

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudatory Case No.

In the Matter of

KIRKHAM B. WOOD, M.D.

CONSENT ORDER

Pursuant to G.L. c. 30A, § 10, Kirkham B. Wood, M.D. (Respondent) and the Board of Registration in Medicine (Board) (hereinafter referred to jointly as the "Parties") agree that the Board may issue this Consent Order to resolve the above-captioned adjudicatory proceeding. The Parties further agree that this Consent Order will have all the force and effect of a Final Decision within the meaning of 801 CMR 1.01(11)(d). The Respondent admits to the findings of fact specified below and agrees that the Board may make the conclusions of law and impose the sanction set forth below in resolution of investigative Docket No. 20-647.

Findings of Fact

1. The Respondent is Board-certified in orthopedic surgery. He graduated from the Albany Medical College of Union University in 1984. The Respondent has been licensed to practice medicine in Massachusetts under certificate number 219765 since 2004. The Respondent was previously affiliated with Massachusetts General Hospital (MGH) and Brigham & Women's Hospital. The Respondent is now a professor at Stanford Medical School in California.

Patient A

2. Patient A, a sixteen-year-old male, sustained a traumatic coccyx injury during a bicycle accident in 2010.

3. On June 13, 2011, the Respondent performed a coccygectomy on Patient A at MGH.

4. During his first post-operative visit on June 28, 2011, Patient A reported sharp coccygeal pain with poor pain control. He denied fevers. His incision appeared clean, dry, and intact with intact suture. Patient A was prescribed Vicodin and Ibuprofen and advised to return in six weeks. The Respondent's name is included on this office report.

5. On August 9, 2011, Patient A returned to MGH. Patient A reported that he had no relief of pain and that he experienced drainage and redness around his surgical wound. Patient A was exquisitely tender over the remainder of the wound and hypergranulation tissue was noted at the distal margin. The area was treated with silver nitrate and Patient A's parents were taught to do the same. No imaging or laboratory tests were performed. The Respondent asked to see Patient A in two months.

6. Patient A saw his primary care provider (PCP) on August 12, 2011 and September 7, 2011, continuing to complain of increased pain at the bottom of his spine. An MRI performed on September 9, 2011 revealed a large fluid collection compatible with an abscess.

7. On September 19, 2011, Patient A returned to the Respondent's clinic complaining of a great deal of pain in the incisional area flesh. The Respondent withdrew 5-10 cc of seromatous-type fluid and sent it for culture. Patient A reported some relief after this procedure. Blood tests were performed and were in the normal range. The Respondent planned to see Patient A in two months.

8. Aside from a telephone call in October 2011, Patient A had no further office visits with the Respondent at MGH.

9. On August 13, 2012, the Respondent's office received a call from Patient A's PCP reporting that Patient A had intermittent sanguineous drainage at the inferior aspect of the coccygeal incision.

10. In August 2012, Patient A and his parents sought a second surgical opinion from Physician B. Physician B noted Patient A to have lower sacral erythema, induration, purulent drainage, extreme tenderness, and a sinus tract distal to the healed surgical incision. On August 24, 2012, Physician B performed an incision and drainage of Patient A's pericoccygeal abscess with possible rectal fistula. The abscess was deep and there were two sinus tracts with retained suture material.

11. Following an MRI on December 13, 2012, Physician B diagnosed Patient A with "true osteomyelitis." Physician B and colleagues concluded that this was a long-standing infection following the original surgery or possibly dating back to pre-operative cortisone shots that Patient A received after the bicycle accident.

12. In April 2014, Patient A filed a medical malpractice suit against the Respondent alleging negligent treatment and substandard care between June and September 2011.

13. On December 19, 2017, after a twelve-day trial, the jury entered a verdict in Patient A's favor. Specifically, the jury found the Respondent to be negligent in his care and treatment of Patient A and that the Respondent's negligence was a substantial contributing factor in causing Patient A's injuries. The jury also found that Patient A sustained a substantial or permanent loss or impairment of a bodily function or substantial disfigurement, or other special circumstances which warranted a finding that limiting pain and suffering damages to

\$500,000, would deprive Patient A of just compensation for the injuries sustained as a result of the Respondent's negligence. The jury awarded Patient A compensatory, pain and suffering, and lost earning capacity damages.

14. The Respondent's motions for judgment notwithstanding the verdict, new trial, and remittitur were denied on February 6, 2018.

15. On April 23, 2020, the Massachusetts Appeals Court affirmed the lower court's denial of the post-trial motions and maintained the jury's verdict.

Patient B

16. Patient B, a sixty-one-year-old female, presented to the Respondent for evaluation of degenerative lumbar scoliosis and spinal stenosis in April 2015.

17. On September 2, 2015, Patient B underwent a T10-L5 posterior fusion with the Respondent. The surgery began at 8:02am.

18. An intraoperative x-ray taken on September 2, 2015 at 9:42am noted "needle level is difficult to determine due to the degree of spinal deformity."

19. An intraoperative x-ray taken at 10:42am noted that "probe level is difficult to determine due to degree of spinal deformity and rotatory curvature."

20. An intraoperative x-ray taken at 1:01pm notes "intraoperative images show multiple pedicle guide pins spanning T10-L5 according to numbering used on prior CT."

21. The Respondent's operative note reports that he "placed pedicle screws bilaterally at T9 and T10, on the left at T11, bilaterally at T12, L1, L2, only on the left at L3, bilaterally at L4, and bilaterally at L5."

22. Patient B was transferred from the operating room to recovery at 4:50pm; no further x-rays were taken on September 2, 2015.

23. On September 5, 2015, Patient B's x-rays taken at 12:37pm noted "post-surgical changes with pedicle screws extending into T10-L5 and right S1. Marked scoliosis upper thoracic spine. No definite evidence of hardware complications."

24. On September 6, 2015, Patient B was transferred to a rehabilitation hospital where she remained until discharge on September 11, 2015.

25. On September 16, 2015 at 10:45am, Patient B returned to the operating room with the Respondent.

26. The Respondent's operative note reports that the "rod on the left side was disconnected from the more superior rod and repositioned so that it was adequately in the L5 pedicle screw. All nuts were secondarily tightened down. On the right-hand side the rod was also removed, and the screw intended for L5 was placed into a better position in the L5 and then the rod also reconnected and cross-linked in 2 locations."

27. An intraoperative x-ray taken on September 16, 2015 at 12:18pm notes "removal of the right-sided paraspinous rod and horizontal cross bar. There has been placement of a pedicle marker on the right at L5. The previous right S1 screw has been removed."

28. Patient B was transferred from the operating room to recovery at 1:37pm.

29. The Respondent failed to meet the standard of care with regard to Patient B by:

- a. failing to recognize the unintended screw placement at S1;
- b. failing to take a final intraoperative x-ray on September 2, 2015 to confirm the final screw placement; and
- c. upon discovery of the pedicle screw at right S1 on post-operative day three, September 5, 2015, delaying corrective surgery for an additional eleven days.

Conclusion of Law

A. The Respondent has violated G.L. c. 112, §5, ninth par. (c) and 243 C.M.R. 1.03(5)(a) 3 in that he engaged in conduct which calls into question his competence to practice medicine, including but not limited to practicing medicine with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions.

B. The Respondent has violated 243 C.M.R. 1.03(5)(a) 17 in that he committed malpractice within the meaning of G.L. c. 112, § 61.

Sanction and Order

Pursuant to G.L. c. 112, § 5A and 243 C.M.R. 1.05(7), the Respondent's license to practice medicine is hereby REPRIMANDED. This sanction is imposed for each violation of law listed in the Conclusion section and not a combination of any or all of them.

Execution of this Consent Order

Complaint Counsel and the Respondent agree that the approval of this Consent Order is left to the discretion of the Board. The signature of Complaint Counsel and the Respondent are expressly conditioned on the Board accepting this Consent Order. If the Board rejects this Consent Order in whole or in part, then the entire document shall be null and void; thereafter, neither of the parties nor anyone else may rely on these stipulations in this proceeding.

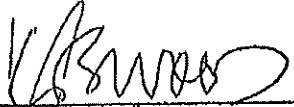
As to any matter in this Consent Order left to the discretion of the Board, neither the Respondent, nor anyone acting on his behalf, has received any promises or representations regarding the same.

The Respondent waives any right of appeal that he may have resulting from the Board's acceptance of this Consent Order.

The Respondent shall provide a complete copy of this Consent Order with all exhibits and attachments within ten (10) days by certified mail, return receipt requested, or by hand


delivery to the following designated entities; any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which the Respondent practices medicine; any in- or out-of-state health maintenance organization with whom the Respondent has privileges or any other kind of association; any state agency, in- or out-of-state, with which the Respondent has a provider contract; any in- or out-of-state medical employer, whether or not the Respondent practices medicine there; the state licensing boards of all states in which the Respondent has any kind of license to practice medicine; the Drug Enforcement Administration Boston Diversion Group; and the Massachusetts Department of Public Health Drug Control Program. The Respondent shall also provide this notification to any such designated entities with which the Respondent becomes associated in the year following the date of imposition of this reprimand. The Respondent is further directed to certify to the Board within ten (10) days that the Respondent has complied with this directive.

The Board expressly reserves the authority to independently notify, at any time, any of the entities designated above, or any other affected entity, of any action it has taken.




Kirkham B. Wood, M.D.
Licensee

26 JUN 23
Date



Vincent P. Dunn, Esq.
Counsel for Licensee

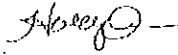
6/28/23
Date



Rachel N. Shute, Esq.
Complaint Counsel

7/05/2023
Date

So ORDERED by the Board of Registration in Medicine this 3rd day of August
2023.



Holly Oh, M.D.
Vice Chair