**STATE OF RHODE ISLAND**
**AND PROVIDENCE PLANTATIONS**

**DEPARTMENT OF HEALTH**
**BOARD OF MEDICAL LICENSURE AND DISCIPLINE**

**IN THE MATTER OF:**
**KENNON MILLER, M.D.**
**License Number MD011459**
**BMLD Case Numbers C11-308, C14-457 and C13-748A**

## CONSENT ORDER

Kennon Miller, M.D. (hereinafter "Respondent") is licensed as a physician in Rhode Island. The Board of Medical Licensure and Discipline (hereinafter "Board") through its investigating committee voted to find unprofessional conduct against Respondent due to the delay in removing a ureteral stent that had been placed by another surgeon, and the Board makes the following:

## FINDINGS OF FACT

1. Respondent is a licensed physician in the State of Rhode Island and was issued his license on May 3, 2004. He graduated from Dartmouth Medical School in 1987. His office is located at University Urological Associates, 450 Veterans Memorial Parkway, Building 14, East Providence, Rhode Island. His primary specialty is urology, in which he is board certified. He has privileges at Memorial, Rhode Island, Miriam, Women & Infants', and Veterans Administration Hospitals.

2. On June 6, 2008, Respondent was emergently called into part of a nine-hour gynecological, urological and colorectal surgery on Patient A at

Women and Infants' Hospital. Patient suffered a bladder injury during the hysterectomy phase of the operation, and Respondent successfully repaired the injury despite difficulties presented by the injury itself, the structure of the bladder, and degradation of some of the tissue in the bladder.

3. Although the Respondent appropriately placed a stent in the left side of the bladder, another surgeon had placed the right stent but did not indicate this in the surgical notes. A resident surgeon removed the left stent in another procedure in which Respondent did not participate, but the resident did not recognize the right-side stent and it remained in place. Based on the resident's report, Respondent believed both stents had been removed.

4. Respondent viewed a cystogram (bladder image) that had been taken on July 7, 2008, to assess the integrity of the bladder repair and to ensure no contrast fluids were escaping from the bladder, but he did not visualize the right-side stent. Although a radiologist ordinarily interprets such cystograms, and although the radiologist later found the right stent, the radiologist's dictation was not completed or provided to Respondent for about six months. During that period, patient had numerous complaints including frequency, infection and discomfort, which could have been caused by the remaining stent or the severity of the bladder injury. Respondent saw the patient five times in the three months after surgery to

monitor for complications.

5. In December 2008, patient had an abdominal computerized tomography (CT) scan that revealed the right stent, which could not be removed in Respondent's office due to its partial calcification. It was removed in surgery in January 2009, which stopped the symptoms the patient had been experiencing.

6. Respondent correctly noted in his response to the Board that the multiple surgical teams were involved in a complex case; operative notes did not reference the right-side stent; the radiologist delayed interpretation of the image that displayed the right stent; and as a result of this case the hospital's Department of Urology adopted and implemented a new protocol for identifying ureteral stent placement and monitoring timely removal. He acknowledged that the stent should have been removed earlier than it had been.

7. Patient B was appropriately evaluated by respondent for a urethral stricture and performed the appropriate surgical procedure.

8. As part of the procedure, tissue was taken from the buccal mucosa and a graft was used to complete the procedure.

9. A gauze sponge was placed in the patient's cheek during the procedure

which should have been removed in the recovery room. Respondent believed the recovery room nurse had removed the gauze as instructed post-operatively in the recovery room.

10. The resident physician was told by the recovery room nurse that the gauze had been removed by the nurse herself and this information was shared with the respondent.

11. On post-operative day #5, the patient complained of pain, swelling and foul odor coming from his cheek. Patient B subsequently went to the emergency department.

12. The emergency department physician evaluated patient B and contacted Respondent and an alleged gauze material was removed by the emergency department physician.

13. The committee found that Respondent did not provide adequate post-operative care, and did not adequately supervise the resident physician which led to a retained foreign body.

14. Respondent is in violation of Rhode Island General Laws § 5-37-5.1(19) for nonconformance to the standard of acceptable and prevailing medical practice in his area of expertise.

**Based on the foregoing, the parties agree as follows:**

1. Respondent admits to the jurisdiction of the Board.

2. Respondent has reviewed this Consent Order and understands that it is subject to final approval of the Board; and this Consent Order is not binding on Respondent until final ratification by the Board.

3. If ratified by the Board, Respondent hereby acknowledges and waives:

   a. The right to appear personally or by counsel or both before the Board;

   b. The right to produce witnesses and evidence on his behalf at a hearing;

   c. The right to cross examine witnesses;

   d. The right to have subpoenas issued by the Board;

   e. The right to further procedural steps except for those specifically contained herein;

   f. Any and all rights of appeal of this Consent Order; and

   g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review.

3. Respondent agrees to this Reprimand on his physician license.

4. Respondent agrees to a probationary period of one (1) year from the date of the ratification of this Consent Order.

5. Respondent agrees to take a total of twenty (20) additional hours of Board-approved Category 1 CME in topics that include: patient safety, risk management or intraoperative safety.

6. Respondent agrees to pay to the Rhode Island General Treasury an administrative fee within sixty (60) days of ratification of this order of $1,850.

Signed this 20th day of February, 2015.

Kennon S Miller, MD
Kennon Miller, M.D.

Ratified by the Board of Medical Licensure and Discipline on the ___ day of February, 2015.

Michael Fine, M.D.
Director of Health