

Before the
Administrative Hearing Commission
State of Missouri



STATE BOARD OF REGISTRATION)	
FOR THE HEALING ARTS,)	
)	
Petitioner,)	
)	
vs.)	No. 13-1070 HA
)	
HARRY C. EGGLESTON, M.D.,)	
)	
Respondent.)	

DECISION

Harry C. Eggleston, M.D., is subject to discipline because he delegated the administration of anesthesia to inadequately trained personnel; he was negligent in his medical documentation practices and in treating a patient; instruments at his surgery center were not properly rinsed and cleaned; and he misinformed a patient about the outcome of a surgical procedure.

Procedure

On June 17, 2013, the State Board of Registration for the Healing Arts (“the Board”) filed a complaint alleging that Eggleston’s license is subject to discipline. The Board amended its complaint twice. On October 8, 2013, Eggleston filed an answer and a motion to dismiss Count XIV of the Board’s second amended complaint. We denied the motion on October 25, 2013.

Eggleston filed another motion to dismiss, or in the alternative, motion in limine, on April 15, 2014. We denied that motion on April 22, 2014.

We held a hearing on April 28-29, 2014. Glenn Bradford and Rene Ugarte represented the Board, and Gregory P. White represented Eggleston. At the hearing, the Board dismissed Count XIV of the second amended complaint. We issued an order setting a schedule for filing proposed findings of fact, conclusions of law, and written arguments.

Eggleston filed his written argument on September 17, 2014. At the same time, he filed the medical records of patients BM, LW, and DD. He stated that the files had been misplaced when he closed his surgery center, but had recently been found. He asked for leave to review the files to determine whether they contained proper documentation, one of the issues in the Board's complaint. We notified the Board that we construed Eggleston's request as a motion to reopen the record, to which it could respond by January 9, 2015. The Board filed no response to the motion. We grant Eggleston's request to reopen the record and we admit the medical records of patients BM, LW, and DD as exhibits J, K, and L, respectively.

The Board filed the last written argument on October 10, 2014. Simultaneously, it filed a motion to amend the complaint to conform to the evidence by adding a new Count XIV. Eggleston responded to that motion on January 15, 2015. We discuss our ruling on that motion below under the heading, "Count XIV."

Findings of Fact

1. Eggleston has been licensed by the Board as a physician and surgeon since 1972. He practices in the area of ophthalmology.
2. At all times relevant herein, Eggleston owned and operated the Surgical Center of Creve Coeur ("SCCC") in Creve Coeur, Missouri. SCCC, which is now closed, was an ambulatory surgery center.

DHSS Observation of SCCC – June 26, 2012

3. On June 26, 2012, a team of three nurses from the Missouri Department of Health and Senior Services (“DHSS”) observed three surgeries at SCCC.
4. Three patients underwent surgery on that day: BM, LW, and DD.
5. Nurse Karen Maine observed care in the pre- and post-operative areas at SCCC. She interviewed patients and staff members, and reviewed the medical records for BM, LW, and DD.
6. All three patients underwent conscious sedation for their procedures after being administered midazolam, a benzodiazepine, the trade name for which is Versed. Midazolam is a Schedule IV controlled substance. Section 195.017.8(2)(ii).¹
7. JD administered midazolam to BM and DD. JD was an “agency nurse,” one employed by a contract agency that supplied nursing staff to work at SCCC on a temporary basis.
8. June 26, 2012 was JD’s second day to work at SCCC. He was not aware of the location of the crash cart or SCCC’s emergency procedures.
9. SW, another agency nurse working at SCCC that day, administered midazolam to LW.
10. June 26, 2012 was SW’s first day to work at SCCC. She did not receive an orientation, was not familiarized with SCCC’s emergency procedures, and did not know where the oxygen shut-off valve or the crash cart were.
11. JD and SW were supplied by the same contract agency. A consultant for SCCC, Catherine Montgomery, had called the agency on June 25, 2012, to inquire about their credentials. She determined, based on what she was told, that that they were qualified to administer conscious sedation.
12. JD had worked in an emergency room. He was certified in advanced cardiac life support (“ACLS”), and had assessed himself as proficient in administering anesthetic and reversal

¹ Statutory references are to the RSMo Cum. Supp. 2013 unless otherwise indicated.

medications. SW had also worked in an emergency room, was ACLS-certified, and had assessed herself as able to proficiently and independently administer conscious sedation. Both nurses had taken independent study courses in conscious sedation.

13. Nurse Diana Pendleton observed the surgeries inside the operating room.

14. LW received four milligrams of midazolam. A typical patient undergoing conscious sedation receives one to two milligrams.

15. At 7:40 a.m., during LW's surgery, he started to move his feet, hands, and head, to the extent that Eggleston asked the staff to hold his head and hands. Such movement is a sign of inappropriate sedation. Excessive movement after sedation suggests that the patient has either experienced a hypoxic seizure or a paradoxical reaction.

16. A hypoxic seizure is a seizure in response to a lack of oxygen. Medications such as midazolam suppress the respiratory drive. If breathing slows too much, the blood oxygen saturation decreases to the point that a person may have a seizure as a "way of trying to slap itself back awake." Ex. 1 at 23 (Moyes deposition). A hypoxic seizure is a dangerous event.

17. A paradoxical reaction is a loss of bodily control under sedation. It is less dangerous than a hypoxic seizure, although the patient's movements may complicate the surgery.

18. At about 7:47 a.m., Eggleston told SW to give LW a drug to reverse the effect of the midazolam (the "reversal agent" or "reversal medication").

19. SW did not know what drug to give LW. She exited the operating room and asked for reversal medication. She also said she did not have a key to the narcotics box. She went back into the operating room to find out what medication to administer.

20. SCCC's director of nursing, who was inside the operating room, told SW to search her lab jacket pockets for the keys, but SW could not find them.

21. SW then left the operating room again and asked for the assistant director of nursing. The assistant director of nursing said she did not know what medication Eggleston wanted to use as the reversal agent.

22. Eventually, the director of nursing left the operating room and retrieved the reversal medication from the narcotics box. She used her cell phone to look up information about the reversal agent, and placed the cell phone near SW in the operating room.

23. The narcotics box has three separate locks and two or three separate keys. But on June 26, 2012, the keys to the narcotics box were in its key slot, and the narcotics box was unattended for a period of time.

24. Later the director of nursing retrieved the keys from their slot.

25. The reversal medication was administered to LW at 7:57 a.m., ten minutes after Eggleston asked for it, and 17 minutes after LW began moving during the operation.

26. After the surgery, Eggleston told the staff not to give patients so much Versed because it caused patients to “go to sleep” and “rock and roll all over the bed.” Ex. 13 at 25.

27. Pendleton noted that SCCC had three full sets of cataract instruments, and three surgeries were scheduled for that day.

28. Based on her review of SCCC’s sterilization log book, she believed one cataract instrument set had been sterilized on a short cycle identical to the sterilizer’s “flash” cycle.

29. Flash sterilization of instruments is a process by which unwrapped instruments are quickly sterilized. It is not appropriate in most circumstances because it may not fully protect against infection.

30. June 26, 2012, was the instrument technician’s first surgery day to work in that role at SCCC. She had one day of training from the previous instrument technician.

31. Pendleton observed six irrigation cannulas² with black residue on them. The residue wiped off easily with a dry gauze pad.

32. Pendleton observed the instrument technician removing instruments, including the irrigation cannulas, from the sonic cleaner containing an enzymatic solution, then placing them on a dry towel without rinsing them. Staff F then placed them on a sterilization tray and wrapped them with sterilization wrap.

33. The label on the enzyme solution bottle contained instructions to rinse the instruments thoroughly after soaking them. Staff F did not know to do this, and was not instructed to rinse the instruments.

34. Failing to rinse instruments after removing them from an enzyme solution and then subjecting them to heat sterilization may result in a residue of denatured detergent on the instruments.

35. The use of instruments with retained detergent residue may cause Toxic Anterior Segment Syndrome, or TASS, a complication from intraocular surgery that can be very damaging to the eye.

36. On June 26, 2012, Eggleston assessed BM post-operatively with his left, ungloved hand touching the patient's right shoulder. He then walked to the next post-operative area and assessed LW with his left, ungloved hand touching that patient's right shoulder.

37. It is below the standard of care for a physician to not wash his hands or use foaming alcohol after touching one patient and before touching another.

38. Physician adherence to these hand hygiene standards varies from 36% to 62%.

² A cannula is a tube for insertion into a vessel, duct, or cavity. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 282 (30th ed. 2003).

39. The medical files for BM, LW, and DD contain informed consent forms, preoperative assessments, and discharge diagnoses for their June 26, 2012 procedures. They also contain operative reports, but LW's operative report is missing its second page. The first page mentions that LW underwent a vitrectomy on that day.

Care of Patient LB – November 2009

40. Patient LB presented to Eggleston on November 6, 2009,³ complaining of flashing lights and floaters in his right eye.

41. Eggleston examined LB's eye and made notes of his examination. He often used a scribe to make such notes.

42. One page of the notes Eggleston produced to the Board for LB states, for the right eye: "Lots of lattice / perculum @ 11°." Ex. 7 at 93. For the left eye, the note states:

Couldn't see ret tear or RD.
Hgb @12°
Lattice
Hard to see thru has a bad cat
Subj: visual dist.
Lattice degen
Hgb
Horseshoe tear c̄ detach.⁴

Id. The treatment plan indicated on the note was to return in two weeks with a note for "IOC instr. get before work up." *Id.* This page of notes is dated November 6, but contains no patient name.

43. Another page of notes for LB's November 6 visit contains a list of pre-printed conditions. The following are circled for the right eye: flashes/floaters; posterior vit. detach. "Retinal detach" is not circled. A note on that page says "couldn't find hole or tear c̄ [illegible]." *Id.* at 95.

³ All subsequent dates referencing Eggleston's care of LB are in 2009 unless otherwise indicated.

⁴ In this note, we assume that "RD" stands for retinal detachment. "c̄" is a standard medical abbreviation for *cum*, the Latin word for "with."

44. The retina is the inside film of the eye, where the photoreceptors are located. Ex. 1 at 16. An operculum is a small hole in the retina that floats over and above the retina. *Id.* at 14. A horseshoe tear is a torn flap of the retina. *Id.* at 15. The two diagnoses are inconsistent with one another.

45. A horseshoe tear is a medical emergency. Failure to treat a horseshoe tear with detachment emergently may lead to a retinal detachment, in which fluid leaks under the retina from the retinal tear.

46. A retinal detachment that is not treated emergently may lead to permanent loss of vision or even loss of the eye.

47. LB returned to Eggleston on November 20. Eggleston diagnosed him with a horseshoe tear with detachment in his right eye and treated him on that day with argon laser retinopexy, described as “spot welding” and sealing down of the peripheral retina. Ex. 1 at 17.

48. LB returned to Eggleston on November 30. Eggleston again treated the horseshoe tear in his right eye with argon laser retinopexy.

Care of LB – December 2009

49. LB returned to Eggleston again on December 9, this time for cataract surgery in his left eye.

50. Eggleston performed a phacoemulsification, or cataract removal, with an intraocular lens (“IOL”) implant. During the course of the surgery, Eggleston also performed a vitrectomy, which is a complication from cataract surgery that occurs approximately 3% of the time.

51. A vitrectomy is a removal of the vitreous. The vitreous is the “jelly in front of the retina.” Ex. 1 at 27. It has the consistency of egg white.

52. Eggleston’s notes regarding the December 9 surgery on LB indicate that “pt. moved around too much”, and that two people held his arms and legs down. Ex. 7 at 27.

53. The December 9 operative note describes the procedure as:

- 1) Phaco c̄ IOL OS⁵ Block
- 2) Patch

Id.

54. LB returned to Eggleston for follow-up visits on December 10 and 12. On December 12, his vision was poor and it was measured by counting fingers because he could not read the eye chart.

55. LB returned again for follow-up on December 14. During this exam, it was noted that the IOL was dislocated and hanging by a haptic. LB's vision was still poor and evaluated by "counting fingers."

56. An IOL is smaller than the eye's natural lens. It is held in place by small "arms" called haptics.

57. A lens hanging by a haptic is likely to fall into the posterior portion of the eye (behind the iris). A lens that falls posteriorly may fall into the vitreous and cause damage to the retina.

58. Eggleston scheduled LB for another surgery on December 16 in order to recenter the IOL, or remove and replace it.

59. On December 16, Eggleston was unable to remove the first IOL. It fell into the vitreous. Eggleston implanted a new IOL into LB's eye.

60. The December 16 operative note describes the procedure as:

- 1) Recenter IOL OS – Remove c̄
- 2) Replace IOL

Ex. 7 at 32.

⁵ "OS" is an abbreviation *oculus sinister*, or left eye; "OD," for *oculus dexter*, or right eye. DORLAND'S at 1328 and 1300, respectively.

61. LB returned to Eggleston on December 17 for a follow-up exam. LB asked him if he was able to remove the hanging lens. Eggleston told him he had.

62. The note for LB's December 17 visit records the intraocular pressure ("IOP") in his left eye at 0 to 1 and further states: "Pt. has bandage leave IO OS. Did not take IOP. Wound revision OS. OS bandage." Ex. 7 at 106.⁶

63. Normal IOP is 10 to 20. A pressure of zero to one would occur only in an eye with a wound leak, or a dying eye.

64. LB had glaucoma, a condition involving increased IOP that causes pathologic changes in the optic disk and defects in the visual field. DORLAND'S at 776. He had been taking medication to reduce his IOP. Eggleston stopped LB's glaucoma medication and administered a series of saline injections to the eye with a blunt cannula to raise the pressure. He did not document the saline shots.

65. Eggleston saw LB on December 18. On that date, the IOP in his left eye was 2 – 3. By December 21, the pressure in LB's left eye had returned to normal range.

66. All notes pertaining to LB after December 17 state: "follow up IOL recenter & wound revision." Ex. 7 at 33, 34, 35. None mention that the first IOL remained in his eye.

67. LB consulted another ophthalmologist, Howard Short, M.D., on January 4, 2010, for a second opinion. Short told him the dislocated IOL was still in his eye.

68. In the fall of 2010, LB's vision deteriorated. He consulted a third ophthalmologist, who informed him he had macular edema. Macular edema is swelling of the macula, which is the most important part of the retina, the "sharp vision spot" through which people read, recognize faces, and see to drive. Ex. 1 at 99.

⁶ Although this note seems internally contradictory, Eggleston agreed that the IOP in LB's left eye on December 17 was 0 to 1. Tr. 143.

69. After a short course of conservative therapy with topical medications, a vitreoretinal specialist surgically removed the dislocated lens. After that, the edema gradually subsided, and LB's vision gradually improved.

Expert Witnesses

Four expert witnesses testified in this case. We recognize Eggleston himself as an expert under § 490.065, RSMo 2000. Catherine Montgomery, a registered nurse, testified on Eggleston's behalf as an expert in regulatory compliance for ambulatory surgery centers. Howard Short, M.D., an ophthalmologist in Washington, Missouri, testified for Eggleston regarding the care of LB. Andrew Moyes, M.D., an ophthalmologist in Kansas City, Missouri, testified for the Board on the care of LB, Eggleston's practices regarding the delegation of conscious sedation, and Eggleston's medical records.

Evidentiary Rulings

Eggleston's Objections

At the hearing, both parties introduced depositions into evidence. Eggleston provided exhibits with written lists of objections to four of the Board's deposition exhibits. Of those, three are objections to depositions of the DHSS nurses who surveyed SCCC in June 2012. It is unnecessary to rule on many of the objections because the Board does not rely on the testimony at issue. For example, Eggleston's Exhibit B, objections to the deposition testimony of Beverly Rex, contains the following: "Page 40 -- OBJECTION to any testimony about removal of cap with teeth. She didn't see it." The testimony at issue refers to a technician's alleged removal of a cap from a bottle with his teeth, but such an incident does not appear in the Board's complaint or in its proposed findings of fact or conclusions of law. In short, it is irrelevant to this case and there is no reason to rule on that or similar objections. Additionally, certain "objections" in the exhibits are not objections at all, but mere observations. For example, Exhibit C, objections to

the deposition testimony of Diana Pendleton, contains the following: “Page 16 – Wiped off residue with gauze.” No objection or basis for objection is noted.

We do, however, sustain Eggleston’s hearsay objections. Thus, in Exhibit 4, we sustain the objections to Pendleton’s testimony regarding her interview with a scrub tech on page 18, lines 10 to 14, and to her testimony about her interview with the SCCC administrator on page 19, lines 19-13. In exhibit 5, we sustain Eggleston’s objections to Karen Maine’s testimony about her interview with the assistant director of nursing at SCCC.

We note two more specific objections to these depositions. Eggleston objected to Maine’s testimony regarding any violation of state or federal rules and regulations governing ambulatory surgical centers. The basis for his objection is that she identified no such specific state or federal law or regulation, but merely refers to those posted on the Web site CMS.gov. We sustain the objection, but also note that those particular laws and regulations are not relevant to the issues in this case. In his written argument, Eggleston argues that Exhibit 13, the DHSS statement of deficiencies relating to the June 26, 2012 survey, has no probative value because none of the laws or regulations were put into evidence, and there was no evidence that any of them pertained to the conduct of a physician. The issues are defined by the Board’s complaint, which does not pertain to SCCC itself, but to Eggleston’s responsibility for proper medical practice there. The report is relevant as a foundation for Moyes’ testimony, as discussed below, and as evidence of the events of June 26, 2012.

Finally, Eggleston objected to any testimony referencing a prior survey by the DHSS team done in March 2012 as beyond the scope of the pleadings, particularly with reference to an exhibit to Exhibit 3 in this case, Beverly Rex’s deposition. We agree that any violations the team may have observed during the March survey are beyond the scope of the pleadings, and we

sustain the objection to the extent that any testimony discusses violations or observations from that survey.

We discuss Eggleston's objections to the deposition testimony of Moyes, the Board's primary expert, at greater length. There are 37 such objections.

Objections to Moyes' Testimony

1. Page 18 -- 11/6 and 11/20 B-Scan and Fluorescein Angiography outside the scope of pleading. Objection -- Sensory Motor exam outside the scope of pleading. *Sustained.*
2. Pages 19-20 -- Billing outside scope of pleading; laser procedure is conjecture with respect to billing. *Sustained.*
3. Page 22 -- Objection to hearsay evidence of the Board of Ambulatory Care's observation -- doesn't refer to what Moyes is relying on. *Overruled. Moyes is clearly relying on the July 2012 DHSS statement of deficiencies, in evidence as Exhibit 13. Experts are allowed to rely on facts or data reasonably relied on by experts in the field in forming their opinions. Section 490.065; Kivland v. Columbia Orthopaedic Group, LLP, 331 S.W.3d 299, 311 (Mo. banc 2011). They typically rely on hearsay in the form of medical records or other reasonably reliable sources. The DHSS records are an example of such.*
4. Page 22 -- Objection to life threatening testimony. Moyes doesn't say how. *Overruled. Moyes explains this at length in other portions of the deposition.*
5. Page 22 -- Objection to testimony regarding seizures. No evidence that he was having a seizure. *Overruled. Section 334.100.2(5) provides that a physician may be disciplined for conduct that "may" be harmful to a patient. Actual harm is not needed.*
6. Page 22 -- Objection to statements that there were no trained anesthesia/anesthetist care. State was provided all information regarding training of personnel. *Overruled. Eggleston*

furnished no legal basis for this objection. Expert testimony based on a mistake of fact is not inadmissible although it may be accorded little weight.

7. Page 23 -- Objection to testimony relating to hypoxic seizure. No evidence or notes of such by the State or by Eggleston's chart. *Overruled. See comment to 5, above.*

8. Page 27 -- Moyes testimony relating to haptic being treated two days after observed outside standard of care. Object. Does not state on what basis. *Overruled. Moyes testifies that a lens hanging by a haptic is an emergent condition.*

9. Page 29 -- Eggleston put in the wrong power lens. Lines 19 through 24. Objection, doesn't say why it is the wrong power and doesn't state that it is below the standard of care. *Overruled; Eggleston testifies as to both points.*

10. Page 34 -- Moyes testifies that Eggleston never properly determined the correct power of the anterior IOL. Objection to all testimony relating to anterior lens power. Moyes never testifies it is under the standard of care or would cause harm to the patient. *Overruled; see comment to 9.*

11. Page 35 -- LB returned two days later outside the standard of care. Objection. Doesn't say why it is outside the standard of care and conflicts with LB's recollection (page 7 of exhibit to Short deposition). *Overruled. There is a basis in the record for Moyes' testimony here; just because it is inconsistent with another portion of the record does not mean it is inadmissible.*

12. Page 35 -- Moved a lot outside standard of care. Objection doesn't state why. *Overruled. Moyes' testimony throughout the deposition explains the basis for this opinion.*

13. Page 36 -- Patient should be seen 24 to 36 hours later. Objection. Patient was. *Overruled; see comment to 11.*

14. Page 37 -- Objection to testimony relating to injections of saline solution. Doesn't identify type of saline solution, doesn't say it is below standard of care. *Overruled. The type of*

saline solution is irrelevant; the treatment with saline solution is part of the course of treatment of LB and provides context for other aspects of his treatment.

15. Page 42 -- Noted tremor lines 1 through 5. Objection. Not within the scope of the pleadings. *Sustained.*

16. Page 42 -- Objection to testimony relating to improper personnel for anesthesia. State had records that there were qualified personnel. *Overruled; see comment to 6.*

17. Page 45 -- Tremors being a violation of the standard of care. Objection. Not within the scope of the pleadings. *Sustained.*

18. Page 46 -- Objection to lines 12 through 15 regarding endangerment of patients' lives. There were trained personnel there. There is no testimony that anybody was hurt. *Overruled; see comments to 5 and 6.*

19. Page 48 -- Objection to testimony relating to anesthesia being administered by untrained personnel. Lines 18 through 25. Doesn't state why it is below the standard of care. The state was provided documentation that the personnel were properly trained. *Overruled; see comment to 6.*

20. Page 50 -- Lines 7 through 12 -- objection regarding anesthesia by untrained personnel and the qualifications of the training of the staff. *Overruled; see comment to 6.*

21. Page 53 -- Objection to testimony that LB was misinformed. See Eggleston notation of 12/21. *Overruled; see comment to 11.*

22. Page 54 -- objection to lines 9 through 15 relating to swelling and loss of vision. There is no testimony or facts cited by Moyes or notes indicating anything Eggleston did caused [LB]'s eye to swell or lose vision. *Overruled; Moyes expresses the basis for this opinion throughout his deposition.*

23. Page 57 -- Multiple procedures being billed for, Lines 20 through 24. Objection. Testimony is based upon suggestion and this allegation falls outside of the scope of the pleadings. *Sustained.*

24. Page 60 -- Lines 15 - 19. Objection. The representatives from DHSS did not observe the [LB] procedure. *Overruled.*

25. Page 61 -- Objection to testimony relating to sterilization. Moyes admits he is not an expert on sterilization. Lines 21-24. *Sustained.*

26. Page 63 -- Objection to testimony that toxic anterior segment syndrome “can happen” with the use of intraocular instruments. Lines 1 through 7. No evidence that this occurred, mere speculation. *Overruled; see comment to 5.*

27. Page 64 -- Objection to any criticisms of hand washing. *Overruled; no legal basis for objection.*

28. Page 70 -- Objection to any testimony relating to page 2 of the 11/6 operative report of LB. Nowhere is the name “LB” on the page. *Overruled; see comment to 11.*

29. Page 76 -- Objection to any testimony that Moyes renders regarding posterior removal of an intraocular lens. He has removed no lenses through the posterior segment. Lines 18 - 25 and page 77 lines 1-10. *Overruled. Moyes does not testify as an expert about the technique for posterial removal of an IOL, but about the necessity for such.*

30. Page 78 -- Objection to any testimony regarding damage to the eye as a result of a lens remaining in the vitreous: a) Moyes has never removed one posteriorly; b) bases his opinion on common ophthalmic knowledge, lines 19 - 21; c) no meetings were cited, no speeches, no literature. *Overruled; see comment to 29.*

31. Page 83 -- Objection to testimony that macular edema was caused by Eggleston procedure resulting from lens being left in the vitreous. Lines 10 through 25. *Overruled; see comment to 22.*

32. Page 98 -- Objection to testimony of Moyes, lines 18 - 22. Moyes states that Dr. Joseph correlated the causative effect, but does not cite where Dr. Joseph did so. Further, a correlation is not a direct result by definition. *Overruled; see comment to 22.*

33. Page 99 -- Objection to testimony that lens is rubbing on the macula or other places in the retina. Moyes testifies that he has not seen it. Lines 19 - 20. Also refer to Dr. Joseph's notes 000215, "intraocular lens was present in the inferior vitreous space. Haptic stuck in the inferior vitreous space." *Overruled; see comment to 3.*

34. Page 107 -- Objection to any testimony relating to retinal detachment of IOL being left in the posterior vitreous chamber as opposed to removing it. Lines 4 - 9. *Overruled; there is no legal basis for this objection. See also comment to 11.*

35. Pages 107-08 -- Objection to Moyes testimony relating to complications experienced by LB as a result of the lens remaining in the vitreous. Moyes bases his opinions on common ophthalmic knowledge. *Overruled; see comment to 22.*

36. Page 109 -- Lines 1 - 5. Objection. Eggleston did see [LB] the next day and Moyes had the state's records to reflect this. *Overruled; see comment to 11.*

37. Page 120 -- Objection to Moyes being an expert. He is only referred [sic] three posterior IOLs falling into the vitreous fluid. Three does not constitute an individual being an expert. *Overruled; see comment to 22.*

The Board's Objections

We took two other evidentiary issues with the case. At the hearing, Eggleston introduced Exhibit G, a 2014 article from the journal *Cataract & Refractive Surgery*, during his direct

testimony. The Board timely objected on the grounds that experts are not allowed to use scientific literature to bolster their testimony.

The use of such literature is generally prohibited during direct examination of an expert witness because the literature is hearsay. *Kelly v. St. Luke's Hospital of Kansas City*, 826 S.W.2d 391, 396 (Mo. App. W.D. 1992). An exception exists if the witness wrote the article, *Byers v. Cheng*, 238 S.W.3d 717, 729 (Mo. App. E.D. 2007), which is not the case here. Such literature may also be used on cross-examination to test the credibility of a witness. Again, that was not its use in this case. We sustain the objection.

The Board also objected on the basis of relevancy to Exhibit H, a binder provided by Eggleston to DHSS in response to its 2012 investigation of SCCC. Eggleston contends it is relevant to show that the Board had certain documents in its possession that it did not share with Moyes, its expert. But we agree with the Board that the exhibit is not relevant.

The function of this Commission in administrative proceedings is to render the administrative agency's final decision. *State Board of Registration for the Healing Arts v. Trueblood*, 368 S.W.3d 259, 266 (Mo. App. W.D., 2012). We "step into the shoes" of the agency and remake its decision. *Department of Social Services v. Mellas*, 220 S.W.3d 778, 783 (Mo. App. W.D., 2007). Thus, what the Board knew, and when it knew it, and what its expert knew, and when he knew it, are all irrelevant to our decision making in this case. We make our decision based on "the entire record of relevant admitted evidence" at the hearing. *Missouri Real Estate Appraisers Commission v. Funk*, 306 S.W.3d 101, 105 (Mo. App. W.D., 2010).

We sustain the Board's objection to Exhibit H.

Conclusions of Law

We have jurisdiction over this matter. Sections 334.100.2 and 621.045. The Board has the burden to prove, by a preponderance of the evidence, that Eggleston is subject to discipline.

See *Kerwin v. Mo. Dental Bd.*, 375 S.W.3d 219, 229-30 (Mo. App., W.D. 2012) (dental licensing board demonstrates “cause” to discipline by showing preponderance of evidence). A preponderance of the evidence is evidence showing, as a whole, that “the fact to be proved [is] more probable than not.” *Id.* at 230, quoting *State Bd. of Nursing v. Berry*, 32 S.W.3d 638, 642 (Mo.App. W.D., 2000). When evidence conflicts, we must assess the credibility of witnesses, and we have the discretion to believe all, part, or none of a witness’ testimony. *Dorman v. State Bd. of Registration for the Healing Arts*, 62 S.W.3d 446, 455 (Mo. App., W.D., 2001).

The Board contends there is cause to discipline Eggleston under § 334.100, which states in pertinent part:

2. The Board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by this chapter . . . for any one or any combination of the following causes:

* * *

(4) Misconduct, fraud, misrepresentation, dishonesty, unethical conduct or unprofessional conduct in the performance of the functions or duties of any profession licensed or regulated by this chapter, including, but not limited to, the following:

* * *

(d) Delegating professional responsibilities to a person who is not qualified by training, skill, competency, age, experience or licensure to perform such responsibilities;

* * *

(5) Any conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public; or incompetency, gross negligence or repeated negligence in the performance of the functions or duties of any profession licensed or regulated by this chapter. For the purposes of this subdivision, “repeated negligence” means the failure, on more than one occasion, to use that degree of skill and learning ordinarily

used under the same or similar circumstances by the member of the applicant's or licensee's profession;

(6) Violation of, or attempting to violate, directly or indirectly, or assisting or enabling any person to violate, any provision of this chapter or chapter 324, or of any lawful rule or regulation adopted pursuant to this chapter or chapter 324;

* * *

(13) Violation of the drug laws or rules and regulations of this state, including but not limited to any provision of chapter 195, any other state, or the federal government;

* * *

(19) Failure or refusal to properly guard against contagious, infectious or communicable diseases or the spread thereof; maintaining an unsanitary office or performing professional services under unsanitary conditions[.]

The Board also cites § 334.097, which states:

1. Physicians shall maintain an adequate and complete patient record for each patient and may maintain electronic records provided the record-keeping format is capable of being printed for review by the state board of registration for the healing arts. An adequate and complete patient record shall include documentation of the following information:

- (1) Identification of the patient, including name, birthdate, address and telephone number;
- (2) The date or dates the patient was seen;
- (3) The current status of the patient, including the reason for the visit;
- (4) Observation of pertinent physical findings;
- (5) Assessment and clinical impression of diagnosis;
- (6) Plan for care and treatment, or additional consultations or diagnostic testing if necessary. If treatment includes medication, the physician shall include in the patient record the medication and dosage of any medication prescribed, dispensed or administered;
- (7) Any informed consent for office procedures.

2. Patient records remaining under the care, custody and control of the licensee shall be maintained by the licensee of the board, or the licensee's designee, for a minimum of seven years from the date of when last professional service was provided.

3. Any correction, addition or change in any patient record made more than forty-eight hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time and name of the person making the correction, addition or change shall be included, as well as the reason for the correction, addition or change.

* * *

5. The Board shall not initiate disciplinary action pursuant to subsection 2 of section 334.100 against a licensee solely based on a violation of this section. If the board initiates disciplinary action against the licensee for any reason other than a violation of this section, the board may allege violation of this section as an additional cause for discipline pursuant to subdivision (6) of subsection 2 of section 334.100.

The Board also cites 19 CSR 30-1.034, which states in pertinent part:

(1) Physical Security.

(A) Controlled substances listed in Schedules I and II shall be stored in a securely locked, substantially constructed cabinet.

(B) Controlled substances listed in Schedules III, IV and V shall be stored in a securely locked, substantially constructed cabinet. However, pharmacies may disperse these substances throughout the stock of noncontrolled substances in such a manner as to obstruct the theft or diversion of the controlled substances.

Counts I - IV -- Delegation of Responsibility for Conscious Sedation

Three registered nurses from DHSS made an unannounced visit to SCCC on June 26, 2012. Eggleston performed three surgeries on that day. All three patients underwent conscious sedation, administered by two separate agency nurses. Patient LW moved a lot during surgery, to the point that Eggleston instructed SW, the agency nurse who administered his sedation, to get a reversal drug. Neither SW nor the assistant director of nursing at SCCC knew the appropriate reversal drug. The director of nursing used her cell phone to look up the drug and instructions for its use. Then, there was a delay in administering the reversal drug while SW and staff looked for the keys to the narcotics box in which the reversal medication was stored. In all, 17 minutes

elapsed between the time the patient began moving excessively and the administration of the drug, ten of which elapsed after Eggleston asked for the drug. The Board alleges that these events are cause to discipline Eggleston under § 334.100.2(4)(d), as a delegation of duties to unqualified personnel, and § 334.100.2(5), as both negligence and conduct that could have been harmful to patients.

The outlines of what happened that day are not in dispute. But to further support its allegations, the Board relies on the testimony of the DHSS nurses, including their reports of their conversations with the two agency nurses who worked at SCCC that day, JD and SW. The Board argues that JD and SW were improperly trained in conscious sedation and were not oriented at SCCC to its emergency procedures or the location of the oxygen shut-off valve or crash cart.

Eggleston denies these further allegations. His expert Catherine Montgomery testified that she had reviewed the credentials of JD and SW with the contract agency nurse manager prior to their coming to work at SCCC on June 26, 2012. She determined that JD had worked at an emergency room, was certified in ACLS, had assessed himself as being able to administer anesthetic and reversal medications, and had taken a recent home study course in conscious sedation. She determined that SW was also ACLS certified, had taken a course in conscious sedation, had worked in an emergency room, and had self-assessed as being able to proficiently and independently administer conscious sedation. She concluded they were qualified to administer conscious sedation.

We agree that the nurses' credentials seem to be adequate. But § 334.100.2(4)(d) provides cause to discipline a physician who delegates professional responsibility to a person “not qualified by training, skill, competency, age, experience or licensure.” “Training” is the “development of a particular skill or group of skills: instruction in an art, profession, or

occupation.” WEBSTER’S THIRD INTERNATIONAL DICTIONARY 2424 (unabr. 1986). It seems evident that SW was not prepared to handle the situation with LW on June 26, 2012. She did not know what reversal agent to administer to him, she did not know where to find the drug, and then she could not find keys to retrieve the drug once she had determined the appropriate reversal agent to administer. Her lack of preparedness led to a significant delay in administering the agent to LW. We conclude she was not properly trained or instructed to administer conscious sedation at SCCC.

At the hearing, Eggleston defended himself against this allegation by stating that he delegated such staffing matters to others. Such delegation is obviously not improper – it is clearly contemplated by § 334.100.2(4)(d) – but Eggleston is ultimately responsible for what happens to his patients in the operating room. He was the delegator-in-chief; if he hired others to ensure SCCC was adequately staffed, it was his responsibility to ensure that they would hire competent and qualified medical staff, and orient them to SCCC’s procedures and safety protocols. If the staff he employed were not properly oriented, they could not care for SCCC patients safely.

The agency nurses themselves stated that they were not informed of the facility’s emergency procedures or the location of the crash cart. We do not conclude that the nurses themselves were unqualified to administer conscious sedation, but we do conclude that they were not sufficiently oriented to the facility before performing important tasks there. Thus, when they administered conscious sedation to the three patients undergoing surgery on June 26, 2012, Eggleston had delegated professional responsibility to inadequately trained personnel. This is cause for discipline under § 334.100.2(4)(d).

Moyes testified, and we find, that such inappropriate delegation could have been harmful or dangerous to the physical or mental health of the patients undergoing anesthesia. Thus, it is

also cause to discipline Eggleston under § 334.100.2(5). Finally, Moyes testified that it fell below the standard of care.

The Board's complaint, its written argument, and the evidence in this case repeatedly use the term "standard of care," which is not found in § 334.100.2. The Board alleges that Eggleston is subject to discipline under § 334.100.2(5) for repeated negligence, defined therein as "the failure, on more than one occasion, to use that degree of skill and learning ordinarily used under the same or similar circumstances by the member of the applicant's or licensee's profession." Thus, if we find that Eggleston failed to use that degree of skill and learning ordinarily used under the same or similar circumstances by an ophthalmologist on an occasion, we will find that to be an instance of negligence. We further note that several cases that discuss the licensing of medical professionals equate negligence with a deviation from the standard of care. *See Albanna v. State Bd. of Regis'n for the Healing Arts*, 293 S.W.3d 423, 431-32 (Mo. banc 2009 (repeated departures from the standard of care constitute repeated negligence); *Tendai v. State Bd. of Regis'n for the Healing Arts*, 151 S.W.3d 358, 367 (Mo. banc 2005) (*overruled on other grounds by Albanna*) (the first step in determining whether gross negligence exists is to determine the applicable standard of care for ordinary negligence); *Kerwin*, 375 S.W.3d at 226 (same).

We find Moyes' testimony that Eggleston's delegation of conscious sedation to inadequately trained nurses was below the standard of care is credible. Therefore, we also find that it was negligent.

Count V -- Inadequate or Incomplete Patient Records

The Board contends that Eggleston failed to maintain adequate and complete patient records for patients BM, LW, and DD, as required by § 334.097. Specifically, it alleges that their records failed to include a complete operative report, a discharge diagnosis, and complete informed consent. For LW, particularly, the Board alleges that the patient underwent a

vitrectomy that was not recorded in his file. In its written argument, the Board alleges some additional deficiencies—no preoperative assessment by a physician and documented discharge orders or instructions – that we do not address in this decision. *See Missouri Dental Board v. Cohen*, 867 S.W.2d 295, 297 (Mo. App. W.D., 1993) (failure to plead charges in disciplinary complaint against licensee precluded Commission from considering those charges).

As previously discussed, we reopened the record in this case and admitted the medical files of these patients after the hearing was held and the written arguments were filed. Eggleston filed them with the proposed findings of fact and conclusions of law he filed after the hearing. In that document, he stated, “If this Commission will allow leave, the parties can review and address whether the informed consents were properly executed, and the vitrectomy procedure properly noted.” *Resp. Proposed Findings of Fact and Conclusions of Law* at 7-8. The Board did not object to the admission of the medical files. We find that further written argument as to the significance of the records is unnecessary; they speak for themselves.

All the records alleged to be missing from these patients’ files are in fact present in the Exhibits J, K, and L, with the partial exception of LW’s operative record. The operative notes are clearly incomplete, as the page that begins the note ends mid-sentence. In addition, the “surgery center chart auditing” checklist in the file indicates that the operative report needs to be completed. That one page, however, does list a vitrectomy as an additional procedure that was performed.

The lack of a complete operative report in a patient’s chart is clearly a deficiency, and as we discuss later, it may violate the standard of care. But the Board did not allege that under this count. It alleged that the record deficiencies violated § 334.097.1 and were thus cause for discipline under § 334.100.2(6). Section 334.097.1 requires physicians to maintain “an adequate

and complete patient record for each patient.” The statute further sets forth the documentation that an adequate and complete patient record must include:

- (1) Identification of the patient, including name, birthdate, address and telephone number;
- (2) The date or dates the patient was seen;
- (3) The current status of the patient, including the reason for the visit;
- (4) Observation of pertinent physical findings;
- (5) Assessment and clinical impression of diagnosis;
- (6) Plan for care and treatment, or additional consultations or diagnostic testing if necessary. If treatment includes medication, the physician shall include in the patient record the medication and dosage of any medication prescribed, dispensed or administered;
- (7) Any informed consent for office procedures.

This list does not include operative reports or reports of office procedures, although it includes informed consent for such procedures.⁷

Because § 334.097 does not require physicians to maintain operative reports, we find no violation of that statute, and no cause to discipline Eggleston under § 334.100.2(6) for any deficiencies in the medical records of BM, LW, and DD.

Count VI -- Improperly Sterilized Surgical Instruments

The Board alleges that Eggleston failed to ensure that instruments used in surgery were properly sterilized, and that this failure could be harmful to the physical health of a patient or the public, and constituted a failure to properly guard against contagious, infectious, or communicable disease. In particular, it alleges that instruments were “flash sterilized” at SCCC, which is below the standard of care, and that on June 26, 2012, the instrument technician did not rinse surgical instruments after they were cleaned in an enzyme solution, and that Pendleton observed black residue that she could easily wipe off on irrigation cannulas, which are instruments used in cataract surgery.

⁷ We note that operative reports may be required by other laws or regulations such as 19 CSR 30-30.020(1)(F) (medical records for patients in ambulatory surgical centers must be maintained and must include anesthesia records and description of surgical procedures). The Board did not plead a breach of this regulation.

Both experts agreed that flash sterilization for surgical instruments falls below the standard of care. But the evidence is inconclusive as to whether flash sterilization was used on instruments on June 26, 2012. The Board argues, based on the statement of deficiencies prepared by DHSS after its June inspection of SCCC, that the instruments were sterilized on setting #4, which was four minutes of sterilization at 270 degrees followed by one minute of dry time. Although setting #4 was not labeled a “flash cycle”, the sterilization and dry time and temperature were identical to setting #1, which was labeled the “flash” setting. Ex. 13 at 13-14. Montgomery testified, from the manual for the sterilizer, that it had not four, but two cycles, so while she was not at SCCC on the day in question, she did not think the surveyors had proved any instrument was flash sterilized on June 26, 2012. All of this evidence is hearsay, and none of it is particularly persuasive. We find the Board has not carried its burden on this point.

Montgomery also attempted to rebut the Board’s evidence that instruments had black residue on them. She testified that Eggleston had brown autoclave tape on his instruments, and that she believed this was what the surveyor saw instead of black residue. But Pendleton’s testimony on this point was clear: she saw black residue on several instruments that easily wiped off with a dry gauze pad. Such a residue could not be confused with autoclave tape.

Finally, the evidence that the instrument technician did not rinse instruments after removing them from an enzymatic solution is un rebutted. Moyes testified that such instruments that are subsequently heat sterilized will retain a residue of denatured detergent, which may cause TASS, a serious complication that can lead to eye damage and vision loss.

We find the residue left on instruments and the failure to rinse instruments properly are incidents or practices that are or could be harmful to the physical health of a patient. They are cause to discipline Eggleston’s license under § 334.100.2(5). We do not find cause to discipline his license in connection with these incidents or practices under § 334.100.2(19). “Contagious”

means “capable of being transmitted from one individual to another.” DORLAND’S at 412. “Infectious” means “caused by or capable of being communicated by infection.” *Id.* at 929. “Communicable” means “capable of being transmitted from one person or species to another.” *Id.* at 397. All of these adjectives, as applied to disease, signify that the disease must be spread from a person or species to another person or species. Although there is evidence in the record that residue on instruments may cause TASS, there is no evidence that TASS is a contagious, infectious, or communicable disease as defined above.

Count VII -- Hand Hygiene

On June 26, 2012, after performing surgery on patients, Eggleston failed to wash his hands between two patient interactions. He touched BM with his left, ungloved hand, on the patient’s right shoulder. He then walked to the next post-operative area and touched LW with his left, ungloved hand, on that patient’s right shoulder. The Board contends that this conduct falls below the standard of care and is a conduct or practice that is or might be harmful or dangerous to the health of a patient.

Moyes testified that it is below the standard of care for a physician to not wash his hands or use foaming alcohol after touching one patient and before touching another. But he agreed that physicians neglected to do so “daily.” Ex. 1 at 138. He drew a distinction between strict adherence to hand hygiene in the operating room, which should be at 100%, and when seeing patients outside the operating room. Montgomery testified that the rate of hand hygiene adherence by physicians ranged from 36 to 62%. Both agreed that physicians should always wash their hands or use foaming alcohol between touching patients, but that it did not always happen, and Moyes also admitted that the risk of endangerment from such a lapse is low. Based on this testimony, we do not find that one instance of failing to wash hands or disinfect them between touching patients outside the operating room is unreasonably harmful or dangerous to

the health of a patient. Nor can we conclude that Eggleston failed to properly guard against infectious or communicable disease. The incident is not cause for discipline under § 334.100.2(5) or (19).

Count VIII -- Narcotics Box Keys Unattended

The Board alleges there is cause to discipline Eggleston under § 334.100.2(13) because he violated 19 CSR 30-1.034(2), which requires controlled substances to be stored in a securely locked cabinet. Midazolam, a Schedule IV controlled substance, was stored in SCCC's "narcotics box." The Board argues that even though the door was locked, the same key locked both the inside and outside door, and was left unattended in the lock on the outside door of the box.

Eggleston presented evidence from Montgomery that SCCC was compliant with the regulation because the narcotics box had three separate keys. Her testimony on this point was confusing because at one point she stated there were two keys:

Q: There were three different locks?

A.: Correct.

Q: Did two of the locks take the same key?

A: There were two, yes. There were two different keys.

Q: Two different keys but for the three – of the three locks –

A: We had three different keys.

Ex. F at 29.

Whether the narcotics box had two or three separate keys, a security system is only effective if the keys and locks are properly used and attended. Montgomery was not at SCCC on June 26, 2012. Karen Maine, one of the DHSS inspectors, testified that during the episode when nurses were attempting to find a reversal agent for patient LW, she observed the assistant

director of nursing find the keys to the narcotics box unattended in the key slot of the narcotics box. She also observed that five minutes later, the keys to the narcotics box were still in the key slot. Later, the director of nursing removed them, so this may have been a brief episode. Nonetheless, Maine directly observed the keys to the narcotics box in the key slot, unattended, for a period of time long enough for someone to access the box. We find the Board proved a breach of 19 CSR 30-1.034(2), and there is cause to discipline Eggleston under § 334.100.2(13).

Count IX – No Preoperative Physicals for BM, LW, and DD

The Board alleges that Eggleston failed to perform or update the physical examination on BM, LW, and DD prior to operating on them, and that such failure was conduct that could be harmful to the physical health of a patient, and negligent. As evidence, the Board cites Moyes' deposition, in which he stated: "Histories and physicals were not updated on the day. That's pretty typical as we go through and talk to the patient, make sure there's no interval change in their condition." Ex. 1 at 63.

As evidence of the standard of care, this testimony is insufficient. In addition, Moyes based his testimony on the DHSS notice of deficiencies, which also noted that preoperative examinations for these patients were not documented. Ex. 13 at 66. But Exhibits J, K, and L each contain a "pre-op assessment" form for these patients, dated June 26, 2012, and signed and dated by an RN and Eggleston. We find no cause to discipline Eggleston under this count.

Count X -- Care of LB – November 2009

The Board contends that Eggleston's treatment of LB in November 2009 is cause for discipline for several reasons: first, because he failed to treat a detached retina noted on November 6 on an emergency basis; second, because he failed to document his impressions and a treatment plan on November 20; and third, because he failed to document his impressions and a treatment plan in connection with his laser treatment of LB on November 30.

Horseshoe Tear/Detached Retina

A page in the records Eggleston supplied to the Board as part of LB's medical file contains the notation "horseshoe tear c̄ detach" on November 6. Eggleston argues that LB did not have a horseshoe tear on November 6, but that he mistakenly supplied a page of another patient (SM)'s medical record to the Board. It is impossible to know whether he did so. Eggleston points out that LB's name does not appear on the page at issue, although other information consistent with LB's condition does. For example, the page describes LB's left eye as having lots of lattice and an operculum, which Eggleston agrees he had. It also states that LB's left eye had a "bad cat", or cataract, and appears to call for an IOL instrumentation analysis before his next work-up. Again, these are consistent with LB's condition. But the notes on the left eye also state "Horseshoe tear c̄ detach."

Whether or not the medical record belongs to LB, we conclude, for several reasons, that LB did not have a horseshoe tear with detached retina in his left eye on November 6. First, all the physicians who testified in this case, including Eggleston, agreed that a detached retina is a medical emergency that must be treated immediately. When LB presented to Eggleston with a horseshoe tear with detachment on November 20, Eggleston treated him immediately with argon laser retinopexy. It seems unlikely that Eggleston would not have done the same on November 6. Second, another page in LB's record for November 6 states: "couldn't find hole or tear." Third, LB himself reported that on November 6 Eggleston told him he did not find a "torn retina or anything." Ex. 6 at 11. Finally, the horseshoe tear that Eggleston diagnosed and treated on November 20 was in LB's *right* eye. The November 6 note of a "horseshoe tear c̄ detach" is written in the space on the form for the patient's *left* eye. If a horseshoe tear had been present in LB's left eye on November 6, it should have remained in that eye. Perhaps the November 9 medical record at issue did not belong to LB; perhaps it did, and the horseshoe tear notation was

a scrivener's error. We do not know, but a preponderance of the evidence indicates that LB did not have a horseshoe tear or detached retina on that date and that Eggleston did not fail to meet the standard of care in failing to treat it properly.

Inadequate Documentation

The Board also contends that Eggleston failed to document his impressions and a treatment plan for LB on both November 20 and November 30.

Preliminarily, we note that Eggleston's medical records are difficult to decipher. Many pages are repeated, and they are not in chronological order. The notes are typically very brief and the handwriting is often not legible. In addition, the parties placed multiple sets of such records into evidence – Exhibits B, 1, and 7. Therefore, establishing that Eggleston did *not* document something is a difficult task that requires poring through many duplicative pages.

Pages 24-27 and 96-98 of Exhibit 7 document LB's visits with Eggleston on November 20 and 30. They are duplicates and the Board refers to 96-98 in its brief, so we do the same. Page 98, dated November 20, notes that LB visited SCCC on November 6. Below it notes a "large tear" and "early detachment." The "impression," "plan," and "planned procedure" sections are left blank. Page 96, dated November 30, contains the following information under "impression":

RD (partial multi affects)

subj. visual dist.

PSC

HS

[illegible]

"Plan" is left blank, but "planned procedure" says "OD Argon Laser." Operative notes for the November 20 and 30 procedures are present in the record.

These records are obviously scanty. We agree with the Board that the November 20 record lacks a treatment plan. But, though it may not appear in the space provided for “impression,” “large tear” and “early detachment” are clinical impressions.⁸ Thus, the record is deficient under § 334.097.1(6), but not (5). And, spare though it may be, the November 30 record contains both an impression and a planned procedure.

Eggleston is subject to discipline under § 334.100.2(6) for failing to record a treatment plan for LB on November 20, in violation of § 334.097.1(6).

Count XI -- Care of LB, December 2009

The Board argues that Eggleston is subject to discipline for his care of LB during December 2009 for a number of reasons. Three of these do not appear in the Board’s complaint. We cannot find cause to discipline a licensee for reasons not alleged in the licensing agency’s complaint. *See Dental Bd. v. Cohen*, 867 S.W.2d at 297. Therefore, we do not discuss or find discipline for the following allegations: lack of informed consent by LB on December 9 because the consent form inaccurately described the personnel who would administer local anesthesia; failure to document and keep accurate records of LB’s anesthesia on December 9; Eggleston’s decision to leave the displaced IOL in the vitreous of LB’s eye; and Eggleston’s failure to correctly select the appropriate power IOL in the December 16 procedure to replace the displaced IOL.

We discuss the allegations that appear in the Board’s complaint under this count below.

⁸“Impression” is not defined in § 334.097.1 or in the record. Moreover, neither DORLAND’S nor WEBSTER’S contains a pertinent definition. We infer, from the context, that a clinical impression is a physician’s post-assessment opinion of a patient’s diagnosis.

No Operative Report for December 9 and 16 Procedures

There is no detailed operative report for the cataract removal and vitrectomy Eggleston performed on LB on December 9, or of the second surgery Eggleston performed on LB on December 16. The Board alleges this violates § 334.097 and “the applicable standard of care.”

LB’s record contains a one-page form with notes regarding the procedure performed on December 9. The form describes the procedure as “Phaco c̄ IOL OS Block” and “Patch.”

Further notes say:

Pt moved around

Pt moved around too much

2 people holding pt’s legs & arms

Vitrectomy

Miostat

Looked at him with the 78 mm lens and he looked good – HCE

Patch until 5:00 pm then begin [illegible] drops. Will begin Diamox as soon as he gets home.⁹

Although this record is certainly sparse, we cannot say it violates the requirements of § 334.097 because that statute does not specify what an operative report must contain. But Moyes testified that he had never seen an operative record “with this paucity of information and this lack of detailed description of the actual surgical procedure, and I would say that that is outside the standard of care for a major surgery.”¹⁰ Ex. 1 at 20. We find Moyes’ testimony credible and therefore find the medical record violates the standard of care.

⁹ Ex. 7 at 27.

¹⁰ Moyes further described a major surgery as “defined by incision into the eye and going to the operating room.” Tr. 20.

LB's operative record for December 16 is even more sparse. The procedure is described as "Recenter IOL OS – Remove c̄ Replace IOL." It also says "HCE used the maxfield 20 D lens" and "Miostat" and contains additional information about the lens specifications. It then states:

Pt. moved a lot

nylon stitch

patch & shield

Bandaged

Ex 7 at 32. Moyes again described this operative note as "inappropriate" Ex. 1 at 28. As it contains even less information than the December 9 note that we have already found violated the standard of care, we find that the December 16 note also fell short of the standard of care.

Because Eggleston's documentation of the operations he performed on LB on December 9 and 16 fell below the standard of care, we find he was negligent on those occasions.

Failure to Delegate Responsibility for Conscious Sedation to Qualified Person

We discuss this issue under Count XII.

Failure to See Patient the Day after Operation on December 9

LB's initial cataract operation was on December 9. There is no documentation in his medical records indicating that Eggleston saw him for follow-up on December 10. The Board alleges precisely this – that Eggleston failed to *document* such a visit, then, that "failure to examine the patient on the first postoperative day is a violation of the applicable standard of care." *Second Amended Complaint* ¶76.

The distinction between what Eggleston documented and what he did is important here. Eggleston testified that he did see LB the day after his December 9 surgery, and LB stated in his deposition that he saw Eggleston the day after his surgery. Given the state of Eggleston's

medical records, the lack of such a record in his file is by no means conclusive. We conclude that Eggleston did see LB the following day, but either failed to document the visit or lost the record. Such inadequate documentation would violate § 334.097.1, but that is not what the Board alleged under this count. We do not find cause to discipline Eggleston for failure to timely see LB following his December 9 surgery.

Failure to Repair Dislocated IOL Emergently

Eggleston saw LB for follow-up on December 12 and again on December 14. During the latter exam, Eggleston noted that LB's new IOL was dislocated and hanging by a haptic. Eggleston scheduled LB for surgery to try to recenter the IOL on December 14. The Board alleges that the surgery should have been scheduled the next day, and that scheduling it two days later was outside the standard of care.

Moyes' testimony supports the Board's contention. He testified that an IOL hanging by a haptic is a medical emergency because when a lens is dislocated to that extent there is a high likelihood that it will fall posteriorly into the vitreous and cause retinal damage. Eggleston disagreed, but Moyes' testimony is more credible on this point. We find that Eggleston's delay in scheduling LB for surgical repositioning or replacement of the dislocated IOL for two days after he discovered it breached the standard of care.

Misinforming Patient

On December 16, Eggleston was unsuccessful in his attempt to remove the dislocated IOL from LB's eye. The documentation for that procedure reads, "Recenter IOL OS – Remove \bar{c} Replace IOL." On January 4, 2010, LB went to see Short, who informed him that the dislocated IOL was still in his eye. LB stated that Eggleston told him he had removed the dislocated IOL; Eggleston denies that he did.

By a preponderance of the evidence, we determine that Eggleston told LB that he had removed the IOL: first, because Eggleston's notes state that he removed the IOL; second, because LB told both Short and his subsequent treating physician that Eggleston told him that he had removed the IOL, thus sparing him the need to see a retina specialist. It seems unlikely that LB would have possessed the knowledge to fabricate the latter piece of information, which was dependent on knowledge that the type of doctor to perform that procedure would be a retina specialist.

The Board contends that such inaccurate charting and patient miscommunication amount to misconduct, fraud, misrepresentation, dishonesty, unethical conduct or unprofessional conduct. It also alleges that it falls below the standard of care.

Misconduct means "the willful doing of an act with a wrongful intention[;] intentional wrongdoing." *Missouri Bd. for Arch'ts, Prof'l Eng'rs & Land Surv'rs v. Duncan*, No. AR-84-0239 (Mo. Admin. Hearing Comm'n Nov. 15, 1985) at 125, *aff'd*, 744 S.W.2d 524 (Mo. App., E.D. 1988). Misrepresentation is "a falsehood or untruth made with the intent of deceit rather than inadvertent mistake." *Hernandez v. State Bd. of Regis'n for the Healing Arts*, 936 S.W.2d 894, 899 n. 2 (Mo. App., W.D. 1997), quoted in *Kerwin*, 375 S.W.3d at 229. Fraud is an intentional perversion of truth to induce another, in reliance on it. *Id.* It necessarily includes dishonesty, which is a lack of integrity or a disposition to defraud or deceive. WEBSTER'S THIRD INTERNATIONAL DICTIONARY 650 (unabr. 1986).

"Unprofessional conduct" eludes a precise definition. Chapter 334 does not define the term, and this Commission and the courts of this state have struggled to impose standards in applying the phrase. *Perez v. State Bd. of Regis'n for the Healing Arts*, 803 S.W.2d 160, 164 (Mo. App., W.D. 1991) defined unprofessional conduct as "any conduct which by common opinion and fair judgment is determined to be unprofessional or dishonorable." But in *Albanna*

v. State Bd. of Regis'n for the Healing Arts, 293 S.W.3d 423, 431 (Mo. banc 2009), the Missouri Supreme Court criticized the *Perez* definition of unprofessional conduct, calling it “circular,” and stated:

This Court interprets “unprofessional conduct” in this case to refer, first, to the specifications of the matters “including, but not limited to” those 17 grounds specified in as subparagraphs (a)-(q) of section 334.100.2(4) . . . [T]his Court recognizes that significant notice issues would arise if grounds not based in statutory language, (whether in subparagraphs (a)-(q) or somewhere else in the statute), were attempted to be used to provide a basis for a finding of unprofessional conduct.

“Unethical conduct” similarly eludes definition. In some professions that have codified rules of ethics such as attorneys and real estate appraisers, “unethical conduct” is more readily defined. We know of no such authority in the medical profession, however, and the term is defined neither in Chapter 334 nor in case law. “Ethical” means “being in accord with approved standards of behavior or a socially or professionally accepted code: MORAL . . . conforming to professionally endorsed principles and practices[.]” WEBSTER’s at 780.

Applying the above definitions, we find that Eggleston’s actions of falsely telling a patient he had achieved a result after a procedure, and falsely documenting that result, constitute misconduct, misrepresentation, fraud, and dishonesty. We also find, despite our struggle to define the terms, that these actions were unprofessional and unethical. There is cause to discipline Eggleston under § 334.100.2(4). We also find, as Moyes testified in his deposition, that Eggleston’s misinforming LB of the result of the December 16 surgery fell below the standard of care. Thus, this conduct is also cause to discipline Eggleston under § 334.100.2(5).

*Failure to Document or Inform Patient of
Medical Basis for Saline Shots in Eye*

The day after his revision surgery, the intraocular pressure [IOP] in LB’s left eye dropped dangerously low. The note for December 17 records it at 0 to 1 and further states: “Pt. has

bandage leave IO OS. Do not take IOP. Wound revision OS. OS bandage.” Ex. 7 at 106.

Eggleston stopped LB’s glaucoma medication and administered a series of saline injections to the eye with a blunt cannula to raise the pressure. The saline injections were not documented in the medical record. On December 18, LB’s IOP measured 2 -3. By December 21, the pressure in LB’s left eye had returned to normal range.

Eggleston told LB that the very low pressure in his eye was caused by his glaucoma medication, which does indeed lower IOP. But the extremely low pressure, combined with the notation “wound revision,” make it likely that the low pressure was due to a wound leak, as concluded by Moyes.

The Board contends not only that Eggleston failed to document the saline injections, but that he misleadingly told LB that his IOP was low because of his glaucoma medication when in fact it was low because of a leak of the surgical wound. The Board’s evidence for the latter allegation is LB’s deposition in which he testified that Eggleston told him, “Well, I’ve left you on the pills and the, uh, drops too long and lost all the pressure in your eye. So, we’ll have to take you down to surgery and, uh, shoot seven shots of saline solution in your eyeball.” Ex. 6 at 19. But there is no evidence that this is *all* Eggleston told LB. The Board did not carry its burden to show that Eggleston misled LB on this point.

But we agree that the omission of any mention of the saline injections into LB’s left eye to raise its pressure violated § 334.097.1(6) as failure to document a plan for care and treatment of LB’s dangerously low IOP. We further determine that the failure to document the saline injections violated the standard of care, as Moyes testified. There is cause to discipline Eggleston under § 334.100.2(5) and (6).

Count XII -- Conscious Sedation of LB

The Board alleges that Eggleston delegated the administration of LB's conscious sedation to staff that did not have adequate training, skill, or competency in conscious sedation based on the fact that staff did not know which reversal agent to use or how to administer the agent. It also alleges that the fact that Eggleston noted excessive movement during both LB's surgeries meant that LB was improperly sedated and that Eggleston should have made changes to his anesthesia protocol to ensure LB's safety. The Board contends this conduct was negligent and could have been harmful to LB's health.

The record contains no evidence regarding the qualifications of the person who administered conscious sedation to LB, or the training or qualifications of that person. Thus, we cannot find cause to discipline Eggleston under § 334.100.2(4)(d) for any events in connection with LB's sedation.

We have found that excessive movement under sedation is a sign of improper sedation and may be a sign of a dangerous event such as a hypoxic seizure. Eggleston operated on LB twice within one week. Both times LB underwent conscious sedation, and both times he "moved too much." Moyes testified: "If we have a patient having significant movement issues a second time, it's the physician's job to look out for the well-being of his patient and either provide the appropriate anesthesia personnel [or] take this person to another facility where they can be given appropriate anesthesia." Ex. 1 at 35. Eggleston should have taken greater care, particularly with the second operation, not to improperly sedate LB. His failure to do so was conduct that could have been harmful to LB's health, and it was negligent.

Count XIII -- Repeated Negligence

We have found that Eggleston was negligent in several respects, by:

- delegating conscious sedation to agency nurses who were not sufficiently oriented to SCCC or trained in its emergency procedures;
- inadequately documenting the surgical procedures for LB;
- waiting two days to operate on LB's displaced IOL that was hanging by a haptic;
- improperly sedating LB on December 16, 2009;
- failing to document the saline injections to LB's left eye; and
- misinforming LB as to the result of LB's December 16 surgery.

These multiple instances of negligence constitute cause to discipline Eggleston for repeated negligence under § 334.100.2(5).

Count XIV

On October 10, 2014, in lieu of a reply brief, the Board filed a motion to amend its complaint to conform to the evidence under Missouri Supreme Court Civil Rule 55.33, which states:

(b) Amendments to Conform to the Evidence

When issues not raised by the pleadings are tried by express or implied consent of the parties, they shall be treated in all respects as if they had been raised in the pleadings. Such amendment of the pleadings as may be necessary to cause them to conform to the evidence and to raise these issues may be made upon motion of any party at any time, even after judgment[.]

The Board asks us to add a new Count XIV, which states, in pertinent part:

89. At all times material hereto and in particular during surgeries performed by Respondent on patient LB and other patients as referenced in Counts I through XIII, herein, and hereby incorporated herein by reference, Respondent was afflicted with a medically-diagnosed medical and physical condition, to-wit, an essential tremor of his hands, which condition restricted and limited his ability to safely and competently perform microsurgery on the eyes of his patients.

90. Knowingly conducting delicate eye surgeries on patients while afflicted with a tremor was conduct by Respondent that was or

could have been harmful and dangerous to the physical health of a patient or the public and further constituted negligence and repeated negligence.

91. The above constitutes cause to discipline Licensee's license pursuant to § 334.100.2(5) RSMo. 2000.

Eggleston filed a written response in opposition to the Board's motion on January 15, 2015.¹¹

The Board argues that Eggleston failed to object to evidence of the tremor and, except for Moyes' deposition, evidence regarding the danger to patients posed by the tremor. Other witnesses testified without objection about Eggleston's tremor and their concerns about it. Eggleston himself testified about his tremor at the close of the hearing. Eggleston argues that he timely objected and that the issue is related to other issues in the case, so the implied consent rule does not apply.

Both parties rely on *Missouri Dental Board v. Cohen*. In *Cohen*, the Dental Board pled in Count I of its complaint that Cohen was subject to discipline under § 332.321.2(5) and (12), but set forth no specific allegations regarding the alleged conduct that would demonstrate the causes for discipline in those statutes. 867 S.W.2d at 296. The evidence at hearing evidently could have supported the cause to discipline Cohen under the above statutes, and at the close of the hearing, the Dental Board made an oral motion to conform the pleadings to the evidence. *Id.* at 297. Cohen did not object and we granted the motion. *Id.* However, in our decision, we determined that we could not consider whether the demonstrated conduct was cause to discipline because the specific violations were not included in the Board's complaint. *Id.* at 296.

The court of appeals agreed with this conclusion. It found that the three additional charges supporting cause for discipline under Count I were not alleged in the Board's complaint. *Id.* at 297. It was not convinced that Cohen was adequately on notice about the unpleaded

¹¹ Despite the three-month period between the motion and the response, Eggleston's objections were timely filed.

charges. *Id.* Although the court seemingly accepted the applicability of Rule 55.33 to proceedings before this Commission,¹² it found that the Board’s pleadings did not meet the level of specificity required by our regulation governing complaints. *Id.* It also stated:

Implied consent cannot be found where, as here, the evidence which was not objected to was relevant and admissible to other issues in the case. “The implied consent rule applies only where the evidence presented bears solely on the unpleaded issue and not upon issues already in the case.”

Id. (internal citations omitted).

Whether or not Rule 55.33 is applicable to proceedings before this Commission, 1 CSR 15-3.350(2)(A) requires an agency’s complaint to set forth:

3. Any fact supporting the relief that the agency seeks, including any conduct that a licensee has committed that is cause for discipline, with sufficient specificity to enable the licensee to address the charge at hearing; and
4. Any provision of law that allows discipline for such facts.

Regulation 1 CSR 15-3.350(4) further states:

After the respondent serves a responsive pleading, petitioner shall amend the complaint only with the commission’s leave. The motion shall include the amended complaint proposed to be filed. *Petitioner shall not amend the complaint less than twenty (20) days before the hearing without respondent’s consent.*

Emphasis added.

It is true that the record contains substantial evidence establishing that Eggleston has a tremor in his hands and that he was aware of the tremor. Eggleston argues that he objected to the

¹² It is unclear whether the *Cohen* court actually held this, given its simultaneous reliance on our regulation. In general, the Missouri Supreme Court’s rules of civil procedure have no force of law before the Administrative Hearing Commission. *Dillon v. Director of Revenue*, 777 S.W.2d 326, 329 (Mo. App., W.D. 1989); *Dorrell Re-Insulation v. Director of Revenue*, 622 S.W.2d 516, 518 (Mo. App., W.D. 1981). An exception applies if the legislature specifically incorporates them by reference into statutes that apply to this Commission. See *Wheeler v. Board of Police Commissioners of Kansas City*, 918 S.W.2d 800, 803 (Mo. App. W.D., 1996). Section 536.073.2 authorizes us to adopt the Supreme Court discovery rules, which we have done in 1 CSR 15-3.420(1). No such authority applies to Rule 55.33. In addition, the court in *Duncan v. Missouri Bd. for Arch’ts, Prof’l Eng’rs & Land Surv’rs*, 744 S.W.2d 524, 539 (Mo. App., E.D. 1988), on which *Cohen* relied, discussed the doctrine of amendment to conform to the proof as applied to one of our cases, but it did not base its analysis on Rule 55.33.

tremor-related issues during Moyes' deposition, but he did not object to evidence regarding the tremor on a number of other occasions. During opening statements, Eggleston's counsel noted that, "Nowhere in the pleadings is tremors mentioned." Tr. 15. This is not an explicit objection, and given the fact that Eggleston himself addressed his tremor at the end of the hearing, it is hard to consider that he did not waive objections to such evidence. It is also true that even Short, Eggleston's own expert, testified that eye surgeries such as those Eggleston performed required fine hand movements and fine eye-hand coordination, and an eye surgeon who does microsurgery that has an observable tremor in his hands is cause for concern. This evidence was admitted into the record without objection. If the issue were properly pled, we would agree that Eggleston's continued performance of ophthalmologic microsurgery with such a tremor was cause to discipline his license.

But the Board did not plead any facts relating to Eggleston's tremor or that it was an additional cause for discipline. The Board argues the evidence of Eggleston's tremor and the risks and dangers related to it were not relevant or material to any other issue in the pleadings and that the issues were therefore tried by consent. We agree they were not directly relevant to the other allegations in the Board's complaint, but in a more general sense, they were, as the Board repeatedly alleged throughout its complaint that Eggleston's conduct was harmful or dangerous to the health of a patient and cause for discipline under § 334.100.2(5).

We are also concerned about Eggleston's notice, not just that the tremor existed, but that it might be used as a separate cause for discipline. Eggleston testified that he consulted with a neurologist and had been cleared to perform surgery. Tr. 205. It is difficult to imagine that Eggleston would not have used this and other expert testimony about tremors in his defense to a claim that the tremors, in and of themselves, were potentially harmful to patients.

We deny the Board's motion to amend its complaint to conform to the evidence.

Summary

Eggleston is subject to discipline under § 334.100.2(4), (4)(d), (5), (6), and (13).

SO ORDERED on February 6, 2015.

*\s\ Karen A. Winn*_____

KAREN A. WINN

Commissioner