COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss. Board of Registration in Medicine

Adjudicatory Case No.

In the Matter of

KIRKHAM B. WOOD, M.D.

STATEMENT OF ALLEGATIONS

The Board of Registration in Medicine (Board) has determined that good cause exists to believe the following acts occurred and constitute violations for which a licensee may be sanctioned by the Board. The Board therefore alleges that Kirkham B. Wood, M.D. (Respondent) has practiced medicine in violation of law, regulations, or good and accepted medical practice as set forth herein. The investigative docket number associated with this order to show cause is Docket No. 20-647.

Biographical Information

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.

Factual Allegations

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 would. 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 paraspinal 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.

Legal Basis for Proposed Relief

A. Pursuant to G.L. c. 112, §5, eighth par. (c) and 243 CMR 1.03(5)(a)3, the Board may discipline a physician upon proof satisfactory to a majority of the Board, that he engaged in conduct that places into question the Respondent's competence to practice medicine, including but not limited to gross misconduct in the practice of medicine, or practicing medicine fraudulently, or beyond its authorized scope, or with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions.

B. Pursuant to 243 CMR 1.03(5)(a)17, the Board may discipline a physician upon proof satisfactory to a majority of the Board, that said physician has committed malpractice within the meaning of M.G.L. c. 112, § 61.

Nature of Relief Sought

The Board is authorized and empowered to order appropriate disciplinary action, which may include revocation or suspension of the Respondent's license to practice medicine. The Board may also order, in addition to or instead of revocation or suspension, one or more of the following: admonishment, censure, reprimand, fine, the performance of uncompensated public service, a course of education or training, or other restrictions upon the Respondent's practice of medicine.

Order

Wherefore, it is hereby **ORDERED** that the Respondent show cause why the Board should not discipline the Respondent for the conduct described herein.

By the Board of Registration in Medicine,

Holly Oh, M.D.
Vice Chair

Date: 8/3/2023