadequately related to the same surgery that is at issue in Count 1 of this case. However, as the prior Kohler decision showed, this was in no way a cover-up by Dr. Kohler and it should not affect the consideration of Count 1, except in the limited context of the laches defense, discussed *infra* at footnote 62.

6 *In re Kohler* at 21.

While the 2008 reprimand was not a trivial matter, it is important to recognize that the board's decision acknowledged that Dr. Kohler's conduct may have been "not consciously dishonest."[7] Indeed, Dr. Kohler's failure to report the Washington proceedings on his Alaska applications had first come to the board's attention because Dr. Kohler had self-reported his failure to disclose in an e-mail to Dr. Head, who was then the board's chair.[8] The board made a finding that Dr. Kohler had interpreted a question on the application in a way that was "perplexing" and "not reasonable," but it did not make a finding that he was dishonest.[9] As a further clarification, Dr. Head stated on the record, following the board vote in which he voted to adopt the decision, that he "did not believe there was any deceit or fraud involved in this case."[10]

C. Procedural History of this Case

The manner in which the division has presented the current case against Dr. Kohler is unprecedented and extraordinary. A full appreciation of the choices that have been made in bringing this case to the board is essential to understanding the result ultimately recommended by the ALJ.

1. 2010 Accusation

In December of 2010 the division initiated this case by filing a three-count accusation against Dr. Kohler. The three counts encompassed two surgeries:

(a) an anterior cervical decompression and fusion performed on patient M.C. in 2000 in the State of Washington, some years before Dr. Kohler was licensed in Alaska; and

(b) a kyphoplasty performed on patient J.M. in Alaska in early 2008.

Broadly, the division alleged that the two surgeries were performed incompetently and negligently and that, taken together, they demonstrated professional incompetence.

The first of these two surgeries—the operation on M.C. eleven years ago—had already been the subject of an investigation by the Washington Medical Quality Assurance Commission, which had found no fault with it. However, the division does not accept the result reached by that body and, beginning with the 2010 accusation, has sought a reevaluation of the surgery by the Alaska board.

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7 *Id*. at 13.
8 *Id.* at 6-7.
9 *Id.* at 13.
10 Minutes of the Alaska State Medical Board, July 24, 2008.

As required by statute, the accusation was referred to the Office of Administrative Hearings for a hearing and recommendation, a process that must ordinarily be completed in 120 days.[11] The attorneys for the division and Dr. Kohler jointly requested a week-long hearing beginning March 21, 2011, and their request was granted.

2. Amended Accusation

On March 4, 2011, the division moved to amend its accusation to add several new allegations. In general, AS 44.62.400 gives an agency an absolute right to amend an accusation at any time before the evidence closes, subject only to a requirement that the respondent be given a reasonable opportunity to prepare a defense to any new charges. The motion to amend was therefore granted.

The amended accusation added a third, fourth, and fifth basis for licensing action against Dr. Kohler. These were:

(c) a cervical laminoplasty and subsequent microdiscectomy performed on patient D.D. in Alaska in late 2007;

(d) a microdiscectomy performed on patient V.R. in Alaska in early 2010; and

(e) a pattern of inadequate charting, deficient consent forms, and other documentation errors noted in the peer review proceeding conducted by the Mat-Su Regional Medical Center (MSRMC).

In addition to the existing allegation of "professional incompetence, gross negligence, or repeated negligent conduct," the new accusation alleged that Dr. Kohler had engaged in "unprofessional conduct," both generally and in the specific area of failing to maintain adequate records.

The division had been investigating the D.D. matter since the spring of 2010[12] and the V.R. matter since the summer of 2010.[13] The omission of these two matters from the original accusation has not been fully explained. The division had known about the MSRMC proceeding since the summer as well, although that proceeding did not reach a formal conclusion until about the time the first accusation was filed.[14]

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[11] *See* AS 44.64.030, 44.64.060.

[12] *See* Ex. 40.

[13] *See* Ex. 6.

[14] Testimony of Colleen Nelson. The division then sought all of the backup documentation from the hospital, receiving those in early February of this year.

Notwithstanding the addition of these matters just two and a half weeks before the hearing, Dr. Kohler did not ask for additional time to prepare his defense.[15] The parties felt that the hearing could still be accommodated in the week they had agreed upon.

3. Second Amended Accusation

Two business days before the scheduled hearing, the division again amended its accusation. This second amendment added 24 new spinal surgeries to the allegations, contending that each of them constituted an independent basis for discipline. These additional cases were:

(f) a microlaminectomy/discotomy and a second laminectomy performed on patient P.L. in Alaska in 2009.

(g) a lumbar fusion performed on patient L.L.B. in Alaska in 2009.

(h) a lumbar interbody fusion performed on patient C.M. in Alaska in 2009.

(i) a cervical fusion performed on patient F.P. in Alaska in 2008.

(j) a second surgery involving many procedures performed on patient F.P. in Alaska later in 2008.

(k) a foraminotomy performed on patient D.K. in Alaska in 2007.

(l) a cervical laminoplasty and lumbar recess decompression performed on patient K.C. in Alaska in 2007.

(m) a second surgery involving several procedures performed on patient K.C. in Alaska in 2008.

(n) a cervical laminoplasty and other procedures performed on patient V.T. in Alaska in 2008.

(o) a kyphoplasty performed on patient M.T. in Alaska in 2007.

(p) a cervical discectomy and fusion and lateral formaminotomies performed on patient G.B. in Alaska in 2007.

(q) a cervical arthrodesis performed on patient F.C. in Alaska in 2009.[16]

(r) a surgery involving many procedures performed on patient S.K. in Alaska in 2007.

(s) a failure to see patient S.K. in the emergency room when she presented with complications two weeks after the above surgery.[17]

(t) a cervical laminoplasty performed on patient A.O. in Alaska in 2008.

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[15] Dr. Kohler's counsel initially reacted by indicating that he would need a delay, but later retracted that request. *See* Ruling on Prehearing Motions (March 10, 2011).

[16] Part way through the hearing, the division withdrew this item from the accusation.

[17] This is the single new event alleged in Count 20. Count 20 also makes various additional allegations about the original surgery, which was principally handled in Count 19 (corresponding to paragraph (r) of this summary).

(u) a lumbar decompression with microdiscectomy performed on patient L.M.B. in Alaska in 2009.

(v) a placement of stimulators, with foraminotomies and facetectomy, performed on patient D.B. in Alaska in 2009.

(w) a kyphoplasty performed on patient K.S. in Alaska in 2007.

(x) a cervical discectomy and fusion and placement of a drain performed on patient H.C-M. in Alaska in 2008.

(y) a disc arthroplasty performed on patient C.D. in Alaska in 2009.[18]

(z) a lumbar fusion with removal of thoracic lipoma performed on patient C.H. in Alaska in 2008.[19]

(aa) an open reduction and fusion of a C7 facet fracture, foraminotomy, and discectomy performed on patient R.R. in Alaska in 2009.[20]

(bb) a microdiscectomy with foraminectomies and laminotomy performed on patient J.R. in Alaska in 2008.

(cc) a lumbar decompression performed on patient A.S. in Alaska in 2007.

The addition of these 24 additional cases vastly expanded the overall proceeding. It was the division's statutory right to dictate this expansion, even at the eleventh hour. However, the division's choice to do so has had certain consequences that will be revisited later in this decision.

It should be noted that the division had other procedural routes it could have chosen. Most simply, it could have brought the 24 new matters under a separate accusation. A second accusation, filed when the division first learned of the new matters, would likely have brought those 24 items to hearing in May. Both sets of alleged violations would likely have been available for the board to evaluate in tandem at its regular meeting in late July.[21] Alternatively, the division could have amended its accusation and then moved for a continuance of the March 21 hearing. The outcome of such a motion would depend on many factors; what is significant is that it was not requested.

When an accusation has been amended, AS 44.62.400 requires that the respondent be given "a reasonable opportunity to prepare a defense to it." Dr. Kohler elected to let the division

[18] Part way through the hearing, the division withdrew this item from the accusation.

[19] Part way through the hearing, the division withdrew this item from the accusation.

[20] Part way through the hearing, the division withdrew this item from the accusation.

[21] The smaller case that was already slated for hearing on March 21-25 could have led to a proposed decision by mid-April. The board might have been able to take that proposed decision up in its May meeting—if it wished—but it would not have been required to do so (*see* AS 44.64.060(e)), and thus both cases could have been considered as a unit in July.

put on its case as scheduled and as the division apparently desired, but asked for one month to prepare his defense. This was granted, with Dr. Kohler's defense (and the division's rebuttal case) deferred until the following month.

4. Conduct of the Hearing

The Second Amended Accusation was filed on the day after the division's pre-hearing brief was due. The division filed no pre-hearing brief at all.

When the hearing began, the presentation on items (f) through (cc) seemed entirely unprepared. The division relied on a single expert for these items, a Texas neurosurgeon named Pedro Caram, who phoned his testimony in from various locations. Dr. Caram had not gone over the cases with the division before testifying. His testimony was conclusory, scattered, and self-contradictory. Moreover, Dr. Caram—who has previously been suspended by the American Academy of Neurologic Surgeons for giving a false opinion in a malpractice case—demonstrated in a number of ways that he could not be relied on to be fair and truthful. Apart from Dr. Caram's off-the-cuff, unconvincing remarks, the division offered no means for the ALJ to understand these surgeries.

The division's presentation time was not limited. The division concluded its case in chief and rested in just over three days of hearing time.

It may be reasonable to ask why the division would add a vast array of complex, new counts to the case when it was manifestly unprepared to prove them. The answer may be revealed by the testimony of Dr. Burnett, a division expert who reviewed just three cases. In written reports in 2010 he had found that two of them met the standard of care. Since writing the reports, however, Dr. Burnett had been exposed to the Second Amended Accusation, and his testimony at the hearing repeatedly veered into the allegations in that document. He simply could not help himself from assuming that at least some of the allegations must be true. These bare, unproven allegations colored the rest of Dr. Burnett's testimony and colored his views on whether Dr. Kohler should continue to practice. Placing so many allegations on the table is a powerful tactic with an effect similar to innuendo.

After Dr. Caram testified, the division voluntarily dismissed four counts of the Second Amended Accusation that had relied on Dr. Caram's opinions. When the division completed the rest of its presentation, the ALJ had serious misgivings about whether the division had met its burden of proof regarding the remaining parts of the case that rested on Dr. Caram's testimony. To streamline the case and to avoid putting Dr. Kohler to the expense of defending counts that

had already failed, he invited Dr. Kohler's counsel to move to dismiss the Caram counts. This invitation was accepted. In addition, Dr. Kohler moved to dismiss certain other counts. For reasons explained in Parts III and IV below, the ALJ granted the motion in part, largely or entirely dismissing an additional 18 counts of the Second Amended Accusation and substantially limiting two others. Like most dismissals and summary adjudications by an ALJ, this ruling remained subject to eventual ratification or rejection by the board.

The evidentiary hearing then reconvened, and Dr. Kohler presented a defense to the surviving portions of the case. The division presented a brief rebuttal case.

During the course of the hearing, the following exhibits were admitted:

Exhibit	**Disposition**
Division 1-3, 5-10, 12-14, 16-25, 28-34, 38, 40-42, 44, 46, 51, 53, 55, 58[22], 62, 63, 65	Admitted
Division 4, 11, 15, 56, 59-61	Admitted with hearsay limitation[23]
Division 36[24] and 37[25]	Admitted with partial hearsay limitation as described in footnotes at left
Kohler B, D, H, O, Q[26]	Admitted
Kohler P	Admitted with hearsay limitation[27]

Division Exhibits 26, 27, 35, 39, 43, 45, 47-50, 52, 54, and 64 were withdrawn. Division Exhibit 57 was not offered. Kohler Exhibits A, C, E-G, and I-M were not offered.

[22] Admitted to illustrate testimony.

[23] Pursuant to AS 44.62.460(d), this evidence "may be used to supplement or explain direct evidence but is not sufficient by itself to support a finding."

As provided in Part V of the Scheduling Order of January 19, 2011, and as discussed with counsel during the hearing, this limitation was only applied if a hearsay objection was timely asserted at the hearing.

[24] A relevance objection regarding this exhibit was overruled during the hearing, but a ruling was deferred on a limiting hearsay objection. That objection is overruled at this time insofar as Exhibit 36 is offered to prove what procedures the MSRMC appellate panel followed, what findings it made, and what action it and the MSRMC board took. *Cf.* Alaska R. Evid. 803(6). Exhibit 36 must be treated as hearsay, and therefore subject to the AS 44.62.460(d) hearsay limitation, to the extent that it is relied on as proof of what particular witnesses or individuals said; for example, it is hearsay with respect to the purported quotation from Dr. Kohler on page KOHL 015779.

[25] A relevance objection regarding this exhibit was overruled at the hearing, but a ruling was deferred on a limiting hearsay objection. That objection is overruled at this time insofar as Exhibit 37 is offered to prove what procedures the MSRMC Judicial Review Committee followed, what findings it made, and what action it took. *Cf.* Alaska R. Evid. 803(6). Exhibit 37 must be treated as hearsay, and therefore subject to the AS 44.62.460(d) hearsay limitation, to the extent that it is relied on as proof of what particular witnesses or individuals said; for example, it is hearsay with respect to the purported quotation from Dr. Erickson on page KOHL 015657.

[26] Q admitted to illustrate testimony.

5. Role of Private Counsel in Prosecution of the Hearing

An Anchorage law firm, Dillon & Findley, represented patient J.M. in a malpractice suit, now settled, that arose out of her surgery. The firm currently represents patient D.D. in a *pending* malpractice lawsuit against Dr. Kohler.[28] It is fair to say that the J.M. and D.D. cases are the core of the division's case against Dr. Kohler.

During much of the hearing, Dillon & Findley attorney Margaret Simonian closely assisted the division in presenting its case. At times she sat at counsel table with the division's attorney. During the cross-examination of Dr. Grissom, her whispered questions to the division's counsel (which the division's counsel would then repeat to the witness) became so dominant that the witness began to answer the whispered question rather than wait for the official question.[29] Ms. Simonian eventually promised to cease this practice, but then during the testimony of Dr. Ringer she moved a chair behind the division's counsel and began passing questions on notes, until she was admonished not to do so. This kind of alliance between private malpractice counsel and a state attorney representing a licensing authority—with the latter appearing to be, at times, a mouthpiece or stalking horse for the former—is uncommon.[30] Unless cases assembled and presented by means of such an alliance are given a careful and skeptical review, there is potential to deprive board proceedings of their legitimacy.

III. Dismissal of Allegations Relying Solely on Dr. Caram

A. Nature of Dr. Caram's Testimony

The division had first engaged its sole expert witness on the new matters in the Second Amended Accusation, Dr. Pedro Caram, six business days before the hearing.[31] Dr. Caram testified that he had had "no opportunity" to go over the Kohler materials since participating in the MSRMC proceeding eight months previously. Once his telephonic testimony began (it was delayed because the division had not ascertained what time zone he was in), he testified extemporaneously, devoting a few minutes of scattered testimony to each case. To be precise, during Dr. Caram's direct testimony regarding the 24 new cases, he began talking about a different neurosurgery every six minutes and fifteen seconds, on average. He did not explain

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27 See note 23 above for the nature of this limitation.
28 Statement of Margaret Simonian just prior to Ringer testimony.
29 An example of this—not the only one—can be heard on Recording File 20 at 1:35:00 and following.
30 The undersigned has not observed such an arrangement in 25 years of practicing law.
31 Cross-exam of Pedro Caram.

what the surgeries entailed or how they are ordinarily performed, nor did he explain in a step-by-step way what he understood Dr. Kohler to have done.

B. Dr. Caram's Lack of Credibility

Dr. Caram is a Texas doctor board-certified in neurosurgery. He describes himself as the Chief of Neurosurgery at William Beaumont Army Medical Center. He is the only neurosurgeon there.[32] At the William Beaumont Army Medical Center, he treats a relatively youthful population, dissimilar to the population Dr. Kohler treated.[33] He was engaged to testify in this case at a cost of $1200 per hour.

Dr. Caram is a member of the American Academy of Neurologic Surgeons. In 2003 that body voted 89-6 to suspend him from membership for three months for providing a false expert opinion in a malpractice case.[34]

In addition to the concerns raised by that suspension, Dr. Caram's testimony in this proceeding raised further concerns. The opinions Dr. Caram rendered differed from opinions he had rendered previously about the same surgeries. When confronted with these inconsistencies, at times Dr. Caram stuck to his new opinions, although his explanations for his changes of mind were rarely satisfactory. On one occasion he testified:

> Q. The point is, sir, I started my exam asking you whether you bumped these things into different categories depending on when you do your report and when you testify and you said no you don't but you've gone through two cases now and that's exactly what you've done, isn't it?
>
> A. Yeah, and again, if I'm changing my mind, you know, I'm, I'm able to do that, okay?
>
> Q. Okay.
>
> A. I'm given the opportunity and the right, as a United States citizen, to *change my mind*.[35]

On the other hand, he also responded at times with such declarations as:

> Well now I'm going to stop you right there because I don't have the advantage of having my transcript to look at so I am ultimately held to handicap. Now, in that regard, I don't flip flop, okay, I'm going to stand by what I said but I don't have the information that I had at the time of the hearing, I'm going by my notes that I had that preexisted that, which may have been altered or changed before that hearing. So I don't have any of that information. If I change my mind and it's different from what I said

[32] Direct and cross-exam of Caram.
[33] Cross-exam of Caram.
[34] Re-cross of Caram. The date is drawn from Exhibit 37.
[35] Cross-exam of Caram. Italics indicate where Dr. Caram raised his voice.

> on the transcript, I'm sorry, I'm held, basically handicapped in that regard.[36]

and

> That's fine if I said that I will stand by that.[37]

It is, of course, entirely natural for an expert witness's appraisal of a particular situation to change, occasionally, upon reexamination of that situation, and thus testimony might change from one proceeding to the next. What was absent from Dr. Caram's explanations, however, was any sense that his primary concern was to testify truthfully about his actual, current appraisal of these cases. Instead, he seemed to regard testimony as a game in which one might "stand by" or let oneself be "held to" a prior position, even if one no longer believed it, in order to avoid the perception of flip-flopping.

Further, the opinions Dr. Caram offered, to the extent that one could follow his disorganized testimony at all, were conclusions. He did not "show his work" by explaining the patient's history, describing and illustrating each step of the course chosen and followed by Dr. Kohler, and then describing and illustrating how and where he believed Dr. Kohler went wrong. As Dr. Caram put it in connection with patient A.O., "I'm not going to get into the scientific aspects of it."[38] The ALJ and the board are asked to accept his conclusions on faith, as it is impossible to evaluate the quality of his reasoning.[39]

Finally, insofar as isolated portions of his testimony could be evaluated, Dr. Caram seemed too quick to find fault with Dr. Kohler, as though he viewed that to be his job. For example, he flatly concluded that Dr. Kohler's handling of the D.D. case[40] was "below the standard of care" in part on the basis that Dr. Kohler had engaged in "deceit" by using the word "instrumentation" in such a way in his operative note that it could imply a different kind of procedure from the one he performed.[41] Later it developed that this could be deceitful only if the surgery was billed in a certain way, and Dr. Caram had apparently simply assumed, without checking, that Dr. Kohler had billed it that way.[42]

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36 Cross-exam of Caram.

37 *Id.*

38 Direct exam of Caram, second session. A.O. is the patient in Count 21, or Claim (t) as lettered above.

39 The lack of underlying detail was true both of his testimony and of his report, which appears at Exhibit 15.

40 D.D. is the subject of claim (c) above, which corresponds to Counts 3, 4, and 5 of the Second Amended Accusation.

41 Cross-exam of Caram.

42 Redirect and re-cross-exam of Caram.

On cross-examination, Dr. Caram was combative and unprofessional. His extreme defensiveness and intemperate responses further detracted from his credibility. This testimony must be listened to firsthand to have a full appreciation of its unfortunate nature. The cross-examination begins on file 12 of the digital hearing recording at minute 15.

In light of these deficiencies, Dr. Caram's testimony in this proceeding was not credible and was of no value.

This is not to say that a review by Dr. Caram, if sufficiently explained, could under no circumstances shed any useful light on a medical question, particularly if it were presented to a trained medical panel in a position to interpret some of the underlying records and ask probing questions where needed. Thus, one cannot conclude solely from Dr. Caram's lack of credibility in this proceeding that it was inappropriate for the MSRMC Judicial Review Committee to rely on his testimony to some degree. That panel shared some of the above concerns and discounted much of his testimony, but found other portions of it credible.[43] Nonetheless, as will be seen below in Parts IV-E and IV-F, that panel's reasoning when it did rely on Dr. Caram was in some cases flawed or inexplicable.

C. Voluntary Dismissal of Counts 18 and 26-28

The division voluntarily dismissed Counts 18 and 26-28 after Dr. Caram testified. These counts corresponded to surgeries (q) and (y) – (aa) in the list above.

D. Limited Dismissal of Counts 7-17, 19-25 and 29-30

After the division rested its case, the ALJ reviewed the evidence and concluded that Dr. Caram's testimony was neither credible nor coherent, and that without the benefit of such testimony he could not write meaningful or reliable findings about the neurosurgeries for which Dr. Caram was the sole witness. He informed the parties that he would entertain a motion to dismiss the counts for which Dr. Caram was the sole witness. To inform the parties of the basis for his concern about these counts, he included an appendix of draft text similar to Part B above. Dr. Kohler responded by moving to dismiss Counts 7-30, corresponding to surgeries (f) through (cc) above. In fact, the division had already voluntarily dismissed four of these counts after Dr. Caram testified, apparently in partial recognition of the inadequacies of his testimony. Accordingly, Dr. Kohler's motion actually applied only to Counts 7-17, 19-25 and 29-30.

[43] *See* Ex. 37 at KOHL 15669-71 and 15676.

In responding to the motion, the division did not attempt to persuade the ALJ that any of the observations or assessments in Part B were mistaken. It opposed dismissal primarily by positing that the board might decide to make its own independent review of the evidence relating to these counts. However, dismissal does not foreclose the board from doing so (although the board would, of course, need to hear Dr. Kohler's responsive evidence as well). Moreover, the kind of independent review of large volumes of evidence that the division advocates is not usually practical for a citizen board of busy professionals. The division needs to present a case that is adequate for an ALJ to understand and evaluate. If no such case is presented, the division fails to meet its burden of proof and dismissal will ordinarily follow.[44]

There are certain aspects of the new counts on which Dr. Caram's testimony was not the only evidence on which the ALJ could rely to determine that a violation had occurred. The most important of these is the area of deficient documentation. The allegation was at one time distilled in a single count, Count VII of the Amended Accusation, which alleged that Dr. Kohler had a pattern of deficiency in this regard when he practiced at MSRMC. In the Second Amended Accusation it was distributed among the many individual surgeries. Regardless of how it is packaged, the allegation is supported by an admitted and potentially credible document, the decision of the MSRMC Judicial Review Committee. The allegation therefore was not dismissed, and it will be reviewed in more detail in Part IV-G below.

Also supported by the MSRMC decision were allegations of inadequate identification and management of post-operative complications in cases involving L.B.B. and C.M. who were, respectively, the patients involved in Counts 8 and 9 of the Second Amended Accusation. Those two counts were therefore not dismissed insofar as they related to identification and management of post-operative complications.[45]

In summary, Counts 7, 10-17, 19-25 and 29-30 of the *Second Amended* Accusation [corresponding to surgeries (f), (i)-(p), (r)-(x), and (bb)-(cc)] were dismissed except insofar as they alleged matters covered by Count VII of the *Amended* Accusation. Counts 8 and 9 [corresponding to surgeries (g) and (h)] of the *Second Amended* Accusation were dismissed

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[44] *See, e.g., Mendoza v. Kenosha Beef Intern. and Fire & Cas. Ins. of Connecticut,* 1990 WL 250402 (Wis.App.).

[45] The MSRMC decision also made findings about screw placement "concerns" and about questionable medical judgment. The ALJ has reviewed these sections of the decision and found that they could not meaningfully be transferred to the counts framed in the Second Amended Accusation. Dismissal was not limited on the basis of those findings.

except (i) insofar as they alleged matters covered by Count VII of the *Amended* Accusation and (ii) insofar as they related to identification and management of post-operative complications.

IV. Disposition of Remaining Allegations

The mid-hearing dismissals described in Part III above, coupled with the division's voluntary dismissal of four complete counts, leave a case consisting of allegations against Dr. Kohler for negligence, incompetence, or unprofessional conduct in connection with the following, listed in the order that they will be discussed below:

- Surgery performed on patient M.C. in 2000;
- Surgery performed on patient D.D. in late 2007;
- Surgery performed on patient V.R. in early 2010;
- Identification and management of postoperative complications in connection with patient C.M. in 2009;
- Identification and management of postoperative complications in connection with patient L.B.B. in 2009;
- An alleged pattern of inadequate charting, deficient consent forms, and other documentation errors noted in a peer review proceeding conducted by the Mat-Su Regional Medical Center (MSRMC).
- Surgery performed on patient J.M. in early 2008;

In each instance, it is the division's burden to prove a violation. The standards against which the events must be measured are the following:

Professional incompetence: The board has defined professional incompetence as "lacking sufficient knowledge, skills, or professional judgment in that field of practice in which the physician . . . engages, to a degree likely to endanger the health of his or her patients."[46]

Gross negligence: Gross negligence in the medical context is "an extreme departure from the ordinary standard of care," entailing "more than ordinary inadvertence or inattention."[47]

Repeated negligent conduct: Repeated negligent conduct entails multiple instances of departure from the ordinary standard of care exercised by reasonable members of the profession

[46] 12 AAC 40.970. The division did not cite this regulation.

[47] *Storrs v. Lutheran Hospitals and Homes Soc. of America, Inc.*, 661 P.2d 632, 634 & n.1 (Alaska 1983) (quoting W. Prosser, *Torts* (4th ed. 1971)).

in the respondent's specialty.[48] Both parties to this case agree that the repeated conduct must span multiple events; that is, two negligent errors of judgment in the course of a single surgery would not qualify as "repeated negligent conduct."[49]

Unprofessional conduct: The board has defined unprofessional conduct as "an act or omission . . . that does not conform to the generally accepted standards of practice for the profession."[50] The board's regulation lists a number of specific examples of unprofessional conduct. The one the division particularly relies on in this case is "failing to prepare and maintain accurate, complete, and legible records in accordance with generally accepted standards of practice for each patient . . . ."[51] Also relevant to this case, though not expressly relied on by the division, is the following example from the same regulation: "after performing surgery, failing to continue care of a surgical patient of the licensee through a post-surgery recovery and healing period, either by providing the care directly, delegating the care to one or more [appropriate] individuals . . . , or coordinating with another qualified physician or other medical professional who agrees to assume responsibility . . . ."[52]

A. Principal Witnesses

Before reviewing the allegations individually, it will be helpful to make a general review of the principal witnesses the parties brought to the hearing (omitting Dr. Caram, who has already been discussed).

In weighing the testimony of the different witnesses, the ALJ has been mindful of the observation of Dr. Burnett, one of the division's experts, that "spine surgery is an inexact science" and that "you will never sit in a room and hear more confident opinions on the same patient that are polar opposites than you will in a spine conference."[53]

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[48] The ordinary standard of care appears to be the same as the standard applied in medical malpractice cases under AS 09.55.540(a)(1), that is, "the degree of knowledge or skill possessed or the degree of care ordinarily exercised under the circumstances, at the time of the act complained of, by health care providers in the field of specialty." The division has suggested otherwise in post-hearing briefing, citing *Halter v. State, Dep't of Commerce & Econ. Dev.*, 990 P.2d 1035 (Alaska 1999). However, that case stands only for the proposition that "professional incompetence" is distinct from the malpractice standard; it does not say that "negligence" differs in the licensing and malpractice contexts.

[49] The stipulation on this issue occurred during closing argument.

[50] 12 AAC 40.967.

[51] 12 AAC 40.967(9).

[52] 12 AAC 40.967(28).

[53] Direct testimony of Burnett.

1. Dr. Cruz

Bradley K. Cruz is a board-certified radiologist who has practiced in Anchorage since completing his military service in 1992. Called by the division, Dr. Cruz testified about the J.M. case, one of the two surgeries at issue in this proceeding as originally framed. The J.M. case was a kyphoplasty, a crossover procedure performed by both radiologists and neurosurgeons. Dr. Cruz has been trained in kyphoplasty, has performed a number of them, and is knowledgeable about the procedure.

Dr. Cruz was a methodical witness who worked his way carefully through the images made during the J.M. kyphoplasty and associated procedures, explaining each phase of the surgery. He had a number of criticisms of Dr. Kohler's judgment and technique, which he explained in sufficient detail that one can make an assessment of their validity and significance in a licensing context. His testimony was understated and his demeanor professional. He appeared in person and responded in a straightforward way to cross-examination. Great weight has been given to his testimony.

Two features of Dr. Cruz's practice colored his testimony to a degree. First, he is disenchanted with the kyphoplasty procedure, which seems to make him inclined to suggest abandoning or pausing such a surgery whenever something unplanned has occurred, under circumstances in which most surgeons would move forward. Second, as a radiologist he expects something close to perfection in the handling of fluoroscopic equipment.

2. Dr. Ringer

Andrew Ringer, engaged by Dr. Kohler to testify about the J.M. case, was likewise a superb witness. A fellowship-trained and board-certified neurosurgeon who has performed hundreds of kyphoplasties and who teaches the procedure nationally, he is also on the faculty of the University of Cincinnati College of Medicine. Dr. Ringer came across as entirely frank. He did not reflexively defend Dr. Kohler, nor reflexively critique Dr. Cruz's evaluation; indeed, he seemed to respect and rely on the reconstruction of the surgery that Dr. Cruz had performed. He had reasonable explanations for his partial disagreements with Dr. Cruz.

3. Dr. Patrick

Donald Patrick is a board-certified neurosurgeon located in Texas. He testified by telephone about the J.M. kyphoplasty reviewed by Dr. Cruz, as well as about the anterior cervical decompression and fusion performed on patient M.C. eleven years ago in another state.

Dr. Patrick became a physician in 1962, and he appears to have practiced full time, primarily as a neurosurgeon, for the next 32 years, until he enrolled in law school in 1994.[54] He completely discontinued his practice of neurosurgery in 2002.[55] He remains licensed as both an attorney and a physician, but he reports that it has been "many years" since he treated a patient and charged for it.[56]

Most of Dr. Patrick's testimony related to the kyphoplasty for patient J.M. However, Dr. Patrick has never performed a kyphoplasty, and his grasp of the technique is insecure. For example, he initially testified that this surgical technique involves filling a balloon with methyl methacrylate, a type of bone cement.[57] In so testifying, Dr. Patrick did not simply misspeak; his testimony on this point was detailed and unequivocal, and indeed he went out of his way to fault Dr. Kohler for failing to inject methyl methacrylate inside a balloon.[58] After a break in which the division's counsel had an opportunity to talk to him, Dr. Patrick corrected himself and stated (accurately) that the balloon is never filled with this substance, but rather is used to create a space for subsequent injection of the bone cement.

Dr. Patrick's initial testimony about the function of the balloon represented an absolutely fundamental misunderstanding of the procedure. It is a little bit like hearing an aviation expert testify that the proper way to gain height in an airplane is to move the flaps up and down to simulate the flapping of a bird, and then go on to testify that a pilot fell below the standard of care because he failed to use his flaps this way. It undermines the credibility of any other testimony received from that expert, because it suggests that he is willing to offer opinions on matters he does not understand.

4. Dr. Burnett

Mark Burnett is a board-certified Texas neurosurgeon with strong academic and research credentials who testified by telephone.[59] He has performed more that 50 kyphoplasties, giving his testimony on the J.M. kyphoplasty considerable relevance. His approach to second-guessing another physician's work was more restrained than that of the division's other experts, seeming to give some regard to the variations in individual practice and the complexity of patient

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54 *See* Ex. 9.

55 Cross-exam of Patrick.

56 *Id.*; Ex. 9.

57 Direct exam of Patrick.

58 *Id.* at File 6, 52:00: ". . . he injected . . . not inside a balloon. Not inside the balloon! This is *only*, this procedure is *only* to be done by injecting methacrylate inside the balloon. Safe that way."

59 *See* Ex. 2.

assessment, and this trait added to his credibility. He provided thoughtful perspective on the many criticisms offered by other expert witnesses regarding the J.M. case.

On the other hand, some of his opinions, while interesting, must be approached with caution because he seems to have developed them on the assumption that the many new allegations in the Second Amended Accusation (allegations (f) to (cc) above) must be true. In other words, he is the sort of person who, if seated in a jury pool, might confess to thinking that the defendant must surely be guilty of something or else he would not be sitting at a defense table. This bias may have affected the new opinions he first delivered on the stand in this case after exposure to the new allegations—notably, his revised opinion in the D.D. case. It certainly affected his statements, both initially and in his rebuttal testimony, about the "patterns" he observed, such as his view that Dr. Kohler shows a pattern of discomfort with new surgical techniques that have developed since he was trained.

Dr. Burnett is clearly brilliant, but he is not always careful about facts. In both rounds of his testimony he betrayed a belief that Dr. Kohler did two surgeries at once on D.D.[60] This is something that the division suggested in its accusation, but it is not true, and a more meticulous review of the records would have prevented Dr. Burnett from having this misimpression. The lack of care in this regard somewhat detracted from his credibility.

Another feature of Dr. Burnett is that cost of care is plainly not a factor for him. He perceives no drawback at all to taking extra scans or using more expensive patching material. Insofar as cost is a valid consideration for a surgeon, Dr. Burnett does not weigh it.

5. Dr. McCormack

Bruce McCormack is a board-certified California neurosurgeon who testified at Dr. Kohler's behest. After completing two fellowships in the early 1990s, he was a full-time faculty member at the University of California-San Francisco for several years before moving into private practice. Dr. McCormack testified by telephone. He gave a nuanced evaluation of the D.D. case that was entirely credible. Like Dr. Burnett, he seemed genuinely thoughtful and undogmatic. He had a better grasp of the facts for the matter he reviewed than Dr. Burnett, however.

6. Dr. Wright

[60] Direct testimony of Burnett; direct testimony of Burnett on rebuttal. Dr. Burnett certainly knew better at the time he wrote his report (Ex. 4), but he had not reviewed the case carefully enough before his actual testimony to avoid this error.

Kim Wright, a board-certified Anchorage neurosurgeon, testified at Dr. Kohler's request, primarily about the treatment of V.R. His telephone testimony was matter-of-fact, and his credibility has not been challenged.

7. Dr. Jaconette

Andrew Jaconette, trained at the Mayo Clinic and the University of Iowa, is an Anchorage physician board-certified in both anesthesia and pain management. He testified in person. He provided vivid firsthand testimony about his interactions with Dr. Kohler and about the treatment of patient D.D., who was his patient for nonsurgical aspects of his care. He came across as a candid and insightful physician. The division has not challenged his credibility, and great weight has been given to his testimony.

8. Dr. Grissom

John T. Grissom, II, is a board-certified pain management physician and anesthesiologist based in Wasilla and Anchorage. Dr. Kohler called him to testify in person, primarily as a fact witness regarding his work with Dr. Kohler. As a fact witness, his credibility has not been challenged.

Dr. Grissom has also done more than 50 kyphoplasties, and Dr. Kohler, the division, and the ALJ elicited some opinions from him about the J.M. surgery. He was plain-spoken and provided helpful perspective on complication rates, again unchallenged. His particular theory about how the major complication in the J.M. surgery came about (which, though exculpatory of Dr. Kohler, was elicited by the division rather than Dr. Kohler) was not convincing, as explained more fully below.

9. Dr. Kohler

Dr. Kohler gave lucid testimony about his surgeries. He showed excellent command of the details of all surgeries except the J.M. surgery. Ironically, the division often had to rely on Dr. Kohler to assist it in presenting the visual side of its case. He provided this assistance graciously.

Not everything Dr. Kohler said, particularly in connection with the J.M. surgery, rang true. What the ALJ saw was a man who, faced with a spectacular disaster in one of his surgeries and with resulting accusations that he lacks basic competency, has been casting about for an explanation. His thinking in this effort has not always been consistent or logical. He cannot

quite accept that he failed to see something in the J.M. surgery that should have been obvious to him.

The division has tried to paint Dr. Kohler as a deliberate liar engaged in a cover-up. The ALJ was not persuaded by this aspect of the division's case. For example, the division suggested that Dr. Kohler covered up the J.M. complication by omitting it from his operative report. But Dr. Kohler dictated the report before he knew there had been a significant complication. Similarly, again relating to the J.M. case, the division made much in its closing argument of what it said was the use of "images that were misleading" by Dr. Kohler in his testimony. The division said Dr. Cruz had testified the images were misleading. This is not what Dr. Cruz said. Dr. Cruz simply observed that postoperative views suggested a different needle path than the one Dr. Kohler thought his needle would have taken and marked with a yellow line on one image. He did not suggest that Dr. Kohler had falsified an image, still less multiple images. He just did not agree with Dr. Kohler's theory.[61]

After about an hour of cross-examination, Dr. Kohler became noticeably tired and appeared to have trouble tracking questions.

B. Patient M.C.

Count 1 of the Second Amended Accusation involves a surgery that occurred 11 years ago in the State of Washington, at a time when Dr. Kohler did not have a license in Alaska. The surgery, an anterior cervical decompression and fusion, was performed on patient M.C., a resident of Coupeville, Washington. The Alaska board has licensed Dr. Kohler several times since it first learned of questions regarding this surgery in a disclosure by Dr. Kohler with his 2003 license application. The Washington Medical Quality Assurance Commission reviewed the surgery and found it to be within the standard of care. The Division has offered no evidence to suggest that standards of practice are lower in Washington than they are in Alaska.

[61] Direct exam of Cruz on rebuttal. The division's argument is like saying that someone who draws a line on a map and says, "I think I followed this path from A to B" has created a misleading image if other evidence makes it seem more likely he followed a different path from A to B. In fact, however, the line on the map is not misleading—it accurately depicts what the person is saying he believes his path to have been. Creating a misleading image would be surreptitiously using a map that omits or alters a terrain feature or otherwise has been manipulated to, for example, make the line seem more plausible.

Count 1 was the subject of a mid-hearing motion to dismiss. The ALJ granted the motion and terminated the taking of evidence at the end of the division's case, without the need to hear a defense from Dr. Kohler.[62] The reasons are explained below.

To a large extent, this allegation must be dismissed on the basis of extraterritoriality. The division is seeking a fine of up to $25,000, censure, or reprimand for a Washington event. An Alaska regulatory board cannot impose punitive sanctions for actions a person took outside Alaska at a time when the person had no connection to Alaska—no license, no pending application for licensure, no Alaska residency, no professional activities in Alaska—and where the conduct to be punished did not have effects in Alaska.[63] The division has not argued otherwise in opposing dismissal.

With that said, an Alaska board can undoubtedly decline to continue to license someone on the basis of conduct, even long-ago conduct, that occurred outside its jurisdiction. Thus, if it were discovered now that an Alaska physician had committed an armed robbery in another country before moving to Alaska, the board could terminate the physician's license, not as a punishment but as an act to protect the public in Alaska. Likewise, if the surgery in Washington in 2000 demonstrated that Dr. Kohler is not fit to practice medicine according to Alaska standards, it may be that the board could now revoke his license on the basis of that fact. No such demonstration has been made, however.

The division's case regarding the surgery on M.C. consisted of approximately 18 minutes of testimony from Dr. Donald Patrick, who testified by telephone from Texas. The division also submitted several hundred pages of raw, unexplained medical records. Not only were the records unexplained, but there was no testimony establishing that these are a complete set of the records that existed in 2000 when the surgery was performed.[64]

M.C.'s surgery was complex. Dr. Patrick did not set out what it entailed in any detail. To accept his opinions would require a high degree of trust in his judgment as an expert.

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[62] Dr. Kohler would apparently have offered expert testimony of his own on whether the surgery was competently performed. He would also have presented a laches defense based on the long delay between the time the staff first learned of the M.C. surgery and associated malpractice litigation (2003) and the filing of an accusation (late 2010).

[63] *See, e.g., State v. Sieminski*, 556 P.2d 929, 933 (Alaska 1976) (Alaska regulations "can be applied only against persons having a certain minimum relationship with the state"); *Rolls v. Bliss & Nyitray*, 408 So. 2d 229, 235-236 (Fla. App. 1981) ("One fundamental limitation on the state's police powers is that a state may only legislate in exercise of its sovereignty-based powers within its own boundaries, or at least so that the effects of the law are felt there."); *cf. State v. Jack*, 125 P.3d 311, 318-319 & n.34 (Alaska 2005).

[64] Dr. Patrick conceded that he may not have had the entire file for M.C. Cross-exam of Patrick. This admission was especially telling since Dr. Patrick found fault with the documentation of the surgery.

However, Dr. Patrick greatly undermined his credibility when, as discussed in Part IV-A-3 above, he offered specific testimony in the J.M. kyphoplasty matter that showed an astonishingly poor grasp of a technique on which he purported to be an expert.

In addition to the opinion from Dr. Patrick, the division's evidence revealed that the Washington Medical Quality Assurance Commission evaluated the M.C. case and found Dr. Kohler's performance in that case to be within the standard of care.[65] The division did not inform Dr. Patrick of the Washington commission's evaluation.[66] Firsthand records of the commission's proceedings and determinations were supplied neither to Dr. Patrick nor to the ALJ.[67]

It is not beyond the power of this board to make an evaluation different from that of a sister body on a matter within the primary jurisdiction of the sister organization. This should not occur, however, without a complete exploration of the other body's rationale.

At the close of the division's case, two items were in the balance: first, an official State of Washington determination that a surgery conducted in that jurisdiction more than a decade ago met the standard of care, and second, a few minutes of telephone testimony from a Texas doctor who has done little surgery since going to law school 17 years ago and who betrayed, in his other testimony, a willingness to render opinions about matters he fundamentally misunderstood. On balance, the Washington determination is more persuasive on the present record. Therefore, the division failed to meet its burden of proof on Count 1.

C. Patient D.D.

Three counts of the Second Amended Accusation relate to Patient D.D., a Wasilla resident on whom Dr. Kohler operated in 2007. D.D. has a suit pending against Dr. Kohler, in which he is represented by the firm whose unusual role in this hearing was discussed in Part II-C-5 above.

The division seeks discipline against Dr. Kohler in connection with D.D. for the following alleged violations:

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65 Ex. 1 at 2852.

66 Cross-exam of Patrick.

67 Instead, the division submitted secondhand testimony by affidavit from a Washington Department of Health attorney, in which the attorney seemed to seek to undermine confidence in the commission's determination. This is not a substitute for reviewing the direct records of what the commission actually thought and did.

1. That when Dr. Kohler allegedly "planned [a] lumbar microdiscectomy to follow the cervical procedure" on D.D., he demonstrated professional incompetence, gross negligence, or repeated negligence and committed unprofessional conduct.[68]

2. That when Dr. Kohler allegedly "failed to see [D.D.] in the recovery room, failed to note in [D.D.]'s chart whether he visited the patient in the recovery room, and failed to order an imaging study from the recovery room," he demonstrated professional incompetence, gross negligence, or repeated negligence and committed unprofessional conduct.[69]

3. That when Dr. Kohler allegedly "took 5 hours to complete the cervical laminoplasty on [D.D.] and it involved 3 liters of blood loss, and when [he] took 3 hours to complete the lumbar microdiscectomy on [D.D] and it involved 600 cc of blood loss," he demonstrated professional incompetence, gross negligence, or repeated negligence and committed unprofessional conduct.[70] This allegation will be split into two parts, one for each surgery, in the discussion at the end of this section.

Although D.D. features prominently in the division's allegations, the division put on very little actual testimony about him. Its case consisted of about eleven minutes of testimony from Dr. Burnett and four and a half minutes from Dr. Caram. Thanks to Dr. Kohler's witnesses, however, we do have a general picture of how the care of this individual unfolded.

D.D. is a pharmacist. Over a long period, he has been a chronic pain patient. The evidence in this case indicated that chronic pain patients are frustrating to doctors, and many surgeons will not take such patients.[71] One feature of these patients who have been exposed to pain for an inordinate amount of time is that they can tolerate pain to a certain threshold, but once the threshold is exceeded their ability to tolerate pain goes to zero. Because they have been exposed to high doses of narcotics for a long time, extremely high doses may be required to bring this pain back within their tolerance.[72]

D.D.'s difficulties were left shoulder pain and neuropathic pain, impaired sensation, and weakness in the left arm, as well as low back pain and pain, weakness, and impaired sensation in the left leg.[73] A component of his condition has been depression and anxiety.[74] He has a history of post-traumatic stress disorder.[75]

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68 Count 3.
69 Count 4.
70 Count 5.
71 *E.g.*, direct testimony of Jaconette.
72 Direct testimony of Kohler.
73 Direct testimony of Jaconette; Preop. H&P (Ex. 7); Lutz consultation rpt. (Ex. 7).

In 2005, when D.D. was approximately 48, Dr. Estrada Bernard performed a fusion at vertebrae C5-C6 by an anterior approach. D.D. was disappointed in the outcome of that surgery.[76]

In 2007, D.D., while still suffering from all of the above, saw both Dr. Eule and Dr. Kohler. Imaging showed extensive calcification in the spinal canal which was squeezing the cord between C4 and C7, with early signs of cord damage.[77] Dr. Eule proposed a vertebrectomy at C5-C6 with anterior and posterior fusion.[78] This would be done by an anterior approach, with work behind the esophagus in an area that had already been operated on. D.D. did not favor this option because he had had a very hard time following Dr. Bernard's anterior surgery.[79] Dr. Kohler considered Dr. Eule's recommendation but felt it would be problematic, in part because "it would make it difficult to remove the bone calcification present behind the C4 vertebral body."[80] He instead recommended a cervical laminoplasty. Although the scarring of the cord from ischemia might prove irreversible, the hope was to take the pressure off to reduce the pain and other symptoms.[81]

The cervical laminoplasty would be performed by a posterior approach. A laminoplasty is a procedure developed about 15 years ago that involves hinging the vertebral arch open to create more space and putting additional structural material (in this case a titanium strut) on the open side so that the spinal canal will remain enlarged in that area. It is a fairly involved surgery. There are simpler ways to relieve pressure on the cord in this area, but the laminoplasty has advantages, including facilitating the later placement of a spinal stimulator if needed.[82]

Dr. Kohler also contemplated that he might address left leg issues by performing a microdiscectomy at L5-S1. According to the preoperative report, D.D. was "adamant that he have everything done possible at one clinical trip to avoid any potential further exposure to the operating room and allow him to return to work as soon as possible." Had it been performed, this would have been a lesser procedure at a very different location on the spine, done with the

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74 Direct testimony of Jaconette.

75 Lutz consultation rpt. (Ex. 7).

76 Direct testimony of Jaconette.

77 Direct testimony of Kohler & accompanying images; Preop. H&P (Ex. 7). Dr. Kohler's testimony pointing to preoperative imaging evidence of cord damage was not rebutted. Dr. McCormack characterized the radiographic findings as "very severe."

78 Preop. H&P (Ex. 7).

79 *Id.*; direct testimony of Kohler.

80 Preop. H&P (Ex. 7).

81 Direct testimony of Kohler.

82 *Id.* Dr. Kohler explains this procedure and the reasons for performing it very lucidly.

patient still prone and under anesthesia. Dr. Kohler consented D.D. for this second procedure "on the off chance we could get around to doing it" if the cervical spine work went sufficiently fast.[83]

Dr. Kohler performed the surgery on November 16, 2007. He used cell saver (a means of recycling the patient's own blood cells) to reduce risks associated with transfusions.[84] He also used intraoperative neurophysiological monitoring so as to be alerted to any impingement the surgery might be causing. Both of these take some time to set up.[85]

Once the surgery began, the neurophysiological monitoring indicated that the nerves were in worse condition than anticipated and were very sensitive to irritation from working around them.[86] Whenever the system would alarm, Dr. Kohler would back off and try working from a different position.[87] The surgery went slowly, requiring five hours and nine minutes to complete.[88] All of this was devoted to the cervical laminoplasty; Dr. Kohler did not attempt the L5/S1 procedure. The patient (who is a large man, weighing 242 pounds), lost approximately three liters of blood, of which 2.7 liters were replaced by the cell saver system.[89]

A common adverse event following a cervical laminoplasty is C5-C6 syndrome,[90] also called brachial neuritis,[91] which can cause arm and shoulder pain and weakness as a result of surgical stress. It is relatively benign and normally clears up within six months. Immediately after surgery D.D. "definitely was worse in his shoulder," with additional weakness in his arm.[92] He was requiring a great deal of pain medicine, consistent with his chronic pain profile. When he backed off the pain medicine Dr. Kohler could get D.D. to move his legs, and so the shoulder/arm problem did not appear to Dr. Kohler to be a cord issue but rather a specific nerve root issue, which he assessed as C5-C6 syndrome.[93] If there had been a different pattern,

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83 Direct testimony of Kohler; Preop. H&P (Ex. 7). Dr. Kohler says that very rarely—about once a year—he has had a case where he can get two things done at once, and since this patient was so fearful of surgery, he planned for that contingency. He told the patient the first procedure usually takes a lot of time and he probably would not get to the second.

84 *E.g.*, Lutz consultation rpt. (Ex. 7).

85 Direct testimony of Kohler. Dr. Burnett testified that the latter would take about 15 minutes to set up. There was no testimony about the number of minutes to set up a cell saver system.

86 Direct Testimony of Kohler.

87 *Id.*

88 Perioperative Record (Ex. 7).

89 *E.g.*, Operative Report (Ex. 7).

90 Rebuttal testimony of Burnett; cross-exam of Jaconette.

91 Direct testimony of Kohler.

92 Direct testimony of Kohler. D.D. was already weak in the left arm before the surgery, able to lift only about 10 pounds. Phys. therapy records (Ex. 7). What Dr. Kohler observed was that he was weaker still.

93 Direct testimony of Kohler.

suggesting a hematoma or something else compressing the cord, Dr. Kohler says he would have sent D.D. for an immediate MRI or CT scan, but the absence of such a pattern made him feel a scan was not urgent. With the patient so sedated for pain, there were some concerns about his airway and a transport for a scan did not seem ideal.[94] The following day, D.D. was assessed as safer for transport and a CT scan was performed, which confirmed that there were no impingements to the cord.[95]

After the November 2007 surgery, D.D. told his pain management physician, Dr. Jaconette, that he was doing a little better.[96] At any rate, Dr. Jaconette at no time assessed him as doing worse.[97] D.D.'s situation at home deteriorated during that period, causing additional depression and anxiety that made him difficult to assess.[98]

Dr. Kohler continued to see D.D. for more than a year following the November 2007 surgery. Dr. Kohler recorded these visits in detail, and they show a complex up and down progression of the various neurological issues.[99] About six months after the laminoplasty, D.D. returned to surgery with Dr. Kohler for the microdiscectomy that had been deferred. There was essentially no testimony at the hearing about this surgery.

D.D. eventually went out of state for additional evaluation and received a different surgery on his cervical spine in Colorado. The psychosocial issues also improved for him during this period. He reported to Dr. Jaconette that he felt he was making some headway with his symptoms after the Colorado surgery.[100] The Colorado surgery may have addressed scarring dating from the Bernard surgery.[101]

One can now turn to an evaluation of the specific allegations the division has made regarding Dr. Kohler's care of D.D.:

Allegation: When Dr. Kohler "planned [a] lumbar microdiscectomy to follow the cervical procedure" on D.D., he demonstrated professional incompetence, gross negligence, or repeated negligence and committed unprofessional conduct.

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94 *Id.*
95 *Id.*; direct testimony of Burnett.
96 Direct testimony of Jaconette.
97 *Id.*
98 *Id.*
99 KOHL 12903-12938 (Ex. 7).
100 Direct testimony of Jaconette.
101 Cross-exam of McCormack.

At the outset, one must note that Dr. Kohler *did not* perform the microdiscectomy in the same surgery as the cervical procedure. The division's expert, Dr. Burnett, seemed to lose sight of this fact during at least some of his testimony, but the medical records and the other testimony are very clear that the microdiscectomy was deferred. Thus the division's contention seems to be that Dr. Kohler should be disciplined, not for what he actually did, but for entertaining the notion that he might do a second procedure if time permitted.

It would be a novel, and perhaps dangerous, application of the board's discipline authority to discipline physicians for what they thought about doing rather than for what they ultimately decided to do. In any event, the division's case on this allegation fails for lack of proof. With respect to negligence and gross negligence, no expert testified unequivocally that planning the second procedure would violate the standard of care and represent negligence or gross negligence. Dr. McCormack testified that it would not, and further that he has himself not only planned, but actually performed, a second procedure on rare occasions.[102] As for unprofessional conduct, the division has not explained how consenting a patient for a potential second procedure would represent unprofessional conduct. Finally, there has been no testimony or explanation of how contemplating the second procedure would meet the board's definition of professional incompetence ("lacking sufficient knowledge, skills, or professional judgment in that field of practice in which the physician . . . engages, to a degree likely to endanger the health of his or her patients"[103]).

Allegation: When Dr. Kohler "failed to see [D.D.] in the recovery room, failed to note in [D.D.]'s chart whether he visited the patient in the recovery room, and failed to order an imaging study from the recovery room," he demonstrated professional incompetence, gross negligence, or repeated negligence and committed unprofessional conduct.

The first parts of this allegation—failure to see D.D. in the recovery room and failure to chart such a visit—was not explored in testimony. Dr. Kohler does appear to have seen D.D. immediately after the surgery, and that is how he diagnosed the C5/C6 syndrome. Any charting failures have been handled as a separate documentation allegation, addressed in Part IV-G below.

As to failure to order an imaging study from the recovery room, Dr. Jaconette testified persuasively that it was not below the standard of care to wait 24 hours after D.D.'s laminoplasty

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[102] Direct testimony of McCormack.

[103] 12 AAC 40.970. The division did not cite this regulation

before ordering additional diagnostic tests, pointing out that one cannot treat chronic pain patients the same way one might treat someone "with a virgin neck" who is experiencing these deficits for the first time.[104] He noted that surgeons with more experience with chronic pain patients tend to take more of a watch and wait approach with postsurgical issues of the kind D.D. was experiencing. He characterized waiting in this case to be the more prudent course.

Dr. McCormack agreed, testifying persuasively and in some detail that the likely cause of fixed focal deficit in the left arm such as what D.D. displayed right after surgery is surgical trauma. He explained that the findings were not consistent with an expanding hematoma or other disaster that would necessitate immediate intervention, and thus it made sense to wait until the following day for imaging.[105]

In contrast, Dr. Burnett seems inclined to order tests at the earliest opportunity, but even he, when he first evaluated this case, did not go so far as to place Dr. Kohler's choice below the standard of care.[106]

On balance, the preponderance of the evidence showed that Dr. Kohler's decision not to order imaging on the day of surgery was a valid and reasonable choice, perhaps the best choice available.

Allegation: When Dr. Kohler "took 5 hours to complete the cervical laminoplasty on [D.D.] and it involved 3 liters of blood loss . . . he demonstrated professional incompetence, gross negligence, or repeated negligence and committed unprofessional conduct.

The best evidence was that a typical laminoplasty takes about two and a half hours, but that surgeons work at different speeds and some surgeries go more slowly than what is typical.[107] Five hours is certainly very slow for this surgery.[108] No witness was willing to say the length of the surgery caused it to fall below the standard of care or demonstrated incompetence, and certainly working slowly is not unprofessional conduct.

The typical blood loss for this surgery is a little less than a liter.[109] The surgeons who testified generally acknowledged that blood loss of this magnitude will happen to a competent

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104 Direct testimony of Jaconette.

105 Direct testimony of McCormack.

106 Ex. 4. In the hearing, Dr. Burnett sought to limit this opinion to the surgery itself and to retract any suggestion that the postoperative care met the standard of care. Cross-examination of Burnett. However, he did not offer an unequivocal replacement opinion.

107 *E.g.*, cross-exam of McCormack.

108 Direct testimony of Burnett.

109 Cross-exam of McCormack.

surgeon a few times a year, and that it does not in itself show poor technique.[110] More frequent instances of unexplained high blood loss could indeed raise concerns about technique. In this case, the D.D. case is the only surviving allegation of excessive blood loss, so no such pattern can be demonstrated.

Allegation: When Dr. Kohler "took 3 hours to complete the lumbar microdiscectomy on [D.D] and it involved 600 cc of blood loss," he demonstrated professional incompetence, gross negligence, or repeated negligence and committed unprofessional conduct.

Essentially no proof was offered on this allegation, which relates to the second surgery performed six months after the laminoplasty. Insofar as he touched on it at all, Dr. Burnett acknowledged that this surgery met the standard of care and did not demonstrate professional incompetence.

* * *

In summary, no violation has been proven in connection with Dr. Kohler's care of Patient D.D.

D. Patient V.R.

Patient V.R. is one of two patients added in the division's first amendment to its accusation, two and a half weeks before the hearing. That allegation became Count 6 of the Second Amended Accusation. At the hearing itself, the division's case in chief regarding patient V.R. lasted exactly four minutes. To the extent that we have any detail about this patient and her treatment, it comes from Dr. Kohler's witnesses.

V.R. knew Dr. Kohler's practice manager personally.[111] In early 2010, at the age of 45, she had two falls which resulted in a herniated disc at L4-L5.[112] She came to Dr. Kohler after six weeks. He performed a microdiscectomy at MSRMC on March 19, 2010.[113] During the operation, Dr. Kohler's work inadvertently caused a small tear in the dura and he detected a leak of cerebrospinal fluid (CSF) from an inaccessible location.[114] He patched it with a piece of gelfoam, and observed no further leakage during the rest of the operation.[115] Apart from this event, the surgery was successful.[116] V.R. later re-ruptured the disc and had another repair with

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110 *Id.*; direct exam of McCormack. Dr. Burnett's testimony was essentially consistent with this.
111 Direct testimony of Finn.
112 Ex. 6 at VR 0018; direct testimony of Kohler.
113 *Id.*
114 *Id.*
115 *Id.*
116 Direct testimony of Wright.

Dr. Wright at the same level, who observed no indications that Dr. Kohler had done anything wrong.[117]

It is very common for spine surgeons to have CSF leaks. The occurrence of a leak is not an indication of poor technique.[118]

After the surgery, V.R. had a headache, and she developed one again just before discharge. It later turned out there was continuing CSF leakage, which was stopped on March 29, 2010 with a blood patch (an essentially nonsurgical intervention done with a needle).[119]

In the four minutes of testimony the division's expert, Dr. Burnett, devoted to this case, he identified three deficiencies. First, he felt it would have been "better" for Dr. Kohler to use fibrin glue or a dural patch, which he sees as more modern ways to close a leak.[120] Second, he said that "after the surgery, in general, again this is a generality and frankly like a lot of things in neurosurgery there may not be beautiful data on it, but it is essentially standard of care to keep people down and flat so you take the pressure off their incision area after surgery; maybe he did that but it wasn't in the records that he did."[121] Third, he faulted Dr. Kohler for sending V.R. home with a headache; he noted that the headache was a symptom of further CSF leakage and, while not an emergency, those headaches are "miserable."[122] He would have recommended an MRI prior to discharge.[123] Collectively, he assessed these items as "not great, crisp patient care."[124] Dr. Burnett has unequivocally opined, however, that the care of V.R. met the standard of care (and hence was not negligent) and that it did not show professional incompetence.[125]

As to Dr. Burnett's first concern, he later acknowledged that this was a nit—"a piece of shrapnel sending us all in the wrong direction."[126] Dr. Kohler has a reasonable explanation for preferring foam, since he finds it easier and safer to place in locations he cannot see.[127] One of Dr. Burnett's colleagues published an article in the European Spine Journal concluding that gelfoam is just as effective as the patches Dr. Burnett prefers; Dr. Burnett's only response to this

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117 *Id.*
118 Direct testimony of Wright and Burnett.
119 *See* Ex. 6 at V.R. 0023. Dr. Wright does not consider this a surgery.
120 Direct testimony of Burnett.
121 *Id.*
122 *Id.*
123 *Id.*
124 *Id.*
125 Ex. 4.
126 Direct testimony of Burnett on rebuttal.
127 Direct testimony of Kohler.

is to opine that the European Spine Journal is second-rate.[128] Anchorage neurosurgeon Kim Wright never uses the fibrin patches Dr. Burnett favors.[129] Here one is simply reminded of Dr. Burnett's own caution that "you will never sit in a room and hear more confident opinions on the same patient that are polar opposites than you will in a spine conference."[130] No case for discipline has been made out.

Regarding the second concern, Dr. Burnett's opinion was persuasively rebutted by Dr. Wright. He explained that it takes days or weeks for the dura to heal and bed rest for that length of time creates additional risks; he never puts his patients on bed rest for a CSF leak, and he regards it as outdated advice. Regardless of whether Dr. Burnett or Dr. Wright is correct about bed rest, it has not been demonstrated that electing not to order it is a basis for discipline.

Dr. Burnett's third concern reflects a difference in assessment. Dr. Kohler suspected the CSF leak might be continuing and was watching for signs of leakage.[131] Shortly before discharge, V.R. developed a headache,[132] which can indicate a CSF leak if the headache is positional. Because the headache was not positional, Dr. Kohler believed it was musculoskeletal and that the patient would be better if she got up and out.[133] In retrospect, he may have been mistaken, as the patient continued to have a headache and ultimately got relief through a blood patch procedure; on the other hand, he may have been correct and there may simply have been a delayed leak that started after discharge.[134] Dr. Burnett asserts that an MRI should have been taken before discharge. He has not explained why it would not be reasonable for Dr. Kohler to rely on the non-positional nature of the headache to conclude that it was not an indication of an ongoing CSF leak.

Because Dr. Burnett agrees that the care was not incompetent or negligent, the only basis for discipline for the third concern would be through the prohibition on unprofessional conduct. Dr. Kohler's decision to forego this test because the headache was not the type associated with a CSF leak has not been shown to be unreasonable, and no basis to characterize this as unprofessional conduct has been made out.

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128 Cross-exam of Burnett on rebuttal. The European Spine Journal has an Article Influence Score of 0.708, very slightly below that of the Journal of Neurosurgery in which Dr. Burnett commonly publishes. Article Influence Score measures a journal's prestige based on citations to its articles. http://www.eigenfactor.org/ (accessed 6/2/11).

129 Direct testimony of Wright.

130 Direct testimony of Burnett.

131 *Id.*

132 Ex. 6 at KOHL 003999.

133 Direct and cross-exam of Kohler.

134 Cross-exam of Kohler.

E. Patient C.M.

Patient C.M., a 67-year-old woman on whom Dr. Kohler performed a minimally invasive lumbar fusion in 2009, was the subject of Count 9 of the Second Amended Accusation. The aspects of that count that related to the surgery itself were dismissed at the close of the division's case due to the inadequacy of Dr. Caram's testimony. With respect to identification and management of postoperative complications, however, Dr. Caram's testimony was not the only evidence supporting the division's case, and so that aspect of the count was not dismissed.

The other evidence in the division's case in chief supporting the postoperative aspect of Count 9 was a finding of the MSRMC proceeding. That finding relied primarily on testimony from Dr. Caram to the MSRMC Judicial Review Committee. The ALJ did not find the committee's reliance on Dr. Caram fatal to the committee's credibility because the committee, being made up of physicians, was presumably better able to explore Dr. Caram's assertions to assess which were worthy of belief and which were not.

On this particular allegation, a closer examination of the committee's report shows that it is very weak evidence, however. The committee wrote that after the operation C.M. had pain in her foot and had some difficulty walking, with the pain in this area greater than what she had experienced preoperatively. For this finding, the committee appears to have relied in part on medical records.[135] The finding is not significantly disputed.[136] The committee then stated: "It was later discovered that [C.M.] had bone in her spinal canal at L5 and S1, which was causing her pain."[137] There was a footnote after the comma citing to Dr. Caram's testimony, and Dr. Caram did indeed tell the committee (inaccurately) that C.M. had "bone" in her spinal canal. There was no footnote covering the phrase "which was causing her pain." A close reading of Dr. Caram's testimony to the committee reveals that he never testified that the so-called bone in the spinal canal was causing the pain,[138] and the source of the committee's assumption that it was is unclear. The committee went on to say that "Dr. Kohler apparently believed the pain was chronic pain and did nothing to identify or manage this post-operative complication" and to conclude that this lack of follow-up violated the standard of care.[139]

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135 Ex. 37 at KOHL 015676.

136 It is not clear from the records that were pointed out at the hearing that the foot pain was actually greater than preoperative levels, but it was certainly significant and was a matter of concern that Dr. Kohler noted.

137 *Id.*

138 *See* Ex. 38 at KOHL 015826-015827.

139 Ex. 37 at KOHL 015676.

The main weakness of the committee's handling of this allegation is the lack of any apparent basis for the committee to conclude that the "bone" in the canal was the cause of the pain. Moreover, the committee seems to have taken little time over the question of what was actually in the canal and why it might or might not be significant.

The additional evidence taken in the hearing in the present case—which was unrebutted—showed that postoperative imaging revealed some bone paste in the spinal canal. These specks of bone paste were not near the roots of the nerves that were giving C.M. pain. They were residue of the gritty matrix used in the fusion, and they could be expected to resorb over time. Since the residue was not near the nerves that were causing trouble, Dr. Kohler inferred that the additional pain came from the fact that the operation, by moving vertebrae back into position, had stretched a nerve that had foreshortened over a 30-years history of spondylolisthesis.[140]

Although her previously severe back pain improved after the surgery, the foot pain continued and seems to have troubled Dr. Kohler. He ordered an additional study to investigate possible causes.[141] Thus, the committee's belief, based on Dr. Caram's testimony, that he did "nothing" to identify or manage the complication is clearly erroneous. The parties did not further explore the postoperative care of C.M. at the hearing.

On this limited record, it is more probable than not that bone paste in the canal was unrelated to C.M.'s postoperative foot pain. The evidence also shows that Dr. Kohler identified the foot pain, monitored it, and took at least one step to further investigate it. The division offered no explanation, on rebuttal or otherwise, of why this course might be deemed inadequate. The division has failed to meet its burden to prove that postoperative identification and management of complications for C.M. was deficient in any way.

F. Patient L.B.B.

The L.B.B. case is quite similar to the C.M. case, but the evidence was better developed. The patient was a 57-year-old woman with a body mass index of 40. She had a long history of severe back pain with pain, numbness, and paresthesia in both legs and feet, particularly on the left. These problems had become disabling following a fall five and a half years previously. She

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140 The preceding paragraph was drawn from Dr. Kohler's direct testimony and associated images.

141 Ex. 18 at KOHL 013784.

suffered from a number of other conditions as well, including diabetes, depression, anxiety, and memory loss, the last possibly related to a head injury. [142]

Dr. Kohler performed a minimally invasive lumbar interbody fusion in 2009, which was the subject of Count 8 of the Second Amended Accusation. The aspects of that count that related to the surgery itself were dismissed at the close of the division's case due to the inadequacy of Dr. Caram's testimony.[143] With respect to identification and management of postoperative complications, Dr. Caram's testimony was not the only evidence supporting the division's case, and accordingly that aspect of the count was not dismissed.

As in the C.M. case, the other evidence in the division's case in chief supporting the postoperative aspect of Count 8 was a finding of the MSRMC proceeding. The MSRMC Judicial Review Committee noted that L.B.B had numbness in the distribution of the L4-L5 nerves after the surgery, and stated that the postoperative CT scan showed "bone fragments" in the spinal canal.[144] Based on testimony from Dr. Caram, the committee found that Dr. Kohler had failed to recognize, document, and treat this complication, thereby falling below the standard of care.[145] By following the committee's citations in footnotes, one can ascertain that the single alleged failure to meet the standard of care that Dr. Caram testified to the committee about was failure to go back to surgery to remove the "bone fragments" from the canal,[146] and so that is failure to which the committee is referring and its finding can be used only to support a case based on that failure. Whatever was in the canal was later removed by another surgeon.[147]

In determining the proper disposition of this allegation, it will be important to be mindful of the structure of adjudicative hearings. The division, which has the burden of proof, puts on its case first. The respondent then has an opportunity to present his defense. Finally, the division has an opportunity for rebuttal. The purpose of rebuttal must be solely to respond to the defense.[148] The division cannot prove up new allegations on rebuttal. That would not be fair because the case ends after rebuttal, without an opportunity for the respondent to present a further defense.

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142 Ex. 17 (assorted records used for whole paragraph).

143 On this particular surgery, Dr. Caram never testified to any significant problems with the surgery itself, either in this case or the MSRMC proceeding. *See* Ex. 38 at KOHL 015825. There seems to have been no basis at all for the portion of the allegation that was dismissed.

144 Ex. 37 at KOHL 015675.

145 *Id*. at KOHL 015676.

146 *Id*.; Ex. 38 at KOHL 015825-6.

147 Ex. 37 at KOHL 015676. No evidence was offered on what this second surgery showed.

In this case, for the L.B.B. matter, the division's case consisted solely of the Caram testimony and the MSRMC findings, coupled with some background records. Dr. Kohler's defense then shed a little more light on the circumstances of L.B.B.'s complication. Finally, the division sought to augment its case through rebuttal in a manner that, as will be seen, was not permissible.

L.B.B. was a difficult surgical candidate who was taken on at the request of her other physicians because her quality of life was so poor and would surely remain so if her pain were not controlled.[149] As it happened, the surgery relieved her back pain but left her, at least initially, with more leg pain.[150] A CT scan taken two days after the surgery showed residue of bone paste used during the surgery (the same gritty matrix referred to above in the C.M. case) in two undesired locations: some was in the spinal canal, and some was in the iliopsoas muscle.[151]

Dr. Kohler believed the paste in the iliopsoas muscle was irritating the branches of the femoral nerve passing through that area and was causing the leg pain.[152] He thought it was better not to go back to surgery to remove this irritant, however, because the paste should resorb and corrective surgery would only cause the patient more problems.[153] In this decision he is supported by division expert Dr. Burnett, who agreed that going back into the iliopsoas muscle would not have been productive.[154]

The question raised by Dr. Caram and the MSRMC committee, however, was whether Dr. Kohler should have gone back to surgery to remove the paste (which they believed to be bone fragments) in the spinal canal. On this issue we have very little information. Dr. Caram did not explain why he thought the material in the canal, as opposed to the material in the iliopsoas muscle, was causing the leg pain. The committee had no source other than Dr. Caram, and it likewise offered no reasoning; indeed, the committee seems to have overlooked the fact that there was a second potential cause for the leg pain. Dr. Burnett, a much more credible witness than Dr. Caram, said in passing that he thought the material in the canal "should have come out."[155] But his testimony on this issue was, quite literally, limited to one sentence, and he

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148 *See, e.g., Bray v. Bi-State Dev. Corp.*, 949 S.W.2d 93, 101 (Mo. App. 1997) (purpose of rebuttal "to explain, repel, counteract, or disprove the adversary's proof").

149 Direct testimony of Kohler.

150 *Id.*

151 *Id.*; cross-exam of Kohler; Ex. 17 at KOHL 004448.

152 Direct testimony of Kohler; ; Ex. 17 at KOHL 004448.

153 *Id.*

154 Direct testimony of Burnett on rebuttal.

155 Direct testimony of Burnett on rebuttal.

never actually said that leaving the material in the canal for the time being fell below the standard of care.

What Dr. Burnett felt passionately about, and testified about at length, was his belief that Dr. Kohler should have ordered a CT scan immediately after the surgery.[156] This is consistent with Dr. Burnett's predilection, noted above, to order a scan whenever there is a flicker of doubt since, in his view, scans are no trouble at all. Whether Dr. Burnett is right or wrong about this, it cannot be a basis for discipline of Dr. Kohler. This theory of negligence was first broached in the division's rebuttal case. Because it was not part of the Division's case in chief, it must be disregarded for the reasons discussed earlier in this section.[157]

The only theory on which the division offered cognizable proof was the theory that L.B.B. should have been returned to surgery immediately to remove the bone paste in the canal. Dr. Kohler has a reasonable-sounding explanation for not doing this: he says that there was not much material in the canal,[158] that it was not in a position that would correlate with the leg/foot symptoms, that further surgery on a patient in L.B.B.'s condition was undesirable, and that a subsequent surgery on L.B.B. in fact killed her.[159] The division has offered no response to this explanation; the division simply asks the ALJ to take it on faith that any material in the spinal canal must be removed immediately, on an emergency basis, regardless of patient-specific factors.

With the state of the proof left in this way, it is impossible to conclude with any confidence that the postoperative care of L.B.B. was deficient.

G. Documentation issues

In the Amended Accusation—the middle one of the three accusations filed in this case—the division had a Count VII that alleged that Dr. Kohler committed unprofessional conduct by showing a pattern of inadequate charting and other documentation in his cases. In the Second

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156 *Id*. Dr. Burnett seems to have concluded or assumed that it was immediately clear, following the surgery, that the patient had exacerbated foot symptoms. The ALJ has been unable to locate anything in the patient records to support that view; the patient seems to have been sedated or violent for a day or two after surgery, with the first clear indications of left leg deficit appearing close to the time the CT scan was actually performed. *See* Ex. 17. However, the records are voluminous and the ALJ may have missed something. KOHL 004582, the only record pointed to by the division, is not to the contrary, however.

157 Dr. Kohler's counsel adequately preserved this issue by objecting to rebuttal testimony by Dr. Burnett in an oral motion at the beginning the division's rebuttal case.

158 Dr. Kohler says the granules in the bone paste produce a scatter phenomenon that can make a small amount of material look large, and that a radiologist who thought bone fragments had been used rather than paste would tend to overestimate the volume. The ALJ is not able to assess this explanation.

159 Cross-exam of Kohler.

Amended Accusation, the division distributed the subject matter of the old documentation count among Counts 7-30 of the replacement accusation, so that the inadequate documentation issues were mixed in with alleged inadequacies of the surgeries. When the ALJ dismissed the allegations supported solely by Dr. Caram, he dismissed Counts 7-30 (or, more precisely, the counts in that span that had not already been dismissed voluntarily) with a special exception that preserved the inadequate documentation issue. The dismissal read:

> Accordingly, *Counts 7, 10-17, 19-25 and 29-30 of the Second Amended Accusation are dismissed except insofar as they allege matters covered by Count VII of the Amended Accusation. This dismissal is identical in practical effect as though the listed counts had been dismissed in their entirety and Count VII substituted in their place.*[160]

For all practical purposes, therefore, Count VII of the Amended Accusation was revived. This section of the decision deals with that revived count. For this alleged violation the division seeks a sanction in the nature of a reprimand, continuing education, and a civil fine;[161] the division does not contend that it rises, on its own, the level of suspension or revocation of the license.

The reason for preserving the documentation allegation was that it was not supported solely by Dr. Caram's testimony. The allegation was also supported by the MSRMC report, which seemed to reflect quite a bit of independent evaluation of the documentation by the committee. The committee wrote:

> The Committee finds the evidence in this record overwhelmingly establishes that Dr. Kohler's documentation and charting relating to his surgeries were substantially incomplete in most of the cases presented. His histories and physicals oftentimes were inadequate and lacked complete neurological exams. Most importantly, the physical exams pertinent to the planned surgical procedures were often inadequate. His hospital charts and progress notes also frequently omitted neurological exams and lacked detailed pre-operative and post-operative progress notes. There was worrisome consistency in these inadequacies for all of 2007, 2008, and 2009, even while Dr. Kohler was being encouraged to improve.
>
> Progress notes were found by the Committee to often lack detailed neurological exams and clear-cut plans, raising the question of whether post-operative progress of the patient and care plans are being communicated to the medical team in such a way as to facilitate an efficient and safe recovery. When questioned on the very simple matter of dates and times on his progress notes, Dr. Kohler replied, "I think every note I've done in the last

[160] Order Regarding Counts 1, 7-17, 19-25 and 29-30 (April 20, 2011) at 9. There was a separate, parallel special provision covering Counts 8 and 9.

[161] Division's closing argument.

year and a half has been timed." The Committee reviewed Dr. Kohler's progress notes on ten cases from 2008 and found the following:

> 10 op notes: 2 timed prior to surgery; 4 not timed (60% inadequate)
>
> 24 expected progress notes: 1 no date or time; 4 days no note; 12 not timed (67% inadequate)

The Committee's review of progress notes on 11 cases from 2009 revealed the following:

> 12 op notes: 1 no date or time; 1 wrong date; 5 not timed (56% inadequate)
>
> 24 expected progress notes: 1 no note; 13 no times (57 % inadequate)

The Committee finds that not only does Dr. Kohler have an op note and progress note problem, but also that he has failed to recognize, acknowledge or correct this problem over the two-year period reviewed.

Examples of physical examination deficiencies among the 37 cases presented at the hearing include the complete lack of any rectal exam to assess anal sphincter tone, even in lumbar surgery cases or spinal fracture cases where such pre-operative assessments are essential. Sensory exams are also absent in a number of cases, and such important general findings as obesity or even morbid obesity are often not noted. [Despite the phrasing of this sentence and the previous one, the committee was making a finding only about documentation; it was not finding that these tests or examinations did not occur.]

* * *

In several cases H&P's were outdated. In one case, an H&P from February 23, 2009 was copied forward verbatim, including a typographical error, '15' instead of the customary 'L5', to April 1, 2009, with no mention of the interval nor whether the patient had remained stable or had any change in condition. This raises the question of whether this second H&P was merely copied without a true reassessment and reexamination of the patient on April 1, 2009, to meet the required pre-surgery 30-day limit for H&Ps. Other cases raised similar concerns.

Moreover, the Committee finds that in many cases, Dr. Kohler's surgical consents did not match the procedures actually performed, including where Dr. Kohler's operative plan contemplated surgery at levels of the spine not mentioned in such consents.

The Committee regards timely, complete and accurate documentation in hospital charts, histories, and physicals, neurological exams, progress notes, and discharge summaries and post-operative orders, to be extremely important and required by MSRMC policy, Joint Commission standards and Medicare guidelines. Accurate documentation is critical for the continuation of safe, timely and appropriate care to patients at MSRMC. The Committee finds that the deficiencies in Dr. Kohler's charting and documentation were prevalent, serious, substantial and consistent over three years. The

> Committee tabulated the contents of the histories and physicals, the surgical consents, and the operative reports as they related to the consents. The 37 cases presented were divided by years: 2007, 2008 and 2009. In each category of each year, deficiencies were encountered, with acceptable documents never reaching 50% in any category. Again, there was no pattern of improvement over the years.[162]

The specifics of these findings were essentially unrebutted, although Dr. Kohler would dispute any overall judgment that his documentation is inadequate or "worrisome."

While the MSRMC findings are certainly a damning assessment with respect to compliance with hospital guidelines, one must bear in mind that they are being offered in this case to prove something else: that Dr. Kohler's documentation met the Alaska State Medical Board's definition of "unprofessional conduct," found in 12 AAC 40.967(9), because it constituted "failing to prepare and maintain accurate, complete, and legible records in accordance with generally accepted standards of practice for each patient . . . ." At the same time, the division has expressly stated that it is *not* alleging a violation of a different board regulation about record-keeping, 12 AAC 40.940, and that "there's no reason for you to consider that in this case."[163] 12 AAC 40.940 is the regulation in which the board has expressly laid out "standards of practice for record keeping." It is the regulation that, for example, requires physicians to "indicate the dates that professional services were provided to the patient"[164] and "reflect what examinations . . . were . . . performed."[165] Thus, the division seems to seek a finding that Dr. Kohler fell below "generally accepted standards of practice" for documentation in some way *other* than by violating the "standards of practice for recordkeeping" that the board has laid down.

As troubling as the MSRMC assessment is, the ALJ cannot make the finding the division requests. For an ALJ to make such a finding, there would need to be some credible evidence of the "generally accepted standards of practice" for documentation, against which the patterns the MSRMC committee discerned could be compared. Also, the testimony would need to establish that the "generally accepted standards of practice" in the profession are in some way more extensive or demanding than the board's own "standards of practice for recordkeeping," since the division has stipulated that it alleges no violation of the latter and that there is "no reason" even to consider the latter. By way of testimony on the documentation issues, the division

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162 Ex. 37 at KOHL 015660-015664 (footnotes omitted).
163 Division's closing argument.
164 12 AAC 40.940(b)(4).

offered only Dr. Caram.[166] Dr. Caram was not a credible witness. Moreover, although Dr. Caram criticized documentation in a few instances, he did not compare those particular criticisms to generally accepted standards of practice, nor explain how those standards would be something other than coextensive with the board's minimum regulatory standards.

In short, the ALJ is not in a position to create a standard of practice on this record and to determine that Dr. Kohler fell below it. The board itself could presumably do so, since it is a body equipped with its own medical knowledge and ordinarily need not rely on expert testimony to define the standard of practice.[167] If it were to take this step, the board would need to explain what the standard is and explain how it is different from the standard in 12 AAC 40.940, which the division has stipulated out of the case.

On the chance that the board will embark on this task, the evidence Dr. Kohler offered to counter the MSRMC findings will be summarized here.

Anchorage neurosurgeon Kim Wright says that in all hospitals "every surgeon is always in trouble with the hospital" for such problems as histories and physicals (H&P's) being missing from the file or being outdated according to the hospital standard. He says that getting updated H&Ps into the file is a challenge for everyone involved. He says that "every surgeon that I know of runs into that problem constantly, continually."[168] In his experience, surgeons are particularly forgetful about discharge summaries.[169] Dr. Wright covered for Dr. Kohler at ANMC, and he found nothing deficient about the quality of Dr. Kohler's H&Ps.[170] This testimony was credible and was not rebutted.

Dr. Grissom, a local pain management specialist, shared 20 to 30 patients with Dr. Kohler. He received Dr. Kohler's H&Ps. He found them to be "thorough." He never noted any deficiencies in them.[171] This testimony was likewise credible and was not rebutted.

Dr. Jaconette, another Anchorage pain management specialist, sees patients from all local neurosurgeons and refers back and forth to virtually all of them. He shared many patients with Dr. Kohler. Dr. Kohler operated on a minority of the patients he evaluated, because Dr. Kohler

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165 12 AAC 40.940(b)(5).

166 Dr. Patrick also touched on a documentation issue, finding documentation insufficient in the M.C. case. As noted in footnote 64 above, however, this testimony was valueless because Dr. Patrick may not have had a full set of records to review.

167 *Cf. Storrs v. State Medical Bd.*, 664 P.2d 547, 554 (Alaska 1983) ("The Board is a competent body equipped with the necessary medical knowledge . . . .").

168 Direct testimony of Wright.

169 Cross-exam of Wright.

170 Direct testimony of Wright.

favored nonsurgical options where possible, and he would offer insightful suggestions for such options to Dr. Jaconette. Dr. Jaconette has found Dr. Kohler's workups on his referral paperwork to be "as good if not better than any of the other [neurosurgery] groups . . . on the whole it was better, because, I mean, I don't want to be too hard on the other referring docs but a lot of times I get one page that says 'Please eval and treat' . . . that doesn't tell me anything."[172] He found Dr. Kohler's H&Ps "very complete."[173] As to alleged deficiencies in Dr. Kohler's chart notes, he says "there isn't a single note, physician's note, that isn't lacking in some way shape or form," observing that "you can be picked apart."[174] Dr. Jaconette was as frank and credible a witness as any who testified at the hearing, and he stood up well to cross-examination.

California neurosurgeon Dr. McCormick observed that there has been a big change in what hospitals regard as acceptable documentation in the last three years, which he sees as "all for the good." He has himself been criticized for falling short in this area, and he chuckled as he confirmed, perhaps with understatement, that this kind of criticism is not uncommon. He did not note anything missing in the particular chart he reviewed from Dr. Kohler.[175]

Finally, there was testimony suggesting that MSRMC has an atypical approach to physician privilege matters. This would undermine confidence that findings by its committee could be equated to the standard of practice for the profession generally. Dr. Grissom has never been offered privileges there, even though he has privileges at Providence Alaska Medical Center and Alaska Regional Hospital and has been chief of staff at St. Joseph's Regional Medical Center in Idaho.[176] Mayo-trained physician Andrew Jaconette likewise has no privileges at MSRMC; he elected not to pursue them after an "abrasive" encounter with the MSRMC credentialing committee.[177] After participating in the MSRMC proceeding regarding Dr. Kohler, he felt the standard they applied was unreasonable and one that even he could not meet, and said "honestly, I feel blessed not to have anything to do with them."[178]

To summarize, there is no question that Dr. Kohler fell short of MSRMC guidelines in some of his charting and documentation. It would be much more difficult to equate this shortfall with unprofessional conduct as a licensing matter, particularly in light of the division's

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171 Direct testimony of Grissom.
172 Direct testimony of Jaconette.
173 *Id*.
174 Recross of Jaconette.
175 Direct testimony of McCormack.
176 Direct testimony of Grissom.
177 Direct testimony of Jaconette.

concession that the 12 AAC 40.940 standards are irrelevant to its allegation. The ALJ is legally unable even to attempt this task, having essentially no qualified testimony at his disposal on which to formulate a standard. The board is not precluded from addressing the issue on its own.

H. Patient J.M.

The surgery performed on J.M. was one of the two original allegations in this case, before it expanded exponentially. The division's case regarding this surgery was fully prepared and thoroughly presented.

The division has alleged substandard practice at many junctures of Dr. Kohler's care of J.M. Because the history is complex, this section will begin with a broad overview. There will follow a more detailed history of the surgery itself, with some of the less persuasive allegations taken up as they arise chronologically. Finally, the central deficiency in this surgery will be measured against the standards for negligence, gross negligence, and incompetence.

1. Overview

In March of 2007, when she was in her late thirties, J.M. suffered a very painful back injury while making a jump on a snowmachine. Lacking insurance, she did not immediately get any medical attention. The pain gradually subsided and after about a month she was able to work again. Realizing she needed medical coverage, she changed jobs and began working at MSRMC as a unit secretary. Her pain increased again, and in August of 2007 she was seen in the MSRMC emergency department, where she was diagnosed with spinal compression fractures at T10 and T11.[179]

J.M. saw Dr. Kohler in November of 2007. Dr. Kohler initially referred her to a sports medicine physician for nonsurgical treatment. However, J.M. found that this course of treatment was going to be slow and, desiring more immediate relief, she returned to Dr. Kohler in December of 2007.[180]

J.M. and Dr. Kohler discussed the surgical option of a kyphoplasty.[181] A kyphoplasty is a minimally invasive technique to augment and restore strength to a vertebral body that has suffered a compression fracture. It involves placing a tube into the vertebral body and inserting a balloon, which is then used to expand the body back to its normal height and to create a space.

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178 ALJ questioning of Jaconette.
179 Direct testimony of J.M.
180 *Id.*
181 *Id.*

This space is then filled with a bone cement (in this case, consisting primarily of methyl methacrylate) that hardens to provide strength. The cement is supposed to stay inside the vertebral body; it has no function in any other location. The surgeon uses fluoroscopy to visualize where the needles, tubes, and injected materials are going. A company named Kyphon, Inc. provides kits and training for this procedure.[182]

Dr. Kohler told J.M. that kyphoplasty is usually performed on people whose injury is more recent than hers, but that her films indicated that there were zones of her T10 and T11 vertebral bodies that were still amenable to augmentation by this technique.[183] He told her that he had not had problems with the procedure with other patients and that, most likely, she would be able to walk out after a single overnight stay. J.M. told Dr. Kohler that she would like to go forward.[184]

After standard preoperative procedures and consents, the surgery was done on January 4, 2008. Dr. Kohler worked first at the T11 level. There were no significant complications at the T11 level, though some minor events will be discussed below. He then moved to the T10 level. There was catastrophic leakage of methyl methacrylate into the spinal canal during the procedure at T10 although, as discussed more fully below, this was unnoted at the time. Dr. Kohler then moved to a minor procedure, injecting pain relief medications at the facet joints around T10. The patient was taken to recovery, and Dr. Kohler dictated an operative report, noting no complications.[185]

When J.M. awoke, she was not able to move her legs.[186] Dr. Kohler ordered an emergency CT scan, which identified the leakage of cement into the spinal canal. He then performed an emergency laminectomy to remove the cement, which by all accounts was competently executed. The cement had been in the canal for about two and a half hours.[187] The amount of cement in the canal was "tremendous."[188]

Methyl methacrylate generates significant heat as it cures. Either because of this heat, because of compression of the spinal cord, or because of a combination of the two, J.M. suffered

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182 This procedure was described by many witnesses; there is also a description by the American Academy of Orthopaedic Surgeons in Ex. 5 at KOHL 008790-008792.

183 At times there has been an allegation that J.M. was not an appropriate candidate for kyphoplasty, although that allegation was not strongly pressed at the hearing. To the extent that it is still an issue, the ALJ finds that she was an appropriate candidate. Dr. Ringer so testified, and even Dr. Caram admitted this to be so.

184 Paragraph drawn from direct testimony of J.M.

185 The operative report is in Ex. 5 at KOHL 008807-008810.

186 Ex. 5 at KOHL 008677.

187 This is inferred from the end time of the first surgery and the start time of the second, as recorded in Ex. 5.

significant cord damage. She has had extensive treatment and additional surgeries in an attempt to restore some function, but she still has little use of her legs, and the sensation in her legs is so compromised that she can burn herself severely without being aware of it.[189]

2. The kyphoplasty

A surgeon conducting a kyphoplasty visualizes his work using fluoroscopic images. These x-ray images are taken from two angles, lateral and anterior-posterior (A/P). The images are not continuous or "real time;" rather, the surgeon calls for a view each time he wants to visualize the operative field. Thus, for example, if a needle is being inserted, the surgeon may call for an image or images as the needle is aligned, then advance the needle relying on anatomical knowledge and the feel of what he encounters, then call for another image or pair of images to see where the needle is, and so on. The surgeon can also call for a boosted image, using a higher x-ray dose to get better resolution. A key skill needed for this surgery—in some respects, the most important skill of all—is the ability to follow and interpret the images on the screen and to be able, by mental calculation, to correlate the A/P and lateral views.[190]

Although it is not their primary purpose, the images can serve as a step-by-step record of the surgery that is far more detailed than what is ordinarily available for traditional surgeries. Dr. Kohler was used to using a Siemens fluoroscopy unit that saves, at least initially, all of the views taken during the surgery. For this case an older Phillips unit had been brought in for the lateral views that could save only 16 images, a number more than adequate for most orthopedic surgeries but inadequate to accommodate the 80-100 views that might be taken from each angle in a kyphoplasty. Dr. Kohler was not aware of the save limit on the Phillips machine.[191] This was not an issue in terms of adequately visualizing the surgery; it is only significant in that it has affected forensic reconstruction of the surgery. The upshot is that we have a full set of A/P views for this surgery, but only the first 15 lateral views, which has introduced some uncertainty about the three-dimensional position of instruments and injected materials at times.[192]

As previously mentioned, Dr. Kohler was operating on two levels of the spine. The general objective at each level was to create a working channel into the vertebral body from both

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188 Direct testimony of Kohler.

189 Direct testimony of J.M.

190 Paragraph largely drawn from direct testimony of Cruz and Kohler.

191 Dr. Cruz, who is a radiologist and clearly a perfectionist regarding use of imaging equipment, faults Dr. Kohler for failing to be aware of this issue and failing to insist on arrangements to save a complete set of images from both angles. Another division expert, Dr. Burnett, does not see this as an issue (direct testimony of Burnett on rebuttal). Insofar as there is any allegation that this is a basis for discipline, the ALJ finds no violation.

left and right, inflate two balloons (one on each side) with fluid within the vertebral body, and then withdraw the balloons and inject cement in the cavities they had created. The cement is supposed to stay inside the vertebral body; one is seeking a "fill" of part or all of the cancellous bone that makes up the interior of the body, confined by the denser cortical shell of the body. The important area to fill, at least in cases such as this one, is the anterior portion of the vertebral body, which happens to be the area more distant from the spinal canal.

Dr. Kohler began his work at T11. In seeking to place one of the balloons, he penetrated the front of the vertebral body.[193] This left him with a small hole in the front of the body. Dr. Kohler pulled back to the correct position and used a technique designed to plug the hole. Subsequently there was a balloon rupture within the vertebral body, with a little leakage of fluid and contrast through the anterior wall of the body. Also, some of the cement filling the T11 vertebral body leaked through the anterior wall. The balloon rupture was not caused by the surgeon. While the leakage of cement may have been due to Dr. Kohler's inadvertent penetration of the anterior wall, it is an extremely common occurrence in kyphoplasties. Both leakages at T11 were benign events. Dr. Kohler achieved a good fill at T11.[194]

At T10, Dr. Kohler's initial needle pass from the left side was too far medial and extended too far to the rear, and it passed through the spinal canal. This channel was developed to the point of having a working cannula in it before Dr. Kohler realized it was in the wrong location. He did not realize, however, that he had breached the spinal canal. He withdrew and developed a new channel in the correct location.[195]

After inflation of balloons in the T10 vertebral body, Dr. Kohler began injecting cement. The procedure for injection is as follows. First, the surgeon tests the cement mixture that the tech has prepared to see if it has cured to the right consistency. Once it is at the right consistency, it needs to be injected rather quickly—in a matter of minutes—before it becomes too viscous. There are multiple 1cc injectors ready for the surgeon, and he picks them up successively and inserts them in the working cannula, all the while monitoring the fluoroscopic

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192 Paragraph drawn from direct testimony of Cruz, Springer, and Kohler.

193 This event is clearly visible on lateral view 14 (Ex. 58).

194 Paragraph drawn from direct testimony of Cruz, Ringer, Burnett, and Kohler.

195 This paragraph is drawn primarily from the testimony of Dr. Cruz and the cross-exam of Dr. Grissom. See also Dr. Kohler's Report of Malpractice Claim Settlement dated 1/10/11, Part IV (Ex. 34). Dr. Ringer testified that the needle path posited by Dr. Cruz could not be a needle path because it was filled with cement in the post-procedure CT image, and a needle path could not ordinarily fill with cement because it would be occupied (by a needle or injector) at the time of injection. However, Dr. Ringer seems to have overlooked that there was a prior needle pass that had been withdrawn and that would not have been occupied at the time of injection.

images to see where the cement is going (the cement contains contrast that makes it easy to see).[196]

Less than thirty seconds after Dr. Kohler began injecting on the left side at T10, the surviving fluoroscopic images show extravasation of dark material, traveling in a smooth-sided vertical channel upward and downward from T10. Dr. Kohler continued to inject cement, at first only on the left and then on both sides of the vertebral body, while the vertical shadow became more and more pronounced. After a minute and forty seconds it can clearly be seen extending all the way past the T9 level and well into the T8 level. Injection continued for another minute, so that the period of injection after the leakage first became visible is at least two minutes and forty seconds.[197]

During the early part of this period, there was some contrast circulating in the imagery that can be traced to a pain injection. This ought not to have confused Dr. Kohler, but in any event if he could not clearly see his operative field, he needed to wait for his view to clear.[198]

It has been established that the dark material moving vertically in these images was methyl methacrylate that was spreading inside the spinal canal.[199] Further, although we have only A/P images for this portion of the surgery, those were not the only images available to Dr. Kohler. Dr. Kohler would also have been able to view lateral images—as many and as often as he wished to request them from the tech—and the same vertical spreading would have been visible in the lateral images.[200] With the A/P images alone, one could not ordinarily be certain whether the leakage was anterior or posterior to the vertebral body (although the pattern of the spreading, perfectly outlining the contours of the spinal canal, would suggest the latter).[201] The lateral images, if they were being observed, would have left no doubt that the extravasation was occurring posterior to the vertebral body.[202] This kind of posterior leakage is extraordinarily dangerous, because of the potential to inflict pressure or heat damage on the spinal cord.[203]

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196 This paragraph is drawn from testimony of Kohler, Cruz, and Hill.

197 Direct testimony of Cruz; A/P views 10 to 6 (Ex. 58). Regarding Dr. Kohler's testimony that he had stopped injecting at A/P 7, I do not believe this is correct.

198 Testimony of Cruz.

199 *E.g.*, ALJ questioning of Ringer. Dr. Ringer knows the material was methyl methacrylate because its location and extent matches where methyl methacrylate was ultimately found.

200 ALJ questioning of Ringer. This answers the argument of Dr. Kohler's counsel that the vertical spreading, when seen on the A/P images, might be mistaken for contrast.

201 Direct testimony of Cruz.

202 ALJ questioning of Ringer.

203 All witnesses agreed on this point.

Though not elicited by Dr. Kohler, there was testimony from Dr. Grissom that much of this leakage may have occurred after Dr. Kohler stopped injecting.[204] This is not persuasive because the extent of the spreading already visible by the time of the last image with injectors in place is already coextensive with a postoperative CT image.[205] Moreover, Dr. Grissom was consistently confused about the type of imaging (A/P versus lateral) available in the J.M. case, indicating that he had not done a detailed review of that case.

Dr. Kohler believes he recalls being puzzled by the images as he completed the kyphoplasty, but he clearly did not come anywhere close to a full appreciation of the gravity of the situation. He mentioned no concerns to the anesthesiologist.[206] At best, he may have eventually refrained from further injections of cement because of his discomfort with the images.[207] He then performed a very short procedure to inject medication at the facet joints, which required less than four minutes and may have been done while waiting for a bed to transport the patient to recovery. He dictated an operative report that noted no complications. When the patient awoke with a major neurological deficit, as noted in the overview above, he proceeded correctly and on an emergency basis.[208]

The batch of methyl methacrylate used in this procedure was later recalled because of a concern that it was too slow to cure to the right viscosity. If cement is injected while too viscous, the risk of extravasation could be increased. It is possible that this contributed to the severity of Dr. Kohler's leakage. However, the surgeon is supposed to test the cement before injection to be sure it has reached the correct viscosity.[209]

3. Violations

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[204] ALJ questioning of Grissom.

[205] ALJ questioning of Ringer. Dr. Ringer also testified on direct that the cement does not move much after injection stops.

[206] Direct testimony of Naylor.

[207] Direct testimony of Kohler; cross-exam of Hill. A surgeon normally has six 1cc injectors available for each vertebral body, although not all of them may be used if a good fill is achieved with fewer than six or if injection is discontinued for other reasons. Surgical Tech Warren Hill appears to have the impression that Dr. Kohler did not use all six injectors at T10.

[208] There has been some debate in the case about whether the appropriate course was to awaken the patient and test her for neurological deficits or to take her straight to CT. The issue is largely moot because Dr. Kohler simply did not know that he had a major complication. If he had, awakening the patient before CT would still have been a defensible course. *E.g.*, direct testimony of Burnett; cross-exam of Ringer.

[209] Paragraph drawn from testimony of Kohler and Burnett.

The complication Dr. Kohler experienced in this surgery, a posterior leak to the spinal canal, is a well-recognized risk of the procedure.[210] That is why surgeons must watch for it and stop injecting at the first sign it is occurring.[211]

The problem with this surgery was that Dr. Kohler was not sufficiently attentive to this risk. Knowing that he had made an errant needle pass at T10 should have made him extra cautious because, as Dr. Grissom testified, "it's very easy to bridge the wall of the canal when you put a needle in."[212] Dr. Kohler does not seem to have exercised any extra caution when he started injecting, and he continued doing so for nearly three minutes without appreciating that he was getting massive posterior leakage. It is baffling that he missed the complication for so long, since his attention at this point should have been directed almost solely to where radio-opaque material was spreading as he injected it into the vertebral body.

When Dr. Kohler did not see this development, he was not performing competently, because he was not observing or interpreting the fluoroscopic imagery in a competent manner. The duration of the lapse was extended rather than momentary. It was not like driving up to a level crossing that is usually empty and not remembering to look for a train; it was more like looking directly at the oncoming train for minutes on end without appreciating what it was, and then proceeding across the crossing. This lapse indicates that, in one area of his practice, Dr. Kohler lacks "sufficient . . . skills . . . to a degree likely to endanger the health of his or her patients."[213] This meets the board's definition of professional incompetence.[214] The area in which the incompetence has been demonstrated is surgery conducted using fluoroscopic imagery.

Dr. Kohler's handling of this complication also unquestionably fell below the ordinary standard of care exercised by reasonable members of the profession in Dr. Kohler's specialty, and thus was negligent. However, a single instance of negligence is not a basis for discipline under any statute or regulation of the board. "Repeated negligent conduct" is indeed a basis for discipline, but both parties to this case agree that the repeated conduct must span multiple events, and the J.M. surgery was just a single event.

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210 *E.g.*, cross-exam of Grissom; direct testimony of Ringer.

211 *E.g.*, direct testimony of Ringer and Kohler.

212 Cross-exam of Grissom.

213 12 AAC 40.970.

214 *Cf. Rosi v. State Medical Board*, 665 P.2d 28 (Alaska 1983) (slowness to appreciate or take action on meconium aspiration represented professional incompetence; board's determination affirmed).

A single instance of gross negligence is indeed a basis for disciplinary sanctions. It is a close question whether Dr. Kohler's lapse in the J.M. case rose to the level of gross negligence. In medical cases, gross negligence is "an extreme departure from the ordinary standard of care," entailing "more than ordinary inadvertence or inattention."[215]

In closing argument, Dr. Kohler's counsel argued that gross negligence would be something like the following: the fluoroscope is not working, and the surgeon decides to proceed with the surgery anyway, operating completely blind. That, however, would be recklessness—consciously proceeding in the teeth of a known unacceptable risk. The Alaska Supreme Court has made it clear that conduct does not need to reach that threshold to be grossly negligent. In *Storrs v. Lutheran Hospitals and Homes Soc. of America, Inc.*,[216] the court acknowledged that it had previously equated recklessness with gross negligence, but corrected itself:

> [I]n *Leavitt v. Gillaspie*, 443 P.2d 61 (Alaska 1968), we equated, without discussion, gross negligence with "willful, wanton or reckless misconduct." This is not standard usage. "[M]ost courts consider that 'gross negligence' falls short of a reckless disregard of consequences, and differs from ordinary negligence only in degree, and not in kind. There is, in short, no generally accepted meaning; but the probability is, when the phrase is used, that it signifies more than ordinary inadvertence or inattention, but less than conscious indifference to consequences; and that it is, in other words, merely an extreme departure from the ordinary standard of care." W. Prosser, Torts, 183-84 (4th ed. 1971). In *Leavitt* the issue was whether an instruction that contributory negligence was not a defense to aggravated conduct on the part of the defendant should have been given. When contributory negligence was the rule, a defendant's gross negligence, as that term is commonly understood, did not negate the defense of contributory negligence, while willful, wanton or reckless conduct did. Prosser, *supra*, at 426. Thus, in context the court in *Leavitt* did not err in defining gross negligence in recklessness terms. However, that does not mean that the two concepts are identical for, in theory at least, they are not.

This does not shed much light on what the threshold for gross negligence actually is, however. Published examples are hard to come by and difficult to compare to the present situation. Below are some examples of gross negligence findings in connection with surgical care:

Henry Storrs, M.D.: In the underlying credentialing matter that led to the *Storrs* court case, quoted above, Dr. Storrs was found grossly negligent by a hospital panel after one of his patients died from a post-operative complication of a liver biopsy he performed. The gross negligence was "failure to recognize promptly a life threatening condition (hemorrhagic shock),

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[215] *Storrs, supra,* 661 P.2d at 634 & n.1 (quoting W. Prosser, *Torts* (4th ed. 1971)).

failure to institute basic, appropriate, and timely treatment and failure to assume responsibility to expedite treatment of shock."[217] The court upheld this finding, but did not indicate that it was compelled.

The present case parallels *Storrs* in failure to recognize promptly a catastrophic complication, but it differs from *Storrs* in that once the complication was recognized Dr. Kohler's response was appropriate and timely.

Arthur Gore, M.D.: In a California matter, the Board of Medical Quality Assurance found gross negligence in connection with a surgeon's treatment of postoperative complications. This patient developed a paralytic ileus, became dehydrated, and developed an electrolyte imbalance. The surgeon, thinking the patient's peristaltic action had revived, returned the patient to oral hydration. If the surgeon had reviewed the nurse's notes, he would have known this was premature. The patient had further fluid loss, but the surgeon ordered no electrolyte testing and no administration of electrolytes. He failed to read an x-ray that might also have alerted him to the gravity of the patient's situation. The patient died of cardiac arrest induced by the electrolyte imbalance. The negligent treatment persisted over the course of two days. A California court upheld the finding of gross negligence although, as in *Storrs*, the court did not indicate the finding was compelled by the evidence.[218]

Again, there is a parallel to the present case in the failure to see plain indications of a complication for which the physician ought to have been especially alert. However, the inattention spanned multiple bedside visits and chart reviews.

Ehud Arbit, M.D.: In a New York matter, a review committee under supervision of that state's Administrative Review Board for Professional Medical Conduct found a spine surgeon grossly negligent for operating at the wrong level, equating operating on the wrong disc with operating on the wrong arm or leg. On appeal, the board itself declined to endorse that comparison but nonetheless found the conduct egregious, affirming a sanction for gross negligence.[219]

The degree of disorientation or obliviousness exhibited by Dr. Arbit is perhaps comparable to Dr. Kohler's in the J.M. procedure, but the circumstances are difficult to compare

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216 *Id.*

217 *Storrs*, 661 P.2d at 634. *See also* an earlier case in the same series, *Storrs v. Lutheran Hospitals and Homes Soc. of America, Inc,*. 609 P.2d 24 (Alaska 1980).

218 *Gore v. Board of Med. Quality Assurance*, 167 Cal. Rptr. 881 (Cal. App. 1980).

219 *In re Arbit*, No. 00-369 (N.Y. Admin. Rev. Bd. for Professional Med. Conduct 2001).

directly. There was no court appeal to test whether this threshold for gross negligence would survive judicial review.

Marc Bergman, M.D.: In another New York case, a court declared itself "convice[d]" a surgeon acted with gross negligence when he did not even review a child's chart or examine the child and proceeded to operate on the wrong leg. The physician was censured.[220]

Dr. Bergman's lack of care seems well beyond that of Dr. Kohler.

In the present case, Dr. Kohler's period of inattentiveness was of significant duration (in light of the critical juncture of the surgery that had been reached), and the complication the surgeon failed to appreciate was one he should have been particularly alert to. A finding of gross negligence is probably permissible for the board to make. However, the ALJ assesses this conduct as falling just below the threshold for gross negligence.

V. Remedy

The division has proven one count of professional incompetence. The incompetence demonstrated relates to a particular class of surgery, not to Dr. Kohler's practice as a whole.

Although it is nominally a discipline case, this kind of case is really about patient safety. This board generally has not punished physicians in the traditional sense in incompetence cases, but rather has directed its efforts to imposing appropriate limits on their practice or to seeking to upgrade their performance. Thus in *Rosi v. State Medical Board*,[221] where the board had made a single finding of incompetence based on mishandling of a home birth, the board did not fine or reprimand the physician but instead required him to submit to 12 months of supervision by another doctor in his obstetrical cases and to prepare and complete a plan for further neonatology training. Likewise, this board very recently approved a Consent Agreement with Rene Alvarez, M.D.[222] Dr. Alvarez had been the subject of a large jury verdict for negligence,[223] and the board, apparently in relation to the same incident, approved a remedy whereby Dr. Alvarez would abide by restrictions on his practice imposed by the hospital at which he has privileges. Those restrictions consisted of refraining from certain classes of surgery.[224]

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220 *Bergman v. Sobol*, 564 N.Y.S.2d 571 (N.Y. App. 1991). *See also Willaby v. Bendersky*, 891 N.E.2d 509 (Ill. App. 2008) (where surgeon closed patient without removing a sponge, jury finding of gross negligence upheld).

221 665 P.2d 28 (Alaska 1983). The citation is to the subsequent court appeal, in which the board's action was affirmed.

222 *In re Alvarez*, No. 2010-00641.

223 *Beeks v. Alvarez*, No. 3HO-03-0029 CI (Alaska Superior Court).

224 *In re Alvarez*, No. 2010-00641 (Consent Agreement approved Oct. 28, 2010).

There was persuasive testimony in this case that Dr. Kohler is an asset to the medical community in important respects. He is a compassionate physician who is willing to serve a difficult patient population that many neurosurgeons avoid.[225] By doing so, he provides a potential avenue of relief to people whose lives have been ruined by pain or by the narcotic haze that may have been induced by their pain medications.[226] He is responsive to and works well with other physicians, including in the area of exploring nonsurgical solutions and working on the best plan for patient care.[227]

There is no basis to restrict Dr. Kohler's practice in areas in which incompetence has not been demonstrated, and doing so could deprive the community of a useful resource. In this case, the incompetence related solely to Dr. Kohler's ability to focus on, appreciate, and interpret what he was seeing in fluoroscopic imaging. Dr. Kohler, like Dr. Alvarez, should be required to refrain from conducting surgeries that call for the skill in which he has shown weakness. Restrictive language, modeled in part on the board's language in the matter of Dr. Rosi, has been suggested below.[228] It provides a mechanism for reinstatement to an unrestricted license if Dr. Kohler can demonstrate that he has rectified his deficiency.

VI. Conclusion and Order

The Division of Corporations, Business and Professional Licensing has failed to meet its burden of proof with respect to Counts 1 and 3-31 of the Second Amended Accusation. With respect to Count 2 of the Second Amended Accusation, relating to Patient J.M., the division has proven professional incompetence under AS 08.64.326(a)(8)(A) as set forth above.

As a condition of his license to practice medicine in Alaska, Dr. Kohler shall conduct no surgery in which the operative instruments are visualized by fluoroscopy unless he does so in the presence of and under the direction of a surgeon or radiologist licensed to practice medicine in this state who is experienced in the surgery being performed.

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225 Direct testimony of Grissom and Jaconette.

226 Direct testimony of Jaconette.

227 *Id*. Dr. Jaconette remarked, "this is an amazing thing, to have a neurosurgeon call you back."

228 In the ALJ's view, Dr. Kohler's lapse in following the images during the J.M surgery was sufficiently prolonged and fundamental that it demonstrates, on its own, that he should not perform fluoroscopic surgery while his skills are at the present level. A lesser remedy the board could consider, if it is uncertain whether a single demonstrated instance of incompetence supports this restriction, would be to appoint a committee of three qualified physicians to examine Dr. Kohler's skills, as permitted by AS 08.64.336(c). While this kind of evaluation is ordinarily conducted prior to the filing of an accusation, nothing precludes the board, in its role of safeguarding the public, from using it now.

Dr. Kohler may petition the board for modification or cancellation of this restriction one year or more from the date of adoption of this order. Any such petition must detail any steps Dr. Kohler has taken to improve his competency in relevant techniques, and must propose a means by which his competency can be tested or demonstrated, at his expense, to the satisfaction of the board.

This order shall become effective if adopted by the Alaska State Medical Board below.

DATED this 7th day of June, 2011.

By: *Signed*
Christopher Kennedy
Administrative Law Judge

Non-Adoption Option

B. The Alaska State Medical Board, in accordance with AS 44.64.060(e)(3), revises the enforcement action, determination of best interest, order, award, remedy, sanction, penalty, or other disposition of the case as follows:

As a condition of his license to practice medicine in Alaska, Dr. Kohler shall conduct no surgery in which the operative instruments are visualized by fluoroscopy unless he does so in the presence of and under the direction of a surgeon or radiologist licensed to practice medicine in this state who is experienced in the surgery being performed.

Additionally, to address documentation issues, all charts of operative patients will be subject to peer review, with results forwarded to the board on a quarterly basis.

Dr. Kohler may petition the board for modification or cancellation of these restrictions one year or more from the date of adoption of this order. Any such petition must detail any steps Dr. Kohler has taken to improve his competency in relevant techniques, and must propose a means by which his competency can be tested or demonstrated, at his expense, to the satisfaction of the board.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with AS 44.62.560 and Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 28th day of July, 2011.

By: *Signed*
Signature
Edward A. Hall
Name
Board Secretary
Title

[This document has been modified to conform to the technical standards for publication.]

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