

STATE OF INDIANA,)
)
 Petitioner,)
)
 v.)
)
 JEFFREY P. BOLDUAN, M.D.,)
 License Number 01030767,)
)
 Respondent.)

FILED

DEC 29 1997

HEALTH PROFESSIONS
BUREAU

COMPLAINT

The State of Indiana, ("Petitioner") by counsel, Jeffrey Modisett, Attorney General of Indiana, by Joan Isaacs Wolf, and by Beth Anne Compton, Deputy Attorneys General, pursuant to Indiana Code §25-1-7-7(a), files its complaint against Jeffrey P. Bolduan, M.D., ("Respondent") and in support thereof alleges and states:

1. The Attorney General of Indiana is empowered to bring disciplinary complaints in the name of the State of Indiana before the Medical Licensing Board of Indiana ("Board") pursuant to Indiana Code §25-1-7 *et seq.*
2. The Board is charged with the duty and responsibility of regulating the practice of medicine pursuant to Indiana Code §25-22.5-2-7.
3. The Board is empowered to hold disciplinary hearings pursuant to the authority of Indiana Code Title 25 and Indiana Code §4-21.5-3 *et seq.*

COUNT I

1. The Respondent, whose address on file with the Board is 2014 South Main Street #A, Goshen, Indiana 46526, is a duly licensed physician in the State of Indiana holding medical license #01030767.
2. On June 20, 1982, the Respondent pled guilty to one misdemeanor count of conspiring to obtain money by false pretense and two counts of attempted presentation of false billing claims to the state of Michigan for payment under Medicaid. Respondent was sentenced on July 2, 1982, to two years of probation and fines and costs in the amount of \$13,000. As a result of the above convictions, the Respondent was required to surrender his Michigan medical license on a permanent basis.

3. On October 21, 1983, the Respondent's Indiana medical license was suspended on an emergency basis due to his conviction in Michigan for the crimes of conspiracy to obtain money by false pretenses and filing false Medicare claims. The emergency summary suspension of the Respondent's license was vacated on October 26, 1983, pursuant to the Respondent's petition for limited reinstatement. Respondent's license was reinstated on probation, with terms and conditions which limited his practice of medicine solely and exclusively to professional services at Goshen Memorial Hospital and voluntary community service for the Elkhart County Cancer Society performing prostate and colon cancer screening.

4. A complaint was filed by the office of the Attorney General against the Respondent on February 21, 1984. After a hearing, the Respondent's medical license was placed on probation for a period of two years beginning on February 23, 1984.

5. The Respondent billed Medicare for a biopsy done on patient W.M. on April 28, 1993; however, no biopsy procedure was performed on W.M. that day. The billing was the result of an automatic generation of a "canned" operative report by the Respondent's office. The Respondent instructed his office personnel in the practice of issuing pre-printed reports as a matter of routine, based on the patient schedule.

6. Medicare was billed under CPT Code 76942 for "radiological supervision and interpretation" of the biopsy. Deposition testimony given by the Respondent's secretary established that no supervision or interpretation took place regarding W.M.'s biopsy, nor was such supervision or interpretation a routine practice in the Respondent's office. Additionally, the Respondent billed Medicare under CPT Code 99204 for "the evaluation and management of a new patient" which requires that the office visit contain all of the following components: a comprehensive history; a comprehensive examination; and medical decision-making of moderate complexity. In a deposition statement taken during a malpractice lawsuit filed on behalf of patient W.M., the Respondent testified that the office visit for W.M. which was billed under CPT Code 99204 was extremely limited, involving nothing more than his reporting the results of W.M.'s biopsy.

7. The conduct described above constitutes engaging in fraud or material deception in the course of professional services or activities in violation of Indiana Code §25-1-9-4(a)(1)(B); and a knowing violation of any state statute or rule, or federal statute or regulation, regulating the profession in question, in violation of Indiana

Code §25-1-9-4(a)(3), *to wit*: fees charged by a practitioner for his professional services shall be reasonable and shall reasonably compensate the practitioner only for services actually rendered, in violation of 844 IAC 5-2-9(a).

COUNT II

8. The Petitioner repeats and realleges paragraphs 1-7 of its complaint.

9. On August 21, 1989, the Respondent operated on one year old patient A.D. for treatment of hypospadias. Respondent's postoperative office notes indicate problems including scar tissue causing chordee; skin in the area that "needed to mature;" and excess pubic fat causing the child's penis to look shorter than normal.

10. Despite repeated concerns expressed by the patient's mother, the Respondent did not seek a consultation or initiate further treatment for any of the above problems.

11. On August 11, 1992, A.D.'s mother took him to another urologist for a second opinion. She was referred to Riley Children's Hospital, where A.D. was seen by Dr. Michael Keating. Over the next several years, Dr. Keating performed multiple surgeries to repair and reconstruct the child's penis, including skin grafting and buccal mucosa grafting. The repairs and reconstruction were necessary because of the substandard urethroplasty operation originally performed by the Respondent.

12. The conduct described above constitutes continuing to practice although unfit due to professional incompetence that includes the undertaking of professional activities that the practitioner is not qualified by training or experience to undertake, in violation of Indiana Code §25-1-9-4(a)(4)(A)(i); failure to keep abreast of current professional theory or practice in violation of Indiana Code §25-1-9-4(a)(4)(B); and a knowing violation of any state statute or rule, or federal statute or regulation, regulating the profession in question, in violation of Indiana Code §25-1-9-4(a)(3), *to wit*: failure to exercise reasonable care and diligence in the treatment of patients based upon generally accepted scientific principles, methods, treatments, and current professional theory and practice, in violation of 844 IAC 5-2-5.

COUNT III

13. The Petitioner repeats and realleges paragraphs 1-12 of its complaint.

14. In February, 1990, patient J.C. sought treatment with the Respondent for symptoms of dysuria with some nocturia. The Respondent performed a cystoscopy, cystometrogram, and ultrasound, diagnosing "a question of some nodularity of his prostate which could be a malignancy." Although a biopsy would have

determined whether or not the patient had cancer, the Respondent recommended a transurethral resection ("TUR") of the prostate gland for J.C. Surgery was performed on February 15, 1990.

15. A TUR procedure is not an appropriate procedure to diagnose cancer of the prostate, and is a much more invasive and expensive operation than is warranted for a patient exhibiting symptoms similar to those described by J.C.

16. The conduct described above constitutes continuing to practice although unfit due to failure to keep abreast of current professional theory or practice, in violation of Indiana Code §25-1-9-4(a)(4)(B); and a knowing violation of any state statute or rule, or federal rule or regulation, regulating the profession in question, in violation of Indiana Code §25-1-9-4(a)(3), *to wit*: failure to exercise reasonable care and diligence in the treatment of patients based upon generally accepted scientific principles, methods, treatments, and current professional theory and practice, in violation of 844 IAC 5-2-5.

COUNT IV

17. Petitioner repeats and realleges paragraphs 1-16 of its complaint.

18. On January 31, 1992, patient R.P. presented to Goshen General Hospital with complaints of kidney pain.

19. The Respondent diagnosed a renal calculus, and attempted to manipulate the stone under local anesthesia without success. The Respondent did not use a guide wire through the ureter; did not perform a ureteroscopy; nor did the Respondent use fluoroscopy guidance in attempting to manipulate the kidney stone. Moreover, local anesthesia was inadequate for such a procedure.

20. The Respondent failed to offer R.P. the option of a non-invasive shock wave lithotripsy. Instead, Respondent suggested a more invasive percutaneous approach, which Respondent performed on February 5, 1992.

21. During the operation, the ureteral guide wire broke off and became lodged inside R.P.'s kidney. The Respondent did not approach the family to discuss options, but rather proceeded directly to the operating room and performed an open renal surgery to retrieve the guide wire.

22. On October 1, 1993, a medical review panel found that the Respondent had committed malpractice in his treatment of patient R.P.

23. The conduct described above constitutes knowing violations of any state statute or rule, or federal rule or regulation, regulating the profession in question, in violation of Indiana Code §25-1-9-4(a)(1)(B), *to wit*: failure to give a truthful, candid, and reasonably complete account of the patient's condition to the patient or to those responsible for the patient's care, in violation of 844 IAC 5-2-3; and failure to exercise reasonable care and diligence in the treatment of patients based upon generally accepted scientific principles, methods, treatments, and current professional theory and practice, in violation of 844 IAC 5-2-5.

COUNT V

24. Petitioner repeats and realleges paragraphs 1-23 of its complaint.

25. On January 12, 1993, Patient M.K. sought treatment from the Respondent for chronic bladder infections. Respondent diagnosed a staghorn calculus and poorly functioning right kidney and recommended a right nephrectomy. Respondent failed to offer M.K. the option of more conservative treatment.

26. During surgery, the Respondent encountered severe intraoperative complications, including multiple adhesions, laceration of the vena cava, and massive blood loss. The Respondent called a general surgeon to scrub in to assist him in attempting to control the heavy vascular bleeding.

27. Due to the severe, apparently uncontrolled complications of the surgery, the patient expired in the intensive care unit approximately two hours postoperatively. The Respondent failed to explain the risk of death to the patient or her family prior to surgery, nor did he speak to the family after the patient expired.

28. The conduct described above constitutes continuing to practice although unfit due to professional incompetence that includes the undertaking of professional activities that the practitioner is not qualified by training or experience to undertake, in violation of Indiana Code §25-1-9-4(a)(4)(A)(i); continuing to practice although unfit due to failure to keep abreast of current professional theory or practice, in violation of Indiana Code §25-1-9-4(a)(4)(B); and knowing violations of any state statute or rule, or federal rule or regulation, regulating the profession in question, in violation of Indiana Code §25-1-9-4(a)(3), *to wit*: failure to give a truthful, candid, reasonably complete account of the patient's condition to the patient or to those responsible of the patient's care, in violation of 844 IAC 5-2-3; and failure to exercise reasonable care and diligence in the treatment of patients based upon generally accepted scientific principles, methods, treatments, and current professional theory and practice, in violation of 844 IAC 5-2-5.

COUNT VI

29. Petitioner repeats and realleges counts 1-28 of its complaint.

30. On November 4, 1993, fourteen month old M.J. was brought to the Respondent's office by her mother, who sought a refill on a prescription cream for the child's alleged condition of labial fusion.

31. The Respondent failed to examine the patient, instead scheduling her for surgery under general anesthetic to perform a manual manipulation.

32. The parents sought a second opinion, and the child was seen by another urologist on November 18, 1993. No adhesions were present on examination conducted during the second opinion office visit.

33. The conduct described above constitutes continuing to practice although unfit due to failure to keep abreast of current professional theory or practice in violation of Indiana Code §25-1-9-4(a)(4)(B); engaging in fraud or material deception in the course of professional services or activities in violation of Indiana Code §25-1-9-4(a)(1)(B); and knowing violations of any state statute or rule, or any federal rule or regulation, regulating the profession in question in violation of Indiana Code §25-1-9-4(a)(1)(B), *to wit*: failure to exercise reasonable care and diligence in the treatment of patients based upon generally accepted scientific principles, methods, treatments, and current professional theory and practice, in violation of 844 IAC 5-2-5; and failure to give a truthful, candid, and reasonably complete account of the patient's condition to the patient or to those responsible for the patient's care, in violation of 844 IAC 5-2-3.

COUNT VII

34. Petitioner repeats and realleges paragraphs 1 through 33 of its complaint.

35. On April 1, 1992, the Respondent attempted to perform a ureteroscopy to retrieve a left renal calculus on patient S.S.

36. During surgery, the Respondent perforated the ureter at approximately the mid-point. The Respondent failed to retrieve the stone.

37. The Respondent then attempted to place a stent in the perforated ureter to facilitate healing, however, the stent was misplaced, actually exiting the ureter at the point of perforation and lying free in the retroperitoneum.

38. Despite his documented acknowledgment of the incorrect stent placement, the Respondent did not remove or replace the stent, but rather left it lying in an anatomically improper and useless position, and terminated the procedure. The next morning, the Respondent left the country on vacation, abandoning his patient with no urological consultation for follow up, despite her known failed and complicated postoperative condition.

39. In an opinion dated January 18, 1994, a medical review panel determined that the Respondent failed to comply with the appropriate standard of care in his treatment of S.S.

40. The conduct described above constitutes continuing to practice although unfit due to failure to keep abreast of current professional theory or practice, in violation of Indiana Code §25-1-9-4(a)(4)(B); knowing violations of any state statute or rule, or federal rule or regulation, regulating the profession in question, in violation of Indiana Code §25-1-9-4(a)(3), *to wit*: abandoning a patient, in violation of 844 IAC 5-2-4(a); and failure to exercise reasonable care and diligence in the treatment of patients based upon generally accepted scientific principles, methods, treatments, and current professional theory and practice, in violation of 844 IAC 5-2-5.

COUNT VIII

41. Petitioner repeats and realleges paragraphs 1-40 of its complaint.

42. During a routine physical examination on March 16, 1993, patient W.M. was found to have an enlarged prostate and a prostate-specific antigen ("PSA") reading of 8.7 ng/mL. A normal PSA reading is 0-4 ng/mL; a reading of 10-120 ng/mL indicates prostate cancer.

43. W.M.'s family physician sent him to the Respondent for an ultrasound due to the above findings. The Respondent caused the ultrasound to be performed by Uro-Radiology, a corporation owned by the Respondent and his partner, Dr. Barnes, a radiologist.

44. Dr. Barnes diagnosed a "fairly large hypo echoic nodule" and recommended a biopsy.

45. The biopsy was performed on May 5, 1993. On May 13, the Respondent saw W.M. in his office and told the patient that his biopsy was negative.

46. The Respondent failed to inform his patient that he should follow up with repeated PSA tests and rectal exams at a rate of three per year in order to observe his condition for the possibility of cancer.

47. The Respondent failed to follow up with patient W.M. in any way, indicating in his office note of May 13, 1993, only that W.M. was to return "as needed."

48. Due to increasing problems with his prostate, W.M. saw his new family physician, Dr. Donald Ebersole, on November 4, 1994. Dr. Ebersole did a PSA test which revealed a level of 45.5.

49. W.M. was immediately referred to Dr. Michael Thomas, another urologist, who diagnosed adenocarcinoma of the prostate.

50. Repeated PSA's and rectal exams would have revealed an increasing level of antigen, prompting earlier intervention with a better chance for cure for W.M.

51. Due to the Respondent's lack of follow up on his patient, by the time of diagnosis, W.M.'s prognosis was grave. W.M. died of adenocarcinoma of the prostate in the early spring of 1997.

52. The conduct described above constitutes continuing to practice although unfit due to failure to keep abreast of current professional theory or practice, in violation of Indiana Code §25-1-9-4(a)(4)(B); and knowing violations of any state statute or rule, or federal rule or regulation, regulating the profession in question, in violation of Indiana Code §25-1-9-4(a)(3), *to wit*: failure to give a truthful, candid, and reasonably complete account of the patient's condition to the patient or to those responsible for the patient's care, in violation of 844 IAC 5-2-3; and failure to exercise reasonable care and diligence in the treatment of patients based upon generally accepted scientific principles, methods, treatments, and current professional theory and practice, in violation of 844 IAC 5-2-5.

COUNT IX

53. Petitioner repeats and realleges paragraphs 1-52 of its complaint.

54. The conduct described above constitutes continuing to practice although unfit to practice due to professional incompetence, in violation of Indiana Code §25-1-9-4(a)(4)(A), as "professional incompetence" is further defined by 844 IAC 5-1-1, *to wit*: a pattern or course of repeated conduct by a practitioner demonstrating a failure to exercise such reasonable care and diligence as is ordinarily exercised by practitioners in the same or similar circumstances in the same or similar locality.

WHEREFORE, the Petitioner demands an order against the Respondent, Jeffrey P. Bolduan, M.D., that:

1. Imposes the appropriate disciplinary sanction as determined by the Board;

2. Directs the Respondent to immediately pay all costs incurred in the prosecution of this case; and
3. Provides such further relief as the Board deems just and proper in the premises.

Respectfully Submitted,

Jeffrey A. Modisett
Attorney General of Indiana

By: Jean Isaacs Wolf
Jean Isaacs Wolf
Deputy Attorney General

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CERTIFICATE OF SERVICE

I certify that a copy of the attached Complaint has been served upon the party below, Counsel for the Respondent, by United States mail, first class postage prepaid, on this 29th day of December, 1997.

Mark K. Sullivan
TABBERT HAHN EARNEST & STARKEY
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Indianapolis, Indiana 46204

By: Joan Isaacs Wolf
Joan Isaacs Wolf
Deputy Attorney General
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