

**BEFORE THE BOARD OF CHIROPRACTIC PHYSICIANS**

**STATE OF IDAHO**

In the Matter of the License of:	)	
	)	Case No. CHI-2010-7
LAVERLE E. BRESHEARS, D.C.,	)	
License No. CHIA-428,	)	<b>FINAL ORDER</b>
	)	
Respondent.	)	
_____	)	

THIS MATTER is before the Board pursuant to the March 13, 2014 Amended Complaint ("Amended Complaint") filed by the Chief of the Idaho State Bureau of Occupational Licenses ("Bureau"), the Respondent's July 3, 2013 Answer to Complaint and October 16, 2013 First Amended Answer to Complaint (collectively "Answers"), the August 24, 2014 Recommended Findings of Fact and Conclusions of Law ("Recommended Order") issued by Michael J. Kane, the designated Hearing Officer in this case, and the September 9, 2014 Recommended Order on Reconsideration ("Reconsideration Order") issued by the Hearing Officer.

The matter was considered by the Board at its scheduled meetings on January 30, 2015, February 13, 2015, February 20, 2015, March 13, 2015 and March 24, 2015. The Board, having independently reviewed and considered the Amended Complaint, the Answers, the transcript of the hearing held before the Hearing Officer commencing March 24, 2014 and concluding April 8, 2014, including testimony and other evidence admitted thereat, along with arguments of the parties, the Recommended Order, the Reconsideration Order, the oral argument of the parties before the Board held January 30, 2015, the briefs, motions and other papers filed by Respondent and the Prosecution, the decisions of the Hearing Officer on the motions, and all other matters of record, and good cause appearing therefore, the Board makes its findings and enters the following Order.

THE BOARD HEREBY FINDS AND ORDERS:

1. Jurisdiction. Idaho Code §§ 54-707 and 54-708 empower the Board to administer the Idaho Chiropractic Practice Act ("Act"), codified at title 54, chapter 7, Idaho Code and to regulate the practice of chiropractic in Idaho. The Board's authority and procedures are also governed by the Idaho Administrative Procedure Act, Idaho Code §§ 67-5201, *et seq.*, the Idaho Rules of Administrative Procedure of the Attorney General, IDAPA 04.11.01, *et seq.*, and the statutes and rules establishing the Idaho Bureau of Occupational Licenses which authorize the Board to contract with the Bureau of Occupational Licenses for services, Idaho Code §§ 67-2601, *et seq.*, Idaho Code § 54-4204(6) and IDAPA 24.20.01, *et seq.* As outlined in the Amended Complaint and Recommended Order, Respondent is licensed by the Board to engage in the practice of chiropractic. Respondent's license is subject to the Board's jurisdiction and provisions of the Act. Pursuant to its authority and duty to safeguard the public the Board may impose discipline upon Respondent's license upon finding that Respondent violated the laws or rules governing his license. *See* Idaho Code §§ 54-707, 54-712 and 54-713, and IDAPA 24.03.01, *et seq.*

2. Findings of Fact and Conclusions of Law. Attached hereto as **Exhibit A** is the Recommended Order; attached hereto as **Exhibit B** is the Reconsideration Order. The Recommended Order contains four introductory paragraphs on pages 1 and 2, followed by two sections under the following headings: "Findings of Fact" on pages 2 through 44, and "Conclusion of Law" on pages 44 through 45.

The Findings of Fact section, on pages 2 through 9, includes the Hearing Officer's overview of the case, his decisions concerning alleged due process violations, discussion of the evidence and law, observations on the complexity of the case and on the approach and analysis he used. Beginning on page 9 and continuing through page 44 of the Findings of Fact section, is the Hearing Officer's analysis, individually, of each of the eighteen counts alleged in the Amended Complaint.

The Conclusions of Law section consists of six numbered conclusions, followed by three paragraphs outlining Respondent's rights under the Idaho Administrative

Procedure Act to request reconsideration or take exceptions to the Recommended Order.

a. The four introductory paragraphs of the Recommended Order are incorporated herein and are adopted by the Board. The Findings of Fact section of the Recommended Order is incorporated herein and adopted by the Board, except as modified by the additional findings set forth herein in paragraphs 2.b and 2.c., as the Board's Findings of Fact.

b. Four of the Board's five members are themselves licensed, experienced, active chiropractic physicians, each of whom has been licensed and practiced chiropractic in Idaho for between eleven years and thirty-three years. Board members' careers have also included studying, applying and teaching chiropractic as well as complying with and enforcing the laws and rules applicable to chiropractors licensed to practice in Idaho. The Board finds that the Hearing Officer's interpretations and application of certain legal and ethical requirements which apply to chiropractors in Idaho were in some instances incomplete or incorrect to the extent they conflict with the Board's findings and conclusions herein. Based upon the training, experience and expertise of its members the Board finds there is evidence in the record to sustain more of the violations alleged in the Amended Complaint. Had the Hearing Officer made such findings and conclusions in the Recommended Order, it would have been adopted by the Board with a minimum of revisions. In particular the Board would have likely found violations as alleged in Counts 8, 9 and 11 of the Amended Complaint. With respect to Count 8, the Hearing Officer found that:

The SOAP notes suffer from the same issues as every other record in this case, that is the use of generalities for assessment and no plan but an appointment. They are poor, but the standard of care is not well defined and in any event, the records go back twelve years, prior to the time the standard changed.

Recommended Order, p. 28.

The Board accepts the first sentence, and the first three words of the second sentence, of the above quoted finding of the Hearing Officer. Based upon the reports and testimony of Prosecution's experts and the Board members' own experience and

expertise, the Board finds the standard of care for record keeping in the Treasure Valley, and in Idaho, requires accurate, detailed, legible and appropriately updated patient records. The SOAP format (subjective findings, objective findings, assessment and plan) has been a part of chiropractic training for decades even though some documentation standards have evolved over the years. In this case, however, most of Respondent's records reviewed by the Board fell below currently accepted practice standards and also below the standards applicable to the profession at the time the records were prepared.

Regarding Counts 9 and 11, the Hearing Officer found deficiencies in Respondent's records related to the patient in each count. Yet in each of those counts the Hearing Officer appeared to discount the opinion of the Prosecution's experts, relying primarily on the testimony of Respondent to explain the examination, diagnosis, plan of care and treatments provided, and to answer questions concerning billing. The Board finds that the standard of care requires these matters to be addressed in the patient's records. While Respondent may have provided plausible "after the fact" explanations and answers, the records speak for themselves. Respondent's testimony at the hearing addressed, to the satisfaction of the Hearing Officer, some allegations of abuse, exploitation, and unnecessary or inefficacious treatment. However, to meet the standard of care the documentation should have provided contemporaneous support for Respondent's testimony as to each aspect of his interactions with patients. The Board finds that many of Respondent's records do not meet this standard of care.

With respect to the written record the Board finds that the reports and testimony of the Prosecution's experts defined the standard of care as it applied and evolved over the time period involved in this case. The Board finds that the testimony of Respondent's experts attempting to justify Respondent's conduct based upon distinctions between chiropractic physicians following the American Chiropractic Association ("ACA") philosophical approach, and those following the International Chiropractic Association ("ICA") philosophical approach, had little if any relevance. The Act sets forth the scope of practice for all chiropractic physicians in Idaho. The Board finds that neither the ACA nor the ICA philosophical approach justifies inadequate record keeping, unnecessary or

inefficacious treatment, incompetent or negligent or unethical practice, or any form of abusive or exploitative conduct by a chiropractic physician. The Board also finds that Respondent's additional "late provided" records, which it appears the Hearing Officer used to discount the testimony of the Prosecution's experts, in most instances included very little new or relevant information which had not been reviewed and evaluated by the Prosecution's experts in the process of forming their opinions.

Finally, the Board reviewed a written record. The Hearing Officer observed the witnesses and heard their testimony. The Board commends the Hearing Officer for his handling of a lengthy and complicated case. With the additions and modifications made by the Board herein, the Board accepts the Hearing Officer's findings and conclusions as to the violations that were sustained. The Board reluctantly defers to the Hearing Officer as to violations that were not sustained, particularly as to the three counts discussed above, and subject to the modifications made herein by the Board.

c. The six numbered conclusions in the Conclusions of Law section of the Recommended Order are not adopted as written. The Board's Conclusions of Law are as follows:

i. For the reasons set forth in the Recommended Order as revised by this Final Order, Counts 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, and 17 are dismissed.

ii. Count 1. The Hearing Officer sustained violations of Idaho Code §§ 54-712(13) and (14) in the Findings of Fact and Conclusions of Law as to Count 1 for the reasons set forth in the Recommended Order. The Board accepts the Hearing Officer's Findings of Fact and Conclusions of Law with respect to Count 1. In addition, based upon the Board's independent review of the evidence and its acceptance of the Hearing Officer's Findings of Fact as to Count 1, the Board concludes as a matter of law that Respondent's conduct violated Idaho Code § 54-712(10). The Board finds by clear and convincing evidence that by trying to dissuade V.H. from getting a further evaluation, and by prescribing and selling nutritional supplements to V.H. for the symptoms she presented which Respondent suspected were cancer, Respondent engaged

in conduct which “constitutes an abuse or exploitation of a patient arising out of the trust and confidence placed in [Respondent] by the patient” and her husband in violation of Idaho Code § 54-712(10). *See Recommended Order*, pp. 11-15.

Count 1 is sustained for violation of the following: Idaho Code § 54-712(10) and Idaho Code §§ 54-712(13) and (14) as set forth herein and in the Recommended Order;

iii. Count 2 is sustained for violation of the following: Idaho Code § 54-712(10) as set forth herein and in the Recommended Order;

iv. Count 4 is sustained for violation of the following: Idaho Code § 54-712(10) as set forth herein and in the Recommended Order.

v. Count 14. The Hearing Officer omitted Count 14 in the Conclusions of Law section of the Recommended Order and failed to include a recommendation that it be either sustained or dismissed despite having discussed it in the Findings of Fact. The Board finds the Hearing Officer’s failure to address Count 14 in his Conclusions of Law was inadvertent. Following review of the Hearing Officer’s Findings of Fact with respect to Count 14, at pages 35-38 of the Recommended Order, the Board finds that the Hearing Officer’s findings sustained a violation of Idaho Code § 54-712(13). The Hearing Officer states “I find that this count is sustained in that there is clear and convincing evidence that the spine remodel fell below the standard of care, and even Respondent’s own plan.” *Recommended Order*, p. 37. The Hearing Officer goes on to say “I find the first SOAP note stating the patient was progressing satisfactorily was also below the standard of care to a clear and convincing standard even under the loose record keeping standard of the time.” *Recommended Order*, p. 38.

Based upon the Board’s independent review of the evidence and its acceptance of the Hearing Officer’s Findings of Fact as to Count 14 the Board finds by clear and convincing evidence that a violation of Idaho Code § 54-712(13) is sustained.

Count 14 is sustained for violation of the following: Idaho Code § 54-712(13) as set forth herein and in the Recommended Order.

vi. Count 16 is sustained for violation of the following: Idaho Code §§ 54-712(13) and (14) as set forth herein and in the Recommended Order; and

vii. Count 18 is sustained for violation of the following: Idaho Code §§ 54-712(13) as set forth herein and in the Recommended Order.

d. The Hearing Officer's Reconsideration Order is adopted and incorporated herein by this reference as the findings and conclusions of the Board as to the matters addressed therein. To the extent the Hearing Officer made evidentiary, procedural or other rulings and orders they are part of the record and were reviewed, considered and accepted by the Board in making this Final Order to the extent they are not inconsistent herewith.

3. Violation of Laws and Rules. The Board finds by clear and convincing evidence that Respondent engaged in conduct which was serious, unprofessional and in violation of the statutes and rules governing chiropractic physicians in Idaho. Grounds for discipline exist. The Board may, therefore, impose discipline pursuant to Idaho Code §§ 54-707, 54-712 and 54-713, and IDAPA 24.03.01, *et seq.*

4. Discipline Imposed. Based on its findings and conclusions, the Board imposes discipline upon Respondent and his license as follows:

a. Respondent's license is suspended for a period of sixty (60) days, commencing thirty (30) days after the service date of this Final Order. Thereafter, Respondent's license shall be placed on probation for a period of one (1) year from the date of completion of the suspension.

b. Within one (1) year of the service date of this Final Order, Respondent shall take six (6) hours of continuing education on the subjects of ethics and boundaries, with the courses to be approved in advance by the Board Chair, and present evidence of completion to the Board. The continuing education required by this paragraph 4.b., and any education or tests required by the following paragraphs 4.c. and 4.d., shall be in addition to, and will not be counted toward meeting the annual continuing education requirement applicable to all licensees by the laws and rules of the Board.

c. Within eighteen (18) months of the service date of this Final Order, Respondent shall take and pass all five (5) topic areas of the EBAS Essay Examination, as provided by Ethics and Boundaries Assessment Services, LLC, and have the

examination provider send notification of Respondent's passing the examination directly to the Board. (Information and application for the EBAS Essay Examination can be obtained at: [www.ebas.org](http://www.ebas.org).)

d. Within eighteen (18) months of the service date of this Final Order Respondent shall take and pass the NBCE Part IV Examination administered by the National Board of Chiropractic Examiners, and have the examination provider send notification of Respondent's passing the examination directly to the Board. (Information and application for the NBCE Part IV Examination can be obtained at: [www.nbce.org](http://www.nbce.org).)

e. Respondent shall pay to the Board within six (6) months of the service date of this Final Order a total administrative fine of Two Thousand and No/100 Dollars (\$2,000.00).

f. Respondent shall pay thirty-five percent (35%) of the fees and costs, including attorney fees, incurred by the Board to investigate and prosecute this matter. The amount of the fees and costs that Respondent must pay shall be determined as follows:

i. Within forty-five (45) days from the date of this Final Order, the State, including the Idaho Bureau of Occupational Licenses and the Board's prosecuting attorney must file affidavits, setting forth the fees and costs, including attorney fees, incurred to investigate and prosecute this matter.

ii. If Respondent objects to the fees and/or costs, including attorney fees, claimed by the State, then Respondent may, within seventy-five (75) days from the service date of this Final Order, file a written objection to those fees and/or costs, including attorney fees, and, if Respondent desires, a written request for a hearing on the objection. If Respondent files a timely objection to the State's claimed fees and/or costs, including attorney fees, then the Board will consider Respondent's objection in determining the amount of fees and/or costs, including attorney fees, that Respondent must pay and enter an order identifying the amount to be paid and the date by which payment shall be made.

iii. If Respondent fails to file a timely objection to the fees and/or



costs, including attorney fees, claimed by the State, then the Respondent will have waived Respondent's ability to object, and Respondent must pay thirty-five percent (35%) of the total fee and cost amount, including attorney fees, set forth in the State's affidavits within six (6) months from the service date of this Final Order.

g. The Board hereby ORDERS that Eighteen (18) months from the date of this Final Order Respondent's license is suspended until Respondent provides to the Board satisfactory evidence that:

i. Respondent has fulfilled every requirement of this paragraph 4 of the Final Order; and

ii. Respondent is in compliance with the requirements of the laws and rules of the Board applicable at that time for current licensure.

h. Upon finding that Respondent has complied with and fulfilled all requirements of this Final Order the Board will terminate the suspension of Respondent's license.

i. The Board retains jurisdiction over this proceeding until all terms of this Final Order have been complied with, all amounts have been paid and all matters are finally resolved as set forth herein.

j. All costs and expenses associated with compliance with the terms of this Final Order are the sole responsibility of Respondent.

5. Due Process. This is a Final Order of the Board. Accordingly, Due Process Rights apply as follows:

a. Any party may file a motion for reconsideration of this Final Order within fourteen (14) days of the service date of this order. The Board will dispose of the petition for reconsideration within twenty-one (21) days of its receipt, or the petition will be considered denied by operation of law. *See Idaho Code § 67-5246(4)*.

b. Pursuant to Idaho Code §§ 67-5270 and 67-5272, any party aggrieved by this Final Order or orders previously issued in this case may appeal this Final Order and all previously issued orders in this case to district court by filing a petition in the district court of the county in which: (i) a hearing was held; (ii) the final

agency action was taken; (iii) the party seeking review of the order resides, or operates its principal place of business in Idaho; or (iv) the real property or personal property, if any, that was the subject of the agency action is located.

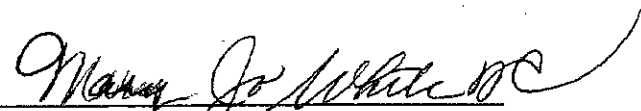
c. Any appeal must be filed within twenty-eight (28) days of: (i) the service date of this Final Order; (ii) the service date of an order denying a petition for reconsideration; or (iii) the failure within twenty-one (21) days to grant or deny a petition for reconsideration, whichever is later. See Idaho Code § 67-5273. The filing of an appeal to district court does not itself stay the effectiveness or enforcement of the order under appeal.

6. The Bureau Chief of the Bureau of Occupational Licenses shall cause a true and correct copy of this Final Order to be served upon Respondent's and the State's attorneys by mailing a copy to them at their respective addresses, as provided.

Dated this 24 day of March, 2015.

Idaho State Board of Chiropractic Physicians

By

  
Mary Jo White, D.C., Chair

### CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 24<sup>th</sup> day of March, 2015, I caused a true and correct copy of the foregoing to be served by the following method to:

Lawrence E. Kirkendall  
ARMSTRONG & KIRKENDALL, CHTD.  
2316 N. Cole Road., Suite F  
Boise, Idaho 83704  
*Attorney for Respondent*

- ☒ U.S. Mail
- ☐ Hand Delivery
- ☐ Certified Mail, Return Receipt Requested
- ☐ Overnight Mail
- ☐ Facsimile: \_\_\_\_\_

Jean R. Uranga  
URANGA & URANGA  
714 N. 5<sup>th</sup> Street  
P.O. Box 1678  
Boise, ID 83701  
*Board Prosecutor*

- ☒ U.S. Mail
- ☐ Hand Delivery
- ☐ Certified Mail, Return Receipt Requested
- ☐ Overnight Mail
- ☐ Facsimile: \_\_\_\_\_

  
Tana Cory, Bureau Chief

**MICHAEL J. KANE**

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Idaho State Bar No. 2652

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AUG 26 2014

OCCUPATIONAL LICENSES

HEARING OFFICER

BEFORE THE IDAHO STATE BOARD OF CHIROPRACTIC PHYSICIANS

In the Matter of:

LAVERLE E. BRESHEARS, D.C.,

License No. CHIA-428,

Respondent,

Case No. CHI-2010-7

RECOMMENDED FINDINGS  
OF FACT AND CONCLUSIONS  
OF LAW

The above-entitled matter came on for hearing on March 24, 2014, and continued through April 8, 2014. The IDAHO STATE BOARD OF CHIROPRACTIC PHYSICIANS ("Board") was represented by Jean R. Uranga. The Respondent, LAVERLE E. BRESHEARS, D.C., ("Dr. Breshears"), was represented by Lawrence E. Kirkendall. The transcript of the proceedings contains twelve volumes, running to 2,900 pages.

The Board presented oral testimony of two (2) expert witnesses and several lay witnesses, hundreds of pages of printed exhibits, plus x-rays, charts and photographs. Dr. Breshears presented the testimony of two expert witnesses, former employees (including a chiropractor),

and testified at length on his own behalf. Dr. Breshears presented hundreds of pages of exhibits, x-rays, charts and photographs.

At the close of the hearing, each party was granted leave to file written closing arguments, the last of which was filed on July 21, 2014.

Upon review of the pleadings filed in this matter, the transcript of the hearing, the exhibits, and the arguments of both counsel, the following recommended Findings of Fact and Conclusions of Law are entered.

### **FINDINGS OF FACT**

Dr. Breshears is the holder of an Idaho license to practice chiropractic medicine, license number CHIA-428, issued by the Idaho State Board of Chiropractic Physicians.

Dr. Breshears practices chiropractic medicine in Boise, Idaho, and has done so for approximately three decades. The allegations against Dr. Breshears are many, and are alleged to have occurred over a period of at least ten years, beginning in some cases as far back as 2002. Because of the way each count in the complaint stated the allegations, and because several statutes and rules were cited as having been violated in each count, the Respondent has alleged that his constitutional rights have been violated, particularly as to alleged lack of notice and the potential vagueness of some of the words in the statutes or rules. The issue was dealt with in pre-hearing proceedings, but leave was granted to re-allege lack of notice should it be demonstrated at hearing that Dr. Breshears had not been adequately advised of the facts or law he was defending against. In the event, Dr. Breshears mounted a painstaking defense, covering each potential aspect of each statute and rule as applied to each count, and I cannot find that he was without notice of the nature or extent of the charges brought by the Board. Similarly, I cannot find that the words complained about in the statutes or rules are unduly vague. For those reasons, the previous Order Denying

Respondent's Motion to Dismiss, filed March 20, 2014, will be adopted as part of this recommended order.

Because Dr. Breshears raises the issue of notice, I am constrained to make the following observation. Many of the counts in the Amended Complaint contained an allegation to the effect that Respondent embarked on a treatment plan without a proper demonstration of what the plan would be and what the patient consented to. This allegation was deduced from the records provided to the Board and its reviewing experts by the Respondent, and singularly lacking was any record in many cases of a plan or consent documents. Well into the hearing, Respondent produced further records which demonstrated that the physical examinations of the patients alluded to in the Amended Complaint had indeed taken place and consent documents had been taken. These records were apparently held outside of the patient charts and files, and Respondent apparently did not think to look for them until the hearing was well underway, and then only at the direction of the undersigned. Board counsel did not object to the eleventh hour production of these records, taking the ethical view that truth should exalt over evidentiary and administrative barriers to the search for that truth. As will be seen, unless otherwise noted below, that portion of any count that alleges a lack of plan or consent will be dismissed as unfounded, as it can now be demonstrated that there was consent to a plan in most cases. I can only express dismay at the time, effort and public money that was wasted as a result of Respondent's lack of attention to detail. This is particularly so because Respondent had earlier engaged in late disclosure by producing highly pertinent documents to the Board after the reviewing experts had reviewed the file and rendered opinions.

Before beginning an analysis of the counts, several points should be made by way of clarification. The first point is that many of the counts in the Amended Complaint were based solely upon a review of the patient records produced by the Respondent. Standing alone, those

records were often deemed by the reviewer as less than adequate. For example, a continuing phrase found scores of times in the "Assessment" portion of the records is: "The patient is progressing satisfactorily." This would usually be the sum and substance of the Assessment portion of the record. The Board's experts make the compelling point that this phrase can mean anything, and certainly would convey nothing to a follow-up chiropractor. This is especially true where the patient was expressing discomfort at the time of the examination or adjustment, yet no mention was made about whether the discomfort was relieved, or even addressed. Respondent rejoins that progressing satisfactorily means that the patient is not going "backwards" or deteriorating. Similarly, the reviewers identified scores of examples where the "Plan" portion of the record would only read: "Patient should return in two [or three] days." This is not a chiropractic plan. It is an appointment. Even one of Respondent's experts (and personal friend) was constrained to admit that the Respondent's record keeping was less than optimal, although "adequate." It is transparent that Respondent's style of note taking was to do the bare minimum amount of work required, and as a result in many ways is the true architect of this highly complex proceeding.

The Board's point is that the records did not justify the treatment rendered. At the hearing, there was much unrefuted oral evidence by Respondent to the effect that one had to look at more than the SOAP notes [Subjective, Objective, Assessment, Plan] to discern the reasons for his treatment of the various patients. The x-rays, the thermographs, the EMGs, the physical examination records and the patient histories and sundry other documents such as insurance forms, and handwritten notes, the argument went, filled in the gaps and justified the treatment of the patients. As will be seen, it cannot be said that in many cases there is clear and convincing evidence that the Respondent's explanations were untruthful or unreasonable. As stated previously, many late disclosed documents spoke to the issue of justification for treatment. Moreover, there

was evidence that the standard of care for record keeping had changed for the chiropractic profession between 2006 to 2009, so it would be inappropriate to judge records a decade old by today's standards. It must be observed however that the Respondent could have saved everyone a great deal of time and expense, and perhaps avoided a significant number of charged violations, had he made an effort to record the reasons for his treatment in the SOAP notes and set forth actual assessments and plans, as opposed to using glittering generalities. During the hearing, everyone, including the Respondent, was forced to hunt through the files like forensic archeologists, searching for clues as to diagnoses, treatment plans, and signs of patient improvement. Often, there was just barely enough found for the Respondent to avoid a finding of a standard of care violation.

The next point that needs to be discussed as a preliminary matter is the claim by the Respondent of a rift or "chasm" between two schools of thought in the chiropractic profession. Much testimony was taken about the supposed differences between the American Chiropractic Association (ACA) and the International Chiropractic Association (ICA). The evidence is that there is some level of disagreement between some members of the associations as to correct treatment methodologies. Some members of one branch of the profession urge treatment of symptoms only, while some members of the other branch urge treatment of asymptomatic spines as a holistic health improvement plan, often involving many years of treatment. Respondent identifies himself as a member of the latter school of thought, though not to the extreme urged by some members of that school. He paints the Board's experts as members of the other branch.

While the evidence is clear that some level of disagreement as to technique exists within the profession, this is neither surprising nor particularly relevant. Chiropractors are bound by the statutes and rules of the state of Idaho, which apply to all licensed members irrespective of philosophy. While the philosophy of the Respondent is of help in understanding decisions made by



Respondent and his treatment plans, the rules and statutes may not be adjusted to fit the circumstances of the individual practitioner's choice of treatment.

The next preliminary point deals with the sale and use of nutritional supplements. The evidence is clear that the sale and use of such supplements is completely unregulated. While the Board experts expressed concern that the Respondent's records were usually devoid of any reference as to why a particular supplement was recommended (or indeed whether it was recommended at all), and that no dosage amounts were recorded, there appears to be no law or standard that requires any recordation of any kind of supplement for any reason. Indeed, the standard of care, if such a phrase can be used here, is that any person can buy any supplement, at any time, for any person, without even speaking to a chiropractor. A purchaser can apparently use a supplement as he or she sees fit, or even can give supplements away to non-patients, without any consequence. With one exception, there was no evidence presented by anyone indicating that any particular supplement was, standing alone, inefficacious as to any particular count. Under those conditions, and with one exception, it is not possible to find a standard of care violation where supplements are alleged to have been improperly dispensed by Respondent, or that Respondent failed to record the need for such supplement.

A corollary issue involving supplements is the propensity of the Respondent to use the terms "prescribed" or "prescription" in reference to supplements purchased from his office. Indeed, Respondent on more than one occasion held out to the public that the supplements could only be had through prescription, or that he had specifically prescribed supplements as to a particular patient. Respondent's explanation is that it was knowingly done so that the patient would be able to access his health care savings plan, satisfy a third party or avoid taxation. If this is true, there is no question that Respondent's behavior was less than forthright, and probably dishonest.

Nevertheless, I am constrained to find that no count alleged this behavior as a ground for discipline (except perhaps in the vaguest way). No finding can be had on the issue for this reason.

A concern of the Board experts pertained to several cases involving what appeared to be on the surface as over-treatment. Records on some patients showed scores or even hundreds of visits by patients with no apparent end in sight, often over many years, and often with no indication of any relief to the patient other than that the patient was "progressing satisfactorily." The Board's experts seemed to opine that if a patient was progressing satisfactorily, then sooner or later he or she would show documented improvement. Therefore, the argument seemed to go, by definition the Respondent was rendering inefficacious treatment, taking financial advantage or otherwise violating the rules and statutes.

This concern led to extensive testimony about the philosophies of the ACA and the ICA, most of which was not particularly relevant. There is a class of patients that do not fit with the "fix the symptom" school of thought, or the "remodel the spine and health will follow" school of thought. In fact, although often poorly documented by the Respondent, many of the patients were seeing the Respondent for maintenance care on an as-needed basis (PRN), or on a more regular schedule. This type of treatment is performed by all the experts who testified at the hearing. Apparently, in maintenance care cases there is no expectation by the patient of a "cure." Rather, the expectation on the part of the patient is temporary relief. There was no testimony by any patient engaging in maintenance care to the effect that the patient had been overcharged, over-treated or that he or she had been misled by the Respondent. Maintenance care, in and of itself, does not violate the rules and statutes pertaining to the profession, even when rendered over a long period of time.

Other patients had elected to receive corrective care, which apparently contemplated a long term series of adjustments. The Board's experts found no consent information substantiating this, but the Respondent provided that documentation as a late disclosure during the hearing. These documents demonstrated that in many cases the patient intended long term care as opposed to immediate relief of symptoms. This went to explain why the SOAP notes were essentially the same over long periods of time.

Another point worthy of preliminary discussion is the Respondent's use of the term "scoliosis." Apparently, most health professionals use the term to indicate a curvature of the spine beyond ten degrees. Respondent apparently uses the term to describe curvature of the spine that he deems to be abnormal, even if it does not exceed ten degrees. On the surface, the number of instances where a patient was described as suffering from scoliosis could lead a person to think that Respondent was engaging in misdiagnosis and over-treatment. The Board experts pointed to the word as an example of misdiagnosis. As it turned out, Respondent was not engaging in misdiagnosis, but in corner-cutting by using the term to fit any abnormal spinal curve, probably because he could not think of a better way to describe what he was seeing. Almost always he would use the word "mild" to temper the description of scoliosis. The word almost always is found in x-ray reports, and there was no evidence it was even imparted to the patient that the patient had scoliosis. No patient testified to anything specific about what the Respondent told the patient about scoliosis or what course of treatment would apply to it. Given that, it cannot be said that respondent's misuse of the term (standing alone) is a violation of any of the alleged counts.

Yet another point needs discussion. Each Board expert opined as to several of the counts to the effect that the actions of the Respondent amounted to misconduct as exploitive of the patient based upon a breach of the trust relationship. Yet, with some exceptions, the patients did not testify

about trust issues. Nor did the board experts speak to the patients. While it is certainly arguable that the records, standing alone, might show some level of misconduct under the statutes and rules for several kinds of misconduct, it is another thing to find to a clear and convincing standard that the trust relationship was violated, absent information about that relationship coming from the patient, or reliable evidence about a breach of trust. Unless otherwise noted, this portion of each count cannot be sustained.

Finally, there was a morass of evidence about the Mercy and Olson guidelines, their perceived shortcomings, their apparent unavailability, their age, whether the profession uses them, competing sets of guidelines, how they are used in individual cases, and portions of the guidelines conflicting with the opinions of the experts. The Mercy and Olson guidelines were adopted to assist the peer review process. They were not adopted to set standards of care, and in fact specifically state they were not created for that purpose. While they do not set the bar for the standard of care, they are useful, as are many of the other documents entered into evidence, in helping understand the standard of care. The standard of care is a fluid concept, and in this case was subject to competing interpretations by the experts. I have relied on the testimony of the experts as opposed to rigid application of the guidelines for that reason. As to any count involving an alleged standard of care violation, it may be presumed I am relying primarily on the expert testimony.

With those preliminary points made, each count will be discussed in turn.

**Count 1 – Patient V.H.**

The count involving V.H. falls into two broad categories. The first deals with a claim of faulty record keeping regarding the justification of neuromuscular reeducation of an 85 year old

woman. The second deals with misdiagnosis of cancer, failure to refer the patient in a timely fashion and treatment with inefficacious substances.

The evidence is clear that Respondent had been treating V.H. off and on over many years. Sometime during that treatment, V.H. was in a serious motor vehicle accident. In 2002, Respondent lost many of V.H.'s records due to a break-in. He still has x-rays taken in 1997. Those x-rays show a severely degenerated spine. Respondent's care was limited to pain control techniques and the patient was seen on a PRN basis. A period of several years without being seen by Respondent led to V.H. coming into Respondent's office in December of 2007. V.H. was feeble and in pain, and Respondent determined to begin a plan of pain relief he styled as neuromuscular reeducation. Although not well expressed in his SOAP notes, Respondent described at length at the hearing what it was he was attempting to do to relieve V.H.'s pain. In addition, the record contains a document of an examination that apparently took place in December of 2007. Plus, Respondent had the prior x-rays.

Although the SOAP notes do not contain a rationale and justification for the treatment, given that V.H. was a long-time maintenance patient, given the x-rays, given the examination, and given that the treatment was designed for pain management only, I cannot find that Respondent's records fell below the standard of care for record keeping to a clear and convincing level. It should be noted that the Board expert, quite fairly, pointed out that it might be arguable that the notes "barely" met the standard as it existed in the beginning of 2008. I cannot find that the treatment was inefficacious, violated the patient's trust, or is otherwise subject to discipline under the rules and statutes.

The second broad category of potential violation found in the count is hotly contested and worthy of extended fact finding.

Respondent is accused of diagnosing V.H.'s breast with red nipple, and recommending nutritional supplements for it, while missing the fact that the nipple was likely cancerous. Further, he is accused of failing to refer V.H. to an appropriate provider, and even of trying to dissuade V.H. from seeking a second opinion with a surgeon. All this is alleged to fall below the standard of care or otherwise violate the statutes and rules. In order to ferret out the facts, I examined the testimony of Respondent, two former employees, the experts and the daughter of V.H., who was present during a conversation with Respondent. In addition, the patient chart, Respondent's first explanation to the Board in writing, and the near-contemporaneous notes of the daughter were also taken into account.

From all this I find the following:

- A chart note by Respondent was made on January 18, 2008, stating, "[t]he patient reported low back pain. The patient also complained of pain & discoloring of the left breast. The patient was examined and *diagnosed* with red nipple." (Emphasis mine).
- The following chart note, made January 21, 2008, made no mention of the red nipple.
- The next chart note, made January 23, 2008, made no mention of the red nipple, except for the following: "The patient was prescribed nutritional supplements *for the red nipple* today." (Emphasis mine).
- A record found in the file demonstrates that eight supplements were "prescribed" on January 23, 2008.
- On January 23, 2008, Karla Halligan, daughter of V.H. and holder of power of attorney for her mother, saw the supplements at V.H.'s home and inquired about them to V.H. and V.H.'s husband (her father). Her father showed Halligan the record demonstrating that the supplements had been purchased from Respondent. Her father told her that it had to do

with color change of V.H.'s nipple, and said, "But that is what all of this medicine is for. It is going to take care of it."

- Halligan observed the nipple, made a note of the conversation and determined to accompany her parents to the next visit with Respondent.
- V.H. returned to Respondent's office on January 25, 2008. Respondent's chart note makes no mention of a conversation with Halligan or reference to the red nipple.
- Halligan attended the treatment session on January 25, 2008, and spoke with Respondent. Halligan made a note of her conversation with Respondent on the evening of January 25, 2008. Respondent told Halligan that the nipple was precancerous, but had been caught in time, being a plugged duct from too much yeast, that the supplements were to address or "fix" the red nipple, and that the nipple could break open and discharge, which would be a sign of healing. Halligan asked about a second opinion, and Respondent suggested a woman who did thermographs as opposed to mammograms, and suggested that a needle biopsy and surgery would not be good for V.H. Halligan states this was the only conversation she ever had with Respondent.
- Respondent denies speaking to Halligan on January 25, 2008, and states he would not make such statements about red nipple, as red nipple is a sign of cancer. He states he assumed it was cancer, but did not want to scare V.H. and urged V.H. to seek treatment with a breast surgeon for the nipple. He states he made this statement on January 18, 2008. He states that on the same day he had Dr. Hawkins, his employee and a chiropractor, look at the nipple. By January 21, 2008, he states he insisted that V.H. see a doctor for the nipple. He states on January 23, 2008, he was told by V.H. and her husband that they had an appointment, so he suggested supplements because he was fairly confident V.H. would be

undergoing surgery. He states that he never spoke with Halligan until February 19, 2008, and that that day was the only time he met with Halligan. He states he, V.H., and Halligan went to a room to inspect the nipple, that Halligan told him never to treat her mother again, or to contact them, and went to the front desk to yell at the staff.

- The chart note of January 28, 2008, is silent as to red nipple. The same day, V.H. was biopsied for cancer at IDX Pathology. A document dated January 29, 2008 shows that the test was positive for malignancy.
- The chart note of January 30, 2008, is silent as to red nipple or cancer, but does contain the following: "The patient *is* sent for diagnostic testing." (Emphasis mine). The Respondent states he was made aware of the result of the test by V.H. and her husband, and that his chart note should have read, "The patient *was* sent for diagnostic testing."
- On February 1, 2008, V.H., her husband and Halligan, met with Dr. Getz, who recommended a mastectomy.
- V.H. saw Respondent on February 2,4,6,8,11, and 13 of 2008. No mention is made of the nipple, cancer, surgery or any aspect of V.H.'s breast in any chart note.
- The chart note of February 19, 2008, does not mention anything about surgery for the breast, even though V.H. was scheduled for surgery the next day. Also missing is any note about Halligan and the alleged encounter where she allegedly told Respondent not to contact V.H. However, the note ends with the following: "The patient should return in one week."
- On March 17, 2008, Halligan spoke on the telephone with Annette Burtzoff, an employee of Respondent. Halligan told Burtzoff that the office should not contact her parents, saying



that Respondent could have killed her mother by treating her cancer with herbal supplements.

- Burtzoff states that she recalls Halligan coming into the office on one occasion and that Halligan was "a little cold." She does not know what went on in the room with Respondent, but Respondent told Burtzoff that he "didn't know where she [Halligan] was coming from." Burtzoff has no idea when this occurred. She does recall the March telephone conversation, and even made a contemporaneous note about it.
- Dr. Hawkins states that he did look at the nipple with Respondent and that Respondent later looked on the internet and saw the discoloration was a sign of cancer, but does not know the date. He states he heard Respondent ask V.H.'s husband if he wanted a referral, which was declined.
- In his written response to the Board investigator dated August 5, 2008, Respondent states he "diagnosed...red nipple," and referred V.H. out for further evaluation on January 18, 2008. At the hearing, he stated at the hearing that red nipple is a symptom, not a disease.
- The Board expert opined that Respondent's conduct fell below the standard of care of the chiropractic profession, and that Respondent rendered inefficacious care in violation of state law.

Clearly, Respondent and Halligan cannot both be right. Either Halligan is wrong about the conversation with Respondent as having taken place on January 25, 2008, or Respondent is wrong about Halligan coming in on February 19, 2008. I find to a clear and convincing standard that Halligan is being truthful. First, she has no motive whatever to manufacture a claim against Respondent, especially one so complex and in such detail. Second, she made a contemporaneous note of the conversation with Respondent, wherein he stated that the nipple was not cancerous, that

it was treatable with supplements, that he had caught it in time before it became cancerous, and that it would not be in the interest of V.H. to be biopsied. Third, Respondent's chart note says that he diagnosed red nipple and makes no mention of possible cancer, or making a referral. Fourth, the chart notes specifically state that the supplements were for the red nipple, not to build up V.H. for surgery. Fifth, the surgery was not even recommended until some five days after the "prescription" for supplements. Sixth, Burtzoff's notes demonstrate that Halligan called Respondent's office and expressed concern about treating cancer with supplements. She would have no reason to do this if she had not been told by her parents and Respondent about the supplements being for the nipple. Seventh, Burtzoff does not corroborate Respondent's story about Halligan making a scene or yelling at the staff. Eighth, Respondent's chart notes specifically state that V.H. should return to the clinic, yet Respondent states he was told that same day not to treat V.H. further. In short, it appears clear and convincing that Dr. Breshears, either misdiagnosed the nipple, or even worse, diagnosed it as potentially cancerous and held that information back from the patient. It is clear and convincing that he tried to dissuade Halligan from getting a further evaluation, and that he attempted to treat the "red nipple" with supplements. It also appears that he may have doctored his chart notes to show a referral for diagnostic testing *after* the breast had already been diagnosed. Finally, it should be noted that Dr. Hawkins did not help clear up matters. Given his testimony, it appears he was referring to January, 30, 2008. If indeed Respondent had gone on the internet on January 18 and found indicia that the nipple was cancerous, it only goes to prove that he held that information from the patient. The allegations in count I are sustained on the claims of falling below the standard of care regarding misdiagnosis, and the promoting of inefficacious treatment.

**Count 2 – Patients K.W., N.W. and L. W.**

The patients in this count are all members of the same family. K.W. is the mother, and only family member to testify, and was the original complainant. N.W. is her husband and L.W. is their son, at the time age nine. This count is primarily based upon a claim of financial exploitation and a claim of unnecessary care.

The facts are somewhat murky since L.W. did not testify, but it appears that K.W. went to Respondent for a checkup and because she had an interest in supplements. She states she was induced to sign up for a long term spinal treatment plan. Thereafter, her husband came in for blood pressure and cholesterol issues as well as for “fuzzy thinking.” He too was persuaded to sign up for a long term spinal treatment plan. L.W. was brought in for bowel issues, and he too was soon embarked upon a long term spinal treatment plan. None of the patients had ever been in a major accident, and were fairly asymptomatic, so it was hard for K.W. to understand why such extensive treatment was necessary. Nevertheless, the family signed up for what is described by Respondent as a level pay plan. This plan in fact is a financial agreement wherein the family agreed to pay \$240 a month for three years. Nowhere in the document is the plan described as a level pay plan, nor does the agreement state that the family will be charged a reduced rate. If services were discontinued, the “remaining balance” had to be paid in full. No explanation was made to the effect that at the end of three years the balance would be forgiven. Indeed, the agreement does not even state what services would be given and at what rate. No monthly billings were sent to the family.

Each patient had a “checklist for patient recommendations” document, although no patient signed such a document; only the Respondent did. This “checklist” envisioned a 1 ½ year treatment plan for the boy, a 2 ½ to 3 ½ year plan for the father and 1 ½ to 2 ½ year plan for the mother. Each plan contemplated beginning with 3 months of intensive care, which, although not

clear, apparently contemplated three visits each week, followed by two visits after the first three months, to be reduced at different times for different family members. These plans began in July and August of 2007. Although the complaint alleges that the patients were "required" to sign a financial plan, no testimony was had, and the record does not show, that the family was forced to do anything. Having said that, it is clear that K.W., at least, was very unclear about what the treatment was for, what the diagnosis of her issue was, or why after three months the adjustments continued on a three times a week basis. When she inquired about why the charges were raised (on paper) for what appeared to be the same treatment, she was told by Annette Burtzoff, "what's the difference? Insurance is paying for it." This, and the fact that treatments were still continuing at three times a week after the intensive care period, caused K.W. to discontinue treatment for the family. They were then hit with a \$3,000 bill. This, Respondent explained, was the balance due under the "level pay" plan. This last turn of events caused K.W. to approach the Board with a complaint.

Another issue raised by the Board in this matter is the apparent lack of medical necessity for the extensive (and expensive) treatment. This allegation led to extensive testimony by Respondent about the differences between relief care and corrective care. Several days after K.W. testified, Respondent produced, for the first time, documents showing that K.W. had chosen corrective care for her son, and N.W. had chosen corrective care for himself. K.W. did not check any of the available boxes, but it appears she too chose corrective care. This corrective care coincided with the long term plans agreed to by the patients, according to Respondent. Respondent also testified at length about the reasons for the corrective care, being based upon histories, examinations, x-rays and thermal scans. This testimony was, in large part, unrefuted.

From all this, while it can be said that K.W. had little understanding of what the treatment was for, or what it was costing, there must have been some level of understanding for her and her

husband to choose corrective long term care. This is especially so since no patient was suffering acute pain. Lack of informed consent has not been alleged. Given the choices made by the patients, coupled with the explanations provided by Respondent and the documents provided, it cannot be said that there was no medical necessity for the corrective care, and hence it cannot be said that Respondent was promoting unnecessary or inefficacious treatment to the evidentiary level required under the law.

Was it financial exploitation? The Board expert opined that it was. K.W. testified she believed she had been exploited financially as a result of the trust given to Respondent. She also testified that she did not feel any different after the treatment, except for being "lighter in the wallet." Respondent explained that the reason no improvement was noted by the family is that they abruptly ended the treatment after five months.

It is possible to exploit a patient, even if the level of care is not unreasonable. While Respondent is entitled to honest pay for honest work, it is not appropriate to propose a three year treatment plan without giving the patient any idea that there would be a significant financial penalty for stopping treatment early. Couple that with the failure to account on a monthly basis for the difference between what was being charged and what the penalty would be, and no reduction of treatment after the three month intensive phase with no explanation of whether there was a charge for this extra treatment, it is clear that this family could have been, and in the event was, blindsided by what is in effect a fee for breaking an unsigned "checklist" of multiple year care. I find clear and convincing evidence that this count is sustained as to conduct amounting to exploitation of a patient arising out of a breach of trust and confidence. The remainder of the count is not sustained.

### Count 3 – Patient M.N.

M.N. was in a motor vehicle accident in 1999. By 2002, she had been seen by at least twenty health care providers, was in acute pain, and was significantly impaired. She went to see Respondent after having been referred for an EMG test. In short order, she had signed up for corrective care, which, according to the document provided her by Respondent, offered the patient that “the goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in its length or time, but is more lasting.” M.N. signed the document which stated in part, “I hereby authorize the Doctor to treat my condition as he deems appropriate through use of manipulation throughout my spine.”

Respondent describes the patient’s case as complex, in which the first steps were to do a trial of chiropractic care. After a period of time, Respondent states that the care became self-directed by M.N. M.N. treated between late 2002 and early 2005. By the end of treatment, M.N. had run up a bill of \$33,790. Respondent held the bill, charging monthly interest, until mid-2008 and turned the matter over to collection. By that time the bill had run to nearly \$52,000. M.N. is deceased. Her husband testified that the care did not help her, that if anything it made her worse. He testified that Respondent reassured “us” that he could solve the patient’s problems.

The SOAP notes of the hundreds of treatment sessions over the years reveal that the patient would come to the office complaining of pain, be adjusted and return a few days later with back and neck pain. The assessment portion of many SOAP notes states that the “patient is progressing satisfactorily.” There is evidence in the record that the patient, at least for a time, felt she was getting relief.

There is also evidence that M.N. had been involved in a lawsuit stemming from the accident, settled the lawsuit, and moved to California. It is unclear from the record whether

Respondent thought he had a lien on the settlement. If so, it was apparently based on oral conversations. No information was put in the record about the amount of the settlement.

The Board expert opined that there was no documentation of medical necessity for the extensive treatment, no plan, and that it violated the standard of care to guarantee results. Although only partially found in the chart notes, it is clear from the rest of the record that Respondent attempted to perform corrective care for a deeply impaired patient, that some of the care may have given temporary relief, that the treatment was intensive and of a long duration, and that the care did not work to the extent the patient hoped it would. That the treatment did not have the result hoped for does not mean that it was inefficacious or below the standard of care. As stated elsewhere, the standard has changed regarding note taking, and the trial plan occurred some twelve years ago. According to the signed consent document, pain relief was a "goal." Given that, I cannot say it is clear and convincing that the Respondent fell below the standard of the time.

As to a guarantee, and with respect to M.N.'s husband, the evidence is neither clear nor convincing that there was a guarantee given. By his own admission, the husband was only present at perhaps ten percent of the treatments and cannot speak to any conversation with M.N. beyond that. The husband stated that the Respondent "seemed to indicate" the nature of the problem, and that he could "free up" her problems. He "thought" that meant she would be cured. As to the reassurance, there is no evidence as to when that occurred, who was present, or what actually was said and by whom. Even under the loose evidentiary standards of administrative law, this count cannot be sustained.

#### **Count 4- Patient L.G.**

This is a complex count. The main thrust of the testimony provided by L.G. and her husband was that she wanted to avoid hip surgery despite the fact that a surgeon had recommended such

surgery and an MRI indicated hip deterioration and apparently demonstrated that hip surgery was indicated. Based upon oral assertions from Respondent to the effect that he could prevent surgery by working on her hip in such a way as to regrow cartilage, and assertions that he had helped other patients to avoid hip surgery, and that he could supply the names of patients he had helped, L.G. agreed to a lengthy course of treatment that involved spinal adjustments and maneuvering of the hip, which according to L.G. caused intense pain. The treatment proved to be a failure, and despite eleven months of treatment (often at three treatments per week) at a cost of nearly \$12,000, L.G. finally had surgery and a hip replacement.

Surprisingly, there is nothing in the body of the complaint that speaks to this course of treatment as being injurious, inefficacious, or exploitive, the assurances given, and the lack of the ability to regrow cartilage. Instead, the complaint speaks to the failure to document the necessity and course of treatment, the need for supplements, and patient's responses to care. A HIPAA violation is asserted, as is a failure to monitor high blood pressure and the alleged making of sexually inappropriate comments to patients is noted. Instead, one must search the attached exhibits to the complaint for an allegation of inappropriate treatment, which is found in a letter from the professional reviewer. Because the complaint states that the letter is incorporated in the complaint, I find that Respondent was on notice of the thrust of the complaint and the testimony of L.G. and her husband.

Respondent flatly denies making the statements to L.G. about being able to regrow cartilage and that he had performed this for other patients, that she would be able to avoid a hip replacement, and that he would give names of patients to L.G. and her husband in order to prove his claims that his treatment plan would work. Instead, Respondent claims that he told L.G. that his treatment would allow her to avoid a hip replacement only for a time, and prolong the period prior to her



getting a replacement. He denies offering the names of patients as references. He also denies any other inappropriate treatment or a HIPAA violation, and denies making an inappropriate statement. He admits that he knows of no way chiropractic care will grow cartilage. He stated that his supplement sales were based on tests demonstrating a need for the supplements.

Based upon the lack of a standard of care, I cannot find a violation regarding any aspect of the supplement dispensation. As to HIPAA, nothing was proven as to what section of HIPAA was violated, nor has one been suggested by the Board in briefing. It is also unclear as to the nature of the conversation about L.G., and whether the statements made to a third party fall within HIPAA. The person allegedly hearing the statements did not testify. I cannot find a violation on this portion of the count. As to high blood pressure monitoring, the evidence seems to be that it would have been advisable, but Respondent was not treating high blood pressure, and there was no evidence presented indicating that the spinal adjustments and hip rotation would have negatively affected the blood pressure. I find no violation on this portion of the count. As to record keeping, again this treatment took place during the time that the standard of record keeping was changing. Although the SOAP notes document the treatment itself, again the assessment and plan portion of the notes were inadequate. However, there is evidence in the file that, taken together, show the reasons for the spinal manipulation and reasons for the rotation of the hip joint. I do not find that this portion of the count is sustained.

However, there is clear and convincing evidence that Respondent engaged in misconduct by making assurances that his treatment would prevent a hip replacement, engaged in rendering inefficacious care, and financially exploited L.G. The "treatment" of the hip was an eleven month course of little more than grinding the leg in its socket, causing extreme pain, for no valid reason. There are several reasons for this finding. First, L.G., an educated and articulate woman, stated

convincingly that the only reason she agreed to the treatment was the Respondent's assurances that he could help her avoid surgery, and had assisted other patients to do the same. There appears to be no motive for L.G. to lie about this, nor subject herself to months of painful treatment only to eventually have surgery anyway. Respondent's late disclosed consent form demonstrates that L.G. checked the box stating that she was leaving treatment decisions in the hands of Respondent – trusting him to do the right thing. Second, L.G.'s husband was clear and convincing that he too spoke to Respondent, was assured that Respondent would be able to prevent hip surgery, and was further told that Respondent would provide names of patients that he had helped avoid hip surgery. In the event, Respondent backpedalled on this promise, and did not provide names. L.G.'s husband has no motive to lie about this. Respondent's claims that he never made such statements are not credible. Third, Respondent did not back up his assertions at trial that he could prolong the period before L.G. would need surgery, and that he had done so for other patients. Respondent failed to provide any evidence, (whether by testimony other than his own assertions, expert testimony, medical treatises, patient records or anything else), that he could even provide the limited relief he states he actually told L.G. and her husband he could provide – that he could delay the need for surgery, potentially for years. In short, it appears to a clear and convincing level that Respondent induced L.G. to subject herself to nearly a year of pain by promising things that were not true, thereby rendering unnecessary and inefficacious treatment, and financially exploiting the patient over the course of a year as a result of the trust relationship between L.G. and the Respondent. In addition, Respondent violated the standard of care by grinding the leg in its socket for eleven months in an attempt to regrow cartilage or otherwise prevent a hip replacement. This portion of the count is sustained.

**Count 5 - Patient J.B.**

Patient J.B. was given treatment over a period of five years by Respondent at the average of one visit a month. The testimony regarding this patient by the Board's expert was based solely upon a records review. J.B. was not interviewed and did not testify. Therefore, the information on this count is limited to the records found in the patient's file, and the testimony of Respondent and Board expert.

The complaint alleges that the records in the file are "poor" and that the chart notes "seemed" to be the same in the areas of treatment diagnosis and assessment, the lack of a patient history and intake form demonstrating why patient was being treated as he was, and that the patient was alleged to have been misdiagnosed with scoliosis.

The records and testimony indicate that J.B. had been a patient of Respondent since 1989 and had been on maintenance care. The records of Respondent were destroyed in 2002, so there was limited information as to the original reasons J.B. engaged Respondent. However, one of Respondent's disclosures was a personal history from 1989 showing that J.B. originally came to see the Respondent complaining of stiffness in the neck. X-rays were taken in 1988, showing cervical flexion trauma, and degenerative joint disease. "Mild" scoliosis was diagnosed in 1988 in the x-ray report at the lumbar and thoracic area. Beyond that the record is silent until 2002. Thereafter, J.B. came in for maintenance treatment 61 times over five years for a total bill of \$2,131.71. I cannot find to the clear and convincing level that this count is sustained. The poor records were apparently adequate enough for the times. The "mild" scoliosis note is simply an expression of opinion in an x-ray note. There is no evidence that that information was imparted to the patient or even was attempted to be addressed. The Respondent explained that the symptomology was pain in the neck and back, and that it was constant for the patient and hence he did not alter his notes during the five

years of maintenance care. This does not appear to be financial exploitation, excessive care, or violation of the standard of care.

This count is not sustained.

**Count 6 – Patient D.V.**

Patient D.V. was seen 46 times over a 14 month period, beginning in 2008. She began treatment at age 17 for back and shoulder pain. The patient was x-rayed, and Respondent noted “mild thoracic scoliosis.” The complaint alleges that this was a misdiagnosis. As explained earlier, this appears to be a way Respondent describes abnormal curvature, even if the curve did not reach the accepted definition of scoliosis. Hence, the word “mild” was used to describe the curve. The complaint alleges that there was inadequate documentation to demonstrate the need for treatment of the lower back, and that the chart notes do not contain a “clear or accurate” diagnosis. Similarly, there is a claim that there is not enough information in the file to substantiate the number of treatments or document why the care was provided.

This case was based upon a records review by the Board expert. D.V. did not testify. Respondent testified as to the meaning of contents of the file, and his reasoning for treatment. His testimony was not impeached.

I do not find that this count is substantiated. There are records in the file that demonstrate low back issues, including an x-ray report and thermal scan information, in addition to the physical examination report (though cryptic, the report, as explained by the Respondent, includes information involving low back issues). While it is true that the chart notes do not contain a diagnosis, there is a document in the file (albeit regarding insurance information) that does include a diagnostic code. While it is not clear that the Respondent explicitly documented why the care was provided, I infer from the above documents, plus the history, that the patient was seeing the

Respondent for neck and back pain. There was oral evidence from the Respondent explaining the number of treatments, which seemed reasonable. Patient was billed less than \$2,000 for the 3 ½ month course of treatment (the Respondent wrote off over \$500). An insurer paid for the treatment without questioning the need for it.

Finally, there is the recurring use of “patient is proceeding satisfactorily” or “patient is feeling better” found in the assessment portions of the chart notes. Interestingly, the patient did not check a box in the (late disclosed) consent form whether she wanted relief care or corrective care. Based upon the unsigned “checklist” found in the file, it appears that corrective care was planned upon over a period of between six months and 1 ½ years. From this, it appears that corrective care was chosen. There is nothing in the file indicating that D.V. was dissatisfied by the treatment, or complained about the length of treatment. Again, while the generalities used by Respondent in his notes are troubling, it appears that Respondent used the above phrases during the corrective care treatment because they were part of a “canned” electronic note, and Respondent did not have much more information to impart. This count is not sustained.

#### **Count 7 – Patient M.R.**

M.R. first appeared in Respondent’s office requesting an adjustment in 2007. She apparently was there upon a referral, and had been adjusted previously. She was given a physical examination by Respondent, and chose to engage in corrective care (as demonstrated in a late disclosed document). The examination demonstrated that M.R. was suffering from neck and back pain, and pain elsewhere in her body. After approximately five treatments, M.R. switched to Dr. Hawkins who apparently treated her continuously to mid-2011. Between 2007 and 2011, M.R. was treated 236 times. She was in an accident in 2009, and Respondent x-rayed her back. At that time she was noted to have “mild” scoliosis. She purchased numerous supplements during her time of

treatment, the first apparently in early 2008, after beginning with Dr. Hawkins. M.R. was not interviewed by the Board staff, and did not testify. This is a count based upon opinion after a documents review.

Most of the count speaks to alleged misconduct, (such as lack of follow-up examination, supplement sales, lack of rationale for the treatment, or poor record keeping), that actually would have been the responsibility of Dr. Hawkins, not Dr. Breshears. (This is yet another example of Respondent's corner cutting causing undue expense to the Board; no SOAP note in this file states who the rendering chiropractor actually was). Although, the Board suggests that Dr. Breshears should be held accountable for the failings of Dr. Hawkins (if any), no compelling law is cited to support that position. I find that most of allegations in the count are unfounded for the reason that most of the work was done by another chiropractor.

There are two portions of the count that apply to Respondent. One of these is the claim of misdiagnosis of scoliosis. This is found in an x-ray report, and no information was provided indicating that the patient was told she had scoliosis, or that even if she was specifically treated for it. Again, this is an example of Respondent's corner cutting for want of a better description of the curvature, as opposed to misdiagnosis.

Second, there is an allegation that thermal scan documentation did not indicate results. In fact, the expert opining on this subject did not demonstrate enough familiarity with the documentation as to scans to persuade me of this allegation. The records speak for themselves, and Respondent adequately described the meaning of the documents in unimpeached testimony. This count is not sustained.

**Count 8 – Patient T.M.**

T.M. was an ice hockey enthusiast who was treated between 2002 to 2011. During that time, according to the Respondent, he was a PRN patient. The initial consent document (late disclosed) shows that T.M. elected to leave the decisions as to what treatment would be the best to Respondent. Respondent decided to try some level of spine remodeling and eventually began to treat the patient with maintenance care. Respondent diagnosed subluxations, as shown on an x-ray report. The file shows two examples of falls on the ice over the years. The average year's chiropractic bill was \$1,500, most of which had remained unpaid by 2011. The file contains EMG and thermal scan narratives (which the Board expert may not have seen when he rendered his initial opinion).

T.M. did not testify, and apparently was not interviewed by the Board staff. This count is based on a records review. The Board expert found that there was not enough explanation contained in the file about the thermal scans. In fact, the expert opining on this subject did not demonstrate enough familiarity with the documentation as to the scans, and in any event there are narratives found in the file that fully explain the meaning of the scans. The records speak for themselves, and Respondent adequately described the meaning of the documents in unimpeached testimony.

The Board expert described the records as "poor." The SOAP notes suffer from the same issues as every other record in this case, that is the use of generalities for assessment and no plan but an appointment. They are poor, but the standard of care is not well defined, and in any event, the records go back twelve years, prior to the time the standard changed.

The Board expert opined that there was no documentation that the patient was improving. T.M., according to Respondent, was a maintenance care patient. The board expert opined that there

was no evidence in the file of examination after injuries. There are two updates to the file showing falls, and there appear to be no examinations regarding those updates. The unimpeached testimony of Respondent is that the updates were informational only, and no examination was warranted.

This count is not sustained.

**Count 9 – Patient E.K.**

E.K. presents a complicated history. The patient began treating with Respondent in 2006, at age 18, with pain from an injury suffered three years earlier. By 2011, she had been in two motor vehicle accidents, a bike crash, and had a fall on ice. Hence, care and billing records changed depending upon whether insurance was going to cover some of the treatment. It appears that Respondent began by attempting to engage in corrective care at first, and adjusted his treatment in each case of injury until the insurance money was depleted, and then resumed the corrective care, until the next injury, then adjusted the care until the insurance money was depleted, then resumed corrective care. Over the five years, patient was indebted to the Respondent for over \$20,000, not counting the monies paid by her or the insurers, while Respondent was selling the young lady supplements. On the surface, this count smacks of overtreatment and financial exploitation. However, there was no hard evidence presented of this. The board's case was limited to the oral testimony of the expert's opinions and his two page report, which was based upon a record review. E.K. did not testify, apparently was not interviewed, and no one familiar with the case came forward except Respondent, whose testimony went essentially unchallenged.

The count begins with an allegation that there is not enough information in the file to justify the initial plan of one to two year treatment, and no updated information justifying continuing care. In fact, the file contains a history demonstrating three years of pain, an examination demonstrating several issues (the expert was not familiar with some of the test names in the chart), a late disclosed



consent form (patient consented to relief care and corrective care), an EMG narrative, a thermal narrative, and an x-ray report (the expert may not have seen the actual x-ray at the time of issuing his report). From this, there is ample evidence to justify a long term plan of care. In addition, there are numerous EMG, thermal narrative and x-ray reports demonstrating continuing updates on the status of the patient. This portion of the count is unfounded.

The next portion of the count is an allegation that the file contains insufficient evidence of examination to justify the level of care after each accident, and that the EMG sheets have no correlation with the care given. From the original information given to the expert, these assumptions are reasonable, but a later disclosure contained EMG, thermal narrative and x-ray reports demonstrating correlation and rationale. This portion of the count is not sustained.

The expert opined that there was no information justifying the supplements given that can be found in the file. There is no standard of care for supplements that requires documentation.

The remainder of the count is based upon the notion that the overall treatment was excessive and exploitative and that the billing records were inaccurate. Again, from the original documents given to the expert, this impression is not unreasonable. Logically, it would seem reasonable that the financial wherewithal of a teenager should be taken into account in developing a plan of care. Further, the notes seem to indicate no end to the plan.

Nevertheless, later disclosed documents flesh out the reasons for the continuing care. Respondent testified in great detail about the plan, the changes necessary due to the several accidents, and that E.K. was helped and is satisfied with the results of the care. Further, there was testimony that E.K. has paid most of the bill, and is doing well in life. In addition, the insurers paid their portion of the bill without qualm. This testimony was not impeached.

Based upon the clear and convincing standard, this count cannot be sustained.

**Count 10 – Patient M.B.**

The count involving M.B. is based only upon a records review. M.B. did not testify, nor does it appear that she was interviewed. The upshot of the board expert's opinion is that the treatment over a period of nine years, between 2002 and 2011, is excessive, without documentation demonstrating the need for 366 visits during those years. The diagnosis did not change during those years, and so, the argument goes, the treatment was ineffective.

The unimpeached testimony of Respondent is that M.B. was a patient who started treatment in 1988, and that by 1993 x-rays showed improvement of her spine. By 2002, she had become a maintenance care patient, who came in of her own accord when she felt pain. She was treated as a PRN patient, and the various update forms found in the file were not new "injuries" but exacerbations of areas already being treated. Hence, the diagnosis did not change. The frequency of care was about once a month in 2002 to about twice a week in 2011. The records, sparse as they are, do seem to indicate maintenance care.

Based upon the clear and convincing standard, this count is not sustained.

**Count 11 – Patient R.E.**

R.E. was a truck driver who walked into Respondent's office one day in January, 2010, complaining about a catch between his shoulder blades. He was given a limited examination. He was manipulated and left. He returned a few days later and received a more thorough examination. He returned to the clinic several more times by which time the catch had been relieved. However, by that time he had embarked on a long term spinal remodeling/corrective care plan, according to Respondent. This plan went on, with adjustments two or three times a week, until mid-2011, and the patient discontinued treatment.

R.E. testified that at the end of the treatment he was no better or worse, that his back was still in pain, and that his catch had been relieved after only a few treatments. His left knee was also worked on and he received pain relief. He stated that he was unsure about the plan, except that it was a "schedule type thing" that dropped to lower numbers of treatment a week after a time. He stated that he did not believe that Respondent "ever really gave me an explanation" for the plan. He stated that the treatment never changed and that all the treatment never gave him further relief after the catch was resolved.

A late disclosed consent form shows that R.E. did not check any of the boxes available to him, but it is clear that he chose corrective care. It is obvious he did so, considering the checklist initialed by the Respondent, and the number of treatments given. After four years, it appears R.E. is unclear about much of the goal of the corrective care plan. Lack of informed consent is not alleged.

R.E.'s insurance paid for some of the treatment, apparently without concern. At the end of a year and one half, he owed Respondent \$4,098, which has yet to be paid.

The Board expert opined that R.E. was double billed for the same examination. This was cleared up by Respondent, who explained the difference between the initial, walk in evaluation and the full examination a few days later. This portion of the count is unfounded.

The expert opined that there was no information justifying the supplements given that can be found in the file. There is no standard of care for supplements that requires documentation.

The expert opined that no diagnostic codes were used in the chart notes, so he was unclear about what the patient was being treated and billed for. The diagnostic codes are found elsewhere in the file, and the standard of care apparently does not require such codes, which are primarily used for insurance purposes, to be placed in the chart notes. There is information found in the history,

examination report, thermal scan and x-ray report to justify the treatment. This portion of the count is unfounded.

Respondent testified that the catch between the shoulders was an acute episode of a chronic condition, and that patient was thermo-scribed every time he came for treatment. The treatments did not vary dramatically because long term corrective care was the goal. That is the reason the treatment did not vary despite the subjective descriptions of pain in varying locations on the body. This testimony was unimpeached. There is no clear and convincing evidence that this case involved excessive treatment. The fact that relief was only partial – though concerning - does not necessarily mean that the treatment was negligent, inefficacious, or exploitive.

This count is not sustained.

**Count 12 – Patient C.C.**

C.C. presented to Respondent in March of 2005. She had been a patient of another chiropractor who had apparently been treating her with an activator on a maintenance care program for a bicycle accident that had occurred fifty years earlier in 1955. The patient history disclosed that the purpose of the visit was for low back pain, and that she wanted a “re-align.” For the next six years, C.C. was adjusted as a maintenance patient approximately one or two times a month until April 2011. C.C. did not testify and apparently was not interviewed. The Board expert limited his opinion to the records.

The count alleges that C.C. had fallen in 2005 and 2008 but there were no records of examination. The count alleges that the patient noted several other issues over the course of the years, but Respondent only treated the lower spine. Also the treatment was the same for each visit.

Respondent produced in late disclosure a consent form demonstrating that C.C. was only seeking relief care, not corrective care. Respondent testified, and the record is clear, that C.C.

wanted one thing only: maintenance relief for her low back pain. She paid a flat rate for each session. The record is clear that she was a PRN patient who came in on her own schedule. Although she noted sinus, gout, shoulder and neck issues from time to time, and also noted her falls, there is no evidence that she wanted treatment for any of these other issues. Hence it is unsurprising the treatment did not change over the course of time – adjustment of her low back and hips.

The count alleges a lack of documentation of the need for supplements, and no dosage amount. There is no standard of care for supplement dispensation or dosage.

Because C.C. was a maintenance care patient from the first day to the last, there is no clear and convincing evidence that Respondent did anything other than he was requested to do by the patient. This count is not sustained.

**Count 13 – Patient T.C.**

T.C., like her relative C.C., came into Respondent's office seeking maintenance care in early 2005. She had been a patient of a California chiropractor for 15 years, resulting from an auto accident occurring in 1982. Her personal history form made it clear that she was seeking maintenance care, as did her late disclosed consent form. The count alleges that there was no examination done to justify the maintenance care. In actuality, there is a record of a physical examination found in the record, plus late disclosed thermal and EMG narratives that coincide with T.C.'s first visit. This portion of the count is unfounded.

Again, a lack of information regarding supplements and dosage amounts is alleged. Again, it is noted there is no standard of care for supplements.

The count alleges that there was insufficient information found in the file to justify the treatment and what she was being treated for. The file shows that patient was treated sporadically

on a PRN basis, about three or four times a month. The file shows the complaints made by the patient, and the adjustments performed. In late 2006, T.C. was in a motor vehicle accident and there are late disclosed documents in the file demonstrating substantial testing, which led to further treatment. Sometime after, T.C. went back on maintenance care.

T.C. did not testify, and apparently was not interviewed. Respondent stated that T.C.'s care was essentially self-directed, that she came in when she felt the need, and despite the Board experts opinion that most maintenance care is delivered twice a month, T.C., like C.C., had previously undergone maintenance care for many years and came for temporary relief when she felt she needed it. This count is not sustained.

**Count 14 – Patient K.S.**

This count is primarily one alleging overtreatment and violation of the standard of care. The patient went to see Respondent at the request of her husband. At intake, her stated reason for seeing Respondent was "1<sup>st</sup> time, x-rays etc." This occurred in January of 2003. 11 years later, in January of 2014, Respondent was still treating the patient. This count is based upon a records review, and K.S. did not testify, nor was she interviewed. The record review stopped as of May, 2011. The same day as her first appointment, the patient elected to allow Respondent to select the type of care appropriate, by checking a box on her consent form. Respondent testified that this is a spine remodeling case, and hence the count will be viewed through this lens as opposed to maintenance care. There is no record found in the file demonstrating a plan to remodel the spine, except for the unsigned checklist of patient recommendations. This checklist contemplated a 2 ½ year plan on the outside. X-rays were to be performed after a year of treatment. There is no indication K.S. agreed to such a long term care remodeling plan of 9 years, other obviously than the fact that she kept returning for treatment. The Respondent testified that the late disclosed x-ray and

EMG reports taken in 2003 justified the corrective care plan. There was a single thermal scan narrative entered in December of 2007. There was also a static EMG and x-ray report on the same date. According to Respondent, this x-ray shows improvement of the spine. There was an x-ray in March of 2008. By definition, the checklist was not followed in that there was no x-ray in 2004, 2005 or 2006, 2009, 2010, or 2011.

The SOAP notes reflect spinal adjustments for the nine year period, with nothing indicating real progress. Surprisingly, the Assessment portion of the first SOAP note, taken the day, K.S. first came to the office states: "the patient is progressing satisfactorily." This, by the Respondent's definition of the phrase (that it is meant to show no deterioration), is an improper assessment. The spinal adjustments continued for the 9 years without anything in the notes to the effect that the patient was becoming healthier or more pain free. Beginning in 2005, there are notes of seven minor accidents with some level of soreness resulting. No mention of how these updates affected the treatment is found in the SOAP notes.

In fairness, it should be pointed out that the patient's schedule of treatment was sporadic, explained by the Respondent as due to her work schedule. Nevertheless, the patient was adjusted 230 times during the nine year period on this alleged plan, and 70 times in the first two years alone. As far as may be determined from the notes, the 2 ½ year end to the plan sailed by without any reference from Respondent in the file. The spinal remodel apparently continued unabated, with no end in sight.

The count alleges improper insurance coding in regard to the original diagnosis. I cannot find any authority that would lead me to find misconduct on this portion of the count. The count also alleges that there is insufficient evidence found in the file to justify the care (apparently this is

meant to mean the 9 years of care). Based upon late disclosed x-ray and EMG reports, I find that there was enough justification to begin a spinal remodel plan.

The count further alleges that there is no documentation found in the file to justify the 9 years of treatment, and nothing indicating the state of the patient during that treatment. I find that there is clear and convincing evidence that this is true. It appears that the patient would go for years without any real attempt by Respondent to monitor the effective level of the spinal remodeling. While it is true that there was thermal scanning done, Respondent admits that such only identifies potential issues, and does not show the true state of the spine the way an x-ray does. Respondent did not even attempt to follow his own plan regarding x-rays for nearly five years. Then, Respondent failed to x-ray for the three years between 2008 and 2011.

It appears from the records, that the patient would arrive, complain of pain, be adjusted and leave. Yet she was always, according to the Respondent, satisfactory, even on the first day. Nothing is shown to give the impression that there was any intent to rethink the plan, or even monitor the spine, except for x-rays taken only after the two accidents. One cannot escape the conclusion that the plan would have continued in perpetuity on automatic pilot had it not been for the Board reviewing the file. Perhaps most telling, the last x-ray in early 2008 showed improvement, but no discussion was had at the hearing by Respondent about when maximum medical improvement would have been reached. Indeed, Respondent did not check the spine through x-ray over the next six years.

I find that this count is sustained in that there is clear and convincing evidence that the spine remodel fell below the standard of care, and even Respondent's own plan. While it is tempting to also find unnecessary or inefficacious care (on the surface the care seems grossly excessive), that cannot be found to the clear and convincing level for the same reason the plan fell below the



standard – there was no appropriate monitoring or documentation. I find that the first SOAP note stating that the patient was progressing satisfactorily was also below the standard of care to a clear and convincing standard even under the loose record keeping standard of the time.

**Count 15 – Patient B.M.**

B.M. started treatments with Respondent in 1991, having been suffering under the same condition for fifteen years, and that he had seen two other health care providers prior to treating with Respondent. Because the records previous to 2002 were lost, it is impossible to determine what happened during those eleven years. However, the records show that B.M. went once a week to Respondent from 2002 until 2011. Respondent testified without impeachment that this was a maintenance care patient, and that the patient was in a profession that required a high degree of physical activity, and that the patient was self-directing in his treatment. B.M. did not testify and was not interviewed by the Board.

The allegations in the count are essentially the same as those in T.C. and C.C. Like the cases of T.C. and C.C., on the surface the number of treatments is concerning as is the lack of documentation demonstrating maintenance as opposed to corrective or temporary care. Nevertheless, it is apparent that this is a maintenance care patient, and that the insurer paid the bills without question throughout the time of treatment. I cannot find that this count is sustained, as there is no evidence of overtreatment or exploitation.

**Count 16 – Patient I.P.**

I.P. was nine years old at the start of her visits with Respondent. From the records, it appears that her family was also a treating with Respondent. I.P. did not testify, nor did any member of her family. Apparently, they were not interviewed.

I.P. was brought in by her mother on April 11, 2006. The purpose of the appointment on the form was "ADD." A physical examination occurred, and other than occasional headaches the only spinal issue was "pain between shoulders." There is nothing indicating the severity or cause of this pain, or even if it was transient pain limited to that day. The mother did not check any of the boxes on the consent form, but did sign it, authorizing the treatment of the spine as Respondent deemed appropriate. Respondent "prescribed" supplements after nutritional testing, and several were purchased on April 18, 2006. No information was provided by the Board or Respondent about how the supplements would be expected to affect ADD, or how long a typical course of treatment would be expected to continue.

What happened next is worthy of close fact finding.

- I.P. returned for evaluation on May 2, 2006. The SOAP note states that she was experiencing headache, stomach ache and sore back. However, coinciding handwritten notes state that the patient was more alert and more attentive. She was instructed to increase her water intake.
- I.P. returned for evaluation on May 30, 2006. No headaches or stomach aches were noted. A thermal scan was taken. No narrative accompanies this scan. No reason is given for taking the scan.
- I.P. returned for evaluation on June 20, 2006. No headaches or stomach aches were noted.
- I.P. returned for evaluation on July 11, 2006. No headaches were noted. She had experienced stomach aches on a few occasions, but also had run out of supplements and was eating poorly.
- I.P. returned four days later on July 15, 2006. The subjective portion of the SOAP note reads in its entirety: "The patient entered the office reporting that she was feeling better with

the nutritional supplements. The patient was examined, evaluated and x-rayed.” The objective portion of the note states that she was still experiencing occasional stomach aches and headaches. She was adjusted in six places, including her hip.

- There is no evidence of a physical examination taking place. The x-ray report states that the patient’s spine was in phase 1 or 2 of subluxation degeneration.
- There is an unsigned checklist in the record, dated July 15, 2006, stating that there would be intensive care for two months, followed by two visits a week for four months. An x-ray was to be taken in a year. The plan was to last between 6 months and 1 ½ years. It is unknown whether this document was shown to the patient’s parents.
- I.P. was adjusted in at least 6 to 8 places three times a week from Mid-July 2006 to Mid-October 2006. She was then adjusted in at least 6 to 8 places twice a week until January of 2007, then sporadically until the first week of September of 2007 when she began again receiving twice a week adjustments through January 2008, which adjustments then occurred sporadically until April 12, 2008, when she was brought in after a motor vehicle accident. During this time, the patient continually complained about back pain. No mention is found in any SOAP note, or any other document in the file dated after July, 2006, about ADD. The supplement purchases dropped off dramatically during this time. The SOAP notes read as if it the goal was a spine remodel, with the patient progressing satisfactorily at all times. It does not appear that any inquiry was made about whether the patient was improving as to alertness or attentiveness. No x-ray was taken in July of 2007, contrary to the plan in the checklist, and none in 2008 until the accident.
- After the accident, a continuing series of x-rays were taken, totaling 38 separate x-rays during the course of treatment as of 2011.

After the accident, the treatments accelerated and continued unabated over the years until they totaled 306 during the five year period beginning in 2006. No new checklist was developed demonstrating a plan, and no record was made of discussions with the parents about a plan, but there are numerous documents demonstrating thermal scans, EMGs, x-rays, updates, pain checks and other forms that seem to indicate some level of a plan, as opposed to adjustments for the sake of adjustments. I cannot find to a clear and convincing standard that the adjustments post-accident were unnecessary, ineffectual, negligent or exploitive.

However, pre-accident there are several areas of concern. Respondent stated he took the x-rays, after consultation with I.P.'s mother for three issues: ADD, constipation, and back issues, and that his plan was to affect the ADD through improvement of the spine. Other than a thermal scan taken two months earlier, there is nothing in the file indicating a need for the x-rays. In fact, the only information on ADD found is a note indicating improvement two months before the x-rays. No mention is made of constipation at all in the notes. Therefore, the taking of the x-rays followed by immediate multiple adjustments is highly suspect. When it is next considered that the patient was placed in a spine remodel mode and that the term "ADD" never appears again in the notes, and that there is no mention of even questioning the level of ADD through the next two years (or for that matter ever again through 2011), I find Respondent's explanations that one of the main reasons for treatment was to affect ADD by remodeling the spine to be wholly unbelievable.

What is even more troubling is that I.P.'s spine seemed to be fairly asymptomatic when she first arrived at Respondent's office. Other than a reference to a sore back (a generic term) some two months earlier, this child seems to have been no different than any other. After the x-ray, when Respondent discovered the "need" for extensive treatment, the patient continuously began to complain about back pain over the course of the months. This fact does not even seem to have

registered on the Respondent. He did not x-ray the spine again in a year, the way he originally planned, but continued the treatments unabated. Respondent did, however, see to it that the family agreed, in October 2006, to pay \$141 per month, on top of whatever insurance paid, for two years. That this time period exceeded the life of the "plan" as described in the checklist seems to have escaped everyone's notice.

Added to this is the fact that the issue of constipation or stomach discomfort, like the ADD a supposed reason for the treatments, completely drops out of the SOAP notes once adjustments start, and is never once mentioned, let alone monitored.

In this context, the assessment "progressing satisfactorily" is deeply suspect. First, Respondent never apparently asked about ADD or stomach issues, so how would he know whether the patient's state was deteriorating? Second, as to the back issues, the patient began with "soreness" but after treatment began to and thereafter continuously referred to pain in her neck, along her back and hip. What is more, the thermal scan and EMG documents appear to show increased levels of discomfort in September and October of 2006 (there are no similar documents until after the accident). So if anything, this patient seems to have been getting worse, not staying the same.

The count alleges that the care as to the pre-accident was excessive and no documentation of the need for the care or the need for the frequency of the care exists. This portion of the count is sustained. I find that there is clear and convincing evidence of unnecessary care, and that Respondent fell below the standard of care for treating this child the way he did, and by failing to document any progress or lack thereof of the ADD or intestinal issues. I further find it clear and convincing that Respondent engaged in negligent care creating a risk of harm (and in this case actual harm) to the patient.

The count further alleges improper billing practices, but there was virtually no testimony by the Board expert on this issue. This portion of the count is not sustained.

The final issue covered by the count is one involving the x-rays. Aside from the lack of justification for the initial set of x-rays, the count alleges that there were too many taken, given the age of the child, over the course of treatment. Although the concerns of the expert were legitimately raised, there was no specific evidence as to I.C. about harmful levels of radiation received by that patient, either as to a particular date, or taken as a cumulative effect over several years. Rather, the evidence is that the expert opined that the taking of multiple x-rays was "too much," without reference to more than personal opinion. Although the Board expert clearly believed, and opined, that Respondent's x-rays were overkill, and even dangerous, the clear and convincing evidence is that in no case did the x-rays exceed the guidelines set by the state and federal governments as to the taking of x-rays, either as to an individual date or in the cumulative. No evidence was adduced as to the state of the x-ray equipment used by Respondent, except that it had been inspected and was approved by the state. In addition, some of the various guidelines entered into evidence recommended x-rays as part of the diagnostic tools of the profession. Given that, this portion of the count cannot be sustained.

**Count 17 was withdrawn by the Board.**

**Count 18 – Patient R.C.**

R.C. was a patient who was disabled and had a history of strokes. He sought treatment with Respondent for neck pain, and his examination revealed pain throughout his spine. He was seeking relief from pain, and a late disclosed document demonstrates he also agreed to corrective care or spine remodeling. He was treated intensively from late November of 2010 to March 2011, and less intensively to August of 2011. R.C. was not interviewed and did not testify.

The count alleges that Respondent misdiagnosed scoliosis. In fact the x-ray report dated November 24, 2009, mentions "mild" scoliosis. This portion of the count is not sustained for the reasons stated elsewhere in these findings.

The count alleges there was no documentation to justify 65 treatments. The missing information was filled in in late disclosures. Thermal and EMG narratives were provided documenting the issues with R.C.'s spine that coincide with the x-ray and physical examination, and a consent form demonstrates the patient chose corrective care.

The count alleges that Respondent continued in the same form of treatment for 1 ½ years. This is true, but this was a corrective care case. The count alleges that Respondent should not have used the term "progressing satisfactorily" when he had an arm and hand issue that was not resolving. Respondent was not treating the arm or hand. These portions of the count are not sustained.

The count cites a failure to refer the patient to a neurosurgeon, but the Board retracted this portion of the count.

The count alleges that the chart notes were poor. They are but they do reflect the corrective care given. There is one exception. Respondent used the term "progressing satisfactorily" at the time of the first visit and examination. Given the testimony of the meaning of the term by Respondent, it is clear that this is an improper note and falls below the standard of care as of 2009. This portion of the count is sustained.

### CONCLUSIONS OF LAW

1. For the aforementioned reasons, Counts 3,5,6,7,8,9,10,11,12,13,15, and 17 are not sustained and should be dismissed;

2. Count 1 is sustained for violation of Idaho Code § 54-712(13) and (14);

3. Count 2 is sustained for violation of Idaho Code § 54-712(10);
4. Count 4 is sustained for violation of Idaho Code § 54-712(10), (13) and (14);
5. Count 16 is sustained for violation of Idaho Code § 54-712(13) and (14); and,
6. Count 18 is sustained for violation of Idaho Code § 54-712(13).

This is a recommended order of the hearing officer. It will not become final without action of the agency head. Any party may file a petition for reconsideration of this recommended order with the hearing officer issuing the order within fourteen (14) days of the service date of this order. The hearing officer issuing this recommended order will dispose of any petition for reconsideration within twenty-one (21) days of its receipt, or the petition will be considered denied by operation of law. See section 67-5243(3), Idaho Code.

Within twenty-one (21) days after (a) the service date of this recommended order, (b) the service date of a denial of a petition for reconsideration from this recommended order, or (c) the failure within twenty-one (21) days to grant or deny a petition for reconsideration from this recommended order, any party may in writing support or take exceptions to any part of this recommended order and file briefs in support of the party's position on any issue in the proceeding.

Written briefs in support of or taking exceptions to the recommended order shall be filed with the agency head (or designee of the agency head). Opposing parties shall have twenty-one (21) days to respond. The agency head or designee may schedule oral argument in the matter before issuing a final order. The agency head or designee will issue a final order within fifty-six (56) days of receipt of the written briefs or oral argument, whichever is later, unless waived by the parties or for good cause shown. The agency may remand the matter for further evidentiary hearings if further factual development of the record is necessary before issuing a final order.



DATED this 25 day of August, 2014.

MICHAEL KANE & ASSOCIATES, PLLC

BY: Michael Kane  
MICHAEL J. KANE  
Hearing Officer

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 25 day of August, 2014, I caused to be served a true and correct copy of the foregoing document by the method indicated below and addressed to the following:

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HEARING OFFICER

BEFORE THE IDAHO BOARD OF CHIROPRACTIC PHYSICIANS

STATE OF IDAHO

In the Matter of the License of:	)	
	)	
LAVERLE E. BRESHEARS, D.C.,	)	Case No. CHI-2010-7
License No. CHIA-428,	)	
	)	RECOMMENDED ORDER
Respondent,	)	ON RECONSIDERATION
_____	)	

Respondent, LAVERLE E. BRESHEARS, D.C., raises two (2) issues on reconsideration. The first deals with a request for an award of attorney's fees and costs pursuant to Idaho Code § 12-117. Respondent states that he prevailed on several of the counts and therefore partial attorney's fees should be awarded. The standard under the statute is that attorney's fees may only be awarded when the agency acted without a reasonable basis in fact or law with respect to that portion of the case wherein Respondent prevailed.

First, it is not clear that a hearing officer has jurisdiction to order attorney's fees in an administrative proceeding. The statute speaks to the state agency or board making the finding as to whether or not the non-prevailing party acted without a reasonable basis in law or fact. The Idaho Administrative Code (IDAPA 04.11.01, *et seq.*) does not speak to the issue at all. However, the scope of the hearing officer's authority, found in Rule 413 of the Idaho Administrative Code, indicates that the agency may limit a hearing officer's scope of authority. Nothing in my charge from the Idaho Bureau of Occupational Licenses states that I have authority to make an award regarding attorney's fees.

Having said that, and to the extent it is helpful to the Board, I do not believe this case was brought without foundation in law or fact. As stated several times in the Recommended Findings of Fact and Conclusions of Law, many of the counts were based upon reviews of the records and Respondent's records were very poor. The experts could have, and in fact did, easily drawn the conclusion from the records presented to them that Respondent's actions fell below the standard of care or otherwise violated the Board's rules and statutes applicable to the Board. Respondent in many cases avoided a finding that he had violated one or more of the Board's rules or statutes applicable to the Board because of late disclosure of information.

Therefore, to the extent that the hearing officer even has jurisdiction on this issue, it is recommended that attorney's fees and costs not be awarded to the Respondent.

The second issue raised for reconsideration involves an allegation that Board expert Dr. Hollingsworth was a Board member and therefore his acting as an expert witness was unconstitutionally unfair to the Respondent because the Board is the ultimate finder of fact. Therefore, the argument goes, Respondent faces a biased tribunal.

This argument is unfounded. The testimony of Dr. Hollingsworth was clear that he was going to retire from the Board in July 2014. Therefore, by definition, he would not be in a position to be part of the review by the Board of the hearing officer's recommended order. In any event, it is both reasonable and a common practice for Board members to serve as experts in proceedings involving testimony as to the standard of care and similar matters. It is, in this hearing officer's experience, universal that Board members who serve as experts do not sit on the Board making the determination as to whether or not to adopt the hearing officer's Recommended Findings of Fact and Conclusions of Law. Although Dr. Hollingsworth did not explicitly testify that he would recuse himself from the Board discussions regarding the Recommended Findings of Fact and Conclusions of Law, because he was not a Board member at the time the recommended order was delivered to the Board, it is apparent that he will not have the ability to bias the Board.

### **PROCEDURAL RIGHTS**

a. This is a recommended order of the hearing officer. It will not become final without action of the agency head. Any party may file a petition for reconsideration of this recommended order with the hearing officer issuing the order within fourteen (14) days of the service date of this order. The hearing officer issuing this recommended order will dispose of any petition for reconsideration within twenty-one (21) days of its receipt, or the petition will be considered denied by operation of law. (*See* Idaho Code § 67-5243(3)).

b. Within twenty-one (21) days after: (a) the service date of this recommended order; (b) the service date of a denial of a petition for reconsideration from this recommended order; or (c) the failure within twenty-one (21) days to grant or deny a petition for reconsideration from this recommended order, any party may in writing support or take exceptions to any part of this

recommended order and file briefs in support of the party's position on any issue in the proceeding.

c. Written briefs in support of or taking exceptions to the recommended order shall be filed with the agency head (or designee of the agency head). Opposing parties shall have twenty-one (21) days to respond. The agency head or designee may schedule oral argument in the matter before issuing a final order. The agency head or designee will issue a final order within fifty-six (56) days of receipt of the written briefs or oral argument, whichever is later, unless waived by the parties or for good cause shown. The agency head (or designee of the agency head) may remand the matter for further evidentiary hearings if further factual development of the record is necessary before issuing a final order.

DATED this 9 day of September, 2014.

MICHAEL KANE & ASSOCIATES, PLLC

BY: Michael Kane  
MICHAEL J. KANE  
Hearing Officer

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 9 day of September, 2014, I caused to be served a true and correct copy of the foregoing document by the method indicated below and addressed to the following:

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MICHAEL J. KANE