

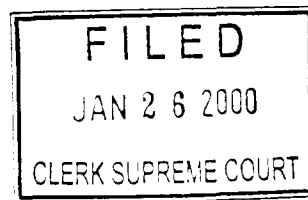
IN THE COURT OF APPEALS OF IOWA

No. 1999-403 (9-656) / 99-0074
Filed January 26, 2000

MICHAEL E. POOLE,
Petitioner-Appellant,

vs.

IOWA BOARD OF MEDICAL EXAMINERS,
Respondent-Appellee.



Appeal from the Iowa District Court for Van Buren County, Robert C. Bates,
Judge.

The Iowa Board of Medical Examiners issued a citation and warning to Dr.
Michael E. Poole, D.O. The doctor appeals from a ruling by the district court
affirming the decision of the Board of Medical Examiners. **REVERSED.**

Timothy D. Roberts of Anderson, Roberts & Porth, P.L.C., Burlington, for
appellant.

Thomas J. Miller, Attorney General, and Theresa O'Connell Weeg, Assistant
Attorney General, for appellee.

Heard by Streit, P.J., and Zimmer and Hecht, JJ.

HECHT, J.

The Iowa Board of Medical Examiners issued a citation and warning to Dr. Michael E. Poole, D.O. The doctor appeals from a ruling by the district court affirming the decision of the Board of Medical Examiners. We reverse.

I. Procedural Background. On September 19, 1996, the executive director of the Board of Medical Examiners of the State of Iowa ("the Board") filed a statement of charges against Dr. Michael E. Poole ("Dr. Poole"), an osteopathic physician. The statement claimed the Board was authorized to take disciplinary action against Dr. Poole following an incident in which he allegedly provided "substandard medical care" to a patient on November 8, 1994. The patient, a five-year-old boy, tragically and unexpectedly died on November 9, 1994. A hearing was held before a panel of the Board on October 30, 1997. The panel's proposed decision was issued on February 16, 1998. Dr. Poole appealed from that decision. Following oral arguments before the full Board, it entered its findings of fact, conclusions of law, decision and order on June 19, 1998. The Board's decision: (1) cited Dr. Poole for violation of Iowa Code sections 147.55 and 148.6(2)(g), and the Board's administrative rule found at Iowa Admin. Code r. 653-12.4(2)(c) and (d); (2) warned Dr. Poole against further violations of the same statutes and rules; and (3) taxed a hearing fee and certain other fees and costs to Dr. Poole. Dr. Poole sought judicial review in district court. On December 22, 1998, the district court affirmed the Board's decision. Dr. Poole appeals.

II. Factual Background. The patient underwent a left orchiopexy and left inguinal herniorrhaphy surgery on November 8, 1994, at the Van Buren County Hospital in Keosauqua. A surgeon from Mount Pleasant performed the surgery

with the understanding family physicians, including Dr. Poole, would provide post-surgical care. A nurse anesthetist improvidently hung an IV bag containing an inappropriate solution that was administered to the patient during surgery. The surgeon completed the surgery at approximately 11:30 a.m., but failed to issue an order controlling the administration of IV fluids before leaving the hospital. Thereafter, a member of the hospital's nursing staff tripled the flow of the IV solution into the patient in the recovery room although there was no order in the chart authorizing the administration of any IV solution whatsoever.

The hospital nursing staff summoned Dr. Poole from his office at approximately 6:00 p.m. to see the patient who was experiencing post-surgical nausea and vomiting. The attending nurse had noticed earlier the absence of a physician's order for IV fluids, but failed to mention this to Dr. Poole. The doctor arrived at the hospital and examined the patient at approximately 6:50 p.m. The patient's father was in the room at the time, but the attending nurse was occupied in the emergency room and unavailable. The hospital chart and IV flow record were not available in the patient's hospital room or at the nurse's station. At the time of the examination, Dr. Poole was not aware: (1) the surgeon had failed to leave an order for IV fluids; (2) the nurse anesthetist administered, and the patient was then receiving, an inappropriate IV solution; and (3) a nurse had tripled the rate of the flow of the inappropriate IV solution after the surgery had been completed despite the absence of a physician's order authorizing administration of IV fluids. Dr. Poole examined the sleeping patient and visited with the boy's father. The doctor concluded the patient should stay in the hospital at least overnight because of the

history of nausea during the day¹, and wrote a progress note directing the IV be continued until the patient was "taking orals without nausea."

Dr. Poole's family practice colleague, Dr. Breckenridge, issued an order at 8:30 p.m. that evening slowing the flow of the IV solution into the patient. Unfortunately, the patient's condition deteriorated markedly during the evening as a result of the administration of an excessive volume of the wrong IV fluids, and he died the following day.

A. *Peer Review.* Thereafter, the Board referred the case to two peer review committees. In its letter to the members of the first committee of February 21, 1996, the Board gave directions concerning the scope of their task:

As peer reviewers for the Iowa State Board of Medical Examiners, you are asked to review and evaluate the enclosed investigative material and medical records with regard to the professional competency of the above referenced physicians and/or with regard to the presence of willful or repeated gross malpractice or, willful or gross negligence. Board rules define professional incompetency in four alternative definitions:

A: A substantial lack of knowledge or ability to discharge professional obligations within the scope of the physician's practice.

B: A substantial deviation by the physician from the standards of learning or skills ordinarily possessed and applied by other physicians in Iowa acting in the same or similar circumstances.

C: A failure by a physician to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician in Iowa acting in the same or similar circumstances.

D: A willful or repeated departure from or the failure to conform to the minimum standards of acceptable and prevailing practice of medicine in Iowa.

¹ The patient had the same surgery on the other side several months before the surgery at issue here. On that occasion, as well, he experienced vomiting and nausea which caused him to stay overnight in the hospital.

Under definitions A-C, professional incompetency constitutes a substantial deviation from the standards of care. Under definition D, the deviation need not be substantial, but must be either willful or repeated.

Dr. Mouw and Dr. Bartlett, members of the first peer review committee, concluded Dr. Poole failed to exercise the degree of care ordinarily exercised by the average physician in Iowa. Although they expressly found other medical professionals involved in the treatment of the patient had *substantially* deviated from the applicable standard of care, they made no such finding with respect to Dr. Poole's medical care. The peer review report of Dr. Mouw and Dr. Bartlett simply found Dr. Poole had "failed to exercise the degree of care that is ordinarily exercised by the average physician in Iowa." The report made no finding of willful or repeated violation of the applicable standard of care by Dr. Poole under the facts of this case.

In a separate report, Dr. Shaffer, the third member of the first peer review committee, opined:

In careful review of these records, it is my opinion that errors did occur in the management of the case; however, I do not believe that they "constitute a substantial deviation or willful or repeated departure from the accepted standard of medical care, willful or repeated gross malpractice or willful or gross negligence."

The Board consulted a second peer review committee of three physicians who were asked to make the same determination as the prior panel. The members of the committee received correspondence delineating the same standards of review.

After reviewing the medical records, Dr. Merritt and Dr. Whitis² responded, in relevant part to the Board's inquiry:

FINDINGS: The committee found that Dr. Poole's involvement with the patient was limited to one brief visit during this hospitalization of 11/08/94 to 11/09/94 at Van Buren County Hospital, and that he provided acceptable standard of care given that limited involvement. Apparently neither the parents nor the nurses had raised any "red flags" about patient Bartholomew's status at that time, other than his post-op nausea.

In the opinion of Dr. Merritt and Dr. Whitis, "the bulk of the blame lies with the nursing staff and hospital for this tragedy of errors."

B. Expert Testimony at Hearing. Three physicians testified at the contested case hearing in this matter. The Board called Dr. Shaffer, a member of the first peer review committee. He testified Dr. Poole's treatment constituted a failure to conform to the applicable standard of care. On cross-examination, however, Dr. Shaffer testified as follows:

Q. And you aren't alleging that my client has committed a substantial deviation from the standard of care, a willful deviation from the standard of care, or a repeated deviation from the standard of care when you make your conclusions? A. No, I'm not.

Dr. Carlson, a board certified family physician, was called to testify by Dr. Poole. He testified Dr. Poole's involvement in the treatment of the patient was "extremely limited and well within the standards of care." He did concede on cross-examination the standard of care requires a physician who enters an order directing continuation of IV fluids to know the flow rate of the IV. He did not testify, however, that Dr. Poole's progress note directing continuation of IV fluids in this

² The third member of the second peer review panel, Dr. Doorenbos, did not join in the report of his two colleagues on the committee. No separate report or testimony of Dr. Doorenbos is found in the record.

case constituted a substantial, willful, or repeated deviation from the standard. Dr. Poole also called Dr. Calderon, an anesthesiologist. He testified Dr. Poole did not violate the applicable standard of care.

Despite the lack of peer review findings or expert testimony showing a substantial, willful, or repeated violation of the standard of care, the Board found Dr. Poole “willfully failed to conform to the minimal standard of acceptable and prevailing practice of medicine and surgery” when he wrote an entry in the patient’s records to “continue IV” even though he did not know what solution was being provided to the patient intravenously or the rate at which it was being infused. The Board further found Dr. Poole provided substandard care when he failed to ensure postoperative care of the patient was properly defined and delegated.

III. Standard of Review. On review of agency actions, we function solely in an appellate capacity to correct errors of law on the part of the agency. *Glowacki v. Iowa Bd. of Med. Exam’rs*, 516 N.W.2d 881, 884 (Iowa 1994). Appeals from district court decisions are governed by Iowa Code section 17A.20. The standard of review is limited to determining whether the district court correctly applied the law in exercising its section 17A.19(8) judicial review function. See *Conoco, Inc. v. Iowa Dep’t of Revenue & Fin.*, 477 N.W.2d 377, 379 (Iowa 1991). We grant only limited deference to the agency on issues of law, including statutory interpretation. See *Norland v. Iowa Dep’t of Job Serv.*, 412 N.W.2d 904, 908 (Iowa 1987). We defer to an agency’s fact finding if supported by substantial evidence. *Glowacki*, 516 N.W.2d at 884. Evidence is substantial when a reasonable mind would accept it as adequate to reach a conclusion. *McConnell v. Iowa Dep’t of Job Serv.*, 327 N.W.2d 234, 236 (Iowa 1982).

IV. Relevant Statutes and Administrative Rules.

~~As Statutes.~~ The Board found, and the district court affirmed, Dr. Poole violated Iowa Code section 147.55. This statute enumerates licensee conduct which may result in suspension or revocation of a health professional's license:

147.55 Grounds.

A license to practice a profession shall be revoked or suspended when the licensee is guilty of any of the following acts or offenses:

.....

2. Professional incompetency.

.....

8. *Willful or repeated violations of the provisions of this Act.*

(Emphasis supplied).

The Board also found Dr. Poole's behavior violated Iowa Code section 148.6. This statute identifies licensee conduct which would justify professional discipline at the hands of the Board. It provides, in relevant part, as follows:

148.6 Revocation.

1. The medical examiners, after due notice and hearing in accordance with chapter 17A, may issue an order to discipline a licensee for any of the grounds set forth in section 147.55, chapter 272C, or this subsection.

2. Pursuant to this section, the board of medical examiners may discipline a licensee who is guilty of any of the following acts or offenses:

.....

g. Being guilty of a *willful or repeated departure from, or the failure to conform to, the minimal standard of acceptable and prevailing practice of medicine and*

~~surgery, osteopathic medicine and surgery or osteopathy.~~

(Emphasis supplied).

B. Administrative Rules. The Board found, and the district court affirmed, Dr. Poole violated certain of its rules, including 653-12.4(2)(c) and (d) which provide, in relevant part:

653-12.4 Grounds for discipline. . . . The board may impose any of the disciplinary sanctions set forth in rule 12.2 (272C) including civil penalties in an amount not to exceed \$10,000, when the board determines that the licensee is guilty of any of the following acts or offenses:

(2) Professional incompetency. Professional incompetency includes but is not limited to:

c. A failure by a physician . . . to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician . . . in the state of Iowa acting in the same or similar circumstances;

d. A willful or repeated departure from or the failure to conform to the minimal standard of acceptable and prevailing practice of medicine and surgery, osteopathic medicine and surgery or osteopathy in the state of Iowa.

(Emphasis supplied).

V. Willful Failure to Conform to the Standard.

A. Statutory Interpretation. The Board found, and the district court affirmed, Dr. Poole "willfully failed to conform to the minimal standard of acceptable and prevailing practice of medicine" when he wrote a progress note directing the

continuation of the IV without knowing either the type of solution or the speed of its infusion. In its discussion of the definition of "willfulness" the Board observed:

Iowa Uniform Jury Instruction 700.5 defines "willful" as "intentional or by fixed design or purpose and not accidental." The Board does not suggest that [Dr. Poole] intended to give the patient the wrong fluid at the wrong rate. However, the Respondent intentionally provided post-operative care to the patient that evening. He examined the patient and prepared a written plan for the continuation of the patient's post-operative care. These actions were willful, as that term is defined in the Uniform Jury Instruction.

The Board thus concluded a "willful" departure from the standard of care requires nothing more than an intent to provide care to the patient. Such a construction would permit discipline of a licensee who intends to provide care within the standard of care, but through ordinary negligence in a single transaction, fails to do so.

We are obliged to "give weight to an agency's construction of a statute so long as the agency does not purport to make law or change the meaning of the law." *Iowa S. Util. v. Iowa State Commerce Comm'n*, 372 N.W.2d 274, 277 (Iowa 1985). A presumption of validity attends any agency rule adopted pursuant to delegated authority. *Overton v. State*, 493 N.W.2d 857, 859 (Iowa 1992). To be successful, any challenge to that authority must be established by clear and convincing evidence. *Dunlap Care Ctr. v. Iowa Dep't of Soc. Serv.*, 353 N.W.2d 389, 393 (Iowa 1984).

Conduct is willful when the actor has intentionally done an act of unreasonable character in disregard of a known or obvious risk that was so great as to make it highly probable that harm would follow. *Fell v. Kewanee Farm Equip. Co.*, 457 N.W.2d 911, 919 (Iowa 1990) (citation omitted); *Larson v. Great West Cas. Co.*, 482 N.W.2d 170, 174 (Iowa App. 1992). "Willful" is considered synonymous

with "wanton" or "reckless", and has been said to lie "somewhere between the mere unreasonable risk of harm in ordinary negligence and intent to harm." *Thompson v. Bolken*, 312 N.W.2d 501, 504 (Iowa 1981). Thus, proof of willful or repeated³ deviation from the standard of care pursuant to Iowa Code sections 147.55(8) and 148.6(2)(g), and rule 653-12.4(2)(d), requires evidence of conduct more culpable than a single transaction or occurrence of ordinary negligence.

The Board offers no authority for its contention the legislature intended the word "willful" in Iowa Code sections 147.55 and 148.6 to refer to conduct tantamount to a single transaction of ordinary negligence. We reject the Board's construction of the relevant statutes because it nullifies the distinction between a singular transaction of ordinary negligence and transactions which constitute willful or repeated deviations from the standard of care. We conclude the Board's construction of the relevant statutes is clearly affected by an error of law.

B. Substantial Evidence of Willful Departure From the Standard. We proceed to determine whether there is substantial evidence in the record to support a finding Dr. Poole's deviation from the applicable standard of care was willful. We note two members of the first peer review panel found Dr. Poole's treatment to be below the applicable standard of care. It is significant, however, they did not expressly find the doctor's deviation from the standard of care to be substantial in nature, and they offered no suggestion his treatment was more culpable than ordinary negligence. Dr. Shaffer, the third member of the first peer review panel, testified specifically Dr. Poole's deviation from the standard was not substantial.

³ The Board makes no claim in this case that Dr. Poole was guilty of repeated violations of the standard of care.

~~We note both reporting~~ members of the second peer review panel were unable even to ~~say~~ Dr. Poole's treatment fell below the applicable standard of care. Indeed, ~~none of the~~ three physician experts who testified at the contested case hearing characterized Dr. Poole's treatment as a *substantial* deviation from the standard, or more culpable than ordinary negligence.

Although the Board is permitted to employ its own expertise in performing its function in evaluating the evidence, it is not free to make findings inconsistent with the record before it. Although evidence in the record indicates Dr. Poole was negligent in the treatment of his patient, there is no substantial evidence supporting a finding his conduct was more culpable than a single transaction of ordinary negligence or rose to the level of willful or repeated deviations from the standard of care. Finding no substantial evidence in the record to support the Board's finding of a willful breach of the standard of care, we reverse.

VI. Substantial Failure to Exercise Ordinary Care. The Board contends even if the record does not support a finding of a willful departure from the applicable standard of care, the discipline imposed on Dr. Poole must stand because his treatment was found to constitute a "failure to exercise, *in a substantial respect*, that degree of care which is ordinarily exercised by the average physician in the ~~State of Iowa~~ acting in the same or similar circumstances." The Board claims this finding pursuant to rule 653-12.4(2)(c) supports the imposition of the sanction imposed in this case. Dr. Poole argues he was not guilty of conduct more culpable than a single transaction of ordinary negligence for which the Board has no power to impose discipline under rule 653-12.4(2)(c).

~~As~~ ~~Interpretation of the Rule.~~ Administrative bodies possess only such power ~~as is~~ specifically conferred or necessarily implied from the statute creating them. *City of Waukeg v. City Dev. Bd.*, 514 N.W.2d 83, 88 (Iowa 1994); *see also Quaker Oats Co. v. Cedar Rapids Human Rights Comm'n*, 268 N.W.2d 862, 868 (Iowa 1978); *Branderhorst v. Iowa State Highway Comm'n*, 202 N.W.2d 38, 40-41 (Iowa 1972) (stating "the general principle obtains that the Commission, like other administrative agencies, does not possess common law or inherent powers, but only the powers which are conferred by statute.") Agency action must be within the legislative grant of authority and consistent with limitations which the agency may have properly established by rule. *Patch v. Civil Serv. Comm'n*, 295 N.W.2d 460, 464 (Iowa 1980). A rule is beyond the scope of delegation if it is at variance with the enabling act or if it amends or nullifies legislative intent. *Elliot v. Iowa Dep't of Transp., Motor Vehicle Div.*, 377 N.W.2d 250, 254 (Iowa App. 1985). An agency may not change the law by giving to a statute an interpretation or construction of which its words are not susceptible. *See Nishnabotna Valley Rural Elec. Coop. v. Iowa Power & Light Co.*, 161 N.W.2d 348, 352 (Iowa 1968). Thus, the Board may not impose discipline for conduct amounting to a single transaction of ordinary negligence unless the legislature conferred such power upon it in sections 147.55 and 148.6(2)(g).

A statute should not be construed so as to make any part of it superfluous unless no other construction is reasonably possible. *Iowa Auto Dealers Ass'n v. Iowa Dep't of Revenue*, 301 N.W.2d 760, 765 (Iowa 1981); *State v. Hauan*, 361 N.W.2d 336, 338 (Iowa App. 1984). We interpret Iowa Code sections 147.55 (8) and 148.6(2)(g) to mean the legislature empowered the Board to sanction licensees

for willful or repeated failures to conform to the minimal standard of care, but not for single transactions of ordinary negligence. We believe the legislature intended the words "willful or repeated" to qualify the words "departure from" and the phrase "failure to conform to" in section 148.6(2)(g). Were this not so, the words "willful or repeated" would be superfluous because all failures (whether willful or repeated, or not) to conform to the applicable standard of care would support disciplinary action against a licensee.

We now turn to the interpretation of Administrative rule 653-12.4(2)(c). Consistent with our interpretation of the enabling statutes, we believe proof of a "failure by a physician . . . to exercise *in a substantial respect* that degree of care which is ordinarily exercised by the average physician" in a single transaction requires evidence of acts or omissions more culpable than ordinary negligence. In view of our determination the authorizing statutes do not permit the Board to sanction a licensee for a single transaction of ordinary negligence, we assume for purposes of this decision the Board's use of "substantial" in the rule necessarily contemplates conduct more culpable than ordinary negligence as an antecedent to licensee discipline. Our assumption is justified in view of the Board's correspondence with the two peer review committees. In each instance, the Board expressly informed committee members they were to decide whether any departures from the standard of care were substantial, willful, or repeated. If any breach of the standard of care constituting ordinary negligence would be sufficient to support licensee discipline, the words "substantial" and "willful" in the Board's rules would be superfluous. Consistent with rules of statutory interpretation, we will not construe the agency rule in a way which renders language superfluous.

~~Accordingly, we conclude~~ the Board may only discipline Dr. Poole pursuant to rule 653-12.4(2)(c) if his breach of the applicable standard of care was either "willful" or "substantial" and more culpable than a single transaction of ordinary negligence.

B. Substantial Evidence of Failure to Exercise Ordinary Care. Dr. Poole contends there is insufficient evidence of a substantial or willful breach of the applicable standard of care in this record to support the Board's imposition of discipline. For the reasons stated in division V. of this opinion, we find no substantial evidence of conduct by Dr. Poole more culpable than a single transaction of ordinary negligence. Accordingly we reverse.

VII. Conclusion. The Board's finding of a willful violation of the standard of care is not supported by substantial evidence in the record. The record shows no evidence of a willful or substantial departure from the applicable standard of care by Dr. Poole in this case. The Board has no statutory authority to promulgate rules calling for licensee discipline for a single transaction or occurrence of ordinary negligence. There is no substantial evidence in the record supporting a finding Dr. Poole's conduct was more culpable than ordinary negligence in this case. Accordingly, we conclude the Board has no power to discipline him under the facts of this case. We reverse.

REVERSED.