

LICENSE NO. D-6119

IN THE MATTER OF
THE LICENSE OF
KENNETH W. O'NEAL, M.D.

BEFORE THE DISCIPLINARY PANEL
OF THE
TEXAS MEDICAL BOARD

ORDER OF TEMPORARY SUSPENSION
(Without Notice of Hearing)

On October 28, 2005, came to be heard before the Disciplinary Panel of the Texas Medical Board (the "Board"), composed of Timothy J. Turner, Chair, Jose M. Benavides, M.D. and David E. Garza, D.O., members of the Board (the "Panel") duly in session, the matter of the Application for Temporary Suspension of the license of Kenneth W. O'Neal, M.D. ("Respondent"). Dinah Brothers represented Board staff. Based on evidence submitted, the Board through this Panel makes the following Findings of Fact and Conclusions of Law and enters this Order Of Temporary Suspension:

FINDINGS OF FACT

1. Respondent is a Texas Physician and holds Texas Medical License Number D-6119, issued by the Board in 1969, which was in full force and effect at all times material and relevant to this Complaint. All jurisdictional requirements have been satisfied.
2. At the direction and approval of a member of the Executive Committee, Roberta M. Kalafut, D.O., President of the Board, appointed Timothy J. Turner, Chair, Jose M. Benavides, M.D. and David E. Garza, D.O., members of the Board (the "Panel") to sit as a Disciplinary Panel in this matter, pursuant to TEX. OCC. CODE ANN. Title 3, Subtitle (the "Act") §164.059(a) and 22 TEX. ADMIN. CODE §187.56.
3. Patient K.S.
 - a. Patient K.S. was an eighty-three year old female with a medical history of congestive heart failure, chronic obstructive pulmonary disease, asthma, gastroesophageal reflux disease, and aortic stenosis.

- b. According to Respondent's narrative to the Board, the patient's objective for seeking treatment was to "improve her quality of life."
- c. The patient's "Health Questionnaire" was completed on February 10, 2005, however, there is no documentation that Respondent examined the patient on that date. Respondent documented the first encounter with the patient on February 16, 2005. There is no documentation that Respondent completed a physical examination. Laboratory work was ordered at this appointment.
- d. According to the patient's medical records, Respondent saw the patient on March 9, 2005, May 4, 2005, and May 12, 2005. The only physical examination records from these appointments are the patient's vital signs. During these appointments, Respondent discussed discontinuing Spiriva, diet, adding vitamins and laboratory results.
- e. On May 4, 2005, Respondent documented that the patient was "breathing much better, increased energy, growing garden." Respondent also noted the patient had increased her time and speed on the treadmill.
- f. On June 2, 2005, Respondent administered "Myers in normal saline." According to Respondent's formulary, Myers Cocktail contains vitamin C, B-complex, magnesium sulfate, calcium gluconate, pyridoxine, methylcobalamine, folic acid, B5, Isotonic Quintin, and normal saline. The time of administration of the Myers Cocktail is not noted by Respondent.
- g. Prior to administration of the Myers Cocktail, the patient's vital signs were blood pressure 121/65; pulse 62 beats per minute, respiration 24. Post administration of the Myers Cocktail, the patient's vital signs were blood pressure 117/60, pulse 60 beats per minute, respiration 24.
- h. At 1205, the Physician's Progress Notes document the patient's vital signs as blood pressure 142/58; pulse 46 beats per minute; with tachypenic respirations at 36. The patient's pulse oximeter reading indicated an oxygen saturation of 94%.
- i. According to the medical records, Respondent left the room to obtain Decadron and returned within three minutes to find the patient had "increased

distress, altered level of consciousness, cyanosis, increased difficulty breathing," and desaturation on room air to 75%.

- j. Cardiopulmonary resuscitation was initiated and emergency services were called.
- k. According to records from the Abilene Fire Department, emergency services arrived to Abilene Integrative Medicine at 1216. At 1217, emergency personnel determined the patient had no respirations and no pulse. The patient was intubated and transported to Hendrick Medical Center.
- l. The patient was pronounced dead at 1250. Records from Hendrick Medical Center identify the patient's cause of death as acute cardiopulmonary arrest.
- m. According to Respondent's narrative to the Board, Respondent administered Myers solution on June 1, 2005 and the patient presented to Respondent's office in respiratory distress on June 2, 2005. This narrative response contradicts with the patient's medical record.
- n. No autopsy was performed on this patient.

4. Patient A.P.

- a. Patient A.P. was an eighty-seven year old female with a medical history of severe, symptomatic aortic stenosis, congestive heart failure, and severe hypertension.
- b. The patient's "Health Questionnaire" was completed on August 6, 2003. Vital signs were recorded at this appointment, however, there is no documentation that Respondent completed a physical examination on that date.
- c. Over the next two years, the patient received numerous intravenous infusions of various mixtures from Respondent. These solutions included Freamine; an IBM mixture which contained vitamins, magnesium sulfate, selenium, zinc and isotonic quinitin; and Myers Cocktail.
- d. On February 9, 2005, the patient presented to Respondent with hypertension. Respondent recorded blood pressure as 158/89. Respondent gave the patient an intravenous infusion of Freamine. No additional vital signs were documented by Respondent.

- e. According to Respondent's narrative to the Board, the patient requested intravenous administration of Freamine on August 3, 2005 so she would "feel better for her birthday."
 - f. On August 3, 2005, the patient presented to Respondent and received an intravenous infusion of Freamine, IR, Taurine, NaCHO₃, and IBM. The patient's vital signs at the initiation of the treatment were blood pressure 139/79; pulse 87 beats per minute; with a room air oxygen saturation of 94%. According to the medical records this infusion began at 1400.
 - g. Ten minutes into the intravenous infusion, the patient reported itching and experienced a drop in blood pressure to 80/40.
 - h. Respondent administered Decadron at 1415 and 1420. At 1420 the patient complained of severe back pain and emergency services were called.
 - i. According to records from the Abilene Fire Department, emergency services arrived to Abilene Integrative Medicine at 1429. Emergency personnel documented that at 1430, the patient had regular respirations and pulse. The patient was transported to Hendrick Medical Center.
 - j. Records from Hendrick Medical Center state the patient was experiencing shortness of breath, diaphoresis, and mid-sternal pain. The physician's clinical impression was that the patient suffered a cardiovascular incident after alternative medicine intervention.
 - k. The patient was a "do not resuscitate" patient and was pronounced dead at 1612.
 - l. No autopsy was performed on this patient.
5. Patient D.T.
- a. Patient D.T. was a fifty-two year old male with a medical history of hypertension and hyperlipidemia.
 - b. The patient's "Health Questionnaire" was completed on December 3, 2004, however, there is no documentation that Respondent examined the patient on that date. Respondent documented the first encounter with the patient on December 15, 2004. Except for taking the patient's vital signs, there is no documentation that Respondent completed a physical examination.

- c. From December 15, 2004 through July 2, 2005, medical records indicate the patient received twenty-two treatments of intravenous vitamins. The majority of these treatments were identified by Respondent as "Chelation Protocol." According to Respondent's formulary "Chelation Protocol" consisted of calcium edetate, Vitamin C, B-Complex, magnesium, isotonic quintin, B5, and normal saline.
- d. Although the patient received twenty-two intravenous infusions as documented on the "Chelation Log," Respondent made only four narrative entries in the patient's medical record.
- e. According to Respondent's narrative response to the Board, the patient presented to Respondent's office on June 2, 2005 for routine chelation treatment. The patient told the office staff he was nauseated due to some chicken he had eaten at lunch. The chelation treatment was administered as planned.
- f. At 1550, shortly after the administration of this solution, the patient began to experience burning eyes and tongue, vomiting and diaphoresis. The patient was given Phenergran related to the vomiting.
- g. At 1625, the patient's blood pressure was 152/88 with a pulse rate of 92 beats per minute. At 1650, the patient's blood pressure was 167/90 with a pulse rate of 103 beats per minute.
- h. The patient's wife arrived to the clinic at 1740 to transport the patient home. The patient continued to experience difficulty breathing. At 1740, the patient's medical record indicates that the patient's vital signs were "within normal limits," however, no blood pressure reading is recorded in the record.
- i. At 1800 emergency services were called to transport the patient to the emergency room. Therefore, Respondent had attempted to manage the patient's condition in the clinic for over two hours.
- j. According to the Abilene Fire Department, emergency services arrived at Abilene Integrative Medicine at 1802 to find the patient in respiratory distress.
- k. Emergency personnel were unable to take a blood pressure reading on the patient.
- l. According to documentation by the Abilene Fire Department, the patient presented to Respondent with nausea, vomiting and diarrhea. There is no

documentation by the Abilene Fire Department that Respondent informed emergency personnel the patient had undergone chelation treatment.

- m. Enroute to Hendrick Medical Center the patient became unresponsive and cardiopulmonary resuscitation was initiated.
- n. The patient arrived to Hendrick Medical Center in cardiopulmonary arrest. Aggressive attempts to revive the patient were unsuccessful and patient was pronounced dead at 1853.
- o. The autopsy report identified the cause of death as "severe occlusive coronary atherosclerosis."

6. Respondent's Formulary

- a. Respondent's formulary for intravenous treatments was contained on typed sheets.
- b. Respondent did not provide the Board any professional research or literature that supported the medical benefits of these intravenous treatments.

7. Board's Expert Panel

- a. The Board's Expert Panel determined Respondent's treatment of patient K.S. was below the standard of care because no physical examination was completed by Respondent. The Panel also held it was below the standard of care to treat a patient with congestive heart failure or respiratory distress with intravenous vitamins. The Panel determined that Respondent did not meet the standard of care for patient K.S.
- b. The Board's Expert Panel determined Respondent's treatment of patient A.P. was below the standard of care because the use of intravenous solutions of saline and vitamins can be potentially harmful in a patient with severe aortic stenosis because of rapid volume overload resulting in pulmonary edema and death.
- c. The Board's Expert Panel determined Respondent's treatment of patient D.T. was below the standard of care because treatment of hypertension and hyperlipidemia must be with medically proven therapies, including statin drugs for elevated lipids and medications to treat hypertension. In the Panel's opinion, Respondent was also below the standard of care for treating a patient in respiratory distress. According to the Panel, Respondent should have immediately transferred the

patient to a facility better equipped to treat the patient's respiratory distress. It is the opinion of the Panel that Respondent's failure to diagnose and treat the patient's acute respiratory failure led to the death of the patient.

- d. The Board's Expert Panel concluded Respondent posed "a real danger to the public" and should not continue practicing integrated medicine.

8. Additional Factual Allegations

- a. Both patient K.S. and patient D.T. died on the same day, June 2, 2005, after receiving intravenous vitamins at Abilene Integrative Medicine.

9. Based on the above Findings of Fact, the Panel, including at least one physician licensed to practice medicine in this state, finds that Respondent is a real danger to the health of Respondent's patients or to the public from the acts or omissions of Respondent caused through Respondent's lack of competence, impaired status, or failure to care adequately for Respondent's patients.

10. Based on the above Findings of Fact, the Panel finds an imminent peril to the public health, safety, or welfare that requires immediate effect of this Order of Temporary Suspension on the date rendered.

CONCLUSIONS OF LAW

Based on the above Findings of Fact, the Panel concludes the following:

1. Section 164.059 of the Act authorizes the Disciplinary Panel to temporarily suspend or restrict the medical license of Respondent if the Disciplinary Panel determines from evidence presented to it that the Respondent's continuation in the practice of medicine would constitute a continuing threat to the public welfare.

2. Based on the evidence presented and the Findings of Fact set forth herein, the Disciplinary Panel concludes the following:

- a. Section 164.051(a)(6) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's failure to practice medicine in an acceptable professional manner consistent with public health and welfare.
- b. Respondent has committed a prohibited act or practice within the meaning of Section 164.052(a)(5) of the Act based upon unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public.

- c. Respondent has committed a prohibited act or practice within the meaning of Sections 164.052(a)(5) and 164.053(a)(4)(B) of the Act based on Respondent prescribing or administering a drug or treatment that is nontherapeutic in nature or nontherapeutic in the manner the drug or treatment is administered or prescribed.
- d. Respondent has committed a prohibited act or practice within the meaning of Sections 164.053(a)(6) of the Act based on Respondent prescribing, administering, or dispensing in a manner inconsistent with public health and welfare.

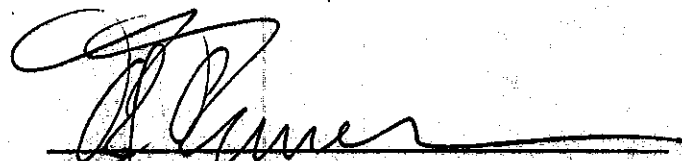
3. Based on the evidence presented and the above Findings of Fact and Conclusions of Law, the Panel determines that Respondent's continuation in the practice of medicine would constitute a continuing threat to the public welfare.

ORDER

Based on the above Findings of Fact and Conclusions of Law, the Panel ORDERS that:

1. Respondent's Texas medical license is hereby Temporarily Suspended.
2. Respondent shall give a copy of this Order to all hospitals, nursing homes, treatment facilities, and other health care entities where Respondent has privileges, has applied for privileges, applies for privileges, or otherwise practices.
3. Respondent shall ensure that any inquiries that are made by any person or entity through any means to Respondent or Respondent's employees regarding Respondent's Texas licensure status are answered by accurate reference to this Order.
4. Upon request by any person or entity, either orally or in writing, Respondent shall provide a complete and legible copy of this Order to the requesting party within ten calendar days of the request.
5. This Order of Temporary Suspension is final and effective on the date rendered.
6. This Order of Temporary Suspension shall remain in effect until it is superceded by an Order of the Board.

Signed and entered this 28th day of October, 2005.



Timothy J. Turner, Chair
Disciplinary Panel
Texas Medical Board