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DEPARTMENT OF HEALTH

STATE OF TENNESSEE
DEPARTMENT OF HEALTH

IN THE MATTER OF:	)	**BEFORE THE BOARD OF**
RALPH M. BARD, M.D.	)	**MEDICAL EXAMINERS**
Respondent	)	
	)	**DOCKET NO: 17.18-053162A**
	)	
License No. 13375	)	
Tullahoma, TN	)	

AGREED ORDER

This matter came to be heard before the Tennessee Board of Medical Examiners, or a duly constituted panel, thereof, on the 21st day of September 2004, pursuant to a Notice of Charges issued against the Respondent. Shirley A. F. Corry, Special Counsel, represented the State. The Respondent was present and represented by Jerry Scott. After consideration of the Notice of Charges, and presentation of counsel, the Board found as follows:

FINDINGS OF FACT

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1. The Respondent has, by his signature on this Order, waived his rights to a contested case hearing and any and all rights to judicial review in this matter.

2. The Respondent further enters into this agreed order in order to resolve this dispute

and neither admits nor denies the specific factual allegations.

3. The Respondent agrees that presentation to and consideration of this Agreed Order by the Board for ratification and all matters divulged during that process shall not constitute unfair disclosure such that the Board or any of its members shall be prejudiced to the extent that requires their disqualification from hearing this matter should this Order not be ratified. Likewise, all matters, admissions and statements disclosed or exchanged during the attempted ratification process shall not be used against the Respondent in any subsequent proceeding unless independently entered into evidence or introduced as admissions.

4. Ralph M. Bard, M.D. (hereinafter 'Respondent') is, and was at all times material hereto, licensed to practice medicine in the State of Tennessee under medical license number 13375.

5. On or about May 17, 2001, the Respondent's hospital privileges were summarily suspended from the medical staff of Harton Regional Medical Center, in Tullahoma, Tennessee.

6. On or about October 15, 2003, the Respondent's hospital privileges were permanently revoked by the Board of Trustees of Harton Regional Medical Center after an appeal hearing.

7. On or about June 9, 1999, "CM", a 43 year old female, was admitted to Harton Regional Medical Center with a complaint of bilateral leg pain, particularly left leg with occlusion of the left iliac artery. "CM's" history included an aortic endartectomy and bypass in 1995.

a. The Respondent placed a Swan-Ganz catheter on June 9, 1999. Patient "CM" was scheduled for left iliac bypass surgery which was performed by Respondent on June 10, 1999.

b. Respondent failed to perform an adequate pre-operative workup and never identified the runoff vessels either at angiography or at the initiation of the operation. The patient hospital records do not include a pre-procedure arteriography.

c. Respondent failed to consider and/or document other options of management for "CM" in that she was far from routine in age, the fact that she had already had a major aortic operation four years previously and she was felt to have a Heparin thrombocytopenia problem.

d. Respondent's selection of a unilateral aorta femoral bypass was an antiquated approach to aorta iliac occlusive disease that has virtually no conceivable application in modern aorta reconstruction. The technique or type of operation used caused failure, in that the second operating surgeon was unable to pass a catheter from the groin through the graft and into the aorta.

e. "CM" was discharged from Harton Regional Medical Center on June 22, 1999 with a follow-up appointment scheduled with Respondent on June 26, 1999.

f. "CM" was readmitted to the hospital via ambulance on June 26, 1999 and was diagnosed with an abdominal aortic occlusion.

g. “CM” expired on June 28, 1999 due to multiple system organ failure.

h. Respondent’s deviation from the standard of care resulted in actual harm to “CM” because the technique or type of operation used caused failure in that the second operating surgeon was unable to pass a catheter from the groin through the graft and into the aorta.

8. On or about January 25, 1995, “AC” a 79 year old female was admitted to Harton Regional Medical Center with a complaint of abdominal pain and vomiting. The Respondent performed a consultative examination on January 27, 1995 and diagnosed Diverticulitis.

a. On January 31, 1995 sometime prior to 5:20 p.m., the Respondent inserted a right #5 French Hahn single lumen catheter for TPN. “AC” developed respiratory insufficiency and a chest x-ray demonstrated a 40% right pneumothorax 1.5 hours after the procedure.

b. Respondent inserted a chest tube and per the nurse’s notes dated January 31, 1995, there was”immediate return of continuous flow of blood upon insertion of the chest tube.”

c. Respondent should have immediately been aware of potential trouble, as one would expect to get air not blood on insertion of a chest tube.

d. The Respondent was notified by the nursing staff of “AC’s” condition and that she continued to bleed.

e. “AC’s” blood pressure plummeted and on February 1, 1995 she expired.

f. The Respondent’s failure to recognize the source of bleeding and institute

appropriate treatment is outside the established standard of care for a general surgeon in the State of Tennessee.

9. "JC", a fifty-four (54) year old female was admitted to Harton Regional Medical Center with a diagnosis of morbid obesity. She was referred to a pulmonogist for an extensive preoperative assessment, but Respondent's medical records neither indicate a recommendation for surgery by the pulmonologist, nor are there any pulmonary function tests noted in the medical records. "JC" had a history of severe COPD.

   a. On 12/23/99, Respondent performed a gastric bypass on patient "JC", and the operative report states " the spleen was removed for visualization".

   b. It is not only inappropriate but a significant departure from accepted surgical principles to remove a normal organ such as a spleen, simply to improve visualization

   c. On December 28, 1999 a gastric graft and swallow were performed. The procedures were considered to be an emergency. The Respondent reviewed the film and findings on 12/28 at 6:10 p.m. Respondent preformed an exploratory laparotomy, resection and repair of gastric ulcer, revision and repair of gastric jejunostomy, insertion of drains and subclavian 7-French Hahn catheter on December 29, 1999 at 1:30 p.m.

   d. The Respondent decided not to perform the operation on December 28 because he didn't think he could mobilize the OR team. He made no attempt to mobilize the team and did not perform the surgery until 1:30 the

next day.

e. "JC" suffered anastomotic breakdown and required a redo operation on 12/29/99, during which there was stated to be a small bowel perforation, but the cause is not cited.

f. During the redo operation the Respondent made a diagnosis of "gastric ulcer with perforation", however, there was no ulcer recognized five days earlier at the time of a very extensive initial procedure on the stomach. A more likely cause of the perforation was devascularization likely related to technical factors.

g. Respondent's technical misadventure was compounded by his malignant neglect of surgical intervention in a timely manner. Respondent waited 18 hours after the diagnosis of an extensive anastomotic leak by the radiologist, to operate on this patient with a documented leak, and dictated in the record that he considered this "good judgement."

h. "JC" was intubated on December 29, January 4 and again on January. A Tracheostomy was scheduled on January 17, 2000, but was not performed until February 1, 2000, one (1) month after the initial intubation. This put "JC" at an unacceptably high risk for tracheal stenosis and represents a gross breach of the established standard of care.

h. "JC" was transferred to Centennial Medical Center on 2/9/00 with an NG tube to decompress her esophagus and on TPN at the request of her family. "JC" expired on 3/6/00.

10. “TA” is a ten (10) year old male admitted to Harton Regional Medical Center through the Emergency Department on 2/22/01 with a complaint of abdominal pain which started the night before.

a. Respondent performed a diagnostic laparoscopy and appendectomy on 2/22/01. The operative report notes “immediately on entering the abdominal cavity a fairly large amount of blood was noted.”

b. A CT scan performed preoperatively did not demonstrate any blood in the abdominal cavity. During the surgical procedure Respondent removed a large amount of blood without identification of the source.

c. The R.N. noted postoperatively that the belly was very distended and the patient developed hypovolemic shock.

d. “TA” continued to bleed and the Respondent ordered fluids which resuscitated the patient, but respondent failed to explore him.

e. On 2/24/01, “TA’ was transferred to Erlanger Medical Center at the request of his parents.

f. “TA” was hospitalized at Erlanger from 2/24/01 through 3/9/01. On 2/28/01 “TA” required additional surgery for right subhepatic abscess, perforated appendiceal stump and retroperitoneal hematoma.

g. The operative finding states, “there was a right subhepatic abscess between the hepatic flexure of the colon, the gallbladder and the liver which had foul-smelling, purulent fluid. The appendiceal stump was 1.3 cm in length and there was a perforation of the stump immediately

adjacent to the staple line. There was a retroperitoneal hematoma extending from the diaphragm to the pelvis and from the right side to the left side at the retroperitoneum. The right retroperitoneal hematoma was fluctuant to palpitation. There was old blood throughout the peritoneal cavity and there was clotted blood within the omentum in the left upper quadrant of the abdomen."

g. Respondent's failure to convert the laparoscopy procedure to an open one to confirm bleeding source, on noticing blood, and failure to perform immediate exploration when it was clear the patient continued to bleed post operation, clearly fall below the required standard of care.

h. Respondent's deviation from the standard of care resulted in actual harm to "TA" because he failed to adequately address the complications related to the appendectomy causing "TA" to require additional surgery and an extended hospital stay.

11. "WD", a 72 year old female first consulted Respondent on 1/31/97, a laparoscopic cholecystectomy, was scheduled for 2/19/97. She underwent this same day procedure as scheduled, but Respondent could not locate her gallbladder, and the patient was assumed to have agenesis of the gallbladder.

a. "WD" suffered continuing blood loss post operatively, but being a Jehovah's Witness refused transfusions.

b. During surgery she was noted to have a gastric outlet obstruction and a fairly extensive procedure was performed to reroute the gastric contents to

the jejunum.

c. Respondent failed to adequately document “WD’s” history which, would have revealed evidence of her severe gastric outlet obstruction which was reportedly found at surgery.

d. Severe gastric outlet obstruction would have provided certain physiological and clinical findings and a preoperative diagnosis with a decision to perform endoscopy prior to surgery may well have obviated the need for surgery at all, thereby sparing the patient the bleeding complications.

e. Respondent’s decision to perform a gastric operation of dubious benefit without consent of “WD” a Jehovah’s Witness who would not accept blood in the event of complications is questionable.

f. Respondent’s decision to intraoperatively oversew the duodenal stump and do a sutured closure of the pylorus rather than to simply perform a gastrojejunostomy is also questionable. A gastrojejunostomy would have been a much less invasive process, accomplish the same ends, i.e. drainage from the stomach into the jejunum and would likely have resulted in less bleeding and fewer complications.

g. Multiple errors in judgment constitute a deviation from the established standard of care. “WD”, at her family’s request was transferred to St Thomas Hospital on 2/24/97. “WD” was diagnosed with a duodenal stump leak and required surgery for the placement of a duodenostomy

tube. Daval and penrose drains. She continued to have complications and expired 3/1/97.

CONCLUSIONS OF LAW

The facts as found in the Finding of Fact in this Order are/would be sufficient to establish violation by the Respondent of the following provisions of the Tennessee Medical Practice Act (T.C.A.§ 63-6-101, et seq.) for which disciplinary action before and by the Board is authorized.

1. Unprofessional, dishonorable, or unethical conduct; T.C.A. § 63-6-214(b) (1);
2. Gross malpractice, or a pattern of continued or repeated malpractice ignorance, negligence or incompetence in the course of medical practice; T.CA. §63-6-214(b) (4).

REASONS FOR DECISION

It is the duty and responsibility of the Tennessee Board of Medical Examiners to provide for the health and safety of the citizens of the State of Tennessee.

Therefore, it is ORDERED as follows:

1. Respondent’s license is suspended for a period of 4 months effective 9/21/04.

2. At the end of 4 months, Respondent's license shall be limited and he shall be restricted from performing surgical procedures of any kind in the State of Tennessee.

3. Respondent shall provide a copy of this Order to the Medical Director of each facility or institution at which Respondent has, or will have, privileges of any kind within ten (10) days of the effective date of this Order.

4. Respondent shall not petition the Board for the lifting of the surgical limitation for 2 years. During this period, Respondent may participate in a mini residency in surgery, but must seek the approval of the Board of Medical Examiners.

5. Respondent shall petition and personally appear before the Board at such time as he seeks to lift the limitation on his license and resume the practice of surgery.

6. Respondent is assessed and shall pay the cost associated with this matter. Payment shall be made pursuant to O.C.R.R.S.T. rule 0880-2-.12(1)(j).

SO ORDERED THIS ________ DAY OF ________________________, 2004 BY THE TENNESSEE BOARD OF MEDICAL EXAMINERS.

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For the Board of Medical Examiners

Approved for entry by:

______________________________ ______________________

Ralph M. Bard, M.D. DATE
RESPONDENT

______________________________ ______________________

Jerry Scott, #2911 DATE
Attorney for Respondent
110 City Center Building
100 East Vine Street
Murfreesboro, TN 37130
(615) 904-1600

______________________________ ______________________

Shirley A. F. Corry #014803 DATE
Special Counsel
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(615) 741-3111

This Order was received for filing in the Office of the Secretary of State, Administrative Procedures Division, and became effective on the_______ day of _________________, 2004.

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Charles C. Sullivan, II, Director
Administrative Procedures Division

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of this document has been served upon all interested parties, or their counsel, by delivering same to their offices or by placing a true and correct copy of same in the United States mail, postage prepaid.

This ___ day of _______________, 2004.

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Special Counsel
Tenn. Dept. of Health