Approved: April 2, 2008
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The meeting was called to order by Chairperson Susan Wagle at 1:30 P.M. on February 12, 2008 in Room 136-N of the Capitol.

Committee members absent:

Committee staff present: Mrs. Terri Weber, Kansas Legislative Research Department
Ms. Nobuko Folmsbee, Revisor of Statutes Office
Ms. Renae Jefferies, Revisor of Statutes Office
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the Committee: Mr. Mark Stafford, General Counsel,
State Board of Healing Arts

Others in attendance: Please see Guest List

Handouts

Upon calling the meeting to order, Chairperson Wagle referred the Committee to the handout from Dr Rory Murphy, the psychiatrist, who testified last Wednesday, February 6, 2008, and did not have testimony. (On the first page are his thoughts he wanted to offer and the remaining pages are his testimony. A copy of his testimony and an article from the Menninger Foundation entitled " An occasional paper from The Menninger Clinic: Psychotherapists who transgress sexual boundaries with patients," by Glen O. Gabbard, MD) A copy of his testimony and attachment are (Attachment 1) attached hereto and incorporated into the Minutes by reference.

Presentation from the Board of Healing Arts

She then called upon Mr. Larry Buening, Executive Director, Board of Healing Arts. However, Mr, Mark Stafford said that he would be testifying for Mr. Buening, who had an accident the night before and has 3 broken ribs, but if there were specific questions the Committee needs to address to him, please feel free to do so. He then went on to introduce Ms. Kelley Stevens, Litigation Counsel for the BHA and Ms. Shelley Wakeman, Disciplinary Counsel for the Board. He began his testimony by saying they appreciate the opportunity to respond to what they perceive to be the Committee's concern, that they had looked at all of the testimony that has been provided to the Committee, and heard the oral statements that have been made. He said that after you have read their testimony and have questions to please call.

Mr. Stafford went on to say that this whole situation involves the government, us and you combined taking somebody's liberty or property. He asked what it takes to prove a case, saying that an allegation made is nothing more that an allegation, it is not proof. He said the first thing that was needed to prove a violation of the Healing Arts Act or other law, is a good description of the violation in the law. He stated he had provided in the testimony some language regarding the finding of professional incompetence and adding, a pattern or repeated acts of practice below the standard of care is needed, according to the statutes; requires persuasive, expert testimony among the members of that profession to reach the conclusion that there has been a breach of the standard of care.

He offered:

- an explanation regarding Mr. Wall's concerns that the Board does not investigate medical malpractice petitions ;

-differences of opinion as to the quality of proof required for an administrative agency to take action against a professional license when misconduct or incompetence is alleged,

- propriety and appearances of propriety in regards to Mr. Wall's email sent to Mr. Buening inviting the Board to share information on his malpractice case;

- explanations as to the testimony regarding Dr. Schroll, Dr. Schneider, and Dr. Geenens; and,

- potential resolutions.

A copy of Mr. Buening's testimony and attachment are (Attachment 2) attached hereto and incorporated into the Minutes by reference.

As there was no further testimony, the Chair asked for questions from the Committee which came from Senators Palmer, Barnett, and Wagle including:

- addressing one misunderstanding regarding Mr. Stafford's concern for anonymous complaining (Senator Wagle remembers talking discussions about two ladies who wanted to remain anonymous, who did not want to come forward before the Committee, but they had filed complaints.

- re: Mr. Buening's January 22, 2008, testimony, page 3, and previously, he was laying out the complaint they received about Dr. Schneider. Then they get to the third paragraph on page three that states, "from October 6, 2005, through the end of the year. the Board received one complaint and four initial reports from the Health Care Plan that malpractice suits had been filed". The questions was the other complaint she said, when Mr. Buening testified, that they were either found that they did not meet the standard of care or you did not consider them that way, the questions is there anyone here who call tell the Committee whether this complaint filed in October 6 did it result in a finding of not meeting standard of care or not and asking the same questions of the two complaints in the next paragraph which were February 7 and 17th. A copy of Mr. Buening's January 22, 2008 testimony has been included in (Attachment 2).

The Chair offered a time line she had made from Mr. Buening's testimony, writing down the dates of complaints, what his findings were, and complaints she was not sure what his findings were. A copy of her time line is (Attachment 3) attached hereto and incorporated into the Minutes by reference..

The Chair then offered a letter from Ms. Tanya Treadway, Assistant United States Attorney, dated October 3, 2006, from the US Dept of Justice in which it appears to her that there is going to be an agreement about sharing information ("By coordinating we will avoid duplicating efforts and we will stay out of the KBHA's way in its administrative proceedings against Dr. Schneider.") and in talking to some of the lawyers at the DOJ, they feel they have a whole different role in our society than the BHA. They feel their case in no way affects the license and in fact their cases don't affect the license unless someone is convicted of a crime, and after the criminal case, the license becomes an asset, therefore they have no authority over the license to practice medicine. She feels if they had followed through with the recommendations and evidence the BHA had, maybe there would not be these deaths. A copy of Ms. Treadway's letter is (Attachment 4) attached hereto and incorporated into the Minutes by reference..

- Does Dr. Schneider still have his license? What date was it taken away and why was it suspended on 1-15-08? How many people died and are licenses not taken away until there are three findings?

- what is your Board's reaction to this? Did fee funds impact this case? What is their annual budget? When are their Board meetings and are they open?

Adjournment

As there were no further questions. The meeting was adjourned. The time was 2:30 p.m.

The next meeting is scheduled for February 18, 2008.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Tuesday, February 12, 2008

NAME	REPRESENTING
Michelle Peterson	Capitol Strategies
Callie + Hartle	KS Assn for Justice (KSAJ)
Bob Williams	Ks Assoc of Osteopathic Med
DAN Morin	KS Medical Society
Allison Peterson	KS Medical Society
ANDREW JACOBS	SELF
Todd Fleischer	Ks. Optometric Assoc
Cory Shoudy	KHPA
Jennifer Bocchieri	KAKE-TV
Austin Hayden	Hein Law Firm
Larry Wall from	Wichita Ks, Representing Patients
Shelly Wakoman	KBHA
Kelli Stevens	KBHA
LARRY BUENING	KBHA
Mark Stafford	KBHA
ASH-HAR QURAISHI	KCTV5
Jeanne Gawdun	KFC

2 in att

Dear Senator Wagle,

An outline of my Committee testimony from 2/6/08 is enclosed, as per your request.

I would like to share some additional thoughts that arose as a result of listening to the Committee's questions and more clearly grasping its role in this matter.

Following the Board's decision about Geenens in December 2004, Mr. Buening was quoted in The Kansas City Star saying, "In the Geenens case, the Board looked for a way to fulfill its obligation to protect the public without destroying his career." The Board required Geenens to attend an ethics class and to have supervision by a psychoanalyst. Those interventions were clearly ineffective, as evidenced by his subsequent behavior and the complaints that ensued. When a bank robber is apprehended, do we send him to therapy and an ethics class? And when was the Board charged with the duty of protecting a physician's career?

Be that as it may, I would like to point out that the Board could have predicted Geenens' recidivism. As I testified to the committee, his attitude was, "Rory, we need to break down the artificial boundary of the physician-patient relationship. Patients need to see us not as doctors but as friends or even as family members." Geenens knew from his training, as all of us trained at the Menninger Clinic did, that his behavior was wrong. He simply didn't care. He thought he knew better. This is exactly the type of attitude, described in Gabbard's paper (copy enclosed), which leads to recidivism. And I had informed the KSBHA about this very attitude during the investigation in 2003. I had also informed the Board that Geenens had a history of inability to maintain appropriate boundaries with numerous patients, not just Dr. Jacobs' wife. A few days of didactic training was not about to change a lifelong pattern of behavior. The Board overlooked this reality, concerning itself instead with protecting Geenens.

I was not the only one appalled by the Board's remedy for Geenens. Dr. David Bellows-Blakely, then President of the Kansas Psychiatric Society, sent a letter to the Board, urging them to reconsider their decision. Apparently he perceived the Board's need for expert input in this area and was concerned about the outcome of the chosen interventions.

So one problem we are facing is that the Board simply lacks the expertise required to make a reasonable decision in such matters Are there even any psychiatrists on the Board? I don't believe so. Apparently in recognition of this fact, the Board is empowered to require physicians under investigation to be evaluated. The physician arranges and pays for this evaluation, which is performed by an independent professional. But what safeguards are in place to make sure that the chosen professional is impartial? What if the professional has a conflict of interest, such as a prior relationship with the physician, or even the simple fact that the physician is paying the bill? I have reason to believe that this is a very important question to ask the Board in the Geenens case. Did he have a prior relationship with his evaluator? If the KSBHA is going to rely upon the opinion of

Testimony Outline for February 6, 2008

William Rory Murphy, M.D.
University of Kansas Medical School graduate (1987)
Residency and Fellowship training, The Menninger Clinic (1993)
Board Certified Child, Adolescent and Adult Psychiatrist (ABPN)
Owner, Psychiatric Associates, Overland Park, KS

Met Dr. Geenens during residency training at Menninger (1989)
We both served on Executive Committee as Fellows' Association representatives
Executive Committee dealt with case of a resident's sexualized relationship with a patient
Geenens remained in touch with me during fulfillment of KMS obligation at Prairie View
Joined his practice in 1997, partner 1998-2001

Geenens behavior became increasingly inappropriate over time
Problems included inability to maintain appropriate boundaries with patients
Changes in appearance and behavior
Sexual relationship with hospital staff and sexual harassment of my office staff
Concerns about quality of his patient care
Abandonment of patients by recurrent cancellations for speaking opportunities (Pfizer)
Prescribing to non-patients, e.g., hairdresser
Mailing prescriptions out of state
Prescribing controlled substances for years without seeing/re-evaluating patients

Became increasingly angry about monitoring and limits set on him and left practice
Began fabricating stories about myself and reasons for leaving practice
Settlement agreement included non-disparagement clause at my request (June 2001)
July-turns off phone lines to two offices and 10 clinicians (thousands of patients affected)
Geenens incites patient to file unfounded complaint about me with the KSBHA
The use of patients to retaliate was a behavior that occurred repeatedly

Quotes from Gabbard's authoritative article about psychiatrist-patient sex.

Subpoenaed by KSBHA in 11/03 and provided extensive documentation to them
September 2004, I speak in general terms to the media about physician-patient sex
October 2004, Geenens releases his retaliatory letter
December 2004, Geenens receives "hand-slap" from KSBHA
The lack of appropriate action by the KSBHA is shocking to myself and other physicians

January 2007, I become aware of libelous letter circulated by Geenens
2006/2007, subpoenaed to provide information regarding Geenens to Missouri Board
Missouri closes case when he agrees to not renew license.
July 16, 2007 I file complaint to KSBHA. Geenens has patient file retaliatory complaint
October 16, 2008, KSBHA letter in response to phone call on status of complaint
Board has not yet interviewed or requested information from me
11/07, 1/08 – additional concerns forwarded to KSBHA-abandoned patients

outside, independent professionals to determine disciplinary actions, what procedures and processes are in place to ensure the integrity of that system?

We heard testimony on Wednesday suggesting that the integrity of the process in the Geenens case was compromised by his relationship with Dr. Ellis. I personally have heard from the patient who currently has a complaint filed with the Board that Geenens bragged that he had not just one, but two friends on the Board who would protect him from a bad outcome. I have no direct knowledge of those facts, nor can I prove them to be true. I do, however, strongly believe that those questions need to be addressed to the Board. If the Board is inadequately funded, or understaffed (as they may contend), it is concerning and must be addressed. If the Board lacks in expertise or is simply inept, those problems also need to be remedied. But if the Board is, in fact, corrupt, it is alarming. If indeed the outcome in the Geenens case is, in the end, simply a result of poor judgment and a lack of integrity of Board processes, then who is accountable for that?

Lastly, let me just say how uplifting it has been to see your interest in this matter. I believe you are performing a very important service for all the citizens of Kansas.

Sincerely,

Wm. Rory Murphy, M.D.

Menninger

An occasional paper from The Menninger Clinic

Psychotherapists who transgress sexual boundaries with patients

by Glen O. Gabbard, MD

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Psychotherapists who transgress sexual boundaries with patients

Glen O. Gabbard, MD

The causes of therapist-patient sex are complex and multi-determined. Efforts to understand why psychotherapists transgress sexual boundaries are hampered by the lure of reductionism and oversimplification. Most of those who examine this issue would prefer to categorize all such therapists as "bad" and "corrupt" as a way of distancing themselves and disavowing any similarities between these therapists and themselves. The pathology of therapists who commit sexual boundary violations generally falls into four broad categories: (1) psychotic disorders, (2) predatory psychopathy and paraphilias, (3) lovesickness, and (4) masochistic surrender. Although a variety of individual psychodynamic factors are involved within each group, this classification is highly useful for informed treatment planning.
(Bulletin of the Menninger Clinic, 58 [1], 124-135)

With sexual misconduct rapidly becoming the number-one liability concern for the mental health professions, the field has been struggling to understand the phenomenon (Apfel & Simon, 1985; Gabbard, 1989; Gartrell, Herman, Olarte, Feldstein, & Localio, 1986; Pope & Bouhoutsos, 1986; Schoener, Milgrom, Gonsiorek, Luepker, & Conroe, 1989). Among these efforts have been several attempts to develop typologies of therapists who transgress sexual boundaries with patients (Averill et al., 1989; Gonsiorek, 1989; Olarte, 1991; Pope & Bouhoutsos, 1986; Twemlow & Gabbard, 1989). A psychodynamic understanding of these therapists and the forces that lead them to resort to such highly self-destructive behavior is more difficult to ascertain.

Part of the difficulty has been a tendency in recent years to politicize therapist-patient sex in such a way as to discourage systematic psychodynamic understanding. The "politically correct" view of the phenomenon in some venues is that thoroughly evil male therapists prey on helpless female patients (Gutheil & Gabbard, 1992). In this model, the problem can be solved simply by eradicating the "bad apples" from the profession. This reductionistic view has the appeal of reassuring therapists that those who engage in sexual misconduct are vastly different from them. Therapists involved in this inappropriate activity are a group of "impaired professionals" who can be differentiated from everyone else by their utterly corrupt superegos and their morally reprehensible behavior.

Another aspect of this narrow view of therapist-patient sex is that it lends itself to sexual stereotypes in the culture (Gutheil & Gabbard, 1992). Men are the seducers, and women are the seduced. In one study of sexual transgressions, when female therapists were involved with male patients, the male patients were regarded as responsible and blameworthy for the behavior, while the female therapists were viewed as their victims (Averill et al., 1989). Although most studies suggest that males are the perpetrators in the vast majority of cases, substantial evidence now demonstrates that females are also involved in sexual misconduct. Moreover, same-sex pairings represent a significant problem, even though they are less frequently reported than opposite-sex pairings (Benowitz, 1991; Gonsiorek, 1989; Gutheil & Gabbard, 1992; Lyn, 1990).

The fact that sexual misconduct is a complex problem involving a variety of different scenarios becomes apparent to anyone who studies a sufficient number of cases. Systematic examination of data often yields results that do not conform to politically correct formulas. At The Menninger Clinic, where therapists who have transgressed sexual boundaries with patients have been evaluated and treated for many years, this diversity of psychodynamic themes has emerged in the work with these individuals. In this article, I will report on a series of pastoral counselors, social workers, psychiatrists, and psychologists whom I have seen in psychoanalysis, psychotherapy, hospital treatment, or consultation, in addition to other cases in which I have been indirectly involved as a supervisor or consultant to other clinicians. In trying to explicate the psychodynamic themes in these therapists, I have encountered a problem related to

confidentiality that others in the field have shared. Because I am discussing the psychology of colleagues who may be recognizable to readers of this article, I am not at liberty to describe the details of individual cases. Instead, I am forced for ethical reasons to talk about the psychodynamic themes I have observed in broad brushstrokes that paint a general picture but leave out the idiosyncratic and specific details of any one therapist.

A psychodynamic classification

It is heuristically useful to group these therapists in rubrics that are psychodynamically based rather than limited to specific diagnostic categories. The vast majority of therapists who become sexually involved with patients will manifest psychopathology that falls into one of four categories: (1) psychotic disorders, (2) predatory psychopathy and paraphilias, (3) lovesickness, and (4) masochistic surrender. The first category, psychotic disorders, is definitely the smallest group, consisting of therapists who suffer from such disorders as bi-polar affective disorder, paranoid psychosis, schizophrenia, and psychotic organic brain syndrome. These therapists generally require extensive treatment that includes pharmacotherapy and vocational counseling to discourage them from continuing in the career of psychotherapist. Because the other three categories are more common and complex from a dynamic perspective, I will consider each of them in substantially more detail.

Predatory psychopathy and paraphilias

Within this rubric I am including not only antisocial personality disorders but also severe narcissistic personality disorders with prominent antisocial features. Although all persons suffering from paraphilias are certainly not psychopathic predators, those who act on their paraphiliac impulses with patients under their care generally have a severely compromised superego and character pathology on the narcissistic to antisocial continuum.

These therapists are generally male, but female practitioners have also been reported to fit this category. Benowitz (1991) described two female therapists who engaged in violent behavior during sex with clients, such as urging a patient to perform violent acts with sharp objects on herself. Another female therapist asked a patient to perform the same behaviors that had been degrading to her in past sexually abusive relationships, a common form of sadistic humiliation in this category of therapists. Male offenders in this group tend to have been involved with a long string of clients and are notoriously refractory to rehabilitation of any kind. When caught, they may pretend to be remorseful and claim that they were in love with the patient. They may be masters at manipulating the legal system as well, so they often escape any severe legal or ethical sanctions.

For therapists in this category, patients are regarded merely as objects to be used for their own sexual gratification. Because these therapists lack empathy or concern for the victim, they are incapable of feeling remorse or guilt about any harm they might have done the patient. This massive failure of superego development appears to be related to profound impairment of internalization during childhood development. The only form of object-relatedness they appear to know is sadistic bonding with others through the exercise of destructiveness and power (Meloy, 1988). Some of these therapists have a childhood history of profound neglect or abuse, and some clinicians have understood their exploitation of others as an effort to achieve active mastery of passively experienced trauma (Schwartz, 1992).

One particular variant operating in same-sex dyads involves split-off homoerotic feelings. Therapists who may ordinarily regard themselves as heterosexual may split off and projectively disavow both their own self-loathing and their sexual feelings toward persons of the same sex (Gonsiorek, 1989). They then act out such feelings secretly with their patients, often with cruel and sadistic methods, as a way of compartmentalizing ego-dystonic homosexual feelings.

Lovesickness

Most therapists who become sexually involved with patients are either predatory or lovesick. In one survey of psychiatrists (Gartrell et al., 1986), 65% of those who had been in a sexual relationship with a patient described themselves as being in love with the patient. Lovesick therapists may be associated with a variety of different diagnostic categories (Gabbard, 1991a; Twemlow & Gabbard, 1989). In some cases, they suffer from less severe forms of narcissistic personality disorder that lack the antisocial features typical of the predatory group. The narcissitic themes in these therapists involve a desperate need for validation by their patients, a hunger to be loved and idealized, and a tendency to use patients to regulate their own self-esteem. Some lovesick therapists may have borderline personality disorder that leads them to quickly idealize patients and impulsively act on their feeling of infatuation. Still others in this category have neurotic problems, while some are essentially normal, from a diagnostic standpoint, but are in the midst of a life crisis.

The most common scenario is that of a middle-aged male therapist who falls in love with a much younger female patient while he is experiencing divorce, separation,

disillusionment with his own marriage, or the loss of a significant person in his life (Gabbard, 1991a; Twemlow & Gabbard, 1989). He may begin to share his own problems with his patient and present himself in psychotherapy sessions as needy and vulnerable. This role reversal is a common precursor to sexual transgressions.

One way of viewing this development in a psychotherapy process is to describe the countertransference as having become erotized in the same way that certain incest victims and borderline patients develop erotized *transference* (Blum, 1973; Gabbard, 1991a). The ability to distinguish a countertransference wish from the reality of the situation is compromised, so that the loving feelings toward the patient lose the "as if" quality characteristic of milder forms of transference. The therapist can no longer appreciate that something from the past is being repeated and that feelings for significant persons from the therapist's past are displaced onto the patient. In light of this loss of insight, a form of "nonpsychotic loss of reality testing" can be observed (Twemlow & Gabbard, 1989, p.83). Outside the particular *folie à deux* that involves the therapist-patient dyad, the therapist's reality testing appears to be intact. Within the dyad, however, a loss of judgment and reality testing makes it difficult for the therapist to see how self-destructive and harmful the relationship has become. Indeed, many lovesick therapists, when confronted, will insist that the relationship transcends any considerations of transference and countertransference.

A variety of psychodynamic themes can be identified in cases of lovesickness. In any single case, one or several of the following issues may figure prominently in the therapist's transgression:

Unconscious reenactment of incestuous longings. There can be little doubt that therapist-patient sex is symbolically incestuous to both therapist and patient. Each member of the dyad is a forbidden object to the other. For the therapist, the psychological proscription is intensified by ethical and legal prohibitions. One way of viewing the development of a sexual relationship in the context of psychotherapy is that it is a re-creation of an earlier incestuous situation for both persons. As Kluft (1989) has noted, incest victims tend to put themselves in situations where they become revictimized and therefore are "sitting ducks" for therapist-patient sex. As Freud (1905/1953) observed, "The finding of an object is in fact a refinding of it" (p.222). Both therapist and patient are refinding forbidden objects from the past, and the therapist colludes in an enactment rather than interpreting the unconscious wish to repeat past trauma, all under the guise of "true love."

Misperception of wish for maternal nurturance as sexual overture. With incest victims in particular, receiving care may be inextricably bound up with sexuality. To be reassured that they are cared for and valued, they may explicitly demand some form of physical contact. The professional boundaries of the relationship may be regarded with contempt, and the longing to be loved and held may be repeated again and again until the therapist acquiesces (Gabbard & Wilkinson, 1994). Therapists often misconstrue the patient's wish for maternal nurturance as a sexual overture and act accordingly. A pregenital need is misunderstood as a demand for genital sexual activity.

Interlocking enactments of rescue fantasies. Apfel and Simon (1985) have noted that the patient's tendency to repeat his or her past may, in fact, be mirrored by the therapist's need to repeat. A female patient may have harbored a childhood fantasy that she was somehow ministering to a father who was despairing over his marriage. Similarly, a male therapist may be unconsciously rescuing his depressed mother. Hence, the therapist-patient dyad is involved in interlocking rescue enactments.

Patient seen as idealized version of the self. Lovesick therapists with narcissistic problems may project aspects of themselves into the patient. This projected ego ideal or idealized self-representation may then obscure the patient's real qualities. Just as Narcissus fell in love with his own image in the water, these therapists are infatuated with an idealized reflection of themselves.

Confusion of therapist's needs with patient's needs. Sullivan (1954) once noted that psychotherapy is a truly unique profession because practitioners must put aside their own needs in the interest of addressing the needs of the patient. An occupational hazard for all therapists is to inadvertently or unconsciously gratify their own needs while they think they are meeting the patient's needs. In cases of sexual misconduct, this dynamic is particularly problematic. Because many therapists grew up in homes where they felt unloved, they may attempt to elicit from their patients the love they did not receive from their parents (Gabbard, in press; Sussman, 1992). Longings to be loved are defended against by giving to others. Many lovesick therapists genuinely feel they are giving something wonderful to their patients, even though they are involved in an ethical transgression. In this manner, they defend against acknowledging their own dependency longings and their use of the patient for their own gratification.

Fantasy that love in and of itself is curative. This theme is also closely related to conscious or unconscious childhood fantasies that persist in adult therapists. They may feel a deep conviction that they would have been much happier as adults if they had been loved as children. Similarly, therapists who transgress sexual boundaries with patients often harbor a belief that they can love the patient better than the patient's own parents did. Many films that feature sexual relationships between therapists and patients suggest that love itself is much more curative than any technique acquired through professional training. In Barbra Streisand's 1991 film, *The Prince of Tides*, for example, the audience is left with the impression that Tom's improvement is primarily related to his love affair with his therapist, rather than to any insight or understanding related to the therapist's professional expertise.

Repression or disavowal of rage at patient's persistent thwarting of therapeutic efforts. For some therapists, the patient's improvement is essential to the therapist's self-esteem. When certain patients continue to deteriorate despite the therapist's most zealous efforts, some therapists may resort to sexual relationships out of despair at the frustration of their omnipotent strivings to heal (Searles, 1979). Their rage at the patient for failing to respond is buried beneath professions of love and caring.

Anger at organization, institute, or training analyst. When therapists work in institutional settings, they may develop bitterness and resentment based on their perception that the institution has mistreated them. Investigations of therapist-patient sex in such settings commonly reveal that anger has been acted out at the organization through the ethical transgression. In cases of pastoral counselors, resentment toward the church or a particular church official may be a fertile field for sexual misconduct. When an analyst is the transgressor, anger at the training analyst or institute is often involved. Such behavior may also represent an unconscious fantasy of revenge against one's parents.

Manic defense against mourning and grief at termination. In every psychotherapy relationship, there is inevitable loss. A paradox of the process is that if treatment goes well, the relationship must end. Neither the therapist nor the patient looks forward to dealing with feelings of grief and mourning at the time of termination. One defensive way to avoid such feeling is to deny the ending by beginning a new, personal relationship (Gabbard, 1990). Indeed, many cases of therapist-patient sex begin as therapy is ending.

The exception fantasy. Some lovesick therapists convince themselves that their sexual relationship with a patient is somehow an exception to accepted ethical guidelines. Often these therapists will view the relationship as having transcended transference or countertransference. They may view themselves and the patient as "soulmates" who were destined to find each other and just happened to have done so in the context of a psychotherapy relationship. The love is regarded as so extraordinary that mundane ethical codes are irrelevant.

Insecurity regarding masculine identity. Male therapists who engage in sex with patients are often insecure about their maleness. Some may be seeking affirmation and validation for themselves as men because they feel they did not receive that sort of affirmation from their mother or father while growing up. The sexual gratification in such cases is secondary to a validation of their gender identity.

Patient as transformational object. Although it is tempting to draw parallels between the forbidden aspects of the oedipal situation in childhood and the boundary violations between therapist and patient as adults, clinical work with such therapists suggests that primitive preoedipal themes are prominent (Twemlow & Gabbard, 1989). One is the wish to be transformed by the patient. Bollas (1987) noted that the mother is initially experienced not so much as a separate person as a process of transformation: "In adult life, the quest is not to possess the object; rather the object is pursued in order to surrender to it as a medium that alters the self" (p. 14). Hence, at the most fundamental level, the therapist may harbor the fantasy that the patient will be a love object that serves as an agent of magical change.

Settling down the "rowdy" man. Although most of the literature on the dynamics of therapist-patient sex has been focused on a male therapist involved with a female patient, female therapists are also prone to attempt misguided efforts to rescue male patients. In such scenarios, the patient tends to be a young man with a personality disorder diagnosis characterized by impulsivity, action orientation, and substance abuse (Gabbard, 1991a). Despite these characterological symptoms, however, the young man usually possesses considerable interpersonal charm and may have a knack for engaging females in a treatment capacity. A female clinician is often drawn to such men with an unconscious fantasy that her love and attention will somehow influence this essentially decent young man to give up his wayward tendencies and "straighten up" (Gabbard, 1991b).

In American literature and film,

there is a pervasive cultural myth that a "rowdy" young man simply needs a "good woman" to settle him down. At the beginning of Clint Eastwood's 1992 film, *Unforgiven*, for example, the protagonist repeatedly comments on how he was a cold-blooded murderer and a drunk until the right woman transformed him into a decent husband, father, and breadwinner. Another theme is these female therapist-male patient dyads relates to the woman's vicarious enjoyment of the danger and risk typified by her male patient's life-style.

Conflicts around sexual orientation. In same-sex dyads, some therapists will use a relationship with a patient as a way of acting out conflicts around their own sexual orientation. In the Benowitz (1991) study of 15 female therapist-female patient liaisons, 20% of the therapists identified themselves to patients as heterosexual, 20% as bisexual, and only 40% as clearly lesbian. Twenty percent said they had not been sexually involved with a woman before, and 33.3% demonstrated internal conflict around their sexual orientation or sexual behavior with women. Gonsiorek (1989) has noted a similar pattern in male therapist-male patient dyads.

Masochistic surrender. The last category involves certain therapists with fundamentally masochistic and self-destructive tendencies who allow themselves to be intimidated and controlled by a patient, even though they know the deleterious consequences of their actions. I am not using "masochistic" here in the Freudian sense of deriving pleasure from pain. Rather, I am describing a relational mode in which the therapist, usually male, allows himself to be tormented by the patient. In the typical scenario, these therapists feel badgered into increasingly escalating boundary violations as a way to prevent suicide (Lyman & Gabbard, 1991). The patient, often an incest victim, may suffer from syndromes such as posttraumatic stress disorder, dissociative disorder, or borderline personality disorder. As a result, the patient may demand some concrete demonstration of love so that the therapist extends hours, holds the patient during sessions, accepts frequent late-night telephone calls, and even gives free therapy. Therapists who fit in this category attempt to accommodate these demands, even though they know better. They often feel that they have no choice. The therapist soon learns that the patient's demands are bottomless and endless and begins to feel tormented. Demands to be held escalate to demands for sexual contact that the therapist feels compelled to oblige.

These therapists characteristically have problems dealing with their own aggression. Setting limits on the patient feels as though it is sadistic. As the patient's demands escalate, the therapist uses reaction formation to defend against growing resentment and hatred toward the patient. Just at the point when the therapist's resentment is reaching monumental proportions, the patient may accuse the therapist of not caring. In such confrontations, therapists often feel that their negative feelings have been exposed. The ensuing guilt feelings lead them to accede to the patient's demands, so that aggression in either member of the dyad is kept at bay.

Clinical work with such therapists commonly reveals an over-identification of the therapist with the patient. In many cases, both parties have childhood histories of abuse. Because of this over-identification, these therapists try to gratify the patient's entitlement to be compensated for suffering as a child. Like lovesick therapists, masochistic therapists may be reenacting their own childhood abuse in addition to the patient's. Unlike lovesick therapists, however, they are not in love with the patient and often feel that they are being "dragged down" by the patient. Some therapists who have masochistically surrendered in this manner describe dissociation or depersonalization during the sexual episode. They feel as though they are just going through the motions of sex or are doing so in an altered state of consciousness.

Many of these therapists recognize the unethical nature of the sexual activity after it has happened, and they attempt to stop the therapy and seek help for themselves. In hope of receiving help, they may masochistically turn themselves in to licensing boards or ethics committees. When litigation enters the picture, they often fare far worse than therapists who are psychopathic predators because they are much less manipulative and they deal with the proceedings in a straightforward and honest manner.

Conclusion

These categories and the psychodynamic themes that accompany them should be considered tentative hypotheses that require further confirmation. There may well be other sexually exploitative therapists who "fall through the cracks" and who require new categories to describe them. In addition to the heuristic value of attempting to classify such thereapists, these groupings are useful in identifying which of the sexually transgressing therapists are likely to benefit from treatment and rehabilitation.

The psychopathic predators are almost always refractory to treatment because they either deny the patient's allegations or do not view them as problematic and requiring treatment. These therapists clearly should not continue in the mental health field. Although *some* persons suffering from paraphilias may be treatable in

some settings, they, too, should not work in a field in which intense and highly intimate relationships are part of the daily practice.

Certain lovesick therapists are also unlikely to be treatable when they are in the throes of infatuation with their patient. They may be puzzled that anybody would suggest treatment for such an ecstatic mutual experience. Because they regard their love as unrelated to transference or countertransference issues, they view psychotherapy as having no purpose. When the infatuation dissipates, however, many of the lovesick therapists then have greater insight into their folly and may be amenable to psychotherapy or psychoanalysis as a way of helping them understand what intrapsychic issues made them vulnerable to such an unethical transgression. Those therapists who have been involved in a masochistic surrender scenario generally are filled with remorse and eager to receive treatment so that they do not repeat such self-destructive behavior.

Even with successful treatment, therapists who have acted on sexual feeling with patients should consider themselves at high risk for repeating the transgression. In most cases, they should probably avoid conducting psychotherapy and instead should confine their work to less intense forms of clinical practice.

Presented at the 50th anniversary celebration of the Topeka Institute for Psychoanalysis, Topeka, Kansas, October 11, 1992. Dr. Gabbard is Distinguished Professor, The Menninger Clinic, and a training and supervising analyst at the Topeka Institute for Psychoanalysis. Reprint requests may be sent to Dr. Gabbard at The Menninger Clinic, PO Box 829, Topeka, KS 66601-0829.

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KANSAS

KATHLEEN SEBELIUS
GOVERNOR

STATE BOARD OF HEALING ARTS

LAWRENCE T. BUENING, JR.
EXECUTIVE DIRECTOR

February 12, 2008

The Hon. Susan Wagle
Chairperson
Senate Committee on Health Care Strategies
Room 221-E
State Capitol Building

Re: Board proceedings involving Dr. Schneider, Dr. Schroll, and Dr. Geenens

Dear Senator Wagle and Members of the Committee:

Thank you for the opportunity to respond to the questions and concerns arising out of the testimony before the Committee on February 5-6. Understandably, the information presented in that testimony leads to questions and concerns if assumed complete and accurate. We believe that additional information will give perspective to the testimony that was either not available to the conferees, or in some cases was not completely or accurately stated by conferees.

The testimony by the previous conferees discussed care by three physicians, Steven Schneider, D.O., John Schroll, M.D., and Douglas Geenens, M.D. Dr. Schneider and Dr. Geenens are currently parties to agency proceedings before the Board, and an agency proceeding to which Dr. Schroll is a potential party is anticipated. We believe that caution is necessary when we discuss these cases to avoid improper release of investigative information or disclosure of unsubstantiated allegations.

I. Initial Policy Issues

There are some initial policy and legal issues that merit consideration prior to delving into the facts surrounding the situations described in the testimony. As background, the Board is authorized to revoke, suspend, or limit a license, or deny an application for a license, or censure or fine a licensee upon a finding of misconduct described at K.S.A. 65-2836. That includes a finding of professional incompetence, unprofessional conduct, or dishonorable conduct. Professional incompetence and unprofessional conduct are defined at K.S.A. 2007 Supp. 65-2837.

Senate Health Care Strategies
Committee
Date: February 12, 2008
Attachment 2

235 SW TOPEKA BLVD., TOPEKA, KS 66603
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Professional Incompetence

The definition of professional incompetence has been discussed in much detail before several Legislative committees. In summary, the Board may not determine that a licensee is professionally incompetent, thereby authorizing disciplinary sanctions, without finding one case of deviation from the standard of care to a degree constituting gross negligence, multiple or repeated instances of deviation from the standard of care constituting ordinary negligence, or manifest incapacity to practice the healing arts. Based upon the statutory definition, the Board does not take disciplinary action based solely on a single act of negligence unless gross negligence can be proven. As a result, we have had many instances where complainants had to be informed that we simply had no authority to proceed on the incident they reported unless and until there were repeated or multiple instances of negligence.

Investigations into allegations of substandard practice have changed over time based upon the available resources. In response to the October 2006 Legislative Post Audit Report, the Board modified its policy, and seeks legislative authority through House Bill 2620 to make investigations into single acts of negligence more fruitful. This is discussed in the Board's response to the post audit report.

Mr. Wall said he was concerned that the Board does not investigate medical malpractice petitions. In truth, the Board's policy is to review all medical malpractice petitions that we receive from the Health Care Stabilization Fund and to treat each one as a complaint. If the information in the petition only alleges a deviation from the standard of care without alleging any other violation of the healing arts act including unprofessional or dishonorable conduct, then the next step in determining whether to open an investigation is to consider the licensee's history. If the licensee has previously been disciplined an investigation is opened. If the licensee is currently under investigation for any reason, most likely the civil petition will be opened as an investigation. If the licensee has a history of one prior malpractice petition that is closely related to the new petition but no other complaints on file then both petitions may result in an investigation, depending on the seriousness of the allegations. If there are three or more prior petitions within the previous ten years then all three petitions will be investigated. However, if the petition is filed in an out of state jurisdiction and the care was rendered largely in out of state hospitals, those petitions will not be opened for investigation unless extraordinary circumstances exist as our subpoenas are not enforceable out of state.

Petitions are treated differently than complaints from other sources because we have difficulty investigating petitions without the cooperation of the patient in many cases, and because the Board has found that investigations into single malpractice petitions, without more, rarely result in a violation of the Healing Arts Act but use a vast amount of investigative resources. The Board looks for trends if the only complaint information we have against a licensee is in the form of malpractice petitions. Other types of complaints are opened for investigation when we receive them. Mr. Wall was

incorrect when he said we have not investigated the care Dr. Schneider provided to any of the patients that he represents either directly or through survivors. Of the instances of patient care that the Board has alleged was substandard, three involve patients represented by Mr. Wall, and at least some of those were initiated from the malpractice petitions that were provided to the Board. Since we began investigating Dr. Schneider, any malpractice petition that came in was opened for investigation or added to the existing investigation that was underway due to a previous complaint.

Finally, the Board is aware that bad outcomes in medical care do not always mean that the physician practiced bad medicine. Licensed professionals might make mistakes, but those mistakes do not always constitute professional misconduct. *See e.g., In re Wall*, 272 Kan. 1298, 1303 (2002).

Quality of Evidence Required for Disciplinary Action

There are differences of opinion as to the quality of proof required for an administrative agency to take action against a professional license when misconduct or incompetence is alleged. Disputed questions of fact in civil cases are decided based upon the preponderance of the evidence. The facts in a criminal matter that might affect a person's liberty must be proven beyond a reasonable doubt.

The standards of proof for these types of cases are based upon constitutional principles. In civil cases, the government has no interest in favoring one party over the other, but rather settles the dispute based upon one side providing evidence of greater persuasive weight than the other. In criminal cases, the government seeks to take a liberty from an individual, and as a result may only do so if there is no reasonable doubt of the person's guilt. In regulatory cases, the government again seeks to affect a liberty and property interest, but for the protection of the public rather than for punitive purposes. The clear and convincing standard has emerged as providing the degree of proof that satisfies the individual's and the public's interests. The government has no other interest in favoring a licensee or a complainant.

The Board has applied this clear and convincing standard to resolve disputed facts, but not to matters of law or policy. This standard of proof is now being considered for codification in House Bill No. 2618.

The standard of proof is an important consideration when weighing the "evidence" that the Board was given and as described in Mr. Wall's testimony. News articles, law enforcement raids, and weak or unwilling witnesses do not prove a case.

Propriety and Appearances of Propriety

Mr. Wall provided an email that he sent to Mr. Buening inviting the Board to share information on his malpractice case (see his exhibit 13). The Committee should note that that Mr. Wall had suggested is limited by K.S.A. 65-2839a and 65-2898a. Those statutes prohibit the release of confidential investigative information.

While there might be some Board information that is a public record, and the Board is granted broad authority to obtain information, the appearance that a Board investigation or prosecution is conducted in collaboration with plaintiff's counsel is just as offensive to the process as it would be if collaboration is with the physician's defense counsel. A licensing board's cooperation or even the appearance of cooperation with a party having a financial or other interest in the outcome of a disciplinary matter is repugnant to well settled notions of justice. The Board must approach its cases as unbiased, unprejudiced, and as judicious as is humanly possible.

II. Testimony Regarding Dr. Schroll

Mr. Eddy described his frustrations regarding communications with the Board, and his belief that the Board did nothing with his complaint until he sent a copy of his communications to Senator Brownlee. Based upon the documentation in our records, Mr. Eddy's complaint was actively and timely investigated. Mr. Eddy was not aware of the investigative activities, and it is understandable how we would have misperceived the events. The following is a chronology of the investigation, excluding the confidential details regarding the attorneys' preparation of the case.

12/12/05	Board receives complaint from Mr. Eddy; for treatment beginning 11/8/05; alleges practice below standard of care
12/14/05	Case is assigned to Lori Denk, Investigator, assigned priority 3
12/15/05	Letter from Ms. Wakeman to Mr. Eddy, advises investigative case opened
1/5/06	Subpoenas and requests for information sent to several health care provider entities
1/18/06	Records and responses begin to arrive at Board office
3/3/06	Investigator submits final investigative report
6/2/06	Case presented to peer review committee
7/25/06	Case prepared for Disciplinary Panel review
9/8/06	Case reassigned to Peter Massey, Investigator, because Ms. Denk resigned; additional patient records needed
9/11/06	Subpoena issued for additional records
10/2/06	Subpoenaed records received
10/13/06	Preparation in anticipation of disciplinary case begins
1/4/07	Email from Mr. Eddy to Melissa Massey, forwarded to Ms. Bellquist; Ms. Bellquist responded by telephone, gave status report but not able to share much information
1/25/07	Email exchange between Mr. Eddy and Ms. Bellquist, who writes:

"This e-mail follows our telephone conversation a few weeks ago. I had told you by the end of January, I would maybe know more about the status of your complaint regarding Dr. Schroll. However, your complaint is still in the investigative stage at this time. As I explained during our telephone conversation, our investigations are confidential. As such, I cannot give you further information about the investigation status or process. [New paragraph] I can tell you that if a complaint is ultimately resolved by public disciplinary action, then we can inform you of that information. Alternatively, if there is no disciplinary action taken, you will also be advised of such with a letter once the

investigation is complete. It may be another couple of months before you hear anything further with regard to your complaint. If you have any question, please do not hesitate to contact me. Thank you." Direct telephone number given.

5/24/07	Email from Mr. Eddy to Ms. Bellquist
5/25/07	Telephone call from Ms. Bellquist responding to email
8/20/07	Email from Mr. Eddy, with copy to Sen. Brownlee
8/23/07	Email from Mr. Buening to Mr. Eddy, advising he will review file and report back to him
8/24/07	Email from Mr. Buening to Mr. Eddy discussing process and advising resolution within 60 days hoped for
11/14/07	Telephone call between Mr. Eddy and Board counsel; Mr. Eddy expresses frustration. *Mr. Eddy expressed for the first time that Dr. Schroll made inappropriate comments to patient.*
12/13/07	Investigator Steve French left telephone message for patient
12/13/07	Mr. French telephone call to Mr. Eddy who described inappropriate comments made by Dr. Schroll; personal interview with patient scheduled
12/20/07	Recorded interview of patient by Mr. French

At this time the matter further proceedings are anticipated. Additional comment on the nature or timing of those proceedings would not be appropriate at this time. It is important to note that this case began as an allegation of practice below the standard of care. As stated above, disciplinary action is authorized if there are multiple or repeated acts of substandard practice. The allegations of inappropriate comments were not made to the Board until December 14, 2007, and the Board's investigative staff responded immediately.

III. Testimony Regarding Dr. Schneider

Mr. Buening prepared a Memorandum dated January 22, 2008 addressed to the Senate Committee on Health Care Strategies describing history of the information of which the Board was aware regarding Dr. Schneider. A copy of that memorandum is attached.

There are three general areas of information that have been described to the Committee. The first involves the effort to terminate Dr. Schneider from the Kansas Medicaid program. The second area involves the failure of the Board's proceeding to progress. The third area involves the insufficient communication with complainants and patients.

SRS Proceeding

Mr. Wall presented this Committee with a letter that bears the date May 24, 2004, (but appears most likely that it should be dated May 24, 2005) stating the intention by Kansas Social and Rehabilitation Services to terminate him from participating in Medicaid Services. This letter appears to have been dated incorrectly, as indicated by the June 8, 2005 letter that SRS sent to Dr. Schneider and which was attached to Mr. Wall's

testimony. Based upon our investigative records, our understanding of the chronology is as follows:

12/3/04	FirstGuard Health Plan (administrator for HealthWave Program/Medicaid) closes Dr. Schneider's clinic to new pain management patients.
1/21/05	FirstGuard implements corrective action plan with Schneider Clinic
4/05	FirstGuard audit shows compliance with corrective action plan
5/9/05	FirstGuard re-opens clinic to new pain management patients
5/24/05	SRS sends notice of intent to terminate Dr. Schneider as Medicaid participant and to terminate HealthConnect contract.
6/2/05	Hearing on letter of intent
6/8/05	SRS Order terminated Dr. Schneider's participation in Medicaid fee-for-service program and HealthConnect
7/6/05	First Amended Petition for Judicial Review and Application for Stay of the June 8 Order, Sg. Co. D. Ct. Case No. 05-CV-2566
7/8/05	Order by Judge Friedel staying Order pending completion of judicial review
8/8/05	Notice of Appeal by SRS
3/16/06	Appeal dismissed

Apparently the matter was returned to the agency (now KHPA rather than SRS) for additional hearings, though the Court appearance docket is not clear whether this was by order or by agreement. The stay order also appears to be in effect. Agency counsel advised Board counsel on February 11, 2008 that the U.S. OIG (Office of Inspector General) had asked the KHPA to hold off on their case, but since then has released KHPA from that request.

This chronology clarifies that the letters in May and June of 2005 do not give independent grounds for the Board to take disciplinary action.

Failure of Board Case to Progress

Mr. Buening's memorandum to the House Committee discusses the many events relating to the Board's case. That memorandum indicates the complaints received beginning in early 2004 through late 2005. Some of the care described in those complaints was determined after investigation and after review by the Board's Osteopathic Review Committee to have been within the standard of care. The review committee and the Board's Disciplinary Panel have reviewed a multitude of cases. It was not until investigation was completed regarding the complaint made in August 2005 that the Board had cause to allege multiple or repeated instances of negligence. The administrative petition was then filed in May 30, 2006. That petition was subsequently amended to add several additional cases.

Questions were raised as to why a disciplinary case initiated in May of 2006 has not yet been concluded. This proceeding is quite complex, and involves several patients and several practitioners. Additional time to proceed was made necessary by the amendment to the petition. Also, the case was stayed in January of 2007 based in part on

the request of the U.S. Attorney's office, though they have denied making that request. Mr. Wall cavalierly stated that this is "a false excuse."

Mr. Wall was not privy to the meeting between Board staff and federal staff on January 22, 2007. He also would not have access to the contemporaneous notes from that meeting. He might not know that Ms. Stevens and the other two Board staff members who were present at that meeting have signed affidavits that verify the request was made and that those affidavits were presented to the U. S. Attorney. Most importantly, the stay of the proceeding was beneficial to the Board's case because it allowed time to strengthen the petition with other instances of alleged violations. Eventually Dr. Schneider was indicted on federal charges, and based upon findings of the U.S. Magistrate that the doctor is a danger to the public, the Board was able to obtain a suspension of the doctor's license while the case is pending.

Lack of Communication to Patients

Board staff readily admits that communication to complainants and patients is not an area of strength, and improved processes are needed. That is not to suggest, however, that the Board's processes are defective from top to bottom. The Board does not act as counsel to the complainant, and it does not have a fiduciary duty to the patient as an attorney does to a client. An attorney's client might very well have personal interests at stake that are jeopardized by an attorney's failure to communicate. A complainant to the Board does not risk losing personal rights by the Board's action or inaction.

Mr. Wall's written testimony describes a news article that reported a statement by Mr. Darrell Hicks, and described that Mr. Hicks never heard back from the Board. Board records indicate that the complaint was received November 29, 2004. On December 20, 2004 Ms. Shelly Wakeman, Disciplinary Counsel, sent a letter to Mr. Hicks stating that an investigation had been initiated. A copy of that letter is attached. Ms. Kelli Stevens, Board Litigation Counsel, and Ms. Diane Bellquist, Associate Counsel, interviewed Mr. Hicks during preparation for hearing in the disciplinary case.

The Board has taken and is taking steps to improve communication. The additional staff positions authorized during the 2007 Legislative Session will benefit in this area.

IV. Testimony Regarding Dr. Geenens

The investigation of Dr. Jacobs' complaint against Dr. Geenens provided the basis for the allegation of sexual misconduct in the Board's action against his license in 2004. This case was very difficult given the high degree of emotion on the part of the witnesses and Dr. Geenens. There was no evidence of a clear and convincing quality to establish that a sexual relationship between Dr. Geenens and Terri Jacobs occurred prior to the termination of the physician-patient relationship. That factor impacted the discipline imposed. The relationship was consensual, and the patient at issue was hostile to the Board's position. It would have been difficult for the Board to conduct an evidentiary hearing when the patient is a hostile witness. Nevertheless, the Board found there were

sufficient grounds to discipline Dr. Geenens for his conduct. Dr. Geenens and Dr. Jacobs's ex-wife are now married.

While we may not comment on the specifics of this particular matter, the Board investigates cases and is very concerned when it appears a physician might have some impairment or character problem underlying the conduct which could put patients at risk. The Board routinely requires such physicians to be evaluated by mental health professionals at facilities specializing in assessing boundary violations. These evaluations and reports of professional opinions guide the Board in determining whether the physician is a risk.

The investigation into Dr. Murphy's July 2007 complaint to the Board is still pending. Our records indicate telephone conversations between Board staff and Dr. Murphy took place on at least three occasions to date, in October 2007, November 2007 and January 2008. Additionally, the Board has a pending case based on a complaint from a former patient. These two cases were under investigation when Dr. Geenens requested termination of his supervision requirement in October 2007. Because the investigative evidence could potentially lead to further Board action or at least be considered in evaluating Dr. Geenens' request for termination, the Board continued the hearing so that Board staff would be able to complete their investigations and have the matters reviewed by the Disciplinary Panel. Specific information contained in those cases remains confidential at this time, but does encompass some of the items mentioned by Dr. Murphy and Dr. Jacobs, and the Missouri Board's investigation.

Dr. Jacobs also testified that three teenage patients committed suicide while being prescribed Zoloft by Dr. Geenens, and inferred Dr. Geenens should have known that Zoloft was dangerous. Our investigative records show all three deaths took place prior to 2003. It wasn't until February 2005 that the FDA made changes to the product labeling by adding a Medication Guide pertaining to pediatric suicidality, and placed a "black box" warning for the drug. At the time of the patient deaths, the FDA had not yet issued a "black box" warning about the potential for suicidal behavior when prescribing the drug for teens, and at that time, it was largely considered to be standard of care to prescribe Zoloft for depression.

The complaint alleging that Dr. Geenens breached patient confidentiality was investigated in 2005. It was closed for lack of evidence. Witnesses said that the patient herself would talk about her ECT treatment. The Board did not have evidence to attribute the breach to Dr. Geenens as it had no direct proof and other sources of the breach could not be excluded.

Several of the other allegations, including the altercation between Dr. Jacob and Dr. Geenens at Starbucks and the workplace sexual harassment, were addressed and considered in the investigation resulting in the prior Consent Order. However they were not specifically mentioned in the Consent Order.

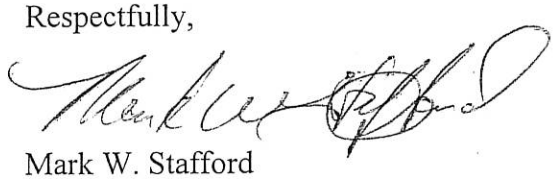
V. Potential Resolutions

The Board has implemented procedures to communicate regularly with patients and witnesses. The new legal assistant position in the Litigation Division will act as a witness coordinator and contact person when disciplinary cases are pending. A similar duty is being implemented for cases that are still being investigated. Additionally, a standard procedure is being implemented for investigators to make personal or telephone contact with patients who have filed complaints. The time frame for making that contact is still being determined, but will be within a short time following assignment of the case.

This committee might also want to consider granting complainants "whistle blower" status so that individuals who fear liability might be encouraged to come forward. The Board is simply not able to address misconduct of which it is not made aware. Finally, if the Committee believes that the Board policy establishing time standards is insufficient, then further discussion between the Committee and Board is appropriate to determine realistic expectations and resources needed to meet those expectations.

In conclusion, the suggestion is made that the State Board of Healing Arts is physician dominated, and that it protects physicians rather than the public. There are three public members on the Board, and one of those public members, Ms. Betty McBride, is the Board president. Ms. Sue Ice is very active in consumer advocacy and patient rights, and regularly attends national meetings of the Citizens Advocacy Center. Recently, Ms. Myra J. Christopher, a nationally regarded bio-ethicist, was appointed to the Board. The late Emily Taylor, Ph.D. previously served on the Board. She was well known for her advocacy in areas of patient rights, women's' rights, and end of life care including quality pain management. The input by the public members has been in the past and continues to be highly regarded and valuable to the overall deliberations of cases presented to the Board.

Respectfully,



Mark W. Stafford
General Counsel

KATHLEEN SEBELIUS
GOVERNOR

STATE BOARD OF HEALING ARTS

LAWRENCE T. BUENING, JR.
EXECUTIVE DIRECTOR

MEMORANDUM

TO: **Senate Committee on Health Care Strategies**

FROM: Lawrence T. Buening, Jr.
Executive Director

RE: **Investigative Processes and Stephen Schneider, D.O.**

DATE: **January 22, 2008**

Good afternoon. I am the Executive Director of the Kansas State Board of Healing Arts and am providing this information on behalf of the Board.

To briefly provide some information on the Board, it was created in 1957 by combining the existing boards that regulated medical doctors, osteopathic doctors, and chiropractors. Currently, the Board is comprised of 15 members, each appointed by the Governor for four-year terms. Five members are medical doctors, three are osteopathic doctors, three are chiropractors, one is a podiatrist and three are appointed from the general public. The Board regulates the practice for approximately 21,500 persons engaged in 13 health care professions.

The Board performs its regulatory functions pursuant to statutes enacted by the Legislature and rules and regulations adopted by the Board to implement those statutes. The Healing Arts Act (K.S.A. 65-2801 *et seq.*) was enacted in 1957 to regulate the professions of medicine and surgery, osteopathic medicine and surgery and chiropractic. K.S.A. 65-2801 has remained unchanged since 1957 and provides that the regulation of the healing arts is required so that "the public shall be properly protected against unprofessional, improper, unauthorized and unqualified practice of the healing arts and from unprofessional conduct by persons licensed to practice...".

To meet its statutory responsibilities in the regulation of the healing arts, the Board has three programs: (1) Licensing and Renewal; (2) Investigation and Disciplinary; and (3) Enforcement and Litigation. The Licensing and Renewal Program goal is to ensure that only those meeting the required qualifications are issued licenses and are allowed to renew those licenses. The goal of the Investigation and Disciplinary Program is to promptly, aggressively and thoroughly investigate matters alleging incompetence,

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unprofessional conduct and other statutorily proscribed conduct and to submit completed investigations to review committees for fair and consistent recommendations. The Enforcement and Litigation Program is involved in restricting or otherwise affecting the license of those individuals who lack professional competence or have committed other violations of the Healing Arts Act.

I have been requested to provide information on the Board's investigative processes. During the summer of 2006, Legislative Division of Post Audit conducted a performance audit of the Board of Healing Arts, that included reviewing issues related to complaint investigations. Attachment 1 constitutes pages 3 through 7 of the Performance Audit Report issued October 2006. The process for reviewing complaints, investigating them, and ordering corrective action is set forth in Figure OV-2 on page 5 of the Report.

Attachment 2 is the Disciplinary Procedure that can be accessed from our website at www.ksbha.org.

Chairperson Wagle has also requested that I provide information to the Committee on a case that has received substantial coverage in Sedgwick County. This press and media coverage began when a Grand Jury indictment was filed in United States District Court on December 20, 2007 against Stephen J. Schneider and Linda K. Schneider, case no. 07-10234-WEB. The Indictment contains 34 counts alleging conspiracy, unlawful distribution and dispensing of controlled substances, health care fraud, illegal monetary transactions, and money laundering. Since the filing of the indictment, a plaintiff's attorney has been quoted on more than one occasion, an editorial appeared in the December 22, 2007 edition of The Wichita Eagle, and two legislators were cited in an article that appeared December 23, 2007. As a result, I have reviewed the information in the Board's possession regarding what information was provided to the Board and when it was provided.

In calendar year 2003, the Board received a police report concerning medication bottles found in the home of a decedent. An investigative case was opened six days following receipt of the report. The investigation revealed that bottles of pills from four practitioners were found in the decedent's home. The autopsy determined that death was due to toxic effects of cocaine. The osteopathic review committee determined that Dr. Schneider did not violate the healing arts act and the matter was closed.

In calendar year 2004, the Board office received three pieces of information. On February 11, 2004, a complaint was received and opened for investigation six days later. Following the conclusion of the investigation, a determination was made that there had been no deviation from the standard of care. A letter was received on March 23, 2004, and an investigation commenced. It was subsequently determined that the standard of care had been met. On November 11, 2004, a complaint was filed. Investigation revealed that the standard of care had not been met. This was the first finding that standard of care had not been met. Pursuant to K.S.A. 65-2837(a)(2), repeated instances of ordinary neglect are required for a violation of the healing arts act to have occurred.

The treatment provided to the patient relating to this complaint has been included in the disciplinary action now pending before the Board.

During the first nine months of 2005, six additional matters came to the Board's attention. Complaints received on March 17, March 25 and April 15, 2005 have all been determined to be within the standard of care. On February 4, 2005, a complaint was received and an investigation opened March 1, 2005. Licensee's conduct in the treatment of this patient was subsequently determined to have been below the standard of care and this matter has been included in the disciplinary action that was originally filed May 30, 2006. Treatment of the patient that was described in the complaint received August 2, 2005, was also determined to be negligence and is included as one of the counts in the matter currently pending before the Board.

The sixth matter received during the first nine months of 2005 was a letter from SRS on May 25, 2005 advising that licensee had been terminated from participation in the Kansas Medicaid program. On July 1, 2005, an appeal was initiated by the licensee in Sedgwick County District Court, case no. 05-CV-2566. As a result, a hearing was conducted July 6, 2005, in which a District Court Judge in Sedgwick County found that there was substantial likelihood of success on the part of the licensee on the appeal. Specifically, the Honorable Karl W. Friedel stated as follows: "From the standpoint of irreparable injury, I find that if this action is not stayed – the action on the part of the State is not stayed there will be irreparable injury not only to the doctor and the clinic, the staff of the clinic, but also to the patients by way of an interference with the doctor/patient relationship. And given the evidence that's provided of the compliance by the clinic with regard to the FirstGuard requirements of remedial action, I find no threat to the public health, no undue harm to the public or the prospect of harm." (Transcript of proceedings, Page 3, Lines 2-12). The Court ordered that the Kansas Division of Health Policy and Finance permit the licensee to continue to participate in the Kansas Medicaid program.

In September 2005, it became a matter of public knowledge that Federal authorities were conducting an investigation and had executed a search warrant on the Schneider clinic. From October 6, 2005 through the end of the year, the Board received one complaint and four initial reports from the Health Care Plan that malpractice suits had been filed---two of these pertained to Stephen Schneider, D.O. and two related to Schneider Medical Clinic, LLC. It should be noted that malpractice petitions are not generally investigated as statistics have shown that only about one in four result in payments or a determination that negligence had occurred by a practitioner.

During the first three months of 2006, the Board received reports from the Plan that four more suits had been filed or a written claim made against the licensee. Also, in addition to copies of Petitions or claims received from both the Fund and Plaintiff attorneys, the Board received two complaints on February 7 and February 17.

On May 31, 2006, the Board initiated a disciplinary proceeding. The treatment relating to six of the patients that were brought to the Board's attention during the first three months of 2006 are currently included in the disciplinary proceeding. In addition, the

disciplinary proceedings involve the treatment provided to patients relating to the complaints received on November 11, 2004 and February 4, 2005.

There may be questions about the length of time it has taken for the Board's disciplinary proceeding to come to a hearing. Since the filing of the disciplinary proceeding, the Board has continued to receive additional complaints and information on malpractice suits filed. Investigations are still ongoing and peer review is being conducted. A Board member was appointed as the Presiding Officer in June 2006. A prehearing conference was then scheduled for July 31, 2006. In August 2006, a substitute Presiding Officer from the Office of Administrative Hearings was designated to hear the case. The Board's attorney filed a 44-page First Amended Petition on September 1, 2006. A second prehearing conference was scheduled for September 25, 2006, resulting in a prehearing order scheduling the matter for hearing on March 26, 2007. On January 26, 2007, an Agreed Order of Stay was entered. This was agreed to as a result of repeated discussions with Federal authorities indicating a Federal indictment would be forthcoming and there was a possibility of a resolution involving both the Federal investigation and the licensee's license to practice in Kansas. A third prehearing conference was scheduled for November 13, 2007, on which date a 56-page Second Amended Petition was filed. On December 27, 2007, a Motion for Emergency Suspension was filed which was heard by the Presiding Officer on January 15, 2008. The Presiding Officer has taken the Motion under advisement and he informed the parties that he would rule as soon as possible.

The Board was aware of an investigation being conducted by Federal authorities prior to the service of the first search warrant in September 2005. Contact with Federal authorities has been continuous. However, it was not until December 2006 and January 2007, that discussions with Federal authorities revealed just how extensive the Federal investigation was. According to the December 21, 2007 issue of The Wichita Eagle the indictment filed December 20, 2007, followed four years of investigation. An Associated Press story appearing January 17, 2008, cites one of the defense attorneys as saying the government has 200 boxes of evidence. A Kansas City Star article posted December 20, 2007, cited United States Attorney Eric Melgren as follows: "Melgren called the case one of the most complicated investigations his office has ever done, and his office worked as quickly as possible, given the circumstances." The full extent of the Federal case was not totally made aware to the Board until the filing of the indictment.

The Board itself is very aware of the concerns of practitioners who are involved in pain management. The abuse and addiction potential of narcotic painkillers and fears of federal and state scrutiny and prosecution discourage many primary-care doctors from treating chronic pain patients. Patients with pain are difficult patients for any doctor to treat.

One past case is of particular note. In July 1994, a licensee was arrested on murder and attempted murder charges. A settlement proposal was provided to the licensee's attorney February 7, 1995, signed by the licensee on February 18, 1995, and accepted by the Board at its meeting April 29, 1995. The settlement resulted in the licensee surrendering his license to practice in Kansas. Eight months later the licensee was convicted of

murder and attempted murder. Subsequently, the appellate courts set aside the convictions. The doctor's license was then reinstated on October 17, 1998. However, the 2000 Legislature determined that the healing arts fee fund, the Attorney General's fund and the State General Fund should each pay the doctor $66,666.

In October 1998, the Board adopted Guidelines for the Use of Controlled Substances for the Treatment of Pain. This was followed in June 2002 by the adoption of a Joint Policy with the Nursing and Pharmacy Boards. Copies of these policies are included as Attachments 3 and 4. Excerpts from the Joint Guidelines include:

> "Inappropriate treatment of pain is a serious problem in the United States. Inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and ineffective treatment."
>
> "Prior to the filing of any allegations, the results of the investigation will be Evaluated by the health care provider's peers who are familiar with the policy statement. Health care providers who competently treat pain should not fear disciplinary action from their licensing board."

In 2006, the Legislature amended the healing arts act as follows:

> "(23) Prescribing, dispensing, administering~~,~~ *or* distributing a prescription drug or substance, including a controlled substance, in an ~~excessive,~~ improper or inappropriate manner ~~or quantity~~, *or for other than a valid medical purpose*, or not in the course of the licensee's professional practice."

This amendment was included with the bill that adopted the Pain Patient's Quality of Care Act. (2006 Senate Substitute for House Bill No. 2649) and, in combination, resulted in the state of Kansas receiving the highest grade for balanced pain policies in the nation by the Pain & Policy Studies Group of the University of Wisconsin Comprehensive Cancer Center. (See Attachment 5).

Cases involving potential overprescribing are extremely difficult and time consuming. Not only must the patient prescription records be obtained, but the investigation must be reviewed by a committee of the practitioner's peers, the Board's Disciplinary Panel and, if proceedings are authorized, an expert who will testify at the hearing. This case was further complicated by a number of factors: patients received prescriptions from a number of prescribers, many of the patients had obtained illegal drugs, and there are more than 40 pharmacies in the vicinity surrounding the Schneider Clinic that could reasonably be used by patients to fill prescriptions. Subpoenas for pharmacy records produce results in different formats. For instance, some pharmacies may provide prescription information based on the date the prescriptions were filled; others may provide information based on the drug prescribed, etc.

A centralized database of prescriptions that could produce results in a standard format would be extremely beneficial. The 2007 Legislature enacted S.B. No. 302 and thereby

created a controlled substances monitoring task force. The report of the controlled substance monitoring task force was presented to the President of the Senate and Speaker of the House on January 16, 2008. The Board would urge adoption of the draft bill enacting the prescription monitoring program act that has been recommended by the task force.

Thank you for your time and I would be happy to respond to any questions.

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ATTACHMENT 1

PERFORMANCE AUDIT REPORT

Board of Healing Arts: Reviewing Issues Related to Complaint Investigations, Background Investigations, and Composition of the Board

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
October 2006

06PA10

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cases last year. Five investigators live in the Topeka area, while the other three live and work from their homes to cover the Kansas City area, the Emporia/Wichita area, and southeast Kansas. All but one of the investigators have a law enforcement background.

- Administration and Information Technology. The agency has five administrative positions and two information technology positions.

More information about the Board can be found in the At-A-Glance box on page eight.

The Board Has Established a Complaint-Handling System With Multiple Levels of Review

The Board's complaint-handling process is shown in ***Figure OV-2*** at right, and is described briefly below.

The Board of Healing Arts considers all "adverse information" it receives about a licensed professional to be a complaint. During fiscal year 2006, the agency received nearly 2,600 pieces of information that it labeled as complaints. ***Figure OV-3*** shows the sources of these complaints, and numbers of each:

Figure OV-3
Sources and Number of Complaints Received
Fiscal Year 2006

Complaint Source	# of Complaints Received
Malpractice petitions received from Health Care Stabilization Fund	668
General public/patients filing a complaint form, calling or e-mailing	580
National reports from organizations that track disciplinary actions	300
Hospitals submitting an adverse findings report	79
Other, such as information self-reported by a doctor on the license application	960
Total	**2,587**

Source: Kansas Board of Healing Arts complaint database.

Agency policy is for staff to review complaints within two weeks of receipt to assess whether the Board has jurisdiction, and whether an investigation should occur.

The Board has established guidelines regarding which complaints will be investigated. The standard is, "If everything the complaint alleges is assumed to be true, when considering the licensees' entire history with the Board, are there grounds for discipline?" Typical allegations that will be assigned for investigation include:

- self-reported issues on an application for licensure (these are sent to the legal department for investigation and review) See ***Appendix C*** for more information

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- a complaint that is the third allegation of substandard patient care, which constitutes a "pattern" of misconduct as defined by the Board
- any allegation of gross negligence, which is defined as wanton or willful misconduct
- a single allegation of unprofessional conduct, such as sexual misconduct with a patient, chemical impairment, surrender of license in another state, or felony conviction

An administrative assistant reads all incoming complaints. If any are "emergencies," they are flagged and priority review. The rest are passed to the attorney responsible for reviewing and screening complaints and assigning them to investigators, as needed.

In fiscal year 2006, about 350 new cases were assigned to investigators for further review and potential disciplinary action.

Complaints that are assigned for investigation are given a priority level. The Board has four priority levels as defined in ***Figure OV-4*** below:

Figure OV-4
Priority Level Descriptions

Level	Description
4	**Emergency:** likelihood of posing an imminent threat of harm to the patient or other person if the behavior continues, and is a violation of law; practicing without a license; felony or misdemeanor that requires immediate investigation to preserve evidence
3	**Priority:** serious violation of the Healing Arts Act that is likely to result in harm to a patient or other person; felony or misdemeanor that requires timely investigation
2	**Important:** a violation of the Healing Arts Act that could result in harm to a patient or other person; violation of a registration requirement or other law; adverse action has been taken by another authority
1	**Other:** Other cases

Source: Kansas Board of Healing Arts

Complaints that don't lead to an investigation are maintained in the licensees' file for possible consideration in the future. Future complaints may be combined with the current complaint to establish a pattern of misconduct that would be the basis for opening an investigation.

The Board has set guidelines for how long different segments of a case should take. We reviewed these guidelines and estimate the Board's total time line for resolving complaints to be about 20 months from the time the complaint was received to the time the case was closed by Board or staff action. ***Figure OV-5*** shows a case progression time line for non-emergency complaints.

The Board has a multi-step process for cases needing disciplinary action. These are described on the next page.

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DISCIPLINARY PROCEDURE

Complaint Form

The Kansas State Board of Healing Arts is comprised of 15 members appointed by the Governor, 12 licensees, and three members from the general public. The Board licenses or registers 13 health care professions and out-of-state contact lens distributors. The mission of the Board is to protect the public by requiring those professionals to meet and maintain certain qualifications and standards of conduct.

Who does the Board regulate?

- Medical Doctors
- Osteopathic Doctors
- Chiropractic Doctors
- Podiatric Doctors
- Physicians' Assistants
- Physical Therapists
- Physical Therapist Assistants
- Occupational Therapists
- Occupational Therapy Assistants
- Respiratory Therapists
- Athletic Trainers
- Naturopathic Doctors
- Contact Lens Distributors
- Radiologic Technologists (effective July 1, 2005)

The Board does not have disciplinary jurisdiction over other health care professions, hospitals, and other health care facilities. When a complaint is received by the Kansas State Board of Healing Arts, staff for the Board makes an initial determination: the complaint must pertain to the practice of the healing arts, and must allege facts constituting a violation of the laws administered by the Board. These two requirements are necessary to open a case for investigation. Sometimes the complaint contains insufficient information and more information may be requested of the complainant.

Examples of Prohibited Conduct

- Commission of acts of gross negligence or multiple acts of ordinary negligence.
- Conviction of a felony or Class A misdemeanor.
- Fraudulent or false advertisements.
- Fraudulent billing.
- Prescribing or distributing drugs for other than lawful purposes.
- The inability to practice the healing arts with reasonable skill and safety to patients by reason of illness, alcoholism, excessive use of drugs, or any mental or physical condition.
- Sexual abuse, misconduct or exploitation related to that person's practice.
- Referring a patient to a health care entity for services, if the licensee/registrant has a significant investment interest in the entity, (10% ownerships or more) unless the person regulated by the Board informs the patient of the interest in writing, and that the patient may obtain such services elsewhere.
- Other acts as proscribed by law .

Once a case is opened, it is investigated by an investigator. This usually involves getting

Guidelines for the Use of Controlled Substances for the Treatment of Pain

Section I: Preamble

The Kansas State Board of Healing Arts recognizes that principles of quality medical practice dictate that the people of the State of Kansas have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about effective methods of pain treatment.

Inadequate pain control may result from physicians' lack of knowledge about pain management or an inadequate understanding of addiction. Fears of investigation or sanction by federal, state and local regulatory agencies may also result in inappropriate or inadequate treatment of chronic pain patients. Accordingly, these guidelines have been developed to clarify the Board's position on pain control, specifically as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

The Board recognizes that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The medical management of pain should be based on current knowledge and research and include the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

The Kansas State Board of Healing Arts is obligated under the laws of the State of Kansas to protect the public health and safety. The Board recognizes that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate purposes.

Physicians should not fear disciplinary action from the Board for prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. The Board will consider prescribing, ordering, administering or dispensing controlled substances for pain to be for a legitimate medical purpose if based on sound clinical grounds. All such prescribing must be based on clear documentation of unrelieved pain and in compliance with these guidelines. If such prescribing meets these criteria, the Board will support physicians whose use of controlled substances has been questioned by another regulatory or enforcement agency.

Allegations of improper prescribing of controlled substances for pain will be evaluated on a case- by-case basis. The board will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these guidelines, if good cause is shown for such

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4. **Periodic Review**
   At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician's evaluation of progress toward stated treatment objectives, such as improvement in patient's pain intensity and improved physical and/or psychosocial function, i.e., ability to work, need of health care resources, activities of daily living and quality of social life. If treatment goals are not being achieved, despite medication adjustments, the physician should reevaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

5. **Consultation**
   The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a co-morbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

6. **Medical Records**
   The physician should comply with and meet the requirements of K.A.R. 100-24-1 in the maintenance of an adequate record for each patient.

7. **Compliance With Controlled Substances Laws and Regulations**
   To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:
"Acute pain" is the normal, predicted physiological response to an adverse chemical, thermal or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.

"Addiction" is a neuro-behavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

"Analgesic tolerance" is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

"Chronic pain" is a pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

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ATTACHMENT 4

Joint Policy Statement of the Boards of Healing Arts, Nursing and Pharmacy on the Use of Controlled Substances for the Treatment of Pain

Section I: Preamble

The Kansas Legislature created the Board of Healing Arts, the Board of Nursing, and the Board of Pharmacy to protect the public health, safety and welfare. Protection of the public necessitates reasonable regulation of health care providers who order, administer, or dispense drugs. The boards adopt this statement to help assure health care providers and patients and their families that it is the policy of this state to encourage competent comprehensive care for the treatment of pain. Guidelines by individual boards are appropriate to address issues related to particular professions.

The appropriate application of current knowledge and treatment modalities improves the quality of life for those patients who suffer from pain, and reduces the morbidity and costs associated with pain that is inappropriately treated. All health care providers who treat patients in pain, whether acute or chronic, and whether as a result of terminal illness or non-life-threatening injury or disease, should become knowledgeable about effective methods of pain treatment. The management of pain should include the use of both pharmacologic and non-pharmacologic modalities.

Inappropriate treatment of pain is a serious problem in the United States. Inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and ineffective treatment. All persons who are experiencing pain should expect the appropriate assessment and management of pain while retaining the right to refuse treatment. A person's report of pain is the optimal standard upon which all pain management interventions are based. The goal of pain management is to reduce the individual's pain to the lowest level possible, while simultaneously increasing the individual's level of functioning to the greatest extent possible. The exact nature of these goals is determined jointly by the patient and the health care provider.

Prescribing, administering or dispensing controlled substances, including opioid analgesics, to treat pain is considered a legitimate medical purpose if based upon sound clinical grounds. Health care providers authorized by law to prescribe, administer or dispense drugs, including controlled substances, should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

A board is under a duty to make an inquiry when it receives information contending that a health care provider treated pain inappropriately. Proper investigation is necessary in order to obtain relevant information. A health care provider should not construe any request for information as a presumption of misconduct. Prior to the filing of any allegations, the results of the investigation will be evaluated by the health care provider's peers who are familiar with this policy statement. Health care providers who competently treat pain should not fear disciplinary action from their licensing board.

The following guidelines are not intended to define complete or best practice, but rather to communicate what the boards consider to be within the boundaries of professional practice. This policy statement is not intended to interfere with any healthcare provider's professional duty to exercise that degree of learning and skill ordinarily possessed by competent members of the healthcare provider's profession.

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medical plan of care. The health care providers involved with the management of pain should evaluate progress toward meeting treatment objectives in light of improvement in patient's pain intensity and improved physical or psychosocial function, i.e., ability to work, need of health care resources, activities of daily living and quality of social life. If treatment goals are not being achieved despite medication adjustments, the health care provider's should reevaluate the appropriateness of continued treatment.

6. **Consultation**
   The health care provider should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement poses a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a co-morbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

7. **Medical Records**
   The medical record should document the nature and intensity of the pain and contain pertinent information concerning the patient's health history, including treatment for pain or other underlying or coexisting conditions. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

8. **Compliance With Controlled Substances Laws and Regulations**
   To prescribe, dispense or administer controlled substances within this state, the health care provider must be licensed according to the laws of this state and comply with applicable federal and state laws.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

Acute pain is the normal, predicted physiological response to an adverse chemical, thermal or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.

Addiction is a neuro-behavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to as "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction. Addiction must be distinguished from pseudoaddiciton, which is a pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Chronic pain is a pain state which is persistent beyond the usual course of an acute disease or

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ATTACHMENT 5

2007 Pain and Policy Report Card and Evaluation Guide
Grade Changes from 2006 to 2007

Arizona
Changed from B to B+ by replacing a previous medical board policy with the Federation of State Medical Board's "Model Guideline for the Use of Controlled Substances for the Treatment of Pain."

California
Changed from C to B by repealing numerous restrictive or ambiguous provisions from laws.

Colorado
Changed from C+ to B by adopting a law that clarifies for practitioners that there is an important distinction between manslaughter and prescribing controlled substances for palliative care; this language identifies a clinical misperception that is pervasive in end-of-life care and attempts to lessen its impact on patient treatment and the professionals who provide it.

Connecticut
Changed from C+ to B by adopting a law that establishes a prescription monitoring program to prevent the improper or illegal use of controlled substances while not interfering with their legitimate medical use; to achieve this objective, the law also establishes a prescription drug monitoring working group that requires that prescription monitoring program information be reviewed by a working group member who is a pain management specialist.

Kansas
Changed from B+ to A by repealing its single remaining restrictive provision from the Medical Practice Act.

Massachusetts
Changed from B to B+ by adopting a law that establishes a palliative care program to ensure that pain and symptom management is an essential part of care for pediatric patients.

New Hampshire
Changed from C+ to B by adopting a law that establishes pain assessment as an essential part of patient care in residential healthcare facilities.

Wisconsin
Changed from B to A by adopting a medical board policy statement based on the Federation of State Medical Board's "Model Policy for the Use of Controlled Substances for the Treatment of Pain."

Report Card Highlights
California and Wisconsin had the greatest grade improvement.

- California's grade improved because of the repeal of numerous restrictions in law.
- Wisconsin's grade improved because the medical board adopted a positive pain management policy.

Kansas and Wisconsin now join Michigan and Virginia as having the most balanced policies in the nation.

Darrell Hicks Investigation (No. 05-00162):

11/29/04:	Complaint rec'd
12/20/04:	Opening letter sent to complainant (**attached**)
1/20/05:	Complainant sent add'l information to Board
3/06:	Copy of Petition rec'd from HCSF
1/8/07:	Complainant is interviewed by Kelli Stevens and Diane Bellquist

KANSAS BOARD OF HEALING ARTS

LAWRENCE T. BUENING, JR.
EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

December 20, 2004

Darrell Williams Hicks
1603 N. Stoney Pt.
Wichita, KS 67212

RE: Complaint against Stephen J. Schnieder, D.O.

Dear Darrell Williams Hicks:

The Kansas Board of Healing Arts is in receipt of the information you sent us regarding the above referenced physician. The disciplinary staff has carefully reviewed the information and assigned these matters for investigation.

Because of the large volume of complaints we receive, it may take some time for this matter to be investigated. You will likely be contacted by an investigator for more information. Kansas law requires that the Board keep matters under investigation confidential. This means that unless public disciplinary action is taken against this physician, we will be unable to advise you of the progress or of the findings of our investigation.

If you are not contacted by an investigator during the investigation, you will be notified when the investigation is concluded.

Sincerely,

Shelly R. Wakeman
Disciplinary Counsel

235 S. Topeka Boulevard, Topeka, Kansas 66603-3068
Voice 785-296-7413 Fax 785-296-0852 www.ksbha.org

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IN THE EIGHTEENTH JUDICIAL DISTRICT
DISTRICT COURT, SEDGWICK COUNTY, KANSAS
CIVIL DEPARTMENT

FILED
2005 JUL 8 PM 4 11
CLERK OF DIST. COURT
18TH JUDICIAL DISTRICT
SEDGWICK COUNTY, KS
BY

Stephen J. Schneider, D.O.,

Plaintiff,

vs.

Kansas Division of Health Policy and Finance,

Defendant.

Case No. 05 CV 2566

COPY

ORDER

This matter came on for hearing before this Court on the 6th day of July, 2005, on Plaintiff's Application for Stay. Plaintiff Stephen J. Schneider, D.O., appears by and through his counsel, Amy S. Lemley and Martha Aaron Ross of Foulston Siefkin LLP. Defendant Kansas Division of Health Policy and Finance specially appears by and through its counsel, Reid Stacey.

WHEREUPON, the Court, having reviewed the First Amended Verified Petition and Application for Stay and the attachments thereto and the Affidavit of Bobbie Graff-Hendrixson submitted by the Agency, and having considered the arguments of counsel, makes the following findings of fact and conclusions of law:

1. Plaintiff filed this action against the Kansas Department of Social and Rehabilitation Services ("SRS") on July 1, 2005, seeking judicial review of that agency's decision to terminate Plaintiff's participation in the Medicaid fee-for-service and the HealthConnect Kansas programs (referred to herein collectively as the "Kansas Medicaid

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program") effective that same day. Also on July 1, 2005, responsibility for the administration of the Kansas Medicaid program was transferred from SRS to Defendant Kansas Division of Health Policy and Finance. The Court finds Defendant is the successor in interest to SRS with respect to the Kansas Medicaid program.

2. Plaintiff is a physician licensed to practice medicine in the State of Kansas. Plaintiff practices medicine in Sedgwick County, Kansas, with Schneider Medical Clinic, L.L.C. ("the Clinic"). One other physician and two physician assistants also are associated with the Clinic. Plaintiff, the Clinic, and the other providers associated with the Clinic collectively are referred to herein as the "Providers." Prior to July 1, 2005, the Providers were participating providers in the Kansas Medicaid program. Providers also are participating providers in the HealthWave program, the Medicaid managed care program delivered by FirstGuard Health Plan ("FirstGuard") pursuant to a contract with Defendant. It was represented by counsel that prior to Defendant's action which is the subject of this action, Providers provided medical care and treatment for approximately 300 Medicaid recipients through the Kansas Medicaid program and approximately 900 Medicaid recipients through the HealthWave program.

3. By letters dated June 8, 2005, Defendant terminated Providers' participation in the Kansas Medicaid program effective July 1, 2005. Providers subsequently were notified by FirstGuard that Plaintiff's participation in the HealthWave program would be terminated effective July 9, 2005. FirstGuard was required to take such action pursuant to its contract with Defendant, which requires FirstGuard to terminate any provider whose participation in the Kansas Medicaid program has been terminated.

4. Plaintiff submitted a timely request for a fair hearing with respect to Defendant's decision to terminate Plaintiff's participation in the Kansas Medicaid program. Plaintiff also requested Defendant to stay the effectiveness of the termination pending the final outcome of the fair hearing. Defendant, however, denied that request. Plaintiff now seeks similar relief from this Court.

5. This Court has jurisdiction to consider this matter pursuant to the Kansas Judicial Review Act, K.S.A. 77-601 *et seq*. Specifically, this Court has jurisdiction to stay the effectiveness of non-final agency action pending the final outcome of an administrative fair hearing process to be conducted pursuant to the Kansas Administrative Procedure Act, K.S.A. 77-501 *et seq*.

6. This Court is the proper venue for this action pursuant to K.S.A. 77-609(b) insofar as Defendant's termination of Providers' participation in the Kansas Medicaid program is effective in Sedgwick County, Kansas.

7. Plaintiff is likely to succeed on the merits of the claim Defendant acted in error in terminating Providers' participation in the Kansas Medicaid program, as further explained in my oral findings on the record.

8. Plaintiff and those Medicaid recipients for whom Providers have provided medical care and treatment would suffer irreparable injury if the requested relief is not granted, as further explained in my oral findings on the record.

9. Defendant will not suffer substantial harm as a result of the stay of the effectiveness of its decision to terminate Providers' participation in the Kansas Medicaid program pending the final outcome of the fair hearing process, as further explained in my oral findings on the record.

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IT IS THEREFORE BY THE COURT ORDERED:

1. The Court grants Plaintiff's oral motion to substitute the Kansas Division of Health Policy and Finance as Defendant in this matter. Plaintiff is directed to serve the Director of Health Policy and Finance with the summons and the First Amended Verified Petition and Application for Stay. All orders entered and all pleadings filed in this case shall identify the Kansas Division of Health Policy and Finance as Defendant.

2. Pending further order by this Court, Defendant shall permit Plaintiff to continue to participate in the Kansas Medicaid program.

3. By no later than close of business on July 13, 2005, Defendant shall deliver to all Medicaid consumers to which Defendant previously gave notice of the Clinic's termination of participation in the Kansas Medicaid program notice that the Clinic is again available to provide medical care and treatment as a participating Primary Care Case Manager in the Kansas Medicaid HealthConnect Kansas program. Such notice shall be delivered in the same manner in which the prior termination notice was provided. If the termination notice was delivered to certain persons or entities via U.S. mail, Defendant shall deposit the notice to the same persons or entities in the U.S. mail by no later than close of business on July 13, 2005.

4. Defendant shall direct FirstGuard to reinstate the Clinic as a participating provider in the HealthWave program pending further order by this Court subject to the same terms and conditions existing prior to June 8, 2005. Defendant shall direct FirstGuard to deliver to those members to whom FirstGuard previously gave notice of the Clinic's termination of participation in the HealthWave program notice that the Clinic is again available to provide medical care and treatment as participating providers in the

HealthWave program. Defendant shall direct FirstGuard to deliver such notice in the same manner in which the prior termination notice was provided. If the termination notice was delivered to certain persons or entities via U.S. mail, Defendant shall direct First Guard to deposit the notice to the same persons or entities in the U.S. mail by no later than close of business on July 13, 2005. (If the termination notice was delivered to a person or entity by electronic mail, facsimile, or telephone, Defendant shall direct FirstGuard to deliver the notice by the same means by no later than close of business on July 13, 2005.) As necessary, Defendant shall enter into a written amendment to its contract with FirstGuard to accomplish those obligations set forth herein.

5. This Order shall remain in effect until the completion of the pending fair hearing process. This matter shall be stayed pending the completion of that process with the exception of further proceedings necessary to enforce this Order. Either party may in the future request the Court lift the stay of this proceeding.

6. The Court does not require Plaintiff to post a bond pursuant to K.S.A. 77-616(e).

Ordered this _____ day of July, 2005.

KARL W. FRIEDEL

The Honorable Karl W. Friedel
Judge of the District Court

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Submitted By:
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Gary Ayers, # 10345
Martha Aaron Ross, #14744

Approved as to form by:

Reid Stacey, #10046
Kansas Division of Health Policy and Finance
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915 S.W. Harrison Street
Topeka, Kansas 66612-1570

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KANSAS BOARD OF HEALING ARTS

LAWRENCE T. BUENING, JR.
EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS
GOVERNOR

December 15, 2005

Steve R. Eddy
2124 South Lennox Drive
Olathe, KS 66062

Re: Complaint against John T. Schroll, M.D.

Dear Mr. Eddy:

The Kansas Board of Healing Arts is in receipt of the information you sent us regarding the above referenced physician. The disciplinary staff has carefully reviewed the information and assigned these matters for investigation.

Because of the large volume of complaints we receive, it may take some time for this matter to be investigated. You will likely be contacted by an investigator for more information. Kansas law requires that the Board keep matters under investigation confidential. This means that unless public disciplinary action is taken against the physician, we will be unable to advise you of the progress or of the findings of our investigation.

If you are not contacted by an investigator during the investigation, you will be notified when the investigation is concluded.

Sincerely,

Shelly R. Wakeman
Disciplinary Counsel

235 S. Topeka Boulevard, Topeka, Kansas 66603-3068
Voice: 785-296-7413 Toll Free: 888-886-7205 Fax: 785-296-0852 www.ksbha.org

TIMELINE

2003 – Received Police Report – deceased had bottles of pills from 4 practitioners

02-11-04 Complaint

03-23-04 Complaint

** 11-11-04 Complaint – 1st finding of standard of care not met

** 02-04-05 Complaint – 2nd finding of standard of care not met

03-17-05 Complaint

03-25-05 Complaint

04-15-05 Complaint

05-25-05 Received letter from SRS – licensee terminated from participation in Medicaid

Sept, 2005 Public knowledge that Feds were investigating and had executed a search warrant

** 08-02-05 Complaint – 3rd finding of standard of care not met

?? 10-06-05 Complaint – what was finding?

Oct 06 thru Dec 31st, 05 4 malpractice lawsuits filed

1st quarter of 2006 4 more malpractice lawsuits filed

?? 02-07-06 Complaint – what was finding?

?? 02-17-07 Complaint – what was finding?

By 1st quarter 06, knowledge of 3 to 6 cases of standard of care not met and 8 malpractice lawsuits according to testimony

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05-31-06 Board initiated disciplinary proceeding. **SIX PATIENTS INCLUDED IN CASE FROM 1st THREE MONTHS OF 2006**. (*These cases were not specifically addressed in testimony*) ALSO INCLUDED COMPLAINTS FROM 11-11-04 and 02-04-05.

01-26-07 Entered an Agreed Order of Stay "*as a result of repeated discussions with Federal authorities indicating a Federal indictment would be forthcoming and there was a possibility of a resolution involving both the Federal investigation and the licensee's license to practice in Kansas.*"

Senate Health Care Strategies Committee
Date: February 18, 2008
Attachment 3

U.S. Department of Justice

Eric F. Melgren
United States Attorney
District of Kansas

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Topeka, Kansas 66683-3592

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500 State Avenue
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VIA TELFAX: 368-7102

October 3, 2006

Mr. Mark Stafford
Kansas State Board of Healing Arts
235 S.W. Topeka Blvd.
Topeka, KS 66603-3068

Re: Stephen J. Schneider

Dear Mark:

Please find enclosed a subpoena for documents related to the KBHA's current case against Stephen J. Schneider. We would ask that your production of documents be an ongoing one during the administrative proceedings so that we can keep up-to-date about what the KBHA is doing, and what Dr. Schneider is doing in response, so that we can best coordinate with the KBHA in our on-going criminal investigation. By coordinating, we will avoid duplicating efforts and we will stay out of the KBHA's way in its administrative proceedings against Dr. Schneider. Consequently, there is no due date on the subpoena – we just ask that you send copies of documents as they are generated. Shelley Wakeman indicated she would send me the Petition and Amended Petition, so there is no need to send me those pleadings.

If you have questions, please do not hesitate to call.

Sincerely,

Tanya J. Treadway

Tanya J. Treadway
Assistant United States Attorney

TJT:tjt
Enclosure
cc: Jim Greer

Senate Health Care Strategies
Committee
Date: February 18, 2008
Attachment 4