IN THE MATTER OF	*	BEFORE THE STATE BOARD
F. KEEN BLAKER, D.C. LICENSE NO. 01074	*	OF CHIROPRACTIC EXAMINERS
RESPONDENT	*	

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FINDINGS OF FACTS, CONCLUSIONS OF LAW AND ORDER

SYNOPSIS OF CASE

By letter dated May 24, 1995, the State Board of Chiropractic Examiners (the "Board") charged F. Keen Blaker, D.C., the Respondent, with certain violations of the Maryland Chiropractic Act (the "Act") as a result of services rendered to Patient A[1] over a six year period of time--from 1988 to 1994--consisting of five office visits. Specifically, the Respondent was charged with the following violations:

> Subject to the hearing provisions of §3-315 of this subtitle, the Board may deny a license to any applicant, reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the applicant or licensee:
>
> (9) Is professionally, physically or mentally incompetent.

Due to the inability to reach a settlement at the prehearing conference, the Respondent chose to have a hearing, which hearing was held before the Board on August 10 and September 14, 1995. The following Boardmembers, constituting a quorum, participated in the decision: Audie Klingler, D.C., President, who presided at the hearing; Howard Lewis, D.C., Vice President; Florence Blanck, D.C., Secretary-Treasurer; Ivy Logan Harris and David Carey, consumer

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[1] Patients' names are confidential.

members.[2] Also present were Roberta Gill, Assistant Attorney General, Board Counsel, and Kitty Travagline, Administrator. The State's case was presented by Janet Brown, Assistant Attorney General, Administrative Prosecutor. Present throughout the hearing were the Respondent and his counsel.[3]

EXHIBITS

The following exhibits were accepted into the record:

BOARD'S EXHIBITS

Board's Exhibit 1-Charge Letter dated 5/14/95

Board's Exhibit 2-Return Receipt

STATE'S EXHIBITS

State's Exhibit 1-Respondent's medical records and Hopkins medical records on Patient A

State's Exhibit 2-Dr. LaVorgna's C.V.

SYNOPSIS OF WITNESS TESTIMONY

The State first presented Patient A who testified that he first sought treatment from the Respondent in 1988 after he had tested positive for HIV in order to be sure that his "body was in

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[2] Paul Goszkowski, D.C., sat through the hearing but did not participate in the hearing or in the discussion because he had recused himself after representing the Board at the prehearing.

[3] The Respondent's wife sat in the room throughout most of the hearing.

line and everything was where it was supposed to be and functioning properly in order to give [his] system an opportunity to better battle this virus and live a longer and healthier life. Patient A further testified that he next saw the Respondent twice in 1989 because his feet were turning out, but after the Respondent worked on them and they straightened up for a brief while and then turned out again he accepted that that was how his feet were going to be. The next occasion that he sought treatment from the Respondent was on January 28, 1994 when he noticed a tightness in his lower back after training for a body building contest. Patient A stated that as a part of that contest he had been lifting a lot of weight and was unable to stretch out the pain which became increasingly pronounced. Patient A further stated that he noticed that he could not lower his left leg all the way to the floor without having pain. Patient A testified that he made an appointment to see the Respondent who saw him on Friday during the ice storm. Patient A further testified that by this time he could not operate the clutch in his car so he had to have someone drive him over to the office. Patient A testified that he held on to the receptionist's counter, unable to put his left leg down, with it bent at the knee. Patient A further testified that while he was standing there, the Respondent made a comment about shoveling walks, which Patient A adamantly denied doing, indicating that he had not shoveled walks in 20 years. Patient A said that he explained to the Respondent that he might have hurt his back in the gym while working out. Patient A testified that the Respondent told him that he had

slipped a disk and he should go lie down on the table. Transcript ("T") 21-28.

Patient A testified that he laid face down on the table and the Respondent began to manipulate his back, making popping sounds. Patient A indicated that the Respondent then pulled and turned his feet. Patient A testified that he was fully dressed, with L.L. Bean insulated boots, heavy dungarees, a thick rubber neck rugby shirt. Patient A testified that thereafter the Respondent told him that the disk was back in place and that he should go home and pack himself in ice for 72 hours, after which he would be fine. Patient A indicated that he complied with the instructions to pack himself in ice for 72 hours and when he took off the ice packs, he was numb. Patient A further indicated that he drove himself the six blocks between his house and his office to do some paperwork but the pain increased. Patient A testified that he called the Respondent's office and told him the pain was back and he went to see him that next day, February 2. Patient A testified that he was dressed in the same manner as at the previous visit and that the Respondent looked at him, while fully dressed, and said that it was obvious that his shoulders and pelvis were out of line to compensate for the fact that the disk was out of line. Patient A further testified that the Respondent touched his lower back and then spent a long time prodding, pulling yanking and twisting his feet, especially the left leg, after which he told him that everything was back in place and he should be fine in a day or two. Patient A indicated that he was driven to the Respondent's office

on this occasion also because he could not operate the clutch. T 28-34.

Patient A testified that thereafter, he went to his primary physician to get some mild pain pills, explaining that he had just come from the chiropractor's who put his disk back in place. Patient A said that he then went home, and took the pain pills and packed himself in ice again. Patient A indicated that whenever he took the ice off the pain would be worse that before and that the pain got progressively worse, with his knee getting higher in the air. Patient A testified that the pain was so bad that he had a friend call an ambulance to take him to Hopkins hospital where he stayed in the emergency room until he was finally seen by the attending physician who asked him what happened. Patient A explained that he had been to a chiropractor who told him he slipped a disk which the chiropractor put back in place. Patient A said that the attending physician brought in a neurologist who tapped his knee and explained that it was not unusual in the case of a slipped disk to have tremors for a while. Patient A said that the physician prescribed some pain medication to alleviate the tremors and that when he took those, he lost consciousness of his surroundings. Patient A testified that soon thereafter, he had lost total control below his waist and had to be taken to Hopkins, in great pain. Patient A stated that on the second visit to Hopkins the same attending physician asked him who was the chiropractor and what did his xrays show. Patient A further testified that when he told her that he had never been xrayed by

the Respondent or had any tests for his "slipped disk," the physician "went ballistic" and gave him a series of tests. Patient A testified that after the tests, the physician, holding a film, started crying and told him that she was very sorry but he has something in his spine that they have to operate to find out what it is. Patient A further stated that the physician told him that here was no disk problem. T 35-39.

Patient A testified that at none of the five visits that he made to the Respondent's office was his blood pressure tested, his pulse rate taken, his health history asked (after the initial visit), or questions about allergies or his HIV-status, nor were any tests given. Patient A testified that all adjustments were performed while he was fully clothed. T 29-37.

In response to cross, Patient A acknowledged filling out a health history form on his first visit to the Respondent, but denied that the Respondent went over the form with him. Patient A also acknowledged that his first visit was 5/30/89 and he was primarily concerned about his swollen lymph nodes in his neck. Patient A further acknowledged that his second and third visits were 6/19 and 6/25/90, respectively, because his feet were turned out. Patient A realized that due to the manner that he was walking he wore his shoes out quickly and when same were replaced, he had no pain. Patient A stated that his next visits were on 1/28 and 2/2/94 for significant low back pain and that he received some pain medication after the 2/2/94 visit from his primary care provider. Patient A further stated that he was seen at Hopkins on 2/6/94 when

he was given Valiums for his excruciating pain and then was admitted to Hopkins on 2/21/94 where he had surgery. Patient A stated that the chiropractic care had not improved his condition, but had numbed him. Patient A indicated that although he was able to return to work briefly on 2/1/94, he was unable to return to work 2/2 and 2/15. Patient A testified that after his 2/2 visit to the Respondent, he had no further reason to call him, although the pain was increasingly worse, because he believed that the Respondent was not able to fix what was wrong with him. Patient A stated that he did not recall all of the tests that were done by the physicians on his 2/6 visit but he did recall that he was gowned and the doctor touched his back and conducted some tests. T 40-66.

In response to questions by the Board, Patient A denied filling out any further health histories after his first visit of 1989. Patient A indicated in the three weeks between his 1/28 visit to the Respondent and his 2/21 admission to Hopkins, he had lost 40 pounds. Patient A said that the Respondent had never weighed him on any of his visits. Patient A acknowledged that the first time that he saw the Respondent for pain was the visit of 1/28/94 when the Respondent did no reflex, range of motion or straight leg testing. Patient A confirmed that, on that visit, the Respondent diagnosed him in the waiting room. Patient A testified that when surgery was performed on his back, the doctors discovered a rapidly growing tumor between L4 and L5. T 69-86.

The State's next witness was Blaise LaVorgna, D.C., Chair of the Ethics and Peer Review Committee of the Maryland Chiropractic Association, who was qualified as an expert in the practice of chiropractic. During Voir Dire, Mr. Weber questioned Dr. LaVorgna about Directional Non-Force Technique (DNFT) that the Respondent exclusively uses. Dr. LaVorgna explained that DNFT was not a specialty in chiropractic, there being no residency programs, no clinical proficiency exams or separate licenses required. Dr. LaVorgna stated that he uses xrays when appropriate, just as he does blood work, uses MRIs, CT scans and ultrasounds. Dr. LaVorgna further stated that he uses DNFT in his practice but not exclusively. T 97-115.

Dr. LaVorgna explained that the chiropractor's primary objective is to make a diagnosis, which should be done through a multifaceted approach starting with a comprehensive history, a comprehensive examination, and using a variety of different assessments, which vary from chiropractor to chiropractor. Dr. LaVorgna further explained that a comprehensive examination requires taking a history of the main complaint, past history, family history, physical exam to include neurological evaluation, orthopedic evaluation, anatomical evaluation, palpatory and reflex testing. Dr. LaVorgna testified that it is standard in chiropractic to take a health history where the doctor discusses with the patient such things as the main complaint, the onset of the problem, the mode of injury and things that exacerbate the pain, past problems that may contribute to the current problem,

previous surgeries or diseases, and family weaknesses that may contribute to the patient's condition. Dr. LaVorgna opined that with regard to Patient A, the Respondent failed to meet the standards of practice. Dr. LaVorgna testified that, with regard to the patient history form that Patient A filled out on his first visit, a number of pertinent questions were not answered, and others were answered vaguely, such as "occupation: self-employed," which would not reveal whether the patient was a mason or an accountant. Dr. LaVorgna further explained that there was no answer besides "other health conditions," and that "main complaint" was "18 months;" furthermore, besides the question "what do you believe is wrong with you," the response was "we'll discuss personally," but there is not any record of what was discussed. Dr. LaVorgna asserted that it is the chiropractor's responsibility to go over the health history form with the patient and fill in the blanks. Dr. LaVorgna testified that for the two June visits a year later, there was no history of any kind obtained and for the one of 1/28/94, the statement"acute low back pain, left worse" is a fragment of a main complaint but there is "no history, no mode of onset, no provocative positioning." Dr. LaVorgna testified that for the visit of 2/2/94, there was no history at all contained in the patient's file. Dr. LaVorgna testified that one could not make a good diagnosis without taking the health history, and, therefore, to do so was below the standard of care. Dr. LaVorgna opined that it was below the standard of care to initiate chiropractic treatment without taking a health history because one needed all of

the information from performing taking a comprehensive health history, performing a comprehensive exam and doing a chiropractic analysis in order to make a diagnosis. T 116-124, 133-134.

Dr. LaVorgna testified that the standard of care is that the physical exam should include a basic visual analysis with the clothing removed in order to look for skin changes, color changes, scars, and any other clues as to what might be causing the problem. Dr. LaVorgna further testified that a physical exam consists of a variety of orthopedic testing as well as range of motion tests and basic neurological evaluation with sensory, motor and reflexes being essential. Dr. LaVorgna explained that for the chiropractic analysis, the chiropractor can choose which technique, such as DNFT, to use. Dr. LaVorgna testified that it is standard, when performing a physical, to take the vital signs, such as height, weight, blood pressure and temperature. Dr. LaVorgna opined that with regard to the Respondent's physical examinations of Patient A on those five occasions, the Respondent failed to meet the standard of care. Dr. LaVorgna stated "I don't think an adequate physical exam was done or documented. T 125-128.

Dr. LaVorgna opined that it is professional incompetence to fail to perform orthopedic tests. Dr. LaVorgna explained that there were a variety of orthopedic tests that a chiropractor could choose from to make a clinical decision in regard to a patient's complaints, and he described one such test. Dr. LaVorgna testified that Patient A's notes contain no evidence that orthopedic tests were performed by the Respondent and concluded that the Respondent

failed to meet the standard of care. With regard to neurological testing, Dr. LaVorgna testified that it is standard to perform tests which include sensory, motor and reflex testing. Dr. LaVorgna explained the different type of tests. Dr. LaVorgna testified that no physical exam was done in 1989, including orthopedic and neurological testing nor were any done for the subsequent visits. Dr. LaVorgna opined that it is below the standard of care to initiate chiropractic treatment without performing a physical exam. T 128-135.

Dr. LaVorgna testified that it was professional incompetence to fail to diagnose Patient A's non-Hodgkin's lymphoma because chiropractors are trained to look for underlying causes of back pain. Dr. LaVorgna further testified that while failure to diagnose that particular illness was not professionally incompetent, a chiropractor should rule out a tumor as the cause of Patient A's low back pain, which the Respondent failed to do. Dr. LaVorgna explained that chiropractors are taught how to identify various types of tumors and they are also taught how to order proper diagnostic studies, such as MRI, to improve one's diagnostic abilities. Dr. LaVorgna opined that the Respondent's failure to document a diagnosis, history, exam and treatment plan for each of Patient A's visits was also incompetent. In support of his position that the Respondent failed to meet the standard of care, Dr. LaVorgna quoted the idiom that "if it is not documented, it was not done." Dr. LaVorgna pointed out that the Respondent did not explain what he did, how he did it, the areas involved, the areas

treated, or the reflexes worked on. Dr. LaVorgna asserted that documentation should be such that any colleague could understand what was done. Dr. LaVorgna concluded that whenever a chiropractor practice below the minimum standards of care that are accepted in the profession, that individual is practicing in an incompetent manner. T 135-147.

In response to cross, Dr. LaVorgna agreed that simply because one chiropractor treated or manipulated a patient in a manner different than Dr. LaVorgna would do it would not make that chiropractor incompetent. Dr. LaVorgna insisted, however, that a proper visual analysis would have to be done by viewing the skin. Dr. LaVorgna asserted that there were some basic, general, minimally accepted standards of care in the practice of chiropractic, although acknowledging that there were different chiropractic techniques. Dr. LaVorgna testified that if proper procedures were met and the chiropractor came up with a wrong diagnosis or treatment, that was not necessarily negligent, but it the minimal standards of care were not followed and the chiropractor misdiagnosed, then that would be negligence. Dr. LaVorgna pointed out that diagnoses can change, but one must pursue the cause of the complaint if one's care does not relieve the problem initially. Dr. LaVorgna indicated that Patient A's cauda equina (blockage of the spinal canal) syndrome was a result of lack of early intervention and explained that chiropractors can refer for a surgical opinion. Dr. LaVorgna testified that the diagnosis of a mass in the cauda equina syndrome is within the capabilities

of a chiropractor who can reach that diagnosis by ordering a muscle biopsy or tumor biopsy. Dr. LaVorgna further testified that Patient A was worse after the second treatment than he was after the first. Dr. LaVorgna testified that office notes are made in a fashion that other professionals can take over the patient's care, if need be, and they must document what has been found and what has been done in a manner that is clearly understood. T 147-169.

Dr. LaVorgna further testified that records must show the subjective---the nature of the patient's complaint--and the objective--what the findings were. Dr. LaVorgna pointed out that with the sparse notes in the five visits that they could not be records of subjective complaints and objective findings simultaneously: they had to be one or the other. Dr. LaVorgna testified that the failure to properly work up the Patient A on January 28, 1994 delayed his care and the detection of the tumor. Dr. LaVorgna further testified that a positive finding on the straight leg test would indicate nerve irritation, which could involve a tumor or a disk or other things. Dr. LaVorgna testified that the DNFT analysis only tested reflexes and reflex testing was only one part of a neurological examination, which consists of sensory, motor and reflexes. Dr. LaVorgna testified that DNFT is a chiropractic analysis, but not a neurological test because it does not establish patency of nerve roots or cord. T 169-181.

In response to redirect, Dr. LaVorgna indicated that even if the Respondent had performed a complete examination on Patient A on 1/28/94, but did not document it, it would still be necessary to

perform another one on 2/2 because of the sensory or reflex deficits that Patient A was experiencing. Dr. LaVorgna confirmed that a chiropractor was responsible for making a diagnosis. Dr. LaVorgna reiterated that the purpose of the doctor's records is to document the patient's health history that occurred in that office and therefore, they should be complete and legible. Dr. LaVorgna described the various type of sensory tests that a chiropractor can conduct and stated that all of the information that makes up an exam, the visual analysis, range of motion, orthopedic testing, neurological testing, palpatory findings, chiropractic assessment, pertinent x-ray data, history all folds together to made the assessment. Dr. LaVorgna opined that DNFT is a method of chiropractic analysis and treatment but the use of a particular method does not absolve the Respondent from his other responsibilities such as diagnosing and proper work up of patients. T 181-192.

In response to questions from the Board, Dr. LaVorgna indicated that any malpractice insurers for chiropractors provide risk management classes which teach record-keeping. Dr. LaVorgna further indicated that chiropractors were required to obtain continuing credit which was designed to keep them abreast of current developments in health care in their specific and related fields. Dr. LaVorgna affirmed that blood and urinalysis was within the scope of practice of chiropractic and that these were tools to enable chiropractors to be able to make proper diagnoses and to better manage their patients. Dr. LaVorgna reiterated that

although different chiropractic treatments are used, the contents of the exam are the same and are according to a standard. Dr. LaVorgna opined that with regard to the treatment of Patient A on the five visits, the Respondent acted incompetently. T 192-200.

In response to follow-up questions by the State, Dr. LaVorgna explained that his opinion regarding the Respondent's incompetence in connection with Patient A dealt with the fact that neither chiropractic standards of care, proper protocols, proper record-keeping or proper patient management were not done. T 201-04.

In his defense, the Respondent called as his first witness Robert Keehn, an orthopedic surgeon licensed in Maryland, who testified that based on the symptoms presented by Patient A to Hopkins on 2/6, he believed an x-ray was not warranted. Dr. Keehn indicated that Hopkins had diagnosed the problem as a muscle spasm on that day after conducting some tests. Dr. Keehn stated that in his practice, unless a patient presents with a trauma, he doesn't x-ray until there is persistent back pain from four to six weeks, and then it is obligatory. Dr. Keehn criticized the Hopkins' doctors for relying on what the patient told them he had been diagnosed with and treated for and not relying on what they saw, the patient's history, their exam and their xrays. Dr. Keehn stated that he believed that, based on the record, Patient A did not have cauda equina syndrome until 2/15 when he came to the emergency room incontinent. Dr. Keehn further stated that the xrays taken on that date were normal. Dr. Keehn concurred with Dr. LaVorgna that the straight leg test would show some irritation on

the sciatic nerve but would not differentiate between a herniated disk and a tumor. T 206-223.

In response to cross, Dr. Keehn testified that if a 46-year old individual presented with complaints of inability to stand on his leg, Dr. Keehn would determine whether there was a history of trauma, and if he had a working diagnosis of sciatica by the history and by his physical exam and seeing studies that were done with the positive findings of decreased sensation and weakness, he would not think that it was obligatory to get an x-ray; he believed that Patient A received a "fairly adequate examination" at Hopkins on the 6th. T 223-232.

In response to questions from the Board, Dr. Keehn testified that if a patient presented to his office who was unable to heel walk, who had a discrepancy in deep tendon reflexes from one side to the other, was unable to extend the left leg, had sciatic symptoms, he would, at a minimum, do such orthopedic testing as sitting root tests, straight leg raising test, palpation of the lumber area. T 234-239.

In response to follow-up questions from the Prosecutor, Dr. Keehn testified that, even though cauda equina syndrome and sciatic findings can be related, he thought that the tumor, which was causing the pain down Patient A's leg, was finally diagnosed by the MR study and not by the x-ray; Dr. Keehn opined that the cauda equina syndrome diagnosed on the 15th could not be diagnosed on the 6th, based upon the sciatic complaints. T 244.

The Respondent's next witness was R. Tyrell Denniston, D.C.,

who has been a chiropractor for sixty-seven years and practicing in Baltimore since 1942. Dr. Denniston acknowledged that he was a member of several societies, having held office in some of them, and had received several awards. Dr. Denniston related that he had practiced DNFT from 1956 until he retired in 1994. Dr. Denniston that on the few occasions where he has testified in court as an expert, it has been in connection with an injury to a patient. Dr. Denniston further testified that he first had training in DNFT in 1956 at a seminar and for many years attended two or three seminars a year given by Dr. Richard Van Rompf, who was the originator of the technique. Dr. Denniston was unable to state whether any chiropractic school taught DNFT as part of its curricula nor whether it is recognized as a specialized field for diplomat status by the trade associations. Based on Dr. Denniston's responses, and after deliberating outside the presence of the parities, the Board allowed Dr. Denniston to testify as an expert in chiropractic and in DNFT. T 256-64.

In response to direct, Dr. Denniston testified that DNFT was practiced all over the United States, with four chiropractic offices in Baltimore following that method. Dr. Denniston testified that DNFT is a form of straight chiropractic whose objective is to determine where there are nerve pressures and make adjustments to get rid of nerve pressure: one does this by analyzing for any structural misalignment, particularly in the spine, and making adjustments to get rid of whatever interference there might be with the nerve flow. Dr. Denniston explained that

straight chiropractors use no physical therapy modalities. Dr. Denniston further explained that there are two national organizations--the American Chiropractic Association, which emphasizes modalities and diverse, and the International Chiropractic Association, which emphasizes straight chiropractic, subluxation based. Dr. Denniston claimed that straight chiropractors make no diagnoses but analyze. Dr. Denniston explained that a DNFT practitioner contacts different parts along a patient's body, recognizing electromagnetic phenomena within the body, and takes sections of the spine to analyze for positives and negatives. Dr. Denniston continued that

> "on each strike, we check the foot to see if we get a reflex. If there is no reflex, that means there's no nerve pressure at that point. If there is, then we go into more detail to determine the exact positioning of the vertebrae, whether it's anterior, posterior, superior, inferior, whatever."

Dr. Denniston testified that adjustments are based on findings during the analysis and if an adjustment was made and the patient still had a negative listing, it would be a definite indication of other problems; conversely, if improvement was noted the analysis and correction worked. Dr. Denniston explained that DNFT is a neurological test and that a DNFT practitioner does not rely on other types of tests to make an analysis. T 264-269.

Dr. Denniston stated that the first time and each time thereafter that a patient comes to his office, he conducts an analysis. Dr. Denniston testified that he did not conduct an analysis and then plan a course of treatment for a period to time

before he reevaluated a patient but that he post-checked every time he made an adjustment to determine if he accomplished what he wanted to as far as ridding nerve pressure. Dr. Denniston stated that a competent practitioner of DNFT could analyze and correct without disrobing the patient and that is was his understanding that many chiropractors do not have the patients disrobe. Dr. Denniston indicated that subluxations could be corrected with one adjustment. T 264-272.

Dr. Denniston concurred with Doctors LaVorgna and Keehn that an x-ray, MRI or CAT scan was not mandated just because a patient presented with back pain with radiation down one leg and unable to put weight on that leg. Dr. Denniston indicated that he would assume the sciatic nerve was involved. Dr. Denniston concluded from the Respondent's records and Hopkins that improvement was noted following the Respondent's treatment and based upon that, there was no need to refer the patient out after both visits. Dr. Denniston testified that there was no evidence of a tumor as opposed to a simple disc involvement at either the first or second visit. T 272-277.

In response to cross, Dr. Denniston testified that in "chiropractic we are looking for a cause, not dealing with symptoms." Dr. Denniston testified that it is not necessary to examine the skin in the location of the pain. Dr. Denniston further testified that "practitioners of DNFT don"t make diagnoses." Dr. Denniston conceded that diagnoses are, however, given to insurance companies, when requested. Dr. Denniston

admitted that the only neurological tests used by DNFT practitioners was DNFT, and that they never do orthopedic tests. Dr. Denniston acknowledged that he took blood pressures on occasion, but not as a routine part of the examination for every patient. Dr. Denniston testified that DNFT practitioners make a record of patients' complaints. Dr. Denniston testified that he did not do range of motion tests. Dr. Denniston stated that since the Respondent did an adjustment on Patient A, the Respondent must have found nerve pressure. Dr. Denniston stated that the Respondent's notations indicated his findings and where he did his adjustments--that his adjustments equalled his findings. T 277-84.

In response to questions from the Board, Dr. Denniston stated that he was not tested in Maryland on orthopedics, physical diagnosis, or x-ray, but only on anatomy, symptomatology and physiology. Dr. Denniston acknowledged that when he attended Palmer Chiropractic College he had courses on symptomatology of the entire body. Dr. Denniston conceded that he had his patients disrobe and that they were disrobed at Palmer. Dr. Denniston explained that prior to his use of DNFT in 1956, he used to use x-ray for information, but since then he uses the contact system and the body gives information by way of reflex. Dr. Denniston indicated that he based his referrals upon what the patient told him upon presentation. Even though Dr. Denniston read the definition aloud of the "practice chiropractic" from the HOA, which definition included "diagnosis, " Dr. Denniston indicated that "[d]iagnosis is the practice of medicine. It's not chiropractic."

Dr. Denniston testified that he took a patient's history, which was contained in his records. On reviewing the Respondent's records of Patient A, Dr. Denniston stated that he saw a history on the 5/30/89 records, which indicated to him that the patient had lymphoma, pain in the cervical area for a period of 18 months. Dr. Denniston conceded that the records did not indicate whether there was a history of injury or what had caused the pain. Dr. Denniston acknowledged that if a doctor told a patient that he had a slipped disk, that would be making a diagnosis. Dr. Denniston testified that he did not see Patient A's complaints recorded for each visit but thought that the fact that the Respondent made adjustments in certain areas indicated that the patient was complaining of a problem in that region. Dr. Denniston acknowledged that the Respondent's records did not indicate whether he found that a reflex was negative or positive or in what manner he adjusted the patient. Dr. Denniston admitted that his records indicated the manner in which he adjusted whereas the Respondent's did not. T 284-303.

In answer to follow-up questions by the Prosecutor, Dr. Denniston changed his answer from that given to the Board: when queried by the Board, Dr. Denniston stated that a chiropractor can sometimes make a diagnosis based upon the way that the patient is standing; subsequently, Dr. Denniston stated that this could not be done but had to be done by examination. Dr. Denniston acknowledged that the Board did not issue a license in "straight" chiropractic and that to be licensed in Maryland, regardless of what technique

one practices, everyone has to take the same examination. Dr. Denniston testified that if a patient's condition had not changed from the prior visit, he would note in his record "as is," but if it had changed, he would note the changes. T 303-310.

The Respondent was his own last witness and testified that he graduated from Palmer College in 1958 and also attended the Chiropractic Institute of New York for an additional year and a half, graduating in 1968, because the President of the Board did not recognize his Palmer diploma. The Respondent further testified that he became licensed in Maryland in 1968 and has been using the DNFT method since that time, having studied under the originator of the technique. The Respondent stated that he has had no prior complaints or malpractice claims filed against him. T 315-19.

The Respondent testified that the first time he saw Patient A was on 5/30/89 and that he present him with a form which the patient filled out in the waiting room, following which he interviewed Patient A in his office, inquiring why he was there and checking "him out from top to bottom verbally." The Respondent further testified that he did not record the answers if there were no problems. The Respondent also testified that he watches the way that patients walk and the way that they carry their shoulders. The Respondent testified that on that date, he conducted the analysis portion of DNFT and adjusted Patient A. The Respondent confirmed that Patient A returned to his office on 6/19/90 and engaged in the same course of conduct. The Respondent testified that when Patient A came to his office on 1/28/94 he was hurting

quite a bit and had trouble putting weight on his leg. The Respondent further testified that Patient A was able to walk to the office although he did so with difficulty and was limping. The Respondent indicated that Patient A said something to him about he had been working out. The Respondent claimed that he asked Patient A what had he been doing and whether he had any traumas, falls or automobile accidents. The Respondent testified that "...if there's nothing there, if there's nothing substantial, I just don't bother writing it in." The Respondent testified that he performed a DNFT analysis on Patient A that day and found a sacroiliac out of place, a fifth lumbar to the right, the fourth to the left, the third to the right and the second to the left, which he noted in the patient's chart. The Respondent further testified that there was also a disc involvement on the left side at L5,S1 and first thoracic on the right. The Respondent denied telling Patient A that he had a slipped disc and denied that he uses that term, but instead claimed that he uses "disc involvement." T 319-24.

In response to cross, the Respondent admitted that he did not record any history on the visits of 6/19/90, 6/25/90 and 1/28/94. The Respondent claimed that his notation of "right knew involvement," "problems with stomach and spleen," and acute lower back, left side worse," for the above dates was a history as well as a presentation and indicated that a history and presentation could be different. The Respondent admitted that he had not written any case history for any of those dates. The Respondent claimed that he performed a physical examination on Patient A on

1/28/94, using DNFT, but acknowledged that he did not take Patient A's blood pressure, pulse, or temperature. The Respondent claimed that he conducted a range of motion test which he did not list because he had to work Patient A's leg to get it down so that Patient A could get on the table. The Respondent acknowledged that he did not conduct an orthopedic range of motion test and that the only neurological test that he performed was the DNFT analysis. Although the Respondent claimed that the DNFT analysis includes everything that constitutes a neurological test, he indicated that he did not know what was meant by a sensory test and that DNFT did not directly test muscle strength. The Respondent acknowledged that the only test that he conducted was for subluxation, which was a reflex test. The Respondent acknowledged that he was aware that Patient A was HIV positive but that he did not inquire about his current health statues or whether he was receiving treatment from any other providers. T 324-32.

In response to redirect the Respondent indicated that no one from Hopkins had requested his notes. In response to questions from the Board, the Respondent acknowledged that is anyone had requested them, they probably would not have been able to figure out what he wrote. The Respondent explained what some of his abbreviations stood for, such as "R" meant "reactive leg." The Respondent admitted that he did not record that the patient walked with a limp. The Respondent indicated that he uses codes for billing but had no courses in diagnosis, although he was tested in that for his license. The Respondent testified that he only wrote

down responses that are to be worked on or a problem, although these were not recorded in Patient A's notes. The Respondent further testified that the notes that he took for Patient A are typical of the type of notes that he generally takes. The Respondent indicated that he may have told Patient A that he had a disc involvement after he made his DNFT analysis while he was on the table. The Respondent claimed that after the adjustment, Patient A was much improved and remained that when he saw him three or four days later, he was hurting and bent over at the waist but still not as bad as before when he was in excruciating pain. The Respondent indicated that on that February visit, he adjusted Patient A's lower back and shoulder after making an analysis that he had some compression at the sacroiliac articulation and first thoracic. The Respondent explained that he had seven areas of involvement on his first visit but only two on the second; both of the latter were included in the former. The Respondent indicated that he usually advises patients to put ice on for 20 minutes and take it off for 20, until they are symptom-free. On the second visit in 1994, the Respondent stated that he thought that Patient A had re-injured himself and told him to take it easy. The Respondent testified that Patient A limped less when he came for the second visit and that he did not record anything in his records noting the patient's condition, alleged cause of the pain (lifting weights) or improvement. The Respondent indicated that although he has thousands of patients and does not write down these things, he re-evaluates them each time they come in. The Respondent testified

that he did not think that there might be a tumor causing some of the compression when he first saw Patient A. The Respondent stated that he would differentiate between a degenerated disc and a disc bulge by x-rays but that he does not x-ray in his office. The Respondent further stated that he did not give this patient physical therapy. The Respondent stated that he believes that he has taken a course in risk management. T 333-45.

FINDINGS OF FACT

1. The Respondent has been licensed in Maryland since 1968 and has a private practice with his son in Baltimore City.

2. The Respondent uses the Directional Non-Force Technique (DNFT) exclusively to perform his chiropractic analysis prior to adjusting patients.

3. DNFT is a form of the straight chiropractic method which determines subluxations by interference with nerve impulses, as reflected by reflexes.

4. Following a DNFT analysis, the Respondent performed adjustments on Patient A on each of Patient A's five visits:

A. Patient A's first visit was on May 30, 1989 following his discovery that he had tested positive for HIV and wanted to get his body in shape to be better able to fight the disease.

(1) Patient A filled out a health history form that left certain pertinent questions either unanswered or partially answered.

(2) Although the Respondent claims to have asked

questions about Patient A's condition, starting from the head and going to the feet, only "lymphy" and "HIV positive" are recorded on the patient's chart. Although the Respondent claims to have made adjustments on that visit, same are not recorded on Patient A's chart. The Respondent failed to perform a physical examination of Patient A prior to performing an adjustment.

B. Patient A's next visit took place on June 1990 for what Patient A indicated was concern about his feet turning outward.

(1) Although Patient A had not received treatment from the Respondent in over a year, the Respondent failed to inquire into Patient A's health status or treatments received from other providers in that interim.

(2) Without updating the patient's health history or conducting an appropriate physical examination, the Respondent performed an adjustment on Patient A. The Respondent failed to note Patient A's subjective complaints, the Respondent's objective findings, his treatment plain and the prognosis.

C. Patient A's next visit took place on 6/25/90 with Respondent's repeating the same deficiencies of history-taking, examination and record-keeping.

D. Patient A's next visit took place approximately 3 1/2 years later, on January 28, 1994 following a hazardous ice storm.

(1) At that visit, Patient A was experiencing excruciating pain in his lower back and could not lower his left leg. Patient A had to use the reception counter to support himself

and had to be driven to the Respondent's office because he was unable to use the clutch on his car. The Respondent looked at the patient and commented that he must have been injured while shoveling snow and that the injury was to his disk.

(2) Patient A denied shoveling snow, attributing the injury to weight-lifting. Patient A was able to limp to the adjustment room, where the Respondent immediately started pulling on his feet and adjusting his back, using the DNFT method.

(3) Although Patient A had not sought treatment from the Respondent in 3 1/2 years, the Respondent failed to inquire about and record any intervening health history, take Patient A's vital signs, perform any diagnostic tests to rule out or confirm the existence of certain diseases or problems, conduct appropriate examination, adequately record his findings, treatment or prognosis. In addition, even though Patient A and the Respondent both concur that the Respondent told him to put ice on his lower back, which the patient did, the Respondent failed to record that he so instructed Patient A or that he instructed him to put same on for twenty minutes and take it off for twenty minutes until the pain ceased.

(4) Because the Respondent failed to provide written instructions to Patient A, Patient A followed a regimen different from that described by the Respondent in that he kept the ice-packs on for 72 hours, as he believed he was instructed to do by the Respondent, removing same only to use the lavatory.

(5) Patient A was numb from the exposure to the

cold, and, following the three day application of ice, he returned to work where he was only able to work for a few hours before the pain returned and he was forced to go home. Patient A called the Respondent to inform him that the pain had returned and received an appointment for the next day.

E. Patient A's fifth visit with the Respondent took place on 2/4/94 when he again arrived in the Respondent's office with assistance. The Respondent observed that Patient A's limp was not as bad as it was on the 1/28 visit.

(1) The Respondent adjusted Patient A's shoulder and lower back area, some of the same areas adjusted previously.

(2) The Respondent failed to take Patient A's intervening health history, vital signs, perform diagnostic tests, do an appropriate physical examination, adequately record the patient's complaints, his findings, assessment and treatment plan or instructions for follow-up care.

F. The adjustments made by the Respondent on each of Patient A's five visits were done while the patient was fully clothed, with no visual examination and no adjustments made to an exposed area. For the 1/28 and 2/4 visits, the patient had on heavy clothing and thick boots.

5. Subsequent to the 2/4 visit to the Respondent, Patient A went to Hopkins where he had emergency surgery performed on 2/ /94 due to a mass in his spinal column. The tumor was later determined to be non-Hodgkin's lymphoma. Patient A spent many months thereafter in physical therapy, learning to walk again.

6. DNFT is a chiropractic technique. It is a form of straight chiropractic. It is not a specialty recognized by the Board or any international association similar to the conferring of a diplomat status on an individual.

7. To practice chiropractic in the State of Maryland includes the diagnosing of misaligned or dislocated vertebrae. The standard of care in the chiropractic community requires that a comprehensive health history of a new patient be recorded and that the history be updated or supplemented in the patient's chart when the patient has new symptoms, problems, complaints, injuries, illnesses or treatments. The standard of care in the chiropractic community requires that a new patient receive a comprehensive examination which includes vital signs, range of motion, orthopedic and neurological tests, any diagnostic studies, including blood, urinalysis and x-rays, and visualization of the area complained of. The standard of care in the chiropractic community is to clearly indicate in the patient's chart the patient's subjective complaints, the chiropractor's objective findings resulting from the examination, an initial and progressive diagnosis, the treatment provided, a treatment plan and any instructions for follow-up care given to the patient. It is the standard of care in the chiropractic community that patient charts should be updated when supplemental information is obtained and that the chart should be legible. If abbreviations are used, there should be a legend explaining the abbreviations.

CONCLUSIONS OF LAW AND DISCUSSION

The Board concludes, by a majority of the quorum, that in regard to the treatment and examination rendered to and notes taken for Patient A on five separate occasions, the Respondent was professionally incompetent, in violation of §3-313(9) of the Act.

The Board bases its conclusion on the fact that the Respondent failed to obtain a comprehensive health history, perform a comprehensive examination, conduct diagnostic studies, record a diagnosis, the areas treated and the treatment plan for Patient A on any of the five visits. The type of chiropractic technique that a practitioner uses is a clinical decision. The fact that the Respondent chooses to exclusively use the DNFT method is within his professional discretion. Practicing straight chiropractic or being a DNFT practitioner does not above the Respondent from adhering to the standard of care expected of a health chiropractor in the state of Maryland. Although the Respondent acknowledged that he was trained in the correct method of examination and treatment, he abandoned that training. Even the Respondent's own expert witness testified that he (Denniston) examined and manipulated patients while they were gowned and recorded patient's complaints and his treatment. The Respondent's note-taking was so woefully inadequate that Dr. Denniston could not understand the Respondent's use of the term "lymphy."

The Respondent was professionally incompetent in that he failed to obtain a health history, perform an adequate physical examination of Patient A, including the visualization of the skin,

conducting appropriate orthopedic and neurological tests prior to making a diagnosis and initiating chiropractic treatment, and ordering pertinent diagnostic tests. Although the Respondent was not incompetent for failing to diagnose a non-Hodgkin's high grade lymphoma, with proper examination and diagnostic testing, the Respondent could rule out or in what type whether a tumor was creating the pain that Patient A experienced. The Respondent indicated that he has treated thousands of patients and that all of his records are similar to the scanty ones kept on Patient A. By failing to record his findings and instructions to Patient A, the Board must conclude that the Respondent did not, in fact, make any findings before he began his treatment of Patient A. It is professionally incompetent for the Respondent to fail to obtain a health history on Patient A, which would include the patient's account of past, present and familial health problems, allergies, surgeries and injuries. It was equally professionally incompetent to fail to perform a physical examination which includes taking height and weight measurements, evaluating blood pressure, respiration, temperature and pulse rate, inspection of and observation of positive presentation, regional palpation, active and passive range of motion testing, muscle strength and provocative testing to include compression. Appropriate examination would also include a thorough examination which tests reflexes and dermatomes. To reach an adequate diagnosis, the Respondent should take into account the patient's subjective complaints and the objective findings of the exam. Due to the

patient's subjective complaints and symptoms, at a minimum, an x-ray referral should have been made for Patient A when he presented on the 28th of January. Visualization of the skin is important as a proper diagnostic procedure due to temperature, color and spasms. Proper disrobement is important because proper contacts could not be made through thick clothing and boots. Although the Respondent was not professionally incompetent for failing to use ICD codes, he was incompetent in failing to record a diagnosis, as well as failing to document the health history, examinations and treatment plan for the five visits.

The Respondent was professionally incompetent in that he failed to order appropriate diagnostic studies. The Respondent was professionally incompetent for initiating treatment without performing a physical examination. A chiropractor shall maintain a legible, organized and detailed file documenting all data collected pertaining to the patient's health status, examination findings and treatment plans, including personal data on the patient, clinical impression and progress notes. Proper documentation allows other health care practitioners to follow the course of treatment, review the diagnosis and to verify the type of care provided.

ORDER

Based upon the aforegoing Findings of Facts and Conclusions of Law, it is this 8th day of February, 1996 by a majority of the quorum of the Board hereby ORDERED that:

The Respondent's license be SUSPENDED for six months and that

suspension be immediately STAYED; and be it further

ORDERED that the Respondent be placed on PROBATION for two years, subject to the following conditions:

1. During the first six months of probation, the Respondent shall complete by submitting evidence of completion to the Board, 48 hours of evaluation in physical diagnosis, in a course pre-approved by the Board and 24 hours of education in record-keeping in a course pre-approved by the Board;

2. Within the first year of Probation the Respondent shall take and pass the Spec examination given by the National Board of Chiropractic Examiners with a passing grade of 75%.

3. The Respondent shall have his practice monitored by a Board-pre-approved mentor who shall, once a week for the first month, every month for the next five months and then quarterly for the rest of the probationary period, assist the Respondent in setting up a record-keeping system and observe that full examinations of patients take place which are properly recorded. The Respondent is to pay for all costs relating to the mentor. The mentor shall submit a written report to the Board at the conclusion of each of the periods outlined above;

4. The Respondent shall submit his records to a random review by the Board to determine whether the standards of care in record-keeping are being met. And be it further

ORDERED that the Respondent shall practice in a competent manner in accordance with the Act; and be it further

ORDERED that this Order becomes effective on the date that it

is signed by the Board; and be it further

ORDERED that if the Board finds that the Respondent has violated the terms of this Order or substantially violated the Act, or if the Board receives an unfavorable report from the Mentor regarding the Respondent's practice of chiropractic, the Board, following notice and an opportunity for a hearing, shall lift the Stay or institute any further sanctions that may be appropriate; and be it further

ORDERED that two years after the effective date of the commencement of Probation, the Respondent may petition the Board to remove the conditions of Probation; however, if the Respondent's practice is still not in accord with the standards of care or the Respondent has not fully complied with the Order, the Board may extend the probation or may modify the conditions of probation. If the Respondent fails to petition the Board, the conditions of Probation remain as is; and be it further

ORDERED that the Background, Synopsis of Witness Testimony, Findings of Fact, Conclusions of Law and Order may be publicly disclosed pursuant to St. Gov't Article, §10-617(h).

Audie Klingler, D.C., President