Approved: May 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 25, 2008 in Room 136-N of the Capitol.

Committee members absent: Senator Peggy Palmer - excused

Committee staff present: Ms. Emalene Correll, Kansas Legislative Research Department
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. Larry Buening, Executive Director,
Kansas Board of Healing Arts

Others in attendance: Please see attached Guest List

**Continued hearing on Kansas Board of Healing Arts responsiveness and complaints from the public**

The Chair announced that the Committee would continue hearing discussions from the Board of Healing Arts, reminding them that a request for open records had been sent. But before they got to that she referred them to their first handout, a recent article from the Associated Press (AP) entitled, "Feds accuse Kansas of jeopardizing doctor's criminal case". She said apparently the AP asked for records between the Kansas Board of Healing Arts (KBHA) and the Department of Justice (DOJ) about the Schneider case and there are some excerpts from a number of letters that are listed in this article of January communications. She referred them to the January 18, 2008 letter revealing to Dr. Schneider's attorney's that there were undercover agents in the clinic. Then it was revealed after one of our hearings that even though they had subpoenaed documents a year ago from the KBHA, the DOJ thought after we had a hearing that they hadn't received all of the documents and so they sent a second subpoena. The KBHA responded in a different court in a civil case rather than respond to the motion in the federal court. They filed a motion in another court and when they filed that motion they attached to it a document, that she understood was put under seal by the Federal Judge and you can read a number of communications about how the Schneider case has been handled between the Legal Staff.. A copy of the article is (Attachment 1) attached hereto and incorporated into the Minutes by reference..

She then asked Mr. Buening if he wanted to respond to this. He called on Ms. Kelley Stevens, Litigation Counsel for the attorneys for the Board's response. The Chair asked Ms. Stevens, as you were sharing information with both parties, was it revealed that undercover agents were in the Schneider facility? Ms. Stevens answered that there was a discovered request for production of documents made by Dr. Schneider's attorney in their administrative case, which basically they request all documents pertaining to our petition against Dr. Schneider and they go through all of their documents to determine which items are privileged work products, which items are attorney client communications and so forth, and then they exclude law enforcement documents. And the document Ms. Treadway references, was an investigative report that our investigators used to title all of their investigative reports "work product". And so they determined that this particular document really was not a work product in the terms of an attorney work product. It was really an investigator's report of events. That document did mention that there had been a KBI informants involved in the matter. We did not disclose any of the law enforcement's own documents that we have as part of our case. Dr. Schneider's attorney was informed that we did have law enforcement documents and that they would not release them unless the presiding officer of the case tells us to. But there was an investigative report that mentioned previous informants that had been there without names or specifics, believe it detailed a conversation between our investigator and the KBI and mentioned informant.

The Chair asked if there was a way they could have not disclosed that? Ms. Stevens responded by saying it was not a law enforcement document it was our investigator's report of what occurred and in her professional opinion, it was not a privileged matter.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

The Chair asked, you don't think that having an undercover agent, someone who is seeking information to prosecute and trying to not have their identity known to a potential criminal, is not a privileged matter in a case like this? Ms. Stevens said this was after the fact and mentioned when they co-investigate a case with federal authorities, they often times share information in a very loose fashion (ex. Email) and our investigation is intertwined with theirs. The Chair said she understands them sharing information with you, but not so sure about you revealing of information back to the person you were investigating. Ms. Stevens said that they were under a discovery request to do so and we did protect all law enforcement documents.

The Chair recognized Senator Journey who asked:

- Was that the document in question actually the KBHA investigator's report that was provided to the physician and was that report provided before the arrest of Dr. Schneider? Ms. Stevens believed that discovery production was before his arrest.

- What is the standard to determine discovery ability of documents held by the Board? And he went on to say, the hearing officer makes a decision based upon whether a document is privileged. Ms. Stevens stated that they do not release attorney work products and that would include some investigator information that was at the direction of the attorney that includes their impressions and anything they are doing in furtherance of their case. They don't produce any of their attorney client communication (their client being their disciplinary panel of board members) and then we did not disclose the federal and state law enforcement documents we had in our possession.

- When you say you have investigative documents, do you mean like actual investigative reports that were complied, for example. by a DEA agent? We currently have those documents. Dr. Schneider's attorney was made aware that we had those, but she has not filed any motion to compel the board to produce them.

- There were two search warrants served on Dr. Schneider's office, one a couple of years ago and one just before his arrest, and it was in between these two search warrants that you told Dr. Schneider's attorney that you had investigative reports? Ms. Stevens said to the best of her recollection would have been the fall of 2006.

-Let's just go to presumption land, if Dr. Schneider's attorney said he needs everything and you said here is all you can have and then he would make a motion to compel that discovery with the hearing officer? Ms. Stevens said they would have produced them for the hearing officer, for an in-camera inspection (to which Senator Journey said, meaning just the hearing officer gets to see.) and, do you believe that the confidential informant or investigator was still in interaction with the Schneiders and their offices during this period of time? Without the document in front of her, Ms. Stevens said, her best recollection was it was past tense.

- Was this report initiated before the search warrant and because you could not produce that discovery for various reasons that are justified you would not be able to use that document in the hearing as substantiation of the claims against the doctor? Ms Stevens said she notified Dr. Schneider's attorney that they were not going to produce them and gave notice to the General Counsel for the KBI that they did have some of their documents and there may be a request by his attorney to produce those and wanted to give them the opportunity to object and to the DEA.

- It is my understanding the US Attorney issued a subpoena to the KBHA for the production of your files (which she said they had three total) and then tell me why you chose to go to a separate civil suit rather than a motion to quash the subpoena in front of the judge that had jurisdiction over the criminal case? Ms. Stevens stated that was not my petition that was filed, but from their General counsel's office. But what she does know that it was not a criminal subpoena but an administrative subpoena to their agency, not part of their criminal case.

- This was before the case was filed? Ms. Stevens said no, after.

- That was probably to take his DEA authorization away from him, it that a fair assumption? Did it originate from the DEA's office or the US Attorney's office? Ms. Stevens replied, the. US Atty's office.

- And all three subpoenas were administrative subpoenas? Ms. Stevens said yes, not in any way part of the criminal action.

- So the petition you filed in the US district court in the civil case was answer to try to quash that subpoena or get a court to intervene to clarify the subpoena for the Board? Ms. Stevens replied I believe it was to clarify it to modify the date.

-Where you asked for so much information it was impossible to comply? Ms. Stevens answered it asked for everything regarding any licensee who had worked for Dr. Schneider's medical clinic and it was much more broad than the previous subpoena they had.

- Was this the third subpoena? Ms. Stevens answered yes, and we had four days to respond to it.

- With the first subpoena did you comply with to the best of your ability? Ms. Stevens responded, it asked for records within our current action against Dr. Schneider.

- And the second one asked for more of the same? Ms. Stevens said it appeared to be almost a duplicate of the first subpoena and the third was much broader.

- When the second subpoena was received were more documents produced because they were not in possession of the Board when the first one was applied? Ms. Stevens replied she did not know what prompted the second subpoena.

- The question was what did you do to answer the second subpoena? Ms. Stevens answered, the first subpoena was to the Board and I, as litigation counsel, responded to it. The second subpoena was responded to by our general counsel's office and without it in front of me, I believe it involved other licensees who might have worked at the Schneider's medical clinic

The Chair stated that seeing the letters back and forth, she is concerned about the tension between the two organizations and cooperation and it appears after she reads this that the federal government did not feel that you had complied with the subpoena. Ms. Stevens stated that in one of Ms. Treadway's conversations with us, it was a continuing subpoena, and since Ms. Stevens felt there was no such thing as a continuing subpoena, and at the time it is issued you produce the documents that exist, it was her understanding that Ms. Treadway felt there were subsequent documents that we were not continuing to produce to her.

The Chair asked:

- Were these subsequent documents new coming in, or documents from the past? Ms. Stevens did not want to speak on Ms. Treadway's behalf.

- Dr. Schneider has always been the owner of the clinic? And you had complaints coming in. You had 70 boxes of information about practitioners in the clinic and possibly about Dr. Schneider since what year? Ms. Stevens felt they were mis-communicating because there were other physicians who maybe worked for Dr. Schneider for a period of a year, and we may have had an investigation concerning that practitioner ten years before he ever worked at Dr. Schneider's medical clinic and an entirely different matter.

- How many additional boxes were sent over for the third subpoena? Ms. Stevens said she would not be able to gauge that because she was not responsible for producing them.

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- Do you typically have this many complaints coming in about one clinic? How many complaints did you have that were directly associated with people while they were working at the Schneider clinic and/or Dr.

Schneider? Ms. Stevens thought this was probably part of the second subpoena, and her recollection was, we additionally received individual subpoenas regarding some of the practitioners and physician assistants and she gave an example.

- Since we have an actual open records request and we are not sure when we will be able to get to that, in the last five years as you looked at the communication, complaints, and investigations you have done with practitioners, physician assistants, Dr. Schneider and whoever else is working there, does there tend to be a lot of files? Ms. Stevens said probably in the last four years are the cases that have been investigated as part of the Schneider medical clinic. She then said that Mr. Buening was going to present all of the complaints regarding Dr. Schneider that they have received and there may have been associated cases.

The Chair then called on Mr. Buening who said he had information available on the Committee's open records request and passed out a copy of the Committee's request and his response. A copy of both is (Attachment 2) attached hereto and incorporated into the Minutes by reference.

Mr. Buening went on to say that there were separate handouts, one for each of the three physicians with information the Committee was inquiring about. The Chair requested he begin with the Schneider case

While Dr. Schneider's information was being passed out, Mr. Buening said in response to the discussion the Chair had with Ms. Stevens, requests were made for physicians who did not ever work at the Schneider clinic as well because they had a physician assistant and also on the third subpoena, the request was made, and the reason they did file something on it, for a seven day continuance in order for them to get the information, the seven days was met, and have not heard that the US Attorney's office were not satisfied with anything they had provided to them. Mr. Buening then offered a spreadsheet responding to a number of the Committee's request with the complaint that was received on August 28, 2003. This packet of information contains:

1.. Dr. Schneider's spreadsheet;

2. A copy of the motion for the emergency that was filed in January and all though not a petition, it could be considered a petition,

3. Board Minutes of June 9 and 10, and August 12, 2006

A copy of the above is (Attachment 3) attached hereto and incorporated into the Minutes by reference.

The Chair asked,

- If she goes to 2-17-06, is it fair to say you had eleven cases of not meeting standard of care? Ms. Stevens cited some of these are multiples as one investigation may have started with one patient but may have involved multiple, so you cannot add up to exactly the number of counts.

- And so one of these represented two or three people? Ms. Stevens said that is correct.

- For clarification, when you appeared earlier you said that you filed a petition and there was concern and you did not want to interfere with the federal case and you asked for a stay, is the first case mentioned filed May, 2006? Mr. Buening said that was correct.

- And so amended the petition and got more information and amended it in November, but the two petitions seem to be very different. The first speaks in general terms, between 2000 and 2005 and multiple occasions of these actions, and then if you look at the amended petition it seems to be specific, is that the

way things are handled? Mr. Buening said when the disciplinary panel met on May 13, 2006, they had

some concerns and wanted something on file and without going into the specifics. Ms. Stevens wanted to get that on file while we got the cases out to get expert opinion and could proceed with the more specific petition filed.

- Your disciplinary panel was very concerned by May, 2006, you took the action they requested and then more cases came in. But yet there was no follow through and then when you thought there was an agreement with the federal government that you best not interfere, you allowed them to pursue the case? Mr. Buening answered right.

As they were running short on time, the Chair asked Mr. Buening if he would mind handing out the information on Dr. Geenens A copy of this handout is (Attachment 4) attached hereto and incorporated into the Minutes by reference.

While Dr. Geenens information was being passed out, Mr. Buening referred the Committee back to Attachment 3, cases 3360 and 3361, stating that these were actually authorized by and sent to an expert on January 31, 2008, under the column "Date Clsd" shows 1-31-07 and should be 1-31-08 for these two. He went on to say on the Geenens issue under the column "Complaint" you see "Renewal Form" three times. We ask seven questions on our annual renewal form with regard to what actions may have been taken against them, ex. being sued, etc. and if they answer yes to any of those questions, we inquire about that. He also referred the Committee to five pending cases, beginning with #02969, saying these are scheduled for presentation to the disciplinary panel March 7, 2008.

The Chair asked:

- Is there a date on here reflecting the date you received the investigative report from Missouri? Mr. Buening said no, but it was on his introductory comments found in Attachment 2.

- What date did you receive the investigative report from Missouri? He answered May 14, 2007.

- In visiting with the investigator in Missouri, they started their case in the spring of 2006 and you stated that by Mary 14, 2007 they had sent you files and Dr. Geenens has agreed to retire his license in Missouri as of October 1, 2007. She went on to say, it is her understanding that a doctor can voluntarily retire his license rather than have that case become public and promise never to license there again. She asked, if you have had this case since May 2007, the Missouri case has been investigated and closed, and you had previous complaints here in Kansas, what is the problem with the expediency of dealing with this case?

Ms. Stevens said that part of Missouri's investigation was based on their 2004 investigation which resulted in disciplinary action against Dr. Geenens in December 2004. In regards to the case #07-00329 that the Chair is familiar with, along with case #08-00183, both are pending as they encompass several complaints they received from a particular professional in the community and KBHA wants to make sure their investigation encompasses all other issues before a decision is made about action.

- If you have a deposition coming from another state, do you not accept that as valid information for your Board and how can it happen so quickly in Missouri? Ms. Stevens responded saying they let people retire their license instead of going to a full hearing. Mr. Buening said they have done this before, but their process has been to proceed and get something on file if it is authorized by the disciplinary panel.

The Chair then called on Senator Journey for questions including:

- Do you have the ability to compel a non licensee to do anything, you cannot hold them in contempt of the BHA if they refuse authority? Mr. Buening said they had subpoena authority, but it is administrative and if they ignore, then they have to go to court to enforce it.

- wouldn't your job particularly in these kinds of cases, be significantly simplified if there was a criminal statute you could rely on and then once they get convicted on that the case is closed, because it has a higher burden of proof than KBHA's clear and convincing evidence requirement for the KBHA?

Mr. Buening said conviction of a Class A misdemeanor or a felony is specifically grounds, whether or not related to the practices of the healing arts and if it is a conviction of a felony not only is it a violation but the Board must revoke the license unless a two-thirds majority of the Board finds by clear and convincing evidence that the individual can rehabilitate to merit the public trust.

The Chair then recognized Senator Brungardt who asked on the range of complaints, not necessarily these, but are they all done in the same order, in a methodical manner, because some case by the nature of the complaint have a really fast track short circuit, and do you ever have any conjunctive activity to suspend someone before you have had a chance to absolutely prove your case? Mr. Buening said KBHA did have the authority to do a temporary suspension and does assign a priority to each case, four being the most urgent priority and one being the less urgent.

Mr. Buening then passed out the information on Dr. Schroll indicating that he had not included the District Court of Appeals information in the 1998 proceedings. And in December 7, 2001, the Committee does have the petition, the initial order that was actually issued by a public member of the Board, petition to review the initial order, and the August 22, 2002 final order. And then again, the Committee has the first page of six court petitions, and minutes where the individual was discussed and those are included from 1998 through 2002. A copy of this spreadsheet and attachments are (Attachment 5) attached hereto and incorporated into the Minutes by reference.

The Chair inquired about the Board members who will be at tomorrow's Committee meeting.

**Adjournment**

As there was no further discussion, the Chair thanked Mr. Buening and the meeting was adjourned. The time was 2:30 p.m.

The next meeting is scheduled for February 26, 2008.

# SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

## GUEST LIST

31 in att.

DATE: Monday, February 25. 2008

| NAME | REPRESENTING |
|---|---|
| Nate Michel | Hein Law Firm |
| Rob Low | FOX 4 News |
| Michelle Peterson | Capitol Strategies |
| [illegible] | KS Assn. for Justice |
| Reagan Cussimanio | KHPA |
| Bob Williams | Ks. Assn of Osteopathic Medicine |
| Todd Fleischer | Ks. Optometric Association |
| Chris Clarke | Post Audit |
| John Kiefhaber | Ks. Chiropractic Assoc. |
| Sandy Braden | [illegible] Ks. |
| Dan Ranney | KHI |
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Please continue passing thank you [illegible]

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# Feds accuse Kansas of jeopardizing doctor's criminal case

## The Associated Press

WICHITA, Kan. - A glance at key documents in the dispute between federal prosecutors and the Kansas Board of Healing Arts over the investigation of Dr. Stephen Schneider:

- Oct. 6, 2006, letter from Assistant U.S. Attorney Tanya Treadway to Mark Stafford at the Kansas Board of Healing Arts: "By coordinating, we will avoid duplicating efforts and we will stay out of the KBHA's way in its administrative proceedings against Dr. Schneider."

- Jan. 18, 2008, letter from Treadway to Stafford: "The KBHA's responses are alarming in that the KBHA evidently, and incredibly, produced to Dr. Schneider and his counsel information in the form of your own legal work product, so marked, that included law enforcement information - specifically, that law enforcement had introduced undercover officers and informants into the clinic. ... Thankfully, as far as we know, no harm came to anyone because of KBHA's reckless and unnecessary production of this information."

- Jan. 22, 2008, letter from U.S. Attorney Eric Melgren to state Sen. Susan Wagle: "At no time did my office request the KBHA to defer its investigation in the interests of our federal investigation."

- Jan. 24, 2008, letter from Treadway to Stafford: "It is difficult to comprehend why you filed a civil case in a criminal matter, and why you failed to file it under seal, given the attachments to the motion. I hope this was not purposeful, especially given our recent notification that the Board previously and inappropriately revealed sensitive law enforcement information to Dr. Schneider's attorney during discovery. It is also difficult to comprehend that the Board is only now informing us it has information dating back to 1995 regarding complaints against Stephen J. Schneider and other providers, and has as many as 70 boxes of documents."

- Jan. 25, 2008, affidavit of Kelli Stevens, KBHA litigation counsel: "On or about March 26, 2007, I had a telephone conversation with AUSA Treadway about the status of the criminal investigation. She told me that due to thin resources, she did not believe she would be able to get an indictment this Summer. AUSA Treadway requested the Board continue to delay our case. She said there was a possibility of a 'global resolution' which would include resolution of the Board's pending disciplinary matter."

- Jan. 25, 2008, affidavit of Diane Bellquist, KBHA assistant general counsel: "Ms. Treadway asked if there was any way the Board office could hold off on our case until the U.S. Attorney's office was able to indict Dr. Schneider, because she was concerned that our proceedings would impede her case."

- Jan. 25, 2008, letter from KBHA executive director Lawrence Buening Jr. to Melgren: "Based on your letter, both the Board's credibility and my personal and professional integrity are now being questioned. ... Why the Board stayed the proceedings has no bearing on either the Federal criminal indictment or the Board's administrative proceeding. However this dispute between our offices is being sensationalized by the media and press and has been used to impugn the Board and me personally. Therefore, I am requesting that there be some acknowledgment by your office of the existence of the request, however informal it may have been."

- Jan. 28, 2008, letter from Melgren to Buening: "I think it would be inappropriate for us, as federal law enforcement, to request a state agency to defer or delay the performance of its duties. Our position was clearly stated in our October 3, 2006, letter to Mark Stafford, and was never changed explicitly or implicitly thereafter. ... To repeat, I am not seeking a public dispute with the KBHA. However, if we continue to be forced into one, while we will make every effort to minimize the same, we will not be willing to agree to misrepresentations regarding our conduct."

- Feb. 1, 2008, letter from Stafford to Treadway: "... you stated your concern that the existence of undercover investigations and confidential informants were revealed in a discovery response. Had this been done wrongfully, I would also have been as disturbed as you. ... Ms. Stevens contacted the proper individuals within the KBI and the DEA to discuss the discovery request, and there was no objection to the release of minimal information as long as no law enforcement document was released."

Recent Comments

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# 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:** **Response to Open Records Request**

**DATE:** **February 25, 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.

This is in response to the open records request dated February 19, 2008, received from the Chair of the Committee and the follow up e-mail that was received February 21.

We have created separate packets providing the information on Stephen Schneider, D.O., Douglas Geenens, D.O. and John Schroll, M.D. requested in paragraphs 1, 3, 5, 6 and 7 of the request.

In response to paragraph 2, the only documents/investigative reports we have received from other states regarding these licensees were documents received May 14, 2007, from the Missouri Board of Registration of the Healing Arts relating to Douglas Geenens, D.O. and incorporated into our case number 07-00329. Although it was not reported to us, we have subsequently learned that Dr. Geenens has retired his license in the State of Missouri.

A review of the packets for each of these individuals follows.

I would be happy to respond to any questions.

Senate Health Care Strategies
Committee
Date: February 25, 2008
Attachment 2

BOARD MEMBERS: BETTY McBRIDE, Public Member, PRESIDENT, Columbus - VINTON K. ARNETT, D.C., VICE PRESIDENT, Hays - MICHAEL J. BEEZLEY, M.D., Lenexa
MYRA J. CHRISTOPHER, Public Member, Fairway - RAY N. CONLEY, D.C., Overland Park - GARY L. COUNSELMAN, D.C., Topeka - FRANK K. GALBRAITH, D.P.M., Wichita
MERLE J. "BOO" HODGES, M.D., Salina - SUE ICE, Public Member, Newton - M. MYRON LEINWETTER, D.O., Rossville - MARK A. McCUNE, M.D., Overland Park - CAROLINA M. SORIA, D.O., Wichita
ROGER D. WARREN, M.D., Hanover - NANCY J. WELSH, M.D., Topeka - RONALD N. WHITMER, D.O., Ellsworth

235 SW TOPEKA BLVD., TOPEKA, KS 66603
Voice: 785-296-7413 Toll Free: 888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org

State of Kansas

Senate Chamber

**Susan Wagle**

RECEIVED

FEB 2 0 2008

KSBHA

February 19, 2008

Mr. Lawrence T. Buening, Jr.
Executive Director, State Board of Healing Arts
235 S.W. Topeka, Blvd.
Topeka, KS 66603

Dear Mr. Buening

As a follow up to our conversation yesterday, I want to clarify that I am really making a request for open records.

Here are the records I am seeking:

1. Dates that complaints were filed since January, 2002 against Steven Schneider D.O., Douglas Geenens M.D., or John Schroll M.D.

2. Dates that your Board received any documents/investigative reports from other States regarding any of the above licensed individuals

3. Dates that investigations regarding these complaints were completed and submitted to your legal council for review.

4. Dates and minutes from disciplinary Board meetings where investigations were discussed regarding any of these individuals.

5. Dates and minutes from full Board meetings where disciplinary actions were discussed in reference to these licensed individuals.

6. Any Court filings or petitions that were filed in any Court regarding any of these individuals licensed by the Board.

7. Any updated or revised Court filings or petitions as they relate to any of these individuals licensed by the Board.

I have discussed this open record request with every member of my committee. They believe that having an outline of complaint dates and Board actions would help them in their deliberations.

Thank you for your cooperation in this matter.

Susan Wagle

REPRESENTATIVE, 30TH DISTRICT
SEDGWICK COUNTY
14 SANDALWOOD
WICHITA, KANSAS 67230

ROOM 128-S
STATE CAPITOL
TOPEKA, KS 66612-1504
(785) 296-7386

**Lawrence T. Buening**

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**From:** Lawrence T. Buening [lbuening@ink.org]
**Sent:** Thursday, February 21, 2008 7:18 PM
**To:** 'Kelli Stevens'; 'Shelly Wakeman'; Mark Stafford (Mark Stafford)
**Subject:** FW: clarification - open records request

FYI.

Lawrence T. Buening, Jr.
Executive Director
Kansas State Board of Healing Arts
785-296-3680

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**From:** Tswagle@aol.com [mailto:Tswagle@aol.com]
**Sent:** Thursday, February 21, 2008 5:34 PM
**To:** lbuening@ink.org; ssnyder@ink.org
**Subject:** clarification - open records request

Larry

In discussing your procedures and policy with staff, I wanted to make it clear that the committee would like to see the actual petitions that were delivered to a hearing officer or to the Board regarding Steven Schneider D.O., Douglas Geenens M.D. and John Schroll M.D.

We would like to review these petitions along with the other information we outlined in the letter dated February 19, 2008.

Thank you for your assistance.

Susan Wagle

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Delicious ideas to please the pickiest eaters. Watch the video on AOL Living.

Stephen Schneider, D.O.
Complaints/Actions
Since January 2002

| Comp | Rec'd Date | Complainant | Patient | CaseNum | Date Opened | Date to RC | Date to DP/Atty | Date Clsd | Comment |
|---|---|---|---|---|---|---|---|---|---|
| | 8/28/2003 | Police Report | patient | 04-00098 | 9/3/2003 | | | 6/14/2005 | death from illegal subst. |
| | 2/11/2004 | patient | patient | 04-00356 | 2/17/2004 | 4/13/2006 | 5/13/2006 | 7/19/2006 | expert-SOC met |
| | 3/23/2004 | patient | patient | 04-00444 | 5/19/2004 | 4/13/2006 | 5/13/2006 | 7/19/2006 | expert-SOC met |
| | 11/29/2004 | family member | patient | 05-00162 | 1/3/2005 | 4/13/2006 | 5/13/2006 | 7/19/2006 | 06-HA100 |
| | 2/4/2005 | family member | patient | 05-00262 | 3/1/2005 | 4/13/2006 | 5/13/2006 | 7/19/2006 | 06-HA100 |
| | 3/17/2005 | patient | patient | 05-00322 | 3/29/2005 | 4/13/2006 | 5/13/2006 | 7/19/2006 | 06-HA100 |
| | 3/25/2005 | other prof. | patient | 05-00336 | 4/5/2005 | 4/13/2006 | 5/13/2006 | 7/19/2006 | 06-HA100 |
| | 4/15/2005 | patient | patient | 05-00360 | 4/29/2005 | 4/13/2006 | 5/13/2006 | 7/19/2006 | 06-HA100 |
| | 5/25/2005 | SRS | NA | 05-00376 | 6/2/2005 | NA | pending-action stayed | | |
| C-00368 | 10/5/2005 | Renewal | NA | NA | NA | NA | NA | 12/30/2005 | |
| C-00382 | 10/5/2005 | Renewal | NA | NA | NA | NA | NA | 12/30/2005 | |
| | 8/2/2005 | family member | patient(s) | 06-00129 | 10/4/2005 | 4/13/2006 | 5/13/2006 | 7/19/2006 | 06-HA100 |
| C-00383 | 10/6/2005 | Renewal | | | | | | 12/30/2005 | |
| C-00400 | 10/6/2005 | family member | patient | 06-00146 | 10/24/2005 | 4/13/2006 | 5/13/2006 | 7/19/2006 | 06-HA100 |
| C-00551 | 10/4/2005 | Renewal | | | | | | 12/30/2005 | |
| C-00710 | 11/8/2005 | Petition | Flickinger | 06-00183 | 12/5/2005 | 4/13/2006 | 5/13/2006 | 7/19/2006 | expert-SOC met |
| C-00953 | 1/13/2006 | Petition | Gaskill | 06-00235 | 1/20/2006 | 8/28/2006 | 11/3/2006 | 11/13/2007 | 06-HA100 |
| C-00982 | 1/19/2006 | Petition | Bible | 07-00200 | 11/9/2006 | 6/26/2007 | 11/3/2006 | 11/13/2007 | 06-HA100 |
| C-01123 | 2/7/2006 | Patient | patient | 06-00280 | 2/24/2006 | 8/28/2006 | 11/3/2006 | 11/13/2007 | 06-HA100 |
| C-01234 | 2/17/2006 | family member | patient | 06-00288 | 2/27/2006 | 9/7/2006 | 11/3/2006 | 11/13/2007 | 06-HA100 |
| C-01294 | 2/27/2006 | atty (Hund) | patient | pending | | | | 5/4/2006 | Complainant didn't respond to ltr |
| C-01313 | 2/6/2006 | Petition | Chapman | 07-00183 | 11/6/2006 | 6/26/2007 | | 12/6/2007 | RC-SOC met |
| C-01400 | 3/8/2006 | Amd. Pet | Gaskill | 06-00235 | 1/20/2006 | 8/28/2006 | 11/3/2006 | 11/13/2007 | 06-HA100 |
| C-01447 | 3/8/2006 | Petition | Hicks | 05-00162 | 1/3/2005 | 4/13/2006 | 5/13/2006 | 7/19/2006 | 06-HA100 |
| C-01513 | 4/4/2006 | AFR | patient | | | | | 4/24/2006 | |
| C-01726 | 5/22/2006 | family member | patient | 06-00417 | 6/20/2006 | | 11/9/2006 | 1/16/2007 | PA disciplined |
| C-02152 | 7/6/2006 | patient | patient | 07-00089 | 9/18/2006 | | 2/6/2007 | 4/17/2007 | no violation |
| C-02939 | 9/12/2006 | Petition | Brawner | 07-00278 | 12/18/2006 | 9/6/2007 | 9/26/2007 | 1/31/2008 | auth. To expert |
| C-02940 | 9/12/2006 | Petition | Kipp | 07-00277 | 12/18/2006 | 9/6/2007 | 9/26/2007 | 12/6/2007 | RC-SOC met |
| C-03047 | 12/27/2006 | KMAP | patient | 07-00311 | 1/3/2007 | 9/6/2007 | 9/26/2007 | 12/6/2007 | RC-SOC met |
| C-03360 | 12/15/2006 | Petition | Tornquist | 07-00365 | 2/8/2007 | 9/6/2007 | 9/26/2007 | 1/31/2007 | auth. To expert |
| C-03361 | 12/15/2006 | Petition | Perkins | 07-00363 | 2/8/2007 | 9/6/2007 | 9/26/2007 | 1/31/2007 | auth. To expert |
| C-04241 | 8/21/2006 | Renewal | NA | | | | | 7/13/2007 | |
| C-05549 | 8/28/2007 | Renewal | NA | | | | | 1/25/2008 | |
| C-06102 | 12/19/2007 | Petition | Mattson | 06-00280 | | | | 1/23/2008 | duplicate |
| C-06103 | 12/19/2007 | Petition | Hambelton | | | | | 1/23/2008 | |
| C-06146 | 1/3/2008 | in house (call) | patient | 08-00304 | pending | | | | patient death 12/07 |
| C-06174 | 1/8/2008 | Petition | Smith | pending | | | | | more info. letter sent 1/16/08 |

Senate Health Care Strategies
Committee
Date: February 25, 2008
Attachment 3

Stephen Schneider, D.O.
Complaints/Actions
Since January 2002

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| C-06245 | 1/18/2008 | NPDB | unknown | pending | | | | | | | |
| C-06273 | 1/24/2008 | NPDB | patient | 06-00235 | 1/20/2006 | 8/28/2006 | 11/3/2006 | 11/13/2007 | 06-HA100 | | |
| C-06340 | 2/5/2008 | family member | patient | pending | | | | | | | |

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KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of )
)
STEPHEN J. SCHNEIDER, D.O. )
Kansas License No. 05-22385 )
) Docket No. 06-HA-00100

## PETITION

COMES NOW the Kansas State Board of Healing Arts ("Petitioner"), by and through Kelli J. Stevens, Litigation Counsel, and Diane L. Bellquist, Associate Counsel, and initiates these proceedings pursuant to the provisions of K.S.A. 65-2836, K.S.A. 65-2851a, and K.S.A. 77-501 *et seq*. For its cause of action, Petitioner alleges and states:

1. Stephen J. Schneider, D.O.'s ("Licensee") last known mailing address to the Board is 7030 S. Broadway, Haysville, Kansas 67060.

2. Licensee is and has been entitled to practice medicine and surgery in the State of Kansas having initially been issued license number 05-22385 on approximately July 1, 1988. Licensee last renewed his license on or about October 1, 2005.

3. Since issuance of license, and while engaged in a regulated profession as a doctor of osteopathy in the State of Kansas, pursuant to K.S.A. 65-2801 *et seq*., Licensee did commit the following act(s):

## COUNT I

4. Petitioner incorporates herein by reference paragraphs 1 through 3.

5. From at least January 1, 2000 to the present, Licensee has practiced osteopathic medicine and surgery in private practice in Haysville, Kansas.

6. Licensee's specialty as he reported to the Board is family practice.

7. From approximately January 1, 2000 to December 31, 2005, Licensee



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and/or the physician assistants under Licensee's supervision treated multiple patients on multiple dates and provided pain management care.

8. From at least 2000 to 2005, Licensee and/or the physician assistants under his supervision prescribed various controlled substances and other potentially addicting medications to patients on multiple occasions.

9. From at least 2000 to 2005, Licensee himself, or through his supervision of physician assistants, failed to appropriately care and treat patients' conditions and/or manage patients' pain.

10. From at least 2000 to 2005, Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence in the treatment of multiple patients, including but not limited to, each of the following acts or omissions:

a. On multiple occasions, Licensee and/or the physician assistants under his supervision diagnosed patients with conditions that were not adequately supported by clinical findings and/or the medical record documentation in the patients' charts;

b. On multiple occasions, Licensee and/or the physician assistants under his supervision prescribed controlled substances and/or potentially addicting medications in excessive amounts and/or with excessive frequency to patients;

c. On multiple occasions, Licensee and/or the physician assistants under his supervision failed to recognize signs of patients' addiction and/or abuse to the controlled substances and/or other potentially addictive medications prescribed by Licensee and/or the physician assistants under his supervision;

d. On multiple occasions, Licensee himself or through his supervision of physician assistants prescribed controlled substances and/or other potentially addicting medications to patients without an adequate basis;

e. On multiple occasions, Licensee himself or through his supervision of physician assistants, inappropriately treated patients' conditions and/or complaints of pain with controlled substances and/or other potentially addicting medications;

f. On multiple occasions, Licensee himself or through his supervision of physician assistants, inappropriately prescribed controlled substances and/or other potentially addicting medications to patients with a history of substance abuse and/or addictions; and

g. Licensee himself or through his supervision of physician assistants failed to adhere to the applicable standard of care to degree constituting ordinary negligence which is believed and alleged and will be disclosed upon proper discovery procedures in the course of these proceedings.

11. Licensee committed acts in violation of the healing arts act, K.S.A. 65-2836 and K.S.A. 65-2837, including but not limited to:

a. K.S.A. 65-2836(b), professional incompetency and/or unprofessional conduct as further defined by K.S.A. 65-2837(a)(2), for repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the Board;

b. K.S.A. 65-2836(b), professional incompetency and/or unprofessional conduct as further defined by K.S.A. 65-2837(a)(3), for a pattern



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of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine; and

c. K.S.A. 65-2836(b), professional incompetency and/or unprofessional conduct as further defined by K.S.A. 65-2837(b)(24), failing to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances.

d. K.S.A. 65-2837(b)(23), prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice.

12. Pursuant to K.S.A. 65-2836, the Board may revoke, suspend, censure or otherwise limit Licensee's license for violation of the healing arts act.

**COUNT II**

13. Petitioner incorporates herein by reference paragraphs 1 through 12.

14. Pursuant to subpoena, Licensee produced specified patient charts to the Board.

15. In several patient charts, Licensee's documentation and/or the documentation of the physician assistants that Licensee supervised is incomplete and inadequate.

16. Some of Licensee's patient charts contain medical records from patients other than the specified patient.

17. K.S.A. 65-2836(b), unprofessional and/or dishonorable conduct as



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further defined by K.S.A. 65-2837(b)(25), failure to keep written medical records which accurately describe the services rendered to the patient.

**WHEREFORE,** Petitioner prays that the Board make findings of fact and conclusions of law that Licensee committed these acts in violation of the healing arts act, that Licensee's license to practice medicine and surgery in the State of Kansas be revoked, suspended, censured, fined or otherwise limited, and that the Board assess such administrative fines and impose such costs against Licensee as it shall deem just and proper and as authorized by law.

Respectfully Submitted,

Kelli Stevens #16032
Litigation Counsel
Diane L. Bellquist #20969
Associate Counsel
Kansas State Board of Healing Arts
235 S. Topeka Boulevard
Topeka, Kansas 66603-3068
Telephone (785) 296-7413

## CERTIFICATE OF MAILING

I hereby certify that a true and correct copy of the foregoing PETITION was served on the 30th day of May, 2006 by hand-delivery and by United States mail, first-class postage pre-paid and addressed to:

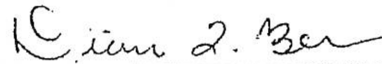
Stephen J. Schneider, D.O.
7030 S. Broadway
Haysville, Kansas 67060

and the original was hand-delivered for filing to:

Lawrence T. Buening, Jr.
Executive Director
235 S. Topeka Boulevard
Topeka, Kansas 66603-3068

and a courtesy copy was mailed to:

Christopher McHugh
Joseph & Hollander, P.A.
500 North Market Street
Wichita, Kansas 67214-3514



Diane L. Bellquist

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KS State Board of Healing Arts

**BEFORE THE BOARD OF HEALING ARTS**
**OF THE STATE OF KANSAS**

In the Matter of )
)
**STEPHEN J. SCHNEIDER, D.O.** )
Kansas License No. 05-22385 ) Docket No. 06-HA-00100
______________________ ) OAH No. 07HA0001 BHA

## SECOND AMENDED PETITION

**COMES NOW** the Kansas State Board of Healing Arts ("Petitioner"), by and through Kelli J. Stevens, Litigation Counsel, and initiates these proceedings pursuant to the provisions of K.S.A. 65-2836, K.S.A. 65-2851a, and K.S.A. 77-501 *et seq*. For its cause of action, Petitioner alleges and states:

1. Stephen J. Schneider, D.O.'s ("Licensee") last known mailing address to the Board is 7030 S. Broadway, Haysville, Kansas 67060.

2. Licensee is and has been entitled to practice medicine and surgery in the State of Kansas having initially been issued license number 05-22385 on approximately July 1, 1988. At all times relevant to the allegations set forth herein, Licensee has held a current license to engage in the practice of medicine and surgery in the State of Kansas, having last renewed his license in or around August 2007.

3. On or about October 10, 2001, Licensee formed a professional association called Haysville Family MedCenter. From about October 10, 2001 through about November 2002, Licensee practiced at Haysville Family MedCenter, P.A.

4. On or about June 4, 2002, Licensee formed a limited liability company called Schneider Medical Clinic ("SMC). From about November 2002 to the present date Licensee has practiced at SMC.



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5. Licensee's specialty as he reported to the Board is family practice.

6. In years 2000-2001, Licensee was the responsible and/or designated physician who directed and supervised Curtis J. Atterbury, a physician assistant practicing at SMC.

7. In years 2002-2005, Licensee was the responsible and/or designated physician who directed and supervised Charles Lee Craig, a physician assistant who practiced at SMC.

8. In years 2002-2005, Licensee was the responsible and/or designated physician who directed and supervised Kimberly Hebert, a physician assistant who practiced at SMC.

9. In year 2004, Licensee was the responsible and/or designate physician who directed and supervised Debra Klingsick, a physician assistant who practiced at SMC.

10. Since issuance of license, and while engaged in a regulated profession as an osteopathic doctor in the State of Kansas, pursuant to K.S.A. 65-2801 *et seq.*, Licensee did commit the following act(s):

## COUNT I

11. Petitioner incorporates herein by reference paragraphs 1 through 10.

12. From approximately March 3, 2004 through June 8, 2004, Licensee had a physician-patient relationship with Patient #1, a thirty-two year old male.

13. During the course of such relationship, Licensee and/or physician assistants under his control evaluated Patient #1 for various complaints and conditions, including chronic back pain and leg pain.

14. Patient #1 had previously been diagnosed with meralgia peresthetica.

15. Licensee obtained the records from patient #1's previous treating physician. The previous treating physician's records revealed that patient #1 had a previous history of drug and alcohol addiction.

16. During the initial office visit on or about March 3, 2004, Patient #1 was seen by a physician assistant under the supervision of Licensee, who diagnosed Patient #1 has having fibromyalgia, Type 2 Diabetes, hypertension, obesity and chronic right leg pain.

17. During the course of such relationship, Licensee and or physician assistants under his control prescribed multiple controlled substances and other medications to Patient #1.

18. During the course of such relationship, Patient #1 exhibited drug-seeking behavior.

19. On or about June 9, 2004, Patient #1 died. The primary cause of death was determined to be accidental overdose of oxycodone and mixed drug intoxication.

20. During the course of such relationship, Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence, specifically including, but not limited to, each of the following acts or omissions:

a. Failure to adequately recognize and address Patient #1's drug seeking behavior;

b. Inappropriately and/or improperly prescribing of pain medications, including controlled substances, to Patient #1;

c. Failure to adequately supervise the care and treatment provided to Patient #1 by the physician assistants under Licensee's supervision; and

d. Failure to adhere to the applicable standard of care to a degree constituting ordinary negligence, which is believed and alleged and will be disclosed upon proper discovery procedures in the course of these proceedings.

21. Licensee committed acts of professional incompetency and/or unprofessional conduct in his care and treatment of Patient #1 in violation of the Healing Arts Act, K.S.A. 65-2836 and K.S.A. 65-2837, including but not limited to:

a. K.S.A. 65-2837(a)(2), repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the Board;

b. K.S.A. 65-2837(a)(3), a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine;

c. K.S.A. 65-2837(b)(24), failure to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

d. K.S.A. 65-2837(b)(23), prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice; and

e. K.S.A. 65-2837(b)(30), failing to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

22. Pursuant to K.S.A. 65-2836, there are grounds for discipline against Licensee's license for violation of the Healing Arts Act. Additionally, the Board may assess a fine against Licensee's license in accordance with K.S.A. 65-2863a(a).

**COUNT II**

23. Petitioner incorporates herein by reference paragraphs 1 through 22.

24. From approximately January 16, 2004 through at least September 26, 2005, Licensee had a physician-patient relationship with Patient #2, a thirty-one year old male.

25. During the course of such relationship, Licensee and/or physician assistants under his control evaluated and treated Patient #2 for various complaints and conditions, including low back pain and anxiety.

26. During the course of such relationship, Licensee and/or physician assistants under his control prescribed multiple controlled substances and other medications to Patient #2.

27. On or about January 11, 2005, Licensee obtained a signed pain management contract from Patient #2.

28. On or about March 9, 2005, Licensee obtained a new signed pain management contract from Patient #2.

29. On or about June 21, 2005, Licensee documented that Patient #2 had a history of early refills.

30. It was documented in Patient #2's medical chart that his urine drug screen collected on or about July 29, 2005, was negative for Lortab metabolite.

31. The actual lab report from Patient #2's urine drug screen collected on or about July 29, 2005, was not in Patient #2's medical medical chart.

32. On or about August 26, 2005, Patient #2 saw another physician at SMC who documented that Patient #2 had a history of early refills and ordered a repeat urine drug screen.

33. The results of the repeat urine drug screen collected on or about August 26, 2005, are not documented in Patient #2's medical chart.

34. At the next office visit, on or about September 26, 2005, Licensee refilled Patient #2's prescription for Lortab, without addressing Patient #2's previous urine drug screen which had been negative for Lortab metabolite, or the results of the repeat urine drug screen collected on August 26, 2005.

35. The actual lab report from Patient #2's urine drug screen collected on August 26, 2005, was not in Patient #2's medical chart.

36. Licensee and/or the physician assistants under his control did not pursue the etiology of Patient #2's low back pain.

37. During the course of the physician-patient relationship, Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence, specifically including but not limited to, the following acts and omissions:

a. Failure to pursue the etiology of Patient #2's low back pain;

b. Failure to appropriately address the results of Patient #2's urine drug screens;

c. Inappropriately and/or improperly prescribing pain medications, including controlled substances, to Patient #2;

d. Failure to adequately supervise the care and treatment provided to Patient #2 by the physician assistants under his supervision; and

e. Failure to adhere to the applicable standard of care to a degree constituting ordinary negligence, which is believed and alleged and will be disclosed upon proper discovery procedures in the course of these proceedings.

38. Licensee committed acts of professional incompetency and/or unprofessional conduct in his care and treatment of Patient #2 in violation of the Healing Arts Act, K.S.A. 65-2836 and K.S.A. 65-2837, including but not limited to:

a. K.S.A. 65-2837(a)(2), repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the Board;

b. K.S.A. 65-2837(a)(3), a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine;



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c. K.S.A. 65-2837(b)(24), failure to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

d. K.S.A. 65-2837(b)(23), prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice;

e. K.S.A. 65-2837(b)(25), failure to keep written medical records which accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results and test results;

f. K.S.A. 65-2836(k), violation of a lawful regulation promulgated by the Board, as further set forth in K.A.R. 100-24-1, failure to maintain an adequate patient record; and

g. K.S.A. 65-2837(b)(30), failure to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

39. Pursuant to K.S.A. 65-2836, the Board may revoke, suspend, censure or otherwise limit Licensee's license for violation of the Healing Arts Act. Additionally, the Board may assess a fine against Licensee's license for violation of the Healing Arts Act in accordance with K.S.A. 65-2863a(a).

## COUNT III

40. Petitioner incorporates herein by reference paragraphs 1 through 39.

41. From approximately March 23, 2004 through at least September 24, 2005, Licensee had a physician-patient relationship with Patient #3, a forty-eight year old female.

42. During the course of such relationship, Licensee and/or physician assistants under his control evaluated and treated Patient #3 for various complaints and conditions, including degenerative disc disease.

43. On or about March 23, 2004, Licensee documented that Patient #3 had previously been diagnosed with hyperlipidemia, hypertension, and that she was seeing another physician for pain management. Licensee documented that Patient #3 wished to continue seeing her other physician for pain management.

44. On or about July 23, 2004, Licensee diagnosed Patient #3 with a history of cervical to lumbar degenerative disc disease.

45. Licensee and/or physicians under his control did not obtain any imaging of Patient #3's spine or pursue any other objective evidence in support of the documented diagnosis of degenerative disc disease.

46. On or about March 15, 2005, Patient #3 entered into a pain management contract with SMC.

47. On or about July 5, 2005, Licensee saw Patient #3 for complaints of neck pain. Licensee documented Patient #3's diagnosis as degenerative disc disease of the cervical spine and prescribed Lortab 10 milligrams once a day.

48. On or about September 24, 2005, a physician assistant under the supervision of Licensee documented Patient #3's diagnosis as degenerative disc disease of the cervical spine and refilled her prescription for Lortab.

49. During the course of the physician-patient relationship, Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence, specifically including, but not limited to, the following acts and omissions:

a. Failure to pursue objective evidence to support the diagnosis of cervical to lumbar degenerative disc disease;

b. Failure to adequately supervise the care and treatment provided to Patient #3 by the physician assistants under his supervision; and

c. Failure to adhere to the applicable standard of care to a degree constituting ordinary negligence, which is believed and alleged and will be disclosed upon proper discovery procedures in the course of these proceedings.

50. Licensee committed acts of incompetency and/or unprofessional conduct in his care and treatment of Patient #3 in violation of the Healing Arts Act, K.S.A. 65-2836 and K.S.A. 65-2837, including but not limited to:

a. K.S.A. 65-2837(a)(2), repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the Board;

b. K.S.A. 65-2837(a)(3), a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine;

c. K.S.A. 65-2837(b)(24), failure to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

d. K.S.A. 65-2837(b)(23), prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice; and

e. K.S.A. 65-2837(b)(30), failure to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

51. Pursuant to K.S.A. 65-2836, there are grounds for discipline against Licensee's license for violation of the Healing Arts Act. Additionally, the Board may assess a fine against Licensee's license in accordance with K.S.A. 65-2863a(a).

**COUNT IV**

52. Petitioner incorporates herein by reference paragraphs 1 through 52.

53. From approximately December 11, 2002 through at least August 11, 2005, Licensee had a physician-patient relationship with Patient #4, a thirty-six year old male.

54. During the course of such relationship, Licensee and/or physician assistants under his control evaluated and treated Patient #4 for various complaints and conditions, including hypertension and chronic back pain.

55. On or about December 11, 2002, Licensee saw Patient #4 for complaints of back pain. Licensee obtained a signed pain management contract from Patient #4, and prescribed narcotic pain medications to #4.

56. On or about January 6, 2003, Patient #4 was seen by a physician assistant under Licensee's supervision, who prescribed pain medications to Patient #4.

57. On or about March 22, 2004, Patient #4 had a urine drug screen collected that was negative for all of Patient #4's prescription medications.

58. On or about April 1, 2004, Patient #4 reported he had lost his prescription.

59. On or about April 1, 2004, a repeat urine drug screen was performed indicating Patient #4 tested positive for oxycodone, but negative for Lortab metabolite.

60. On or about April 1, 2004, SMC staff documented a phone call from a pharmacy which indicated Patient #4 was inebriated when he presented to the pharmacy.

61. On or about April 26, 2004, Licensee ordered an MRI of Patient #4's lumbar spine. However, Patient #4 did not have the MRI.

62. On or about May 19, 2004, Licensee again ordered an MRI of Patient #4's lumbar spine. However, Patient #4 did not have the MRI.

63. On or about August 13, 2004, another physician at SMC documented that Patient #4 claimed to have lost his medications. Patient #4 was warned that his pain management contract would be terminated if he lost his medications again.

64. On or about August 13, 2004, Patient #4 had a urine drug screen collected. The screen was negative for Patient #4's prescription medications.

65. On or about September 7, 2004, Licensee again ordered an MRI of Patient #4's lumbar spine. However, Patient #4 did not have the MRI.

66. On or about September 11, 2004, Patient #4 was admitted to the emergency department at VRMC in Wichita, Kansas due to a suspected drug overdose after he took ten (10) tablets of Soma and a store clerk found Patient #4 not moving and not responsive.

67. On or about September 21, 2004, Patient #4 was admitted to the emergency department at VRMC for a possible seizure after he took a "couple" of Soma tablets and drank alcohol to "feel good."

68. On or about November 10, 2004, Patient #4 was admitted to the emergency department at VRMC due to a drug overdose after he took four (4) tablets of Soma and four (4) tablets of Lortab because he wanted a "buzz."

69. On or about March 22, 2005, SMC staff documented in Patient #4's medical chart that they attempted to contact Patient #4, but were unable to do so. It was also documented, "ask him about dtx? What place?"

70 On or about April 1, 2005, it was documented in Patient #4's medical chart that he did not show for scheduled MRIs three times and did not call.

71. On or about July 7, 2005, Licensee and/or a physician assistant under Licensee's supervision continued to prescribe pain medications to Patient #4.

72. As of August 11, 2005, Licensee had not obtained an MRI or other imaging of Patient #4's lumbar spine.

73. During the course of the physician-patient relationship, Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence specifically including, but not specifically limited to, the following acts or omissions:

a. Failure to adequately address and recognize Patient #4's drug seeking behavior and possible diversion;

b. Inappropriately and/or improperly prescribing controlled substances and other potentially addicting medications to Patient #4;

c. Failure to adequately supervise the care and treatment provided to Patient #4 by the physician assistants under Licensee's supervision; and

d. Failure to adhere to the applicable standard of care to a degree constituting ordinary negligence, which is believed and alleged and will be disclosed upon proper discovery procedures in the course of these proceedings.

74. Licensee committed acts of incompetency and/or unprofessional conduct in violation of the Healing Arts Act, K.S.A. 65-2836 and K.S.A. 65-2837, including but not limited to:

a. K.S.A. 65-2837(a)(2), repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the Board;

b. K.S.A. 65-2837(a)(3), a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine;

c. K.S.A. 65-2837(b)(24), failure to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

d. K.S.A. 65-2837(b)(23), prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice; and

e. K.S.A. 65-2837(b)(30), failing to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

75. Pursuant to K.S.A. 65-2836, there are grounds to discipline Licensee's license for violation of the Healing Arts Act. Additionally, the Board may assess a fine against Licensee's license in accordance with K.S.A. 65-2863a(a).

**COUNT V**

76. Petitioner incorporates herein by reference paragraphs 1 through 76.

77. From approximately November 13, 2001 through at least July 19, 2005, Licensee had a physician-patient relationship with Patient #5, a fifty-four year old male.

78. During the course of such relationship, Licensee and/or physician assistants under his control evaluated and treated Patient #5 for various complaints and conditions, including chronic back pain.



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79. It was documented in Patient #5's medical chart that he had just been released from prison on about November 1, 2001, after having been incarcerated for three (3) years.

80. On or about November 13, 2001, Licensee saw Patient #5 for complaints of back pain resulting from a motor vehicle accident fifteen (15) years ago.

81. It was documented in Patient #5's medical chart that he had previously had an x-ray while in prison which indicated abnormal findings, but an MRI had not been performed.

82. On or about April 12, 2002, Licensee diagnosed Patient #5 with degenerative disc disease and ordered x-rays of his cervical and lumbar spine.

83. Licensee prescribed pain medications, including controlled substances, to Patient #5.

84. On or about June 21, 2002, SMC was informed by the Sam's Club pharmacy that on or about June 13, 2002, Patient #5 filled an old prescription for 90 quantity of Lortab at Wal-Mart. On that same date, Patient #5 also attempted to fill a new prescription for 90 quantity of Lortab at Sam's Club pharmacy.

85. On or about August 6, 2002, a physician assistant under Licensee's supervision denied Patient #5 an early refill of Lortab and obtained a signed pain management contract.

86. On or about March 20, 2003, it was documented that Patient #5 sought an early refill of his Lortab, and another physician at SMC filled the prescription but had warned patient #5 about "drug abuse."

87. On or about May 5, 2003, Patient #5 informed Licensee that the Lortab was not helping his pain anymore. Licensee began prescribing Percocet to Patient #5.

88. On or about June 16, 2003, Licensee documented that Patient #5 requested an early refill of his medications, which Licensee prescribed.

89. On or about June 30, 2003, Patient #5 complained of side effects from the Percocet, and another physician at SMC prescribed Lortab and added Flexeril on an as needed basis.

90. On or about July 21, 2003, Licensee documented that Patient #5 saw an orthopedic specialist outside of SMC and received a Depo Medrol lumbar epidural. Licensee also prescribed Lortab and Flexeril to Patient #5.

91. On or about August 6, 2003, Licensee diagnosed Patient #5 with anxiety and prescribed Xanax, a benzodiazepine. Licensee also began prescribing Duragesic patches to Patient #5.

92. On or about August 18, 2003, it was documented that Patient #5 had a discogram performed by an orthopedic specialist outside of SMC.

93. On or about September 18, 2003, Licensee documented that Patient #5 quit taking his Duragesic patches because they made him feel "weird." On that same date, Licensee prescribed Valium to treat Patient #5's complaints of insomnia. Licensee also documented that the orthopedic specialist had recommended surgery.

94. On or about October 1, 2003, it is documented that Patient #5 wanted to put off surgery for as long as possible. It was documented that his medications were working, but that he would like a sleeping pill. Licensee prescribed another benzodiazepine, Halcion, in addition to Oxycontin, Lortab, and Valium.

95. On or about October 22, 2003, Patient #5 complained that the Oxycontin did not work well enough, so Licensee increased the dosage.

96. On or about November 5, 2003, Patient #5's urine drug screen results were negative for any benzodiazepines.

97. On or about November 26, 2003, Patient #5 indicated that Oxycontin was working but he still needed Lortab for break-through pain. It was documented that Patient #5 was requesting an early refill of Valium.

98. On or about December 10, 2003, Patient #5 complained of side effects from the Oxycontin, so Licensee discontinued Oxycontin and prescribed Avinza.

99. On or about December 26, 2003, Licensee began prescribing Norco in addition to the Avinza.

100. On or about January 13, 2004, it was documented that Patient #5 didn't like Avinza or Oxycontin, so Licensee prescribed Norco.

101. On or about February 17, 2004, Patient #5 complained that the Norco was not helping his pain. Patient #5 received a prescription for Percocet and was instructed to return his Norco medication.

102. On or about February 24, 2004, Patient #5 was seen by a physician assistant under Licensee's supervision. Patient #5 requested a prescription medication for break-through pain. The physician assistant prescribed Avinza, Oxycontin and Norco.

103. On or about March 15, 2004, Patient #5 complained that he was awake the entire previous night driving home from his vacation, in which he ran out of his medication and began having withdrawal symptoms.

104. On or about March 26, 2004, Licensee again began prescribing Duragesic patches to Patient #5.

105. On or about April 8, 2004, Patient #5 complained that he did not experience any relief with the Duragesic patches and requested Oxycontin again. Licensee and/or a physician assistant under the supervision of Licensee prescribed Oxycontin 40 milligrams.

106. On or about April 19, 2004, Patient #5 complained that his pain was not well controlled with the Oxycontin 40 milligrams and requested an increase in the dosage. Licensee increased the Oxycontin and also prescribed Norco.

107. On or about May 10, 2004, Patient #5 complained of withdrawal symptoms. Patient #5 requested Oxycontin 40 milligrams twice a day. Licensee's physician assistant prescribed the Oxycontin as requested by Patient #5 and also prescribed Norco for break-through pain. The physician assistant requested Patient #5 return his Percocet to the clinic at his next visit.

108. On or about May 28, 2004, Patient #5 requested Oxycontin 80 milligrams and Percocet instead of Lortab.

109. On or about June 3, 2004, Licensee documented that Patient #5 was going to taper off Oxycontin.

110. On or about June 7, 2004, Licensee documented that Patient #5 could not get any pain relief with his medications.

111. On or about June 8, 2004, Licensee obtained x-rays which revealed degenerative disc disease of Patient #5's lumbar spine. Licensee referred Patient #5 to an orthopedic specialist outside of SMC.

112. On or about June 14, 2004, it was documented that the orthopedic specialist would not see Patient #5 until a previous bill was paid. On that same date, Licensee again began prescribing Oxycontin and Norco to Patient #5.

113. Patient #5 had a urine drug screen collected on November 16, 2004, which was reported on December 1, 2004, as being negative for Oxycodone.

114. On or about December 20, 2004, Licensee refilled Patient #5's prescription for Oxycontin.

115. Patient #5 had a urine drug screen collected on January 19, 2005, which was positive for three (3) different benzodiazepines. Licensee documented on the lab report that Patient #5 "passed."

116. During the course of the physician-patient relationship, Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence specifically including, but not limited to, the following acts or omissions:

a. Failure to adequately address evidence that Patient #5 was not taking his medications as prescribed.

b. Failure to adequately recognize and address Patient #5's drug seeking behavior and possible diversion;

c. Inappropriately and/or improperly prescribing pain medications, including controlled substances to Patient #5;

d. Inappropriately and/or improperly prescribing multiple benzodiazepines to Patient #5;

e. Failure to adequately supervise the care and treatment provided to Patient #5 by the physician assistants that Licensee supervised; and

f. Failure to adhere to the applicable standard of care to a degree constituting ordinary negligence, which is believed and alleged and will be disclosed upon proper discovery procedures in the course of these proceedings.

117. Licensee committed acts constituting incompetency and/or unprofessional conduct in violation of the Healing Arts Act, K.S.A. 65-2836 and K.S.A. 65-2837, including but not limited to:

a. K.S.A. 65-2837(a)(2), repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the Board;

b. K.S.A. 65-2837(a)(3), a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine;

c. K.S.A. 65-2837(b)(24), failure to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

d. K.S.A. 65-2837(b)(23), prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice; and

e. K.S.A. 65-2837(b)(30), failing to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

118. Pursuant to K.S.A. 65-2836, there are grounds for discipline against Licensee's license for violation of the Healing Arts Act. Additionally, the Board may assess a fine against Licensee's license in accordance with K.S.A. 65-2863a(a).

**COUNT VI**

119. Petitioner incorporates herein by reference paragraphs 1 through 118.

120. From approximately September 29, 2003 to at least February 19, 2004, Licensee had a physician-patient relationship with Patient #6, a twenty-six year old female.

121. During the course of such relationship, Licensee and/or physician assistants under his control evaluated and treated Patient #6 for various complaints and conditions, including anxiety, back pain and pain in her right leg from a broken tibia.

122. On or about September 29, 2003, Licensee prescribed Xanax to treat Patient #6's anxiety and Lortab to treat her pain.

123. On or about October 9, 2003, Licensee's diagnosis for Patient #6 included anxiety, questionable borderline personality disorder, right tibia fracture and fibula fracture.

124. On or about November 7, 2003, it was documented in Patient #6's medical chart that SMC received a telephone call from Patient #6's psychiatrist, Dr. Heidi Steinshouer, with Comcare. Dr. Steinshouer informed SMC staff that Patient #6 had a strong history of alcoholism, narcotic prescription abuse, especially Xanax, and also marijuana abuse. It was documented that Patient #6 had multiple psychiatric hospitalizations, had threatened suicide, and had overdosed on Xanax. Dr. Steinshouer described Patient #6 as having "big drug problems." Dr. Steinshouer recommended that Patient #6 not be prescribed narcotics.

125. On or about November 12, 2003, a physician assistant at SMC denied Patient #6 a refill of her prescriptions for Lortab and Xanax. It was documented in the medical chart that Patient #6 would have to receive all controlled substances from her psychiatrist or orthopedic surgeon.

126. Two (2) notes from Dr. Thomas J. Peters, M.D. at the Wichita Clinic from an office visit on November 18, 2003, were copied to Licensee. Dr. Peters indicated that Patient #6 had requested a refill of her Xanax and Lortab. He gave her a prescription, but when Patient #6 attempted to fill the prescriptions at the pharmacy, Dr. Peters was informed that Patient #6 was taking more than the amount Licensee prescribed to her. Dr. Peters instructed the pharmacy not to fill the prescriptions he had issued.

127. On or about November 18, 2003, it was documented in Patient #6's medical chart that SMC staff received a telephone call from the pharmacy that Patient #6 had obtained prescriptions for Xanax and Lortab through the emergency department at the hospital, and that she attempted to fill the prescriptions at their pharmacy. Patient #6 told the pharmacy staff that she had quit taking the prescriptions from Licensee. When the pharmacy staff notified the emergency department physician, he instructed the pharmacy not to fill the prescriptions. Patient #6 then contacted SMC requesting a refill of her prescriptions.

128. On or about November 19, 2003, Licensee saw Patient #6 to review her medications. Licensee documented that Patient #6 discontinued her Xanax and threw it away. He noted "patient denies abuse."

129. On that same date, Licensee prescribed 100 quantity of Xanax and 100 quantity of Lortab to Patient #6.

130. On or about December 19, 2003, Licensee and/or the physician assistant under his control documented that Patient #6 denied abuse or a drug problem and that she admitted that she had a problem in the 1990's, but not anymore. It was documented that Patient #6 was not seeing her psychiatrist anymore.

131. On or about that same date, Licensee and/or physician assistants that he supervised refilled Patient #6's prescriptions for Xanax and Lortab.

132. On or about January 5, 2004, it was documented in Patient #6's medical chart that her mother called concerned that Patient #6 was smoking marijuana and selling her prescription medications. Her mother also stated that Patient #6 was taking three (3) different antidepressants.

133. On or about February 3, 2004, Patient #6 was seen at SMC. Patient #6 complained that she had been taking too many Xanax tablets and that she wanted to be admitted to the hospital. Patient #6 complained of being unable to sleep and having sweating spells. She expressed her desire to stop taking Xanax and to try something less strong.

134. On that same date, it was also documented that Patient #6's urine drug screen which was collected on or about January 19, 2004, was positive for marijuana, but negative for her prescription medications.

135. On that same date, a physician assistant supervised by Licensee documented that Patient #6 was not to be given anymore narcotics until SMC received a letter from her psychiatrist stating it was okay to do so.

136. On or about February 4, 2004, staff at SMC documented a phone call from the emergency department at the hospital indicating they were not going to give Patient #6 any narcotics, as she had already been there three (3) times.

137. On or about February 4, 2004, Patient #6 had a CT scan of her brain, which was reported as being unremarkable.

138. On or about February 16, Licensee ordered an MRI of Patient #6's brain which was performed the following day. The results were reported as being unremarkable.

139. On or about February 19, 2004, it was documented that Patient #6 was very demanding and she was terminated from SMC for illegal drug use and aberrant behavior.

140. During the course of the physician-patient relationship, Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary and/or gross negligence specifically including, but not limited to, the following acts or omissions:

a. inappropriately and/or improperly prescribing pain medications, including controlled substances, to patient #6;

b. Failure to adequately recognize and address signs of patient #6's drug-seeking behavior;

c. Failure to adequately supervise the care and treatment provided to patient #6 by the physician assistants under Licensee's supervision; and

d. Failure to adhere to the applicable standard of care to a degree constituting ordinary and/or gross negligence, which is believed and alleged and will be disclosed upon proper discovery procedures in the course of these proceedings.

141. Licensee committed acts constituting incompetency and/or unprofessional conduct in violation of the Healing Arts Act, K.S.A. 65-2836 and K.S.A. 65-2837, including but not limited to:

a. K.S.A. 65-2837(a)(1), failure to adhere to the applicable standard of care to a degree which constitutes gross negligence, as determined by the board;

b. K.S.A. 65-2837(a)(2), repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the Board;

c. K.S.A. 65-2837(a)(3), a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine;

d. K.S.A. 65-2837(b)(24), failure to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

e. K.S.A. 65-2837(b)(23), prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice; and

f. K.S.A. 65-2837(b)(30), failure to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

142. Pursuant to K.S.A. 65-2836, there are grounds for discipline against Licensee's license for violation of the Healing Arts Act. Additionally, the Board may assess a fine against Licensee's in accordance with K.S.A. 65-2863a(a).

**COUNT VII**

143. Petitioner incorporates herein by reference paragraphs 1 through 142.

144. From approximately November 12, 2002 until at least July 15, 2004, Licensee had a physician-patient relationship with Patient #7, a twenty-three year old male.

145. Licensee and/or physician assistants under his control evaluated and treated Patient #7 for various complaints and conditions, including back pain resulting from 2 motor vehicle accidents Patient #7 had been involved in over the past year.

146. On or about November 12, 2002, Licensee prescribed Lortab 4 times a day to Patient #7.

147. Licensee did not establish an etiology for Patient #7's back pain.

148. On or about November 23, 2002, a physician assistant under Licensee's supervision examined and treated Patient #7, who complained that the Lortab 4 times a day was not adequately controlling his pain. Patient #7 stated that he previously took Lortab 6 times a day with good pain control.

149. On or about that same date, the physician assistant under Licensee's supervision prescribed Vioxx, Soma and Percocet to treat Patient #7's pain.

150. On or about January 7, 2003, Licensee ordered an MRI of Patient #7's lumbar spine.

151. On or about September 9, 2003, an MRI of Patient #7's lumbar spine was performed. The results were reported as being unremarkable.

152. Licensee did not document a reason for the 8 month delay in obtaining Patient #7's MRI after Licensee had ordered it.

153. On or about September 24, 2003, Patient #7 had a urine drug screen collected which was reported as being positive for marijuana and oxycodone, but

negative for Lortab metabolite and Soma.

154. During his next office visit on or about September 30, 2003, Patient #7 was confronted about his failed urine drug screen and a repeat urine drug screen was collected.

155. The results of the repeat urine drug screen were reported as being positive for his prescription drugs and also marijuana.

156. During his next office visit on or about October 25, 2003, a physician assistant under the supervision of Licensee warned Patient #7 that he would be terminated if he smoked marijuana, but the physician assistant still issued refill prescriptions for Lortab and Soma to Patient #7.

157. On or about December 17, 2003, a physician assistant under Licensee's supervision increased the prescribed amount of Lortab for Patient #7 from 4 times a day to 5 times a day.

158. On or about April 3, 2004, it was documented in the medical chart that Patient #7 needed a urine drug screen on his next visit.

159. During his next office visit on or about May 7, 2004, a physician assistant under the supervision of Licensee documented that Patient #7 was on a tight budget and could not afford the urine drug screen. Patient #7's prescription was refilled, but it was documented that he needed to have a urine drug screen completed before his next visit.

160. On or about July 15, 2004, a physician assistant under the supervision of Licensee documented that Patient #7 had decreased range of motion in his hip, but his MRI results from September 2003, were within normal limits. The physician assistant issued refill prescriptions for Soma and Lortab to Patient #7.

161. On or about July 17, 2004, Patient #7 died due to a mixed drug intoxication.

162. During the course of the physician-patient relationship, Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary and/or gross negligence specifically including but not limited to, the following acts or omissions:

a. inappropriately and/or improperly prescribing prescription medications, including controlled substances, to Patient #7;

b. failure to adequately recognize and address signs of drug-seeking behavior by Patient #7;

c. failure to adequately supervise the care and treatment provided to Patient #7 by the physician assistants under his supervision; and

d. Failure to adhere to the applicable standard of care to a degree constituting gross and/or ordinary negligence, which is believed and alleged and will be disclosed upon proper discovery procedures in the course of these proceedings.

163. Licensee committed acts constituting incompetency and/or unprofessional conduct in violation of the Healing Arts Act, K.S.A. 65-2836 and K.S.A. 65-2837, including but not limited to:

a. K.S.A. 65-2837(a)(1), failure to adhere to the applicable standard of care to a degree which constitutes gross negligence, as determined by the board;

b, K.S.A. 65-2837(a)(2), failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the Board;

c. K.S.A. 65-2837(a)(3), a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine;

d. K.S.A. 65-2837(b)(24), failure to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

e. K.S.A. 65-2837(b)(23), prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice;

f. K.S.A. 65-2837(b)(25), failure to keep written medical records which accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results and test results;

g. K.S.A. 65-2836(k), violation of a lawful regulation promulgated by the Board, as further set forth in K.A.R. 100-24-1, failure to maintain an adequate patient record; and

h. K.S.A. 65-2837(b)(30), failure to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

164. Pursuant to K.S.A. 65-2836, there are grounds for discipline against Licensee's license for violation of the Healing Arts Act. Additionally, the Board may assess a fine against Licensee's license in accordance with K.S.A. 65-2863a(a).

**COUNT VIII**

165. Petitioner incorporates herein by reference paragraphs 1 through 164.

166. From approximately October 13, 2004 through at least January 5, 2005, Licensee had a physician-patient relationship with Patient #8, a forty-five year old female.

167. During the course of such relationship, Licensee and/or physician assistants under his control evaluated and treated Patient #8 for various complaints and conditions, including providing pain management for fibromyalgia and back pain.

168. Patient #8 had previously been treated at Via Christi Riverside Residency Clinic ("Riverside") for chronic low back pain, recurrent migraines and fibromyalgia.

169. At Riverside, Patient #8 had been prescribed controlled substances including Methadone and Fiorcet to treat her pain.

170. On or about May 11, 2004, it was documented in patient #8's medical chart at Riverside, that Patient #8's daughter reported Patient #8 was buying pain medications from another patient of Licensee.

171. On or about June 17, 2004, Patient #8 submitted to a urine drug screen at Riverside, which was positive for hydrocodone (Lortab). However, patient #8 had not been prescribed Lortab.

172. On or about October 13, 2004, a physician assistant under the supervision of Licensee documented in Patient #8's medical chart that she had been terminated from Riverside.

173. On or about that same date, Patient #8 signed a pain management contract with SMC.

174. A physician assistant under Licensee's supervision diagnosed Patient #8 with fibromyalgia and spinal stenosis of the lumbar spine, and prescribed 150 quantity of Methadone 10 milligrams and 90 quantity of Fioricet to Patient #8.

175. The physician assistant under the supervision of Licensee did not obtain any objective evidence to support the diagnosis of fibromyalgia and spinal stenosis of the lumbar spine.

176. On or about October 27, 2004, a physician assistant under the supervision of Licensee diagnosed Patient #8 with bipolar depression and anxiety, and prescribed Risperdal to Patient #8.

177. On that same date, the physician assistant also diagnosed Patient #8 with degenerative disc disease of the lumbar spine, but did not obtain any objective evidence to support such diagnosis.

178. On or about January 5, 2005, it was documented by another physician at SMC that the records from Patient #8's previous provider still had not been received at SMC.

179. On or about January 7, 2005, Patient #8 was admitted to the emergency department of VRMC due to an overdose of her prescription medications.

180. During the course of the physician-patient relationship, Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence specifically including but not limited to, the following acts or omissions:

a. inappropriately and/or improperly prescribing prescription medications, including controlled substances, to Patient #8;

b. failure to pursue objective evidence to support the documented diagnoses of Patient #8's conditions;

c. failure to adequately recognize and address signs of drug-seeking behavior by Patient #8;

d. failure to adequately supervise the care and treatment provided to Patient #8 by the physician assistants under his supervision; and

e. failure to adhere to the applicable standard of care to a degree constituting ordinary negligence, which is believed and alleged and will be disclosed upon proper discovery procedures in the course of these proceedings.

181. Licensee committed acts constituting incompetency and/or unprofessional conduct in violation of the Healing Arts Act, K.S.A. 65-2836 and K.S.A. 65-2837, including but not limited to:

a. K.S.A. 65-2837(a)(2), failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the Board;

b. K.S.A. 65-2837(a)(3), a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine;

c. K.S.A. 65-2837(b)(24), failure to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

d. K.S.A. 65-2837(b)(23), prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice; and

e. K.S.A. 65-2837(b)(30), failure to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

182. Pursuant to K.S.A. 65-2836, there are grounds for discipline against Licensee's license for violation of the Healing Arts Act. Additionally, the Board may assess a fine against Licensee's in accordance with K.S.A. 65-2863a(a).

## COUNT IX

183. Petitioner incorporates herein by reference paragraphs 1 through 182.

184. On or about December 12, 2003, Patient #9, a forty-five year old male, sought pain management at SMC for terminal cancer. SMC staff documented that Patient #9 had completed a twelve-course radiation treatment, a twelve-course chemotherapy treatment, and a rib graft for a bilateral temporomandibular jaw ("TMJ") removal.

185. Licensee prescribed Oxycontin 80 milligrams and Oxy IR 5 milligrams to treat Patient #9's pain.

186. Licensee also prescribed Valium 10 milligrams to treat Patient #9's anxiety.

187. On or about December 18, 2003, Licensee signed a "Physician Order" to admit Patient #9 to Hospice Care of Kansas with a diagnosis of bone cancer.

188. On or about December 20, 2003, Licensee also signed a "Physician Certification of Terminal Illness" certifying that patient #9 had metastatic bone cancer and admitting Patient #9 for Hospice Care of Kansas for the period of December 19, 2003 through March 17, 2004.

189. Licensee did not obtain any of Patient #9's previous cancer treatment records.

190. On or about December 22, 2003, Licensee increased the dosage of Patient #9's Morphine Sulphate Immediate Release from 5 milligrams to 10 milligrams.

191. On or about January 6, 2004, Licensee signed an order for Hospice Care of Kansas to administer Remeron, Soma and Oxycontin to treat Patient #9's pain associated with his bone cancer.

192. On or about January 8, 2004, Licensee prescribed 2 tablets of Oxyocodone 5 milligrams every 1-3 hours as needed to treat Patient #9's pain.

193. On or about January 19, 2004, Licensee began prescribing morphine sulfate to be administered to Patient #9 via a CADD-PCA pump at 5 milligrams per hour with a 1 milligram bolus every 15 minutes as needed.

194. On or about January 20, 2004, Licensee discontinued the morphine sulfate and began prescribing Dilaudid to Patient #9 to be administered via a CADD-PCA pump at 1 milligram per hour with a 1 milligram bolus every 15 minutes as needed.

195. On or about February 19, 2004, Licensee increased the dosage of Patient #9's Dilaudid to 3 milligrams per hour and a 1.5 milligram bolus every 15 minutes as needed.

196. On or about March 3, 2004, Licensee and/or a physician assistant under his supervision, increased Patient #9's Oxydose to 30 milligrams every 2 hours as needed and 5 tablets of Dilaudid 4 milligrams every 6 hours to treat Patient #9's complaints of pain.

197. On or about March 8, 2004, Licensee and/or a physician assistant under his supervision, prescribed Oxydose oral concentrate 50 milligrams; 4 tablets of Oxycontin 40 milligrams; and five tablets of Hydromorphone 4 milligrams to treat Patient #9's pain.

198. On or about March 12, 2004, a physician assistant under Licensee's supervision prescribed Neurontin to treat Patient #9's pain.

199. On or about April 13, 2004, Licensee and/or a physician assistant under his supervision ordered an x-ray of Patient #9's chest, ribs, skull and jaw for determination of metastasis and the progression of the cancer.

200. On or about April 14, 2004, a physician assistant under Licensee's supervision documented in the medical chart that Patient #9 was unable to leave a urine sample for a urine drug screen.

201. On or about May 6, 2004, Patient #9 was discharged from the Hospice Care of Kansas for non-compliance.

202. On or about June 22, 2004, it was documented in Patient #9's medical medical chart at SMC that he wanted to change to total home care.

203. On or about September 22, 2004, Patient #9 was admitted to emergency department of VRMC in Wichita, Kansas after his girlfriend found him passed out. At that time, Patient #9 informed emergency department personnel that his pain was not controlled with his current intravenous Dilaudid every hour. The emergency department plan documented in the VRMC medical chart for Patient #9 included the continuation of Patient #9's home medication, with the exception of Diluadid.

204. Following Patient #9's hospital admission, on or about September 24, 2004, Patient #9 had an office visit with Licensee. An appointment was made for Patient #9 to have a bone scan performed. Licensee also prescribed Dilaudid to treat Patient #9's metastatic cancer.

205. On or about that same date, Patient #9 signed a pain management contract with SMC.

206. On or about that same date, it was documented in Patient #9's medical chart that a urine drug screen could not be performed because Patient #9 did not have the money to pay for it. It was documented that Patient #9 would have the urine drug screen on the next visit and would need to pay that same visit.

207. On or about October 14, 2004, Patient #9 was admitted to the St. John Medical Center in Wichita, Kansas after a pin broke in his temporomandibular joint prosthesis. Patient #9 was relocating to Florida and was in route when it broke. Patient #9 was discharged from St. John Medical Center with instructions to proceed to Florida so corrective surgery could be performed by the same surgeon who initially performed Patient #9's TMJ removal surgery.

208. On or about October 18, 2004, Patient #9 was seen at SMC for a refill of his medications. At that time he also complained that he had broken the pin in his jaw. It was documented in his medical chart that SMC still needed a copy of the certificate of terminal illness from Patient #9. Licensee and/or a physician assistant under his supervision, refilled Patient #9's prescriptions including Dilaudid, Valium, Soma, Oxycontin, and Remeron.

209. On or about November 3, 2004, Patient #9 was seen at SMC. It was documented in his medical chart that Patient #9's bone scan was not completed as he had to reschedule the appointment.

210. On that same date Patient #9 had a urine drug screen collected which later was reported as negative for all of his prescription medications, but positive for cocaine.

211. On or about November 29, 2004, it was documented in Patient #9's medical chart that Patient #9 had surgery at the University of Kansas 2 weeks prior to fix his broken jaw prosthesis. Patient #9 was following up at SMC to have his stitches removed, but he had already removed them himself.

212. On that same date, Patient #9 was terminated from SMC and referred to another provider for "aberrant behavior, noncompliance, and questionable bone cancer."

213. On or about December 8, 2004, SMC notified Kansas SRS of Patient #9's disenrollment in the Medical Assistance Program because he "was committing fraud claiming that he was dying of cancer and he refused to keep any appointments to substantiate his claim, also selling his meds- positive for cocaine."

214. Licensee committed acts constituting incompetency and/or unprofessional conduct in violation of the Healing Arts Act, K.S.A. 65-2836 and K.S.A. 65-2837, including but not limited to:

a. K.S.A. 65-2837(b)(23), prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice; and

b. K.S.A. 65-2837(b)(30), failure to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

215. Pursuant to K.S.A. 65-2836, there are grounds for discipline against Licensee's license for violation of the Healing Arts Act. Additionally, the Board may fine Licensee's license in accordance with K.S.A. 65-2863a(a).

**COUNT X**

216. Petitioner incorporates herein by reference paragraphs 1 through 215.

217. In or about April 2000, Patient #10, a forty-four year old female, was treated by Licensee.

218. Patient #10 had a history which included headaches and back pain.

219. On or about May 3, 2001, an MRI of her cervical spine revealed that Patient #10

had degenerative disk disease, spondylosis and covertebral arthritis. It was also documented that there was congenital fusion and posterior lipping at several levels in the cervical spine.

220. On or about December 18, 2004, Patient #10 was seen by a physician assistant supervised by Licensee for pain caused by a nerve in her right arm. The physician assistant diagnosed Patient #10 with headaches, lower back pain and knee pain.

221. On that same date, the physician assistant administered Nubain 30 milligrams and Phenergan 50 milligrams to Patient #10.

222. Later that same day, Patient #10 returned to SMC for complaints of a jerking sensation and feeling sick. SMC documented in Patient #10's medical chart that she had taken Stadol and Actiq from another patient at SMC.

223. SMC staff documented that Patient #10 was transported to St. Francis Hospital via ambulance.

224. Licensee claimed that after the incident with Patient #10, Licensee restricted the physician assistants' abilities to administer injections of pain medication without prior approval from a physician.

225. Licensee committed acts constituting incompetency and/or unprofessional conduct in violation of the Healing Arts Act, K.S.A. 65-2836 and K.S.A. 65-2837, including but not limited to:

a. K.S.A. 65-2837(b)(30), failure to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

226. Pursuant to K.S.A. 65-2836, there are grounds for discipline against Licensee's license for violation of the Healing Arts Act. Additionally, the Board may assess a fine against Licensee's in accordance with K.S.A. 65-2863a(a).

**COUNT XI**

227. Petitioner incorporates herein by reference paragraphs 1 through 226, inclusive.

228. From approximately February 1, 2003 through June 20, 2005, Licensee had a physician-patient relationship with Patient #11, a forty-seven (47) year old female.

229. During the course of such relationship, Licensee and/or physician assistants under his control evaluated and treated Patient #11 at SMC for various complaints and conditions, including but not limited to, back and neck pain, pain following motor vehicle accidents, migraines, leg pain and numbness.

230. During the course of such relationship, Licensee and/or physician assistants under his control prescribed and/or ordered the administration of multiple controlled substances to Patient #11.

231. From approximately April to September, 2003, Patient #11 continued to receive controlled substance prescriptions from providers other than Licensee and/or physician assistants under his control.

232. During the course of such relationship, Patient #11 exhibited drug-seeking behavior at office visits and was admitted to VRMC due to a suspected overdose.

233. On or about June 20, 2005, Patient #11 was found by her husband in an unresponsive state and was transported by ambulance to VRMC, where she later died.

234. Patient #11's cause of death was determined to be mixed drug intoxication and the manner of her death was accidental.

235. During the course of such relationship, Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence, specifically including, but not limited to, each of the following acts or omissions:

a. Failure to adequately document symptoms and basis for the diagnosis of migraines for Patient #11;

b. Failure to adequately evaluate Patient #11's condition to justify the diagnoses documented and the medications prescribed and/or administered to Patient #11;

c. Failure to adequately recognize and address Patient #11's drug-seeking behavior and signs of drug abuse;

d. Inappropriate and/or improper prescribing of medications, including controlled substances, to Patient #11;

e. Failure to adequately supervise the care and treatment provided to Patient #11 by the physician assistants under Licensee's supervision; and

f. Failure to adhere to the applicable standard of care to a degree constituting ordinary negligence, which is believed and alleged and will be disclosed upon proper discovery procedures in the course of these proceedings.

236. During the course of such relationship, Licensee and/or physician assistants under his control failed to create and/or maintain adequate documentation in the medical record regarding Patient #11's care and treatment.

237. On multiple occasions, Licensee failed to counter-sign the physician assistants' progress notes for office visits with Patient #11.

238. Licensee committed acts of professional incompetency and/or unprofessional conduct in his care and treatment of Patient #11 in violation of the Healing Arts Act, K.S.A. 65-2836 and K.S.A. 65-2837, including but not limited to:

a. K.S.A. 65-2837(a)(2), repeated instances involving failure to adhere to the applicable standard of care to a degree constituting ordinary negligence, as determined by the Board;

b. K.S.A. 65-2837(a)(3), a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine;

c. K.S.A. 65- 2837(b)(24), failure to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

d. K.S.A. 65-2837(b)(23), prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice;

e. K.S.A. 65-2837(b)(25), failure to keep written medical records which accurately describe the services rendered to the Patient, including patient histories, pertinent findings, examination results and test results;

f. K.S.A. 65-2836(k), violation of a lawful regulation promulgated by the Board, as further set forth in K.A.R. 100-24-1, failure to maintain an adequate patient record; and

g. K.S.A. 65-2837(b)(30), failure to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

239. Pursuant to K.S.A. 65-2836, there are grounds for discipline against Licensee's license for violations of the Healing Arts Act. Additionally, the Board may assess a fine against Licensee's in accordance with K.S.A. 65-2863a(a).

**COUNT XII**

240. Petitioner incorporates herein by reference paragraphs 1 through 239, inclusive.

241. From approximately February 10, 2005 through at least December 19, 2005, Licensee had a physician-patient relationship with Patient #12, a fifty-five (55) year old female.

242. During the course of such relationship, Licensee and/or physician assistants under his control evaluated and treated Patient #12 for various complaints and conditions, including but not limited to, back pain, hip and leg pain, fibromyalgia, infection, burns, an abscess, swollen extremities, headaches, systemic lupus erythematosus, ("SLE"), post-herpetic neuralgia ("PHN"), chronic migraines and nausea.

243. During the course of such relationship, Licensee and/or physician assistants under his control prescribed multiple controlled substances and other medications to Patient #12.

244. During the course of such relationship, Patient #12 exhibited drug-seeking behavior at office visits and signs of substance abuse.

245. During the course of such relationship, Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence, specifically including, but not limited to, each of the following acts or omissions:

a. Failure to pursue objective evidence to support Licensee's documented diagnoses of Patient #12's conditions;

b. Failure to appropriately document in and utilize the PADT forms in Patient #12's medical chart;

d. Inappropriate and/or improper prescribing of medications, including controlled substances, to Patient #12;

e. Failure to adequately supervise the care and treatment provided to Patient #12 by the physician assistants under Licensee's supervision; and

f. Failure to adhere to the applicable standard of care to a degree constituting ordinary negligence, which is believed and alleged and will be disclosed upon proper discovery procedures in the course of these proceedings.

246. During the course of such relationship, Licensee and/or physicians under his control failed to create and/or maintain adequate documentation regarding Patient #12's care and treatment.

247. Licensee committed acts of professional incompetency and/or unprofessional conduct in his care and treatment of Patient #12 in violation of the Healing Arts Act, K.S.A. 65-2836 and K.S.A. 65-2837, including but not limited to:

a. K.S.A. 65-2837(a)(2), repeated instances involving failure to adhere to the applicable standard of care to a degree constituting ordinary negligence, as determined by the Board;

b. K.S.A. 65-2837(a)(3), a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine;

c. K.S.A. 65- 2837(b)(24), failure to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

d. K.S.A. 65-2837(b)(23), prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice;

e. K.S.A. 65-2837(b)(25), failure to keep written medical records which accurately describe the services rendered to the Patient, including patient histories, pertinent findings, examination results and test results;

f. K.S.A. 65-2836(k), violation of a lawful regulation promulgated by the Board, as further set forth in K.A.R. 100-24-1, failure to maintain an adequate patient record; and

g. K.S.A. 65-2837(b)(30), failure to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

248. Pursuant to K.S.A. 65-2836, there are grounds for discipline against Licensee's license for violation of the Healing Arts Act. Additionally, the Board may assess a fine against Licensee's in accordance with K.S.A. 65-2863a(a).

**COUNT XIII**

249. Petitioner incorporates herein by reference paragraphs 1 through 248, inclusive.

250. From approximately May 23, 2002 through April 30, 2003, Licensee had a physician-patient relationship with Patient #13 a thirty-four (34) year old female.

251. During the course of such relationship, Licensee and/or physician assistants under his control evaluated and treated Patient #13 at SMC for various complaints and conditions, including but not limited to, chronic neck and shoulder pain, migraines, neck spasms and degenerative disc disease of the cervical spine.

252. During the course of such relationship, Licensee and/or physician assistants under his control prescribed and/or ordered the administration of multiple controlled substances and other medications to Patient #13.

253. On or about April 28, 2003, Patient #13 was found in an unresponsive state in her home and transported by ambulance to Via Christi Riverside, where she was admitted.

254. During the course of her hospital stay at Via Christi Riverside, Patient #13 continued to be unresponsive and developed uncontrolled seizures

255. On or about April 29, 2003, Patient #13 was transferred to the Neurologic Intensive Care Unit at VRMC Saint Francis.

256. Upon admission to the Neurologic Intensive Care Unit, Patient #13 was found to have intractable seizures, multi system failure, including renal failure, respiratory failure and hepatitis secondary to acetaminophen toxicity.

257. On approximately April 30, 2003, Patient #13 died.

Patient #13's cause of death was determined to be complications from mixed drug intoxication and the manner of death was accidental.

258. During the course of such relationship, Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence, specifically including, but not limited to, each of the following acts or omissions:

a. Failure to adequately assess and document Patient #13's reports of pain, pain levels and responses to her medications;

b. Failure to adequately attempt to determine the etiology of Patient #13's complaints of pain;

c. Inappropriately and/or improperly prescribing pain medications, including controlled substances, to Patient #13;

d. Failure to adequately supervise the care and treatment provided to Patient #13 by the physician assistants under Licensee's supervision; and

e. Failure to adhere to the applicable standard of care to a degree constituting ordinary negligence, which is believed and alleged and will be disclosed upon proper discovery procedures in the course of these proceedings.

259. During the course of such relationship, Licensee and/or physician assistants under his control failed to create and/or maintain adequate documentation in the medical record regarding Patient #13's care and treatment.

260. Licensee committed acts of professional incompetency and/or unprofessional conduct in his care and treatment of Patient #13 in violation of the Healing Arts Act, K.S.A. 65-2836 and K.S.A. 65-2837, including but not limited to:

a. K.S.A. 65-2837(a)(2), repeated instances involving failure to adhere to the applicable standard of care to a degree constituting ordinary negligence, as determined by the Board;

b. K.S.A. 65-2837(a)(3), a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine;

c. K.S.A. 65- 2837(b)(24), failure to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

d. K.S.A. 65-2837(b)(23), prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice;

e. K.S.A. 65-2837(b)(25), failure to keep written medical records which accurately describe the services rendered to the Patient, including patient histories, pertinent findings, examination results and test results;

f. K.S.A. 65-2836(k), violation of a lawful regulation promulgated by the Board, as further set forth in K.A.R. 100-24-1, failure to maintain an adequate patient record; and

g. K.S.A. 65-2837(b)(30), failure to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

261. Pursuant to K.S.A. 65-2836, there are grounds for discipline against Licensee's license for violation of the Healing Arts Act. Additionally, the Board may assess a fine against Licensee's in accordance with K.S.A. 65-2863a(a).

**COUNT XIV**

262. Petitioner incorporates herein by reference paragraphs 1 through 261, inclusive.

263. From approximately July 10, through November 14, 2003, Licensee had a physician-patient relationship with Patient #14 a forty-three (43) year old female.

264. During the course of such relationship, Licensee and/or physician assistants under his control evaluated and treated Patient #1 for various complaints of pain.

265. On initial presentation, Patient #14 reported a past medical history of panic attacks, spondylolistheisis, tuberculosis, bone marrow transplant and surgery, for which Patient #14 requested pain management.

266. During the course of such relationship, Licensee and/or physician assistants under his control prescribed and/or ordered the administration of multiple controlled substances to Patient #14.

267. During the course of such relationship, Patient #14 exhibited drug-seeking behavior at office visits and signs of substance abuse.

268. On or about November 14, 2003, Patient #14 was found in an unresponsive state in her home and transported to VRMC by ambulance where she was pronounced dead at or about 1707 hours.

269. Patient #14's cause of death was mixed drug intoxication and atherosclerotic cardiovascular disease and the manner of death was accidental.

270. During the course of such relationship, Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence, specifically including, but not limited to, each of the following acts or omissions:

a. Failure to pursue objective evidence to support the documented diagnoses for Patient #14's condition;

b. Inappropriately and/or improperly prescribing pain medications, including controlled substances, to Patient #14;

c. Failure to adequately recognize and address Patient #14's drug seeking behavior and signs of substance abuse;

d. Failure to adequately supervise the care and treatment provided to Patient #14 by the physician assistants under Licensee's supervision; and

e. Failure to adhere to the applicable standard of care to a degree constituting ordinary negligence, which is believed and alleged and will be disclosed upon proper discovery procedures in the course of these proceedings.

271. During the course of such relationship, Licensee and/or physician assistants under his control failed to create and/or maintain adequate documentation in the medical record regarding Patient #14's care and treatment.

272. Licensee committed acts of professional incompetency and/or unprofessional conduct in his care and treatment of Patient #14 in violation of the Healing Arts Act, K.S.A. 65-2836 and K.S.A. 65-2837, including but not limited to:

a. K.S.A. 65-2837(a)(2), repeated instances involving failure to adhere to the applicable standard of care to a degree constituting ordinary negligence, as determined by the Board;

b. K.S.A. 65-2837(a)(3), a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine;

c. K.S.A. 65- 2837(b)(24), failure to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

d. K.S.A. 65-2837(b)(23), prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice;

e. K.S.A. 65-2837(b)(25), failure to keep written medical records which accurately describe the services rendered to the Patient, including patient histories, pertinent findings, examination results and test results;

f. K.S.A. 65-2836(k), violation of a lawful regulation promulgated by the Board, as further set forth in K.A.R. 100-24-1, failure to maintain an adequate patient record; and

g. K.S.A. 65-2837(b)(30), failure to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

273. Pursuant to K.S.A. 65-2836, there are grounds for discipline against Licensee's license for violation of the Healing Arts Act. Additionally, the Board may assess a fine against Licensee's in accordance with K.S.A. 65-2863a(a).

**WHEREFORE**, Petitioner prays that the Board make findings of fact and conclusions of law that Licensee committed these acts in violation of the Healing Arts Act, that Licensee's license to practice osteopathic medicine and surgery in the State of Kansas be revoked, suspended, censured, fined or otherwise limited, and that the Board assess such costs and impose such administrative fines against Licensee as it deems just and proper and as authorized by law.

Respectfully Submitted,

Kelli Stevens #16032
Litigation Counsel
Kansas State Board of Healing Arts
235 S. Topeka Boulevard
Topeka, Kansas 66603-3068
Telephone (785) 296-7413

## CERTIFICATE OF SERVICE

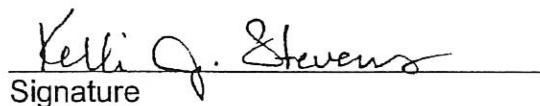
I, hereby certify that I served a true and correct copy of the above and foregoing **SECOND AMENDED PETITION** on the 13th day of November, 2007 by United States mail, first-class postage pre-paid and addressed to:

Martha A. Ross
Lathrop & Gage, L.C.
10851 Mastin Boulevard
Bldg. 82, Suite 1000
Overland Park, Kansas 66210-2007

Edward J. Gaschler
Presiding Officer
Office of Administrative Hearings
1020 South Kansas Avenue
Topeka, Kansas 66612

and the original was hand-delivered for filing to:

Lawrence T. Buening, Jr.
Executive Director
Kansas State Board of Healing Arts
235 S. Topeka Boulevard
Topeka, Kansas 66603-3068


Signature

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

FILED
DEC 27 2007
KS State Board of Healing Arts

In the Matter of )
)
**STEPHEN J. SCHNEIDER, D.O.** )
Kansas License No. 05-022385 ) KSBHA Docket No. 06-HA-00100
______________________________ ) OAH No. 07-HA-0001 BHA

**PETITIONER'S MOTION FOR EMERGENCY ORDER TEMPORARILY SUSPENDING RESPONDENT'S LICENSE**

**COMES NOW** the Petitioner, Board of Healing Arts, by and through Kelli J. Stevens, Litigation Counsel, and pursuant to K.S.A. 65-2838(c) and 77-536(a)(1), moves the Presiding Officer for an emergency order suspending Respondent's license on a temporary basis pending the conclusion of the formal proceedings in this matter. Petitioner alleges that there is cause to believe that grounds exist under K.S.A. 65-2836 for disciplinary action and that Respondent's continuation in practice constitutes an imminent danger to the public health and safety warranting emergency suspension. In support of its motion, Petitioner has filed a Memorandum which is attached hereto and incorporated by reference.

**WHEREFORE**, Petitioner prays the Presiding Officer issue an emergency order temporarily suspending Respondent's license pending the conclusion of the formal proceedings in this matter and for such further relief as the Presiding Officer deems just and proper in the circumstances.

Respectfully Submitted,

Kelli J. Stevens, #16032
Litigation Counsel
Kansas State Board of Healing Arts
235 S. Topeka Boulevard
Topeka, Kansas 66614
(785) 296-7413

## CERTIFICATE OF SERVICE

I, Kelli G. Stevens, hereby certify that a true and correct copy of the above and foregoing **PETITIONER'S MOTION FOR EMERGENCY ORDER TEMPORARILY SUSPENDING RESPONDENT'S LICENSE** was served on the 27th day of December, 2007 by fax and by United States mail, first class, postage pre-paid and addressed to the following:

Martha A. Ross
LATHROP & GAGE, L.C.
10851 Mastin Boulevard
Bldg. 82, Suite 1000
Overland Park, Kansas 66210-2007
(913) 451-0875 *fax*

Edward Gaschler, Presiding Officer
Office of Administrative Hearings
1020 S. Kansas Avenue
Topeka, Kansas 66612
(785) 296-4848 *fax*

and the original was hand-delivered for filing to:

Lawrence T. Buening, Jr.
Executive Director
Kansas State Board of Healing Arts
235 S. Topeka Boulevard
Topeka, Kansas 66603

Kelli G. Stevens
Signature

FILED CAB
DEC 27 2007
KS State Board of Healing Arts

**BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS**

In the Matter of )
)
**STEPHEN J. SCHNEIDER, D.O.** )
Kansas License No. 05-022385 ) KSBHA Docket No. 06-HA-00100
________________________________ ) OAH No. 07-HA-0001 BHA

**MEMORANDUM IN SUPPORT OF PETITIONER'S MOTION FOR EMERGENCY ORDER TEMPORARILY SUSPENDING RESPONDENT'S LICENSE**

In support of its Motion for Emergency Order Temporarily Suspending Respondent's License, Petitioner states as follows:

**I. Kansas Board of Healing Arts Action's Procedural History**

Petitioner initially filed a Petition in this matter seeking disciplinary action against Respondent's license on May 30, 2006. The Petition alleged that Respondent had violated the healing arts act with respect to multiple patients by inappropriately prescribing medications, practicing below the standard of care and inadequate record-keeping. A First Amended Petition was subsequently filed on September 1, 2006, which set forth ten (10) counts alleging violations with respect to specific patients. The parties engaged in discovery pursuant to a Prehearing Order which also gave notice of a formal evidentiary hearing to commence on March 26, 2007.

In January of 2007, Petitioner notified Respondent's counsel that it anticipated enlarging the pending allegations by adding counts for more patients. As such, the parties agreed that in order to efficiently conduct discovery and prepare for the formal hearing, they would ask the Presiding Officer to stay the proceedings until Petitioner filed a Second Amended Petition. On January 29, 2007, an Agreed Order of Stay of Proceedings and Continuance of Formal Hearing was issued by the Presiding Officer and filed with the Board.

On or about November 13, 2007, Petitioner filed its Second Amended Petition, which added four (4) additional counts of violations by Respondent, each pertaining to a specific patient. Subsequently, on or about December 2, 2007, Petitioner dismissed Count IX and X of the Second Amended Petition. Presently, the pending matter involves twelve (12) counts of alleged violations with respect to individual patients, five (5) of whom died while they were patients of Respondent. All five (5) patients died of drug overdoses that included medications prescribed by Respondent or prescribed under his authority.

## II. Facts Regarding Respondent's Federal Criminal Indictment and Detention Pending Trial

On or about December 20, 2007, Respondent and his wife were criminally indicted by a Federal Grand Jury. That matter is now pending in the U.S. District Court for the District of Kansas (Wichita) in Case No. 07-10234-WEB. The Indictment is attached hereto as **EXHIBIT A** and incorporated by reference. The Indictment contains thirty-four (34) counts of felony crimes directly involving Respondent's practice of the healing arts. These include, but are not limited to: conspiracy, unlawful distribution and dispensing of controlled substances resulting in serious bodily injury and death of fifteen (15) patients, unlawful distribution and dispensing of Actiq, health care fraud, health care fraud resulting in serious bodily injury and the deaths of three (3) patients, health care fraud related to Actiq prescriptions, health care fraud related to services rendered, illegal monetary transactions and money laundering. The Indictment also alleges that between 2002 and 2007, ***at least*** (emphasis added) fifty-six (56) of Respondent's patients have died from accidental overdoses. The allegations in the Indictment regarding patient deaths also concern at least two (2) of the patients who are included in Petitioner's Second Amended Petition.

On or about December 20, 2007, the U.S. Government filed a Motion for Special Conditions of Release in Lieu of Detention. The Motion for Special Conditions of Release in Lieu of Detention is attached hereto as **EXHIBIT B** and incorporated by reference. The Motion presented argument in favor of detention stating Respondent is a danger to the community and a flight risk since Respondent presently can prescribe controlled substances and his medical practice is the instrument for committing his crimes. The Government reasoned that the community is physically and economically in danger as long as Respondent can continue to practice. As an alternative to detention, the Motion proposed, in part, a special condition requiring Respondent to surrender his medical license as a means to "reasonably assure the safety of the community."

A hearing was held on December 21, 2007, in the criminal case. At the hearing, Respondent refused to accept special conditions set forth in the Motion. The Government then orally moved for detention. The Honorable Donald W. Bostwick, U.S. Magistrate Judge, issued an Order denying the Government's Motion and detained Respondent and his wife pending trial. The Court's Order filed on December 26, 2007, is attached hereto as **EXHIBIT C** and is incorporated by reference. Beginning on page 10 of the Order, Judge Bostwick specifically addressed whether there were any conditions which could reasonably assure the safety of the community in lieu of Respondent's detention. He stated that the issue of the community's safety was the Court's greatest concern in the case.

Judge Bostwick agreed with the Government's argument that, even if Respondent surrendered his DEA Registration Number, he would essentially still be able to operate through his practice at Schneider Medical Clinic. Finding that the Court lacked authority to require Respondent to surrender his medical license, Judge

Bostwick considered the option of ordering Respondent not to engage in the practice of medicine while on pretrial release. However, he went on to note that the effectiveness of and method for enforcement of such an Order would be questionable. The Court concluded that there were no conditions or combinations of conditions which would reasonably assure the safety of the community if Respondent was granted pretrial release.

## III. Respondent Presently Has the Ability to Engage in the Practice and Maintain an Office for the Practice of the Healing Arts

Respondent currently has an unrestricted licensed to engage in the practice of the healing arts, specifically osteopathic medicine and surgery. Petitioner reasonably believes that Respondent is the sole shareholder in Schneider Medical Clinic, L.L.C., a limited liability company organized to provide professional services in this State. Essentially, it is his alter ego. Schneider Medical Clinic, L.L.C.'s Articles of Organization, Certificate of Licensure, and Annual Reports for 2003-2007 are attached hereto as **EXHIBIT D** and incorporated herein by reference. Schneider Medical Clinic, L.L.C. operates by and through Respondent's authority and operates at the practice location of Schneider Medical Clinic in Haysville, Kansas. Schneider Medical Clinic has continued to operate and provide medical care to patients since Respondent's arrest and detention. It is able to continue providing medical care as long as Respondent is authorized by the Kansas Board of Healing Arts to render the professional services of an osteopathic physician. See K.S.A. 17-2707(b)(8) and K.S.A. 17-7668.

Furthermore, despite being detained in a correctional facility pending trial in his Federal criminal case, Respondent himself is presently able to actively practice

medicine and surgery. Regardless of the Court's findings and decision in the Order detaining Respondent to protect the community, he remains absolutely free to maintain the full scope of his physician-patient relationships and the practice at Schneider Medical Clinic can carry on in his absence. A suspension of licensure would sever that ability in both instances. Under the healing arts act, it is unlawful for a person whose license is suspended to "maintain an office for the practice of the healing arts." K.S.A. 65-2867. If Respondent's license were temporarily suspended, he would not be able to practice individually or practice through Schneider Medical Clinic, the office which he presently maintains for the practice the healing arts.

## IV. An Emergency Order of Temporary Suspension of Respondent's License Is Warranted

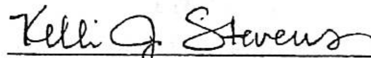
The Federal Indictment contains many similar allegations to those in the Petitioner's pending matter. While Petitioner has not been privy to the Government's evidence and is still in the process of reviewing the Indictment's allegations, the Indictment does include numerous additional claims which would constitute violations of the healing arts act. Based on the allegations in the Second Amended Petition and the Indictment, there is reasonable cause to believe grounds exist for discipline under K.S.A. 65-2836. Secondly, the egregious nature of the allegations in both matters is indicative of a threat of imminent harm to the public health and safety.

Furthermore, the fact that Respondent has been criminally indicted and detained pending trial represents an additional, compelling basis to find Respondent's continuation in practice is an imminent threat to the public health, safety and welfare. Of note in the Indictment, is the shockingly high number of patient deaths from accidental overdoses between 2002 and 2007. Included among these are some of the patients in the Board's action. It is significant that the Government raided Respondent's

practice in September of 2005, and the Board filed its action against Respondent's medical license in May of 2006. The Indictment alleges that nine (9) patients died in 2006 and three (3) have died during the current year. Despite Respondent being on notice of concerns regarding his practice, patients continued to die. As set forth above, the Federal Court in the criminal matter found there was a risk to the community if Respondent was released pending trial due to his ability to continue practicing. The Court's conclusions are based on a clear and convincing evidence standard similar to the Board's required standard of proof. In considering Petitioner's Motion, Petitioner urges the Presiding Officer take official notice of the outcome in the Federal Court's Order of detention as it pertains to the issue at hand.

Illogical as it may seem, Respondent is a threat to the public safety, even while in custody. Judge Bostwick's Order in the criminal case imposing detention pending trial is intended to protect the community from Respondent's ability to practice by holding him in custody. However, as noted previously, Respondent still has the full authority of his license to practice himself and operate through the Schneider Medical Clinic. Under his authority, Schneider Medical Clinic can provide medical care and continue with "business as usual." A temporary suspension of Respondent's medical license will prevent Respondent from actually practicing and from maintaining an office practice while this matter is pending and avert the imminent danger to the public which presently exists.

Respectfully Submitted,



Kelli J. Stevens, #16032
Litigation Counsel
Kansas State Board of Healing Arts
235 S. Topeka Boulevard
Topeka, Kansas 66614
(785) 296-7413

Schneider

# KANSAS STATE BOARD OF HEALING ARTS
**235 S. Topeka Boulevard**
**Topeka, Kansas 66603-3068**

## BOARD MINUTES – Friday and Saturday
**June 9 and 10, 2006**

FORMAT OF MINUTES – Prior to each motion there appears the names of two Board Members in parenthesis. The first made the motion, the latter seconded the motion. Ayes, nays, abstentions and recusals are recorded when requested.

## I. CALL TO ORDER - ROLL CALL (Friday, June 9, 2006)

The Kansas State Board of Healing Arts met at the Board Office, 235 S. Topeka Boulevard, Topeka, Kansas on Friday, June 9, 2006. The meeting was called or order at 2:00 p.m. by Roger Warren, M.D., President.

| | |
|---|---|
| Vinton Arnett, D.C. - | present |
| Ray Conley, D.C. - | present |
| Gary Counselman, D.C. - | present |
| Michael Beezley, M.D. - | present |
| Frank K. Galbraith, DPM - | present (arrived at 2:18 pm) |
| Merle J. Hodges, M.D. - | present (arrived at 2:15 pm) |
| Sue Ice, public member - | present |
| Betty McBride, public member - | present |
| Mark A. McCune, M.D. - | present |
| Carol Sader, public member - | present (arrived at 2:15 pm) |
| Carolina M. Soria, D.O., VP - | absent |
| Roger D. Warren, M.D., Pres. - | present |
| Nancy J. Welsh, M.D. - | present |
| John P. White, D.O. - | present (arrived at 2:40 pm) |
| Ronald Whitmer, D.O. - | absent |

Staff members present were Lawrence T. Buening, Jr., Executive Director; Mark W. Stafford, General Counsel; Shelly R.Wakeman, Disciplinary Counsel; Kelli J. Stevens, Litigation Counsel; Kathleen Selzler Lippert, Associate Counsel; Diane L. Bellquist, Associate Counsel; Charlene Abbott, Licensing Administrator; Cathy Brown, Executive Assistant and Barbara Montgomery, H.R. Manager. The attached sign-in sheet indicates those people who were present during portions of the meeting.

## II. APPROVAL OF AGENDA

(Conley/McCune) Approve agenda with the addition of a request to supervise a third P.A. and the addition of the FSMB report, both of which have been added to the Executive Director's report. Carried.

**Supervision Regulations**
Action on the adoption of these regulations has been postponed until the October Board meeting so that the professional associations have time to meet and come to a consensus on any recommendations for the supervision of nurse practitioners.

**Appointment of Presiding Officers**
Dr. Welsh was appointed as Presiding Officer in the Stephen J. Schneider, D.O. case.

**Request to Supervise More Than 2 PA's**
Dr. Dan Severa requested Board approval to supervise a third (part-time) physician assistant. (Hodges/McCune) Approve request. Carried.

## VII. CALL TO ORDER/ROLL CALL (Saturday, June 10, 2006)

The Kansas State Board of Healing Arts met at the Board Office, 235 S. Topeka Boulevard, Topeka, Kansas on Saturday, June 10, 2006. The meeting was called or order at 8:45 a.m. by Roger Warren, M.D., President.

| | | |
|---|---|---|
| Vinton Arnett, D.C. - | present | |
| Ray Conley, D.C. - | present | |
| Gary Counselman, D.C. - | present | |
| Michael Beezley, M.D. - | present | |
| Frank K. Galbraith, DPM - | present | |
| Merle J. Hodges, M.D. - | present | |
| Sue Ice, public member - | present | |
| Betty McBride, public member - | present | |
| Mark A. McCune, M.D. - | present | |
| Carol Sader, public member - | present | (arrived at 8:54 a.m.) |
| Carolina M. Soria, D.O., VP - | present | |
| Roger D. Warren, M.D., Pres. - | present | |
| Nancy J. Welsh, M.D. - | present | |
| John P. White, D.O. - | present | |
| Ronald Whitmer, D.O. - | absent | |

Staff members present were Lawrence T. Buening, Jr., Executive Director; Mark Stafford, General Counsel; Shelly Wakeman, Disciplinary Counsel; Kelli Stevens, Litigation Counsel; Kathleen Lippert, Associate Counsel; Diane Bellquist, Associate Counsel; Charlene Abbott, Licensing Administrator; Cathy Brown, Executive Assistant and Barbara Montgomery, H.R. Manager. The attached sign-in sheet indicates those people who were present during portions of the meeting.

Laura Barnett, CSR, Appino and Biggs Reporting Service, took and recorded the administrative proceedings conducted.

## VIII. ADMINISTRATIVE PROCEEDING

Schneider

**KANSAS STATE BOARD OF HEALING ARTS**
**235 S. Topeka Boulevard**
**Topeka, Kansas 66603-3068**

**BOARD MINUTES – Saturday**
**August 12, 2006**

FORMAT OF MINUTES – Prior to each motion there appears the names of two Board Members in parenthesis. The first made the motion, the latter seconded the motion. Ayes, nays, abstentions and recusals are recorded when requested.

## I. CALL TO ORDER - ROLL CALL

The Kansas State Board of Healing Arts met at the Board Office, 235 S. Topeka Boulevard, Topeka, Kansas on Saturday, April 8, 2006. The meeting was called or order at 8:30 a.m. by Roger Warren, M.D., President.

| | | |
|---|---|---|
| Vinton Arnett, D.C. - | present | |
| Ray Conley, D.C. - | present | |
| Gary Counselman, D.C. - | present | |
| Michael Beezley, M.D. - | present | (arrived at 8:40 a.m.) |
| Frank K. Galbraith, DPM - | absent | |
| Merle J. Hodges, M.D. - | present | |
| Sue Ice, public member - | present | |
| Betty McBride, public member - | present | |
| Mark A. McCune, M.D. - | present | |
| Carol Sader, public member - | present | (arrived at 8:45 a.m.) |
| Carolina M. Soria, D.O., VP - | present | |
| Roger D. Warren, M.D., Pres. - | present | |
| Nancy J. Welsh, M.D. - | absent | |
| John P. White, D.O. - | present | (arrived at 8:40 a.m.) |
| Ronald Whitmer, D.O. - | present | |

Staff members present were Lawrence T. Buening, Jr., Executive Director; Mark W. Stafford, General Counsel; Shelly R.Wakeman, Disciplinary Counsel; Kelli J. Stevens, Litigation Counsel; Kathleen Selzler Lippert, Associate Counsel; Diane L. Bellquist, Associate Counsel; Charlene Abbott, Licensing Administrator; Cathy Brown, Executive Assistant and Barbara Montgomery, H.R. Manager. The attached sign-in sheet indicates those people who were present during portions of the meeting.

Laura Barnett, CSR, Appino and Biggs Reporting Service, took and recorded the administrative proceedings conducted.

## II. APPROVAL OF AGENDA

## III. APPROVAL OF BOARD MEETING MINUTES



3-76

**Bryan McGinley, R.T.** – Dr. McCune was appointed as presiding officer.

**John B. Lester, M.D.** – A presiding officer will be appointed from the Department of Administrative Hearings.

**Stephen J. Schneider, M.D.** – A presiding officer will be appointed from the Department of Administrative Hearings.

**Michelle Gillum, P.T. (convert to formal hearing)** – Dr. Arnett was appointed as presiding officer.

**Appointment of Delegate & Alternate to the FCLB**

Dr. Counselman was appointed as the delegate and Dr. Arnett was appointed as the alternate.

**Daskalov Consent Order for Surrender**

(Warren/McBride) Ratify acceptance of the Consent Order by the Executive Director. Carried.

**Status of Legislative Post Audit**

Mr. Buening reviewed the status of the Legislative Post Audit. He believes that they will find a few things this agency can improve upon; however, there have been errors in their findings and requests so the final report will need to be reviewed closely.

**KMS/MAP**

Board staff will obtain more information to provide to Doctors McCune and Warren before they contact Mr. Slaughter.

**Joint Meeting with Nursing Board**

Seven board members have indicated that they can attend the joint meeting on Monday, September 11 at 2:00 p.m. with the Kansas Board of Nursing. Several staff members will be attending as well.

**LICENSING ADMINISTRATOR:**

**Approval of Administrative Actions**

(Arnett/Hodges) Approve administrative actions. Carried.

**Approval of Licensee/Registrant List**

(Arnett/Hodges) Approve licensee/registrant list. Carried.

**St. Matthews Univ.**

(Hodges/Warren) Tabled until October board meeting. Carried.

Douglas Geenens, M.D.
Complaints/Actions
Since January 2002

| CompNum | CompReceived | Complainant | Patient | CaseNum | CaseOpene | Review Con | DP | CaseClosed | Comment |
|---|---|---|---|---|---|---|---|---|---|
| NA | 10/14/2003 | Andrew Jacobs | Patient | 04-00193 | 10/27/2003 | NA | 4/2/2004 | 12/22/2004 | Case settled by C.O. |
| NA | 12/19/2003 | Patient | Patient | 04-00294 | 1/6/2004 | NA | NA | 12/21/2004 | Uncooperative patient-no violation |
| NA | 12/8/2004 | Patient | Patient | 05-00138 | 12/21/2004 | NA | 1/6/2006 | 1/6/2006 | No violation |
| C-00363 | 10/5/2005 | Ren. Form | Patient | NA | NA | NA | NA | 10/19/2005 | previous action re: this pt. |
| C-00880 | 12/21/2005 | Federation Rpt* | Other state Board | NA | NA | NA | NA | 1/11/2006 | |
| C-02645 | 10/18/2006 | Ren. Form | Patient | NA | NA | NA | NA | 11/27/2006 | previous action re: this pt. |
| C-02692 | 10/25/2006 | Patient | Patient | NA | NA | NA | NA | 11/20/2006 | No violation alleged |
| C-02969 | 12/18/2006 | Patient | Patient | 07-00329 | 1/22/2007 | | | Pending | |
| C-05197 | 7/17/2007 | Other Professional | | 08-00183 | 10/15/2007 | NA | 11/16/2007 | Pending | |
| C-05500 | 8/20/2007 | Renewal Form | Patient | Same as Case No. 07-00329 | | | | Pending | |
| C-05987 | 11/28/2007 | Other Professional | Patient | 08-00183 | 10/15/2007 | NA | 11/16/2007 | Pending | |
| C-06167 | 1/8/2008 | Other Professional | Patient | 08-00183 | 10/15/2007 | NA | 11/16/2007 | Pending | |
| C-06315 | 1/31/2008 | Patient's mother | Patient | NA | NA | NA | NA | 2/21/2008 | No violation |

* Fed. Rept.: Mo. Action on 12/2/05, reprimand based on another board's action

Senate Health Care Strategies Committee
Date: February 25, 2008
Attachment 4

FILED
DEC 1 1 2004
KANSAS STATE BOARD OF HEALING ARTS

**BEFORE THE BOARD OF THE HEALING ARTS**
**OF THE STATE OF KANSAS**

| | | |
|---|---|---|
| In the Matter of | ) | |
| Douglas Geenens, D.O. | ) | Docket No. 05-HA- 36 |
| Kansas License No. 5-22577 | ) | |
| ______________________ | ) | |

## CONSENT ORDER

COMES NOW the Kansas State Board of Healing Arts ("Board"), by and through Stacy L. Cook, Litigation Counsel, ("Petitioner"), and Douglas Geenens, D.O., ("Licensee"), by and through B K Christopher and move the Board for approval of a Consent Order affecting Licensee's license to practice osteopathic medicine and surgery in the State of Kansas. The parties stipulate and agree to the following:

1. Licensee's last known mailing address to the Board is 4707 College Blvd., #201, Overland Park, Kansas, 66211.

2. Licensee is or has been entitled to engage in the practice of osteopathic medicine and surgery in the State of Kansas, having been issued License No. 5-22577 on February 10, 1989. Licensee's license status is active.

3. The Board is the sole and exclusive administrative agency in the State of Kansas authorized to regulate the practice of the healing arts, specifically the practice of osteopathic medicine and surgery.

4. This Consent Order and the filing of such document are in accordance with applicable law and the Board has jurisdiction to enter into the Consent Order as provided by K.S.A. 65-2838. Upon approval, these stipulations shall constitute the findings of the Board, and this Consent Order shall constitute the Board's Final Order.



4-2

5. The Kansas Healing Arts Act is constitutional on its face and as applied in this case.

6. Licensee agrees that, in considering this matter, the Board is not acting beyond its jurisdiction as provided by law.

7. Licensee voluntarily and knowingly waives his right to a hearing. Licensee voluntarily and knowingly waives his right to a present a defense by oral testimony and documentary evidence, to submit rebuttal evidence, and to conduct cross-examination of witnesses. Licensee voluntarily and knowingly agrees to waive all possible substantive and procedural motions and defenses that could be raised if an administrative hearing were held.

8. The terms and conditions of the Consent Order are entered into between the undersigned parties and are submitted for the purpose of allowing these terms and conditions to become an Order of the Board. This Consent Order shall not be binding on the Board until an authorized signature is affixed at the end of this document. Licensee specifically acknowledges that counsel for the Board is not authorized to sign this Consent Order of behalf of the Board.

9. Licensee's specialty is psychiatry.

10. On January 31, 2003, Licensee began providing medical care and treatment to "Patient A," a forty-three year-old female.

11. Patient A was referred to Licensee by her spouse, a psychologist who had previously referred other patients to Licensee for psychiatric treatment.

12. Licensee treated Patient A for depression and marital issues.

13. Licensee treated Patient A on approximately three occasions.

14. On April 22, 2003, Licensee terminated the physician-patient relationship with Patient A.

15. Following the termination of the physician-patient relationship, Licensee and Patient A began a social relationship.

16. Approximately two months after the termination of the physician-patient relationship, Licensee engaged in a sexually intimate relationship with Patient A.

17. Pursuant to K.S.A. 65-2836(b), as further defined by K.S.A. 65-2837(b)(16), the Board has grounds to revoke, suspend or otherwise limit Licensee's license.

18. According to K.S.A. 65-2838(b), the Board has authority to enter into this Consent Order without the necessity of proceeding to a formal hearing.

19. In lieu of the conclusion of formal proceedings, Licensee, by signature affixed to this Consent Order, hereby voluntarily agrees to the following disciplinary action with respect to his license:

(a) Licensee's license shall be suspended for the duration of six months. The suspension shall be stayed except from December 12, 2004 through December 18, 2004. If Licensee engages in conduct determined to be unprofessional conduct during this time then the Board may remove the stay of suspension;

(b) Licensee is publicly censured for engaging in conduct determined by the Board to be unprofessional conduct;

(c) Licensee agrees to attend and successfully complete the

course on maintaining proper boundaries at Vanderbilt Medical Center held March 9 through March 11, 2005. Licensee must submit proof of satisfactory completion of the course. Licensee must insure that a report of his participation shall be submitted to the Board. Licensee is responsible for all associated expenses; and

(d) Licensee agrees to submit to psychoanalytically-oriented case supervision with particular emphasis on boundary and countertransference issues. The goal of the case supervision is to provide Licensee with insight into areas of weaknesses regarding countertransference and boundary issues. The case supervision shall be performed by a training analyst who is licensed to practice medicine and who is approved by the Board. Licensee is required to meet with the case supervisor a minimum of two times per month, one hour on each occasion. Licensee is expected to present current and past cases for review of the supervisor. Licensee agrees that the case supervisor shall be provided with a copy of the evaluation from Dr. Strasburger and may discuss the supervision with Board staff. Licensee agrees that the case supervisor shall provide a report to the Board each month confirming participation by Licensee and describing the activities. The report is due on or before the

fifteenth day of the following month. Licensee is responsible for all expenses associated with the case supervisor. Such supervision shall be conducted for at least two years and Licensee must obtain Board approval in order to terminate this provision. The case supervisor shall notify the Board of any concerns or recommendations regarding Licensee's practice. Licensee agrees to follow all recommendations of the case supervisor, including any recommendations on the frequency of the meetings. If the Board determines, with the input of the case supervisor, that more intensive work is required, the Board may require case supervision of two times per week for three months.

20. Licensee's failure to comply with the provisions of the Consent Order may result in the Board taking further disciplinary action as the Board deems appropriate according to the Kansas Administrative Procedure Act.

21. Nothing in the Consent Order shall be construed to deny the Board jurisdiction to investigate alleged violations of the Healing Arts Act, or to investigate complaints received under the Risk Management law, K.S.A. 65-4921 *et seq.,* that are known or unknown and are not covered under this Consent Order, or to initiate formal proceedings based upon known or unknown allegations of violations of the Healing Arts Act.

22. Licensee hereby releases the Board, its individual members (in their official and personal capacities), attorneys, employees and agents, hereinafter

collectively referred to as ("Releasees"), from any and all claims, including but not limited to, those alleged damages, actions, liabilities, both administrative and civil, including the Kansas Act for Judicial Review and Civil Enforcement of Agency Actions, K.S.A. 77-601 *et seq.* arising out of the investigation and acts leading to the execution of this Consent Order. This release shall forever discharge the Releasees of any and all claims or demands of every kind and nature that Licensee has claimed to have had at the time of this release or might have had, either known or unknown, suspected of unsuspected, and Licensee shall not commence to persecute, cause or permit to be prosecuted, any action or proceeding of any description against the Releasees.

23. Licensee further understands and agrees that upon signature by Licensee, this document shall be deemed a public record and shall be reported to the National Practitioner Databank, Federation of State Medical Boards, and any other reporting entities requiring disclosure of the Consent Order. The parties agree that the report of Dr. Strasburger is privileged and shall not be disclosed pursuant to K.S.A. 65-4925.

24. This Consent Order, when signed by both parties, constitutes the entire agreement between the parties and may only be modified or amended by a subsequent document executed in the same manner by the parties.

25. Licensee agrees that all information maintained by the Board pertaining to the nature and result of any complaint and/or investigation may be fully disclosed to and considered by the Board in conjunction with the presentation of any offer of settlement, even if Licensee is not present. Licensee further acknowledges that the Board may conduct further inquiry as it deems necessary before the complete or partial acceptance

or rejection of any offer of settlement.

26. Licensee, by signature to this document waives any objection to the participation of the Board members, including the Disciplinary Panel, in the consideration of this offer of settlement and agrees not to seek the disqualification or recusal of any Board member in any future proceeding on the basis that the Board member has received investigative information from any source which otherwise may not be admissible or admitted as evidence.

27. Licensee acknowledges that he has read this Consent Order and fully understands the contents.

28. Licensee acknowledges that this Consent Order has been entered into freely and voluntarily.

29. All correspondence or communication between Licensee and the Board relating to this Consent Order shall be by certified mail addressed to the Kansas State Board of Healing Arts, Attn: Stacy L. Cook, 235 S. Topeka Blvd., Topeka, Kansas 66603-3068.

30. Licensee shall obey all federal, state and local laws and rules governing the practice of osteopathic medicine and surgery in the State of Kansas that may be in place at the time of execution of the Consent Order or may become effective subsequent to the execution of this document.

31. Upon execution of this Consent Order by affixing a Board authorized signature below, the provisions of this Consent Order shall become an Order under K.S.A. 65-2838. This Consent Order shall constitute the Board's Order when filed with the Office of the Executive Director for the Board and no further Order is required.

32. The Board may consider all aspects of this Consent Order in any future matter regarding Licensee.

**IT IS THEREFORE ORDERED** that the Consent Order and agreement of the parties contained herein is adopted by the Board as findings of fact and conclusions of law.

**IT IS FURTHER ORDERED** that in lieu of the conclusion of formal proceedings, Licensee, by signature affixed to this Consent Order, hereby voluntarily agrees to the following disciplinary action with respect to his license:

(a) Licensee's license shall be suspended for the duration of six months. The suspension shall be stayed except from December 12, 2004 through December 18, 2004. If Licensee engages in conduct determined to be unprofessional conduct during this time then the Board may remove the stay of suspension;

(b) Licensee is publicly censured for engaging in conduct determined by the Board to be unprofessional conduct;

(c) Licensee agrees to attend and successfully complete the course on maintaining proper boundaries at Vanderbilt Medical Center held March 9 through March 11, 2005. Licensee must submit proof of satisfactory completion of the course. Licensee must insure that a report of his participation shall be submitted to the Board. Licensee is

responsible for all associated expenses; and

(d) Licensee agrees to submit to psychoanalytically-oriented case supervision with particular emphasis on boundary and countertransference issues. The goal of the case supervision is to provide Licensee with insight into areas of weaknesses regarding countertransference and boundary issues. The case supervision shall be performed by a training analyst who is licensed to practice medicine and who is approved by the Board. Licensee is required to meet with the case supervisor a minimum of two times per month, one hour on each occasion. Licensee is expected to present current and past cases for review of the supervisor. Licensee agrees that the case supervisor shall be provided with a copy of the evaluation from Dr. Strasburger and may discuss the supervision with Board staff. Licensee agrees that the case supervisor shall provide a report to the Board each month confirming participation by Licensee and describing the activities. The report is due on or before the fifteenth day of the following month. Licensee is responsible for all expenses associated with the case supervisor. Such supervision shall be conducted for at least two years and Licensee must obtain Board approval in order to terminate this provision. The case supervisor shall notify the Board of

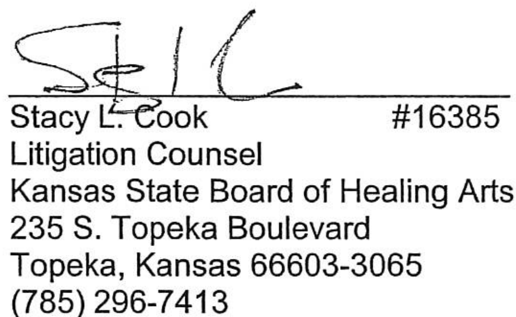
any concerns or recommendations regarding Licensee's practice. Licensee agrees to follow all recommendations of the case supervisor, including any recommendations on the frequency of the meetings. If the Board determines, with the input of the case supervisor, that more intensive work is required, the Board my require case supervision of two times per week for three months.

**IT IS SO ORDERED** on this 10th day of December, 2004

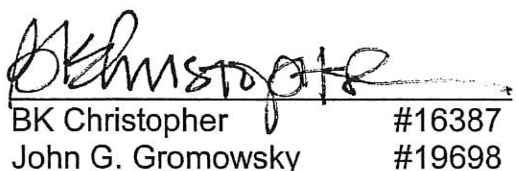
**FOR THE KANSAS STATE BOARD OF HEALING ARTS:**

Lawrence T. Buening, Jr.
Executive Director

**PREPARED AND APPROVED BY:**



Stacy L. Cook #16385
Litigation Counsel
Kansas State Board of Healing Arts
235 S. Topeka Boulevard
Topeka, Kansas 66603-3065
(785) 296-7413



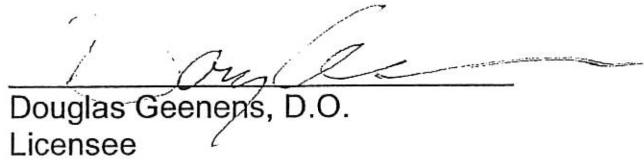
BK Christopher #16387
John G. Gromowsky #19698



4-11

Horn, Aylward & Bandy, LLC
2600 Grand Blvd., Suite 500
Kansas City, Missouri 64108

**AGREED TO BY:**



Douglas Geenens, D.O.
Licensee

December 11

## CERTIFICATION OF SERVICE

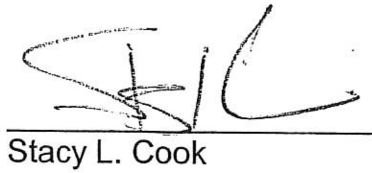
I, Stacy L. Cook, hereby certify that the Consent Order was served this ______ day of ~~November~~, 2004, by ~~depositing the same in the United States mail, postage prepaid~~, ~~and addressed~~ to the following:

hand-delivery

BK Christopher
John G. Gromowsky
Horn, Aylward & Bandy, LLC
2600 Grand Blvd., Suite 500
Kansas City, Missouri 64108

and the original was hand-delivered for filing to:

Lawrence T. Buening, Jr.
Executive Director
Kansas State Board of Healing Arts
235 S. Topeka Boulevard
Topeka, Kansas 66603-3068



Stacy L. Cook



4-13

Geenens

# KANSAS STATE BOARD OF HEALING ARTS
**235 S. Topeka Boulevard**
**Topeka, Kansas 66603-3068**

## BOARD MINUTES - December 11, 2004

**FORMAT OF MINUTES** - Prior to each motion there appears the names of two Board Members in parenthesis. The first made the motion, the latter seconded the motion. Ayes, nays, abstentions and recusals are recorded when requested.

## I. CALL TO ORDER - ROLL CALL

The Kansas State Board of Healing Arts met at the Board Office, 235 S. Topeka Boulevard, Topeka, Kansas on Saturday, December 11, 2004. The meeting was called to order at 8:30 a.m. by Ray Conley, D.C., President.

Vinton Arnett, D.C., present
Ray Conley, D.C., President - present
Gary Counselman, D.C. - present
Frank K. Galbraith, DPM - absent
Merle J. Hodges, M.D. - present
Sue Ice, public member - present
Jana L. Jones, M.D. - absent
Betty McBride, public member - present
Mark A. McCune, M.D. - present
Carol Sader, public member - present
Carolina M. Soria, D.O. - absent
Roger D. Warren, M.D., Vice-President - present
Nancy J. Welsh, M.D. - present
John P. White, D.O. - present
Ronald Whitmer, D.O. - present

Staff members present were Lawrence T. Buening, Jr., Executive Director; Mark Stafford, General Counsel; Stacy Cook, Litigation Counsel; Shelly Wakeman, Disciplinary Counsel; Kelli Benintendi, Associate Counsel; Diane Bellquist, Associate Counsel; Charlene Abbott, Licensing Administrator; Sheryl Snyder, Legal Assistant; and Betty Johnson, Executive Assistant. Also present during portions of the meeting were Judy Janes and Mikel Thomas, M.D., KMS/MAP. Barbara Hoskinson, CSR, Appino and Biggs Reporting Service, took and recorded the administrative proceedings conducted.

## VII. STAFF REPORTS (Continued)

**Executive Director:**

CRIMINAL BACKGROUND CHECKS - (Sader/Ice) Form a committee to study the details and feasibility of the Board doing criminal background checks on applicants and present the findings to the Board in February. Carried.

NOTE: Members of the Criminal Background Check Committee will be Dr. Welsh, Dr. White, Ms. Ice, Ms. McBride, and Ms. Sader.

PHYSICIAN ASSISTANT RULE AND REGULATIONS - The Board directed that the proposed amendments to K.A.R. 100-28a-10 be further considered by the Physician Assistant Council and again reviewed by the Board before starting the adoption process.

KFMC KANSAS HEALTH QUALITY FORUM - The Board gave support as a sponsor of the forum.

## VI. SETTLEMENT AGREEMENTS

(Warren/Ice) Go into closed session pursuant to K.S.A. 75-4318 for the purpose of discussing matters under investigation, which are confidential pursuant to K.S.A. 65-2839a. Carried.

(Galbraith/McCune) Return to regular session. Carried.

JACK DICKSON, D.C. - (Hodges/Counselman) Approve Consent Order as presented. Carried.

DOUGLAS GEENENS, D.O. - (Hodges/Welsh) Approve Consent Order with modification to include a public censure in addition to the other provisions. Carried.

TONY J. FORNELLI, D.P.M. - (Warren/White) Approve Consent Order as presented. Carried.

DIANE MEIER, O.T.A. - (McCune/Welsh) Approve Consent Order as presented. Carried.

DENNIS J. ARTHUR, P.T. - (McCune/Warren) Approve Consent Order as presented. Carried with Ms. Sader recusing herself.

CHARLES W. HASTINGS, M.D. - (Hodges/McBride) Approve Consent Order as presented. Dr. McCune will approve the supervising physician and the CPEP program. Carried.

Geener

# KANSAS STATE BOARD OF HEALING ARTS
235 S. Topeka Boulevard
Topeka, Kansas 66603-3068

## BOARD MINUTES – Saturday
October 20, 2007

FORMAT OF MINUTES – Prior to each motion there appears the names of two Board Members in parenthesis. The first made the motion, the latter seconded the motion. Ayes, nays, abstentions and recusals are recorded when requested.

## SATURDAY, OCTOBER 20, 2007

### I. CALL TO ORDER - ROLL CALL

The Kansas State Board of Healing Arts met at the Board Office, 235 S. Topeka Boulevard, Topeka, Kansas on Saturday, October 20, 2007. The meeting was called to order at 8:30 a.m. by Betty McBride, President.

| | | |
|---|---|---|
| Vinton Arnett, D.C., Vice Pres. - | present | |
| Ray Conley, D.C. - | present | |
| Gary Counselman, D.C. - | present | |
| Michael Beezley, M.D. - | present | |
| Frank K. Galbraith, DPM - | absent | |
| Merle J. Hodges, M.D. - | absent | |
| Sue Ice, public member - | present | |
| M. Myron Leinwetter, D.O. | present | |
| Betty McBride, public member - | present | |
| Mark A. McCune, M.D. - | present | |
| Carol Sader, public member - | absent | |
| Carolina M. Soria, D.O. - | present | arrived at 8:37 |
| Roger D. Warren, M.D. - | present | arrived at approx. 9:00 |
| Nancy J. Welsh, M.D. - | present | |
| Ronald Whitmer, D.O. - | present | |

Staff members present were Lawrence T. Buening, Jr., Executive Director; Mark W. Stafford, General Counsel; Shelly R.Wakeman, Disciplinary Counsel; Kelli J. Stevens, Litigation Counsel; Kathleen Selzler Lippert, Associate Counsel; Dan Riley, Associate Counsel; Katy Lenahan, Licensing Administrator; Cathy Brown, Executive Assistant and Barbara Montgomery, H.R. Manager. The attached sign-in sheet indicates those people who were present during portions of the meeting.

Cameron Gooden, CSR, Appino and Biggs Reporting Service, took and recorded the administrative proceedings conducted.

(Warren/Ice) Go into non-public session to discuss matters closed to the public pursuant to K.S.A. 75-4318 for the purposes of deliberation. Carried with Dr. McCune recusing himself.

(Ice/Conley) Return to open session. Carried.

(Beezley/Conley & Warren) Accept Initial Order as the Final Order of the Board and deny the application for reinstatement. Carried with Dr. McCune recusing himself.

**WENDY L. ESTRELLADO, M.D., DOCKET #08-HA00043** - Conference Hearing on Request for Waiver of Passage of All Steps of USMLE Within 10 Years. Ms. Lenahan presented information before the Board. Dr. Estrellado appeared in person pro se.

(Arnett/Counselman) While applicant did not meet the requirements of K.A.R. 100-7-1 by passing all steps of USMLE within 10 years, she is eligible for license by endorsement under K.S.A. 65-2833 based on Missouri and Pennsylvania licenses. Carried.

**DOUGLAS GEENENS, D.O., DOCKET #05-HA-0036** - Conference Hearing on Request to Terminate Provisions of Consent Order. Ms. Stevens appeared for the Board. Dr. Geenens appeared in person pro se.

(Conley/Warren) Go into closed session pursuant to K.S.A. 75-4318 for the purpose of discussing matters under investigation which are confidential pursuant to K.S.A. 65-2839a. Carried.

(Conley/Warren) Return to open session. Carried.

(McCune/Arnett) To enable staff to obtain additional information as agreed by the parties, continue this matter to the December Board Meeting. Carried.

**VIJENDRA DAVE, M.D., DOCKET #07-HA00052** - Conference Hearing on Request to Terminate Suspension. Ms. Stevens appeared for the Board. Dr. Dave appeared in person pro se.

(Warren/McCune) Go into non-public session to discuss matters closed to the public pursuant to K.S.A. 75-4318 for the purposes of deliberation. Carried.

(Counselman/McCune) Return to open session. Carried.

(McCune/Beezley & Welsh) Request to terminate suspension denied. Dr. Dave is to undergo additional psychiatric evaluation by Heritage Mental Health Clinic or Acumen before coming before the Board again, and at that time he is to submit

Geenens

**KANSAS STATE BOARD OF HEALING ARTS**
**235 S. Topeka Boulevard**
**Topeka, Kansas 66603-3068**

**BOARD MINUTES – Friday and Saturday**
**December 7 and 8, 2007**

FORMAT OF MINUTES – Prior to each motion there appears the names of two Board Members in parenthesis. The first made the motion, the latter seconded the motion. Ayes, nays, abstentions and recusals are recorded when requested.

**FRIDAY, DECEMBER 7, 2006**

## I. CALL TO ORDER - ROLL CALL

The Kansas State Board of Healing Arts met at the Board Office, 235 S. Topeka Boulevard, Topeka, Kansas on Friday, December 7, 2007. The meeting was called to order at 2:00 p.m. by Betty McBride., President.

| | |
|---|---|
| Vinton Arnett, D.C., V.P. - | present |
| Ray Conley, D.C. - | present |
| Gary Counselman, D.C. - | present |
| Michael Beezley, M.D. - | present |
| Frank K. Galbraith, DPM - | present |
| Merle J. Hodges, M.D. - | absent |
| Sue Ice, public member - | present |
| M. Myron Leinwetter, D.O. | present |
| Betty McBride, President | present |
| Mark A. McCune, M.D. - | present |
| Carol Sader, public member - | present |
| Carolina M. Soria, D.O., | absent |
| Roger D. Warren, M.D. - | present |
| Nancy J. Welsh, M.D. - | present |
| Ronald Whitmer, D.O. - | present |

Staff members present were Lawrence T. Buening, Jr., Executive Director; Mark W. Stafford, General Counsel; Shelly R. Wakeman, Disciplinary Counsel; Kelli J. Stevens, Litigation Counsel; Kathleen Selzler Lippert, Associate Counsel; Dan Riley, Associate Counsel; Diane L. Bellquist, Assistant General Counsel; Katy Lenahan, Licensing Administrator; Cathy Brown, Executive Assistant and Barbara Montgomery, H.R. Manager. The attached sign-in sheet indicates those people who were present during portions of the meeting.

## II. APPROVAL OF AGENDA

(Warren/Conley) Approve agenda with the following changes:

Addition of statement from Kathleen Ostrowski at 2:15.
Addition of information on recycling program under Mr. Buening's report

**JAHAN ZEB, M.D., DOCKET #08-HA00062** - Conference Hearing on Request for Licensure by Endorsement. Mr. Riley appeared for the Board. Dr. Zeb appeared before the Board via teleconference.

Applicant graduated from a school that has since been disapproved by the Board. Applicant is licensed in Pennsylvania and Oklahoma.

(Warren/Beezley) Applicant meets the requirements for a license by endorsement and application for licensure is approved. Carried.

**MICHAEL BOLT, M.D., DOCKET #08-HA00010** - Conference Hearing on Petition. Ms. Stevens appeared for the Board. Dr. Bolt did not appear before the Board, and requested a continuance.

By consensus of the Board, this matter was continued and Dr. Warren was appointed as presiding officer.

**DOUGLAS GEENENS, D.O., DOCKET #05-HA-0036** - Conference Hearing on Request to Terminate Provisions of Consent Order. Mr. Riley appeared for the Board. Dr. Geenens did not appear before the Board, and requested a continuance.

By consensus of the Board, this matter was continued.

**IRIS GONZALEZ, M.D., DOCKET #07-HA00005** - Conference Hearing on Request to Terminate Monitoring. Ms. Selzler Lippert appeared for the Board. Dr. Gonzalez appeared before the Board in person pro se.

(Conley/Warren) Terminate limitation on prescribing of controlled substances but have charts randomly audited for the next year and Licensee shall continue to comply with KMS-MAP monitoring contract. Carried.

**GERMAN ZHITLOVSKY, M.D., DOCKET #07-HA00092** - Conference Hearing on Request for Reinstatement. Ms. Stevens appeared for the Board. Dr. Zhitlovsky appeared before the Board with counsel Mr. Robert Gaines.

(Warren/Welsh) Go into non-public session to discuss confidential matters closed to the public pursuant to 75-4318 for the purpose of deliberation. Carried.

(Conley/Warren) Return to open session. Carried.

No motion to stay the order of revocation was made. The existing order stands. Dr. Zhitlovsky was advised to provide a plan that complies with the recommendations in the order before again seeking a stay of the revocation.

John Schroll, M.D.
Complaints/Actions
Since January 2002

| Schroll: CompNum | DateComp Recvd | CaseNum | complainant | patient | CaseOpened | Review Comm. | DP | CaseClosed | comment |
|---|---|---|---|---|---|---|---|---|---|
| | 3/1/2002 | 02-00268 | Petition | patient | 3/11/2002 | 11/17/2003 | NA | 1/28/2004 | soc met |
| | 9/1/2002 | 03-00084 | Petition | patient | 9/16/2002 | 8/18/2003 | NA | 9/24/2003 | soc met |
| | 1/10/2003 | 03-00239 | MMPR | patient | 1/31/2003 | 9/26/2003 | 5/21/2004 | 7/23/2004 | socnotmet-re-opened |
| | 8/4/2003 | 04-00066 | Petition | patient | 8/13/2003 | 11/17/2003 | 5/21/2004 | 7/23/2004 | r/csocnotmet-expertsocmet |
| | 12/4/2003 | 04-00268 | Petition | patient | 12/11/2003 | 1/14/2005 | 12/2/2005 | 12/5/2005 | r/csocnotmet-expert socmet |
| | 3/3/2004 | 04-00390 | Petition | patient | 3/11/2004 | 10/1/2004 | 1/14/2005 | 5/5/2006 | r/csocnotmet-expertsocmet |
| | 4/27/2004 | 04-00476 | Patient | patient | 5/27/2004 | 3/18/2005 | 12/2/2005 | 5/5/2006 | r/csocnotmet-expertsocmet |
| C-00840 | 12/12/2005 | 06-00193 | Pts spouse | patient | 12/15/2005 | 6/2/2006 | 7/26/2005 | Pending | socnotmet |
| C-01276 | 2/6/2006 | 07-00161* | Petition | patient | 10/31/2006 | 9/27/2007 | NA | 11/6/2006 | combined w/07-00011 |
| C-01803 | 5/30/2006 | 07-00011 | Anonymous | several | 7/10/2006 | 9/27/2007 | 10/29/2007 | Pending | |
| C-02275 | 8/14/2006 | 07-00011 | Other profess. | NA | 7/10/2006 | 9/27/2007 | 10/29/2007 | Pending | |
| C-03749 | 6/21/2006 | NA | Renewal form | several | NA | NA | NA | 3/7/2007 | duplicate of prior cases |
| C-05266 | 6/30/2007 | NA | Renewal form | NA | Pending | Pending | Pending | Pending | |

* Closed: duplicates 07-00011

Senate Health Care Strategies
Committee
Date: February 25, 2008
Attachment 5

**BEFORE THE BOARD OF HEALING ARTS**
**OF THE STATE OF KANSAS**

FILED
JAN 3 0 1998
KANSAS STATE BOARD OF
HEALING ARTS

| In the Matter of | ) | |
|---|---|---|
| | ) | |
| JOHN T. SCHROLL, M.D. | ) | Case # 98-00248 |
| | ) | |
| Kansas License #04-17350 | ) | |

**PETITION TO REVOKE, SUSPEND, OR OTHERWISE LIMIT LICENSURE**

COMES NOW, the Kansas State Board of Healing Arts ("Board") by and through its Disciplinary Counsel, Kevin K. LaChance ("Petitioner") and initiates these proceedings under the provisions of K.S.A. 65-2851a and K.S.A. 77-501 *et seq,* and for its cause of action alleges and states:

1. The Board has received certain information, has investigated such information, and has determined there are reasonable grounds to believe John T. Schroll, M.D. ("Licensee") has committed an act or acts in violation of the Kansas Healing Arts Act, K.S.A. 65-2801 *et seq*; K.S.A. 65-2836.

2. Licensee's last known mailing address to the Board is 8901 W. 74th Street, Suite 248, Shawnee Mission, Kansas 66204.

3. Licensee is or has been entitled to engage in the practice of medicine and surgery, having been issued license number 04-17350 on December 9, 1977. At all times relevant to the allegations set forth below, Licensee has held a current license to engage in the practice of medicine and surgery in the State of Kansas, having last renewed his license on June 2, 1997.

4. Since issuance of license, while engaged in a regulated profession as a medical doctor authorized to engage in the practice of the healing arts in the State

of Kansas pursuant to K.S.A. 65-2801 *et seq,* after review by the Board Disciplinary Panel, Licensee did commit the following acts, to wit:

**COUNT 1**

Licensee has committed acts or conduct which violate the provisions of K.S.A. 65-2836(b), dishonorable conduct, in that Licensee has utilized patient treatment encounters for the purpose of selling commercial goods to the patient. Licensee has a personal financial interest in the sales. Licensee has taken advantage of the patient's trust in the doctor-patient relationship to further his commercial venture and personal financial gain under the guise of the provision of health care.

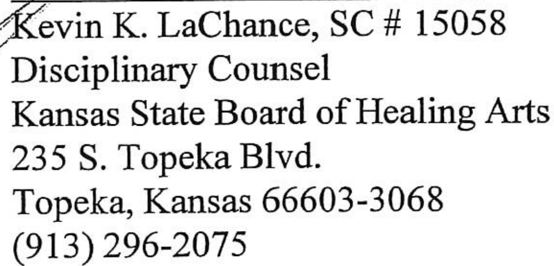
**COUNT 2**

Licensee has committed acts or conduct which violate the provisions of K.S.A. 65-2836(b), unprofessional conduct, as further defined by K.S.A. 65-2837(a)(12), in that Licensee has committed conduct likely to deceive, defraud and/or harm the public. Licensee has utilized patient treatment encounters for the purpose of selling commercial goods to the patient. Licensee has a personal financial interest in the sales. Licensee has taken advantage of the patient's trust in the doctor-patient relationship to further his commercial venture and personal financial gain under the guise of the provision of health care.

**WHEREFORE,** Petitioner prays the Board serve the Licensee with a copy of this Petition as provided by law. Petitioner further prays that upon evidence presented at a hearing before the Board, the Board make findings of fact and conclusions of law that Licensee committed these acts in violation of the Kansas Healing Arts Act, and that the Board take such disciplinary action, assess such

administrative fines and impose such costs against Licensee as it shall deem just and proper and as authorized by law.

Respectfully submitted,



Kevin K. LaChance, SC # 15058
Disciplinary Counsel
Kansas State Board of Healing Arts
235 S. Topeka Blvd.
Topeka, Kansas 66603-3068
(913) 296-2075

**CERTIFICATE OF SERVICE**

I, Kevin K. LaChance, Disciplinary Counsel, Kansas State Board of Healing Arts, do hereby certify that on this 30th day of January, 1998, a true and correct copy of the above **PETITION TO REVOKE, SUSPEND OR OTHERWISE LIMIT LICENSURE** was sent by U.S. mail, first class postage prepaid, to the following:

John T. Schroll, M.D.
8901 W. 74th Street, Suite 248
Shawnee Mission, Kansas 66204

and the original was hand-delivered to:

Mr. Lawrence T. Buening, Jr.
Executive Director
Kansas State Board of Healing Arts
235 S. Topeka Boulevard
Topeka, Kansas 66603-3068

Kevin K. LaChance

FILED
MAY 22 1998
KANSAS STATE BOARD OF
HEALING ARTS

**BEFORE THE BOARD OF HEALING ARTS**
**OF THE STATE OF KANSAS**

**In the Matter of** )
)
**JOHN T. SCHROLL, M.D.** ) **Case No. 98-00248**
**Kansas license no. 04-17350** )
)

# INITIAL ORDER

NOW ON THIS Twenty-fourth Day of April, 1998, comes before the State Board of Healing Arts a Petition to Revoke, Suspend, or Otherwise Limit Licensure of John T. Schroll, M.D. Sitting as Presiding Officer are Donald B. Bletz, M.D., Howard D. Ellis, M.D., Christopher Rodgers, M.D., and Ronald J. Zoeller, D.C. Kevin K. LaChance, Disciplinary Counsel, appears for Petitioner. Respondent John T. Schroll, M.D., appears in person and through Thomas E. Wright, Attorney at Law.

Having the agency record before it, and hearing the evidence and arguments of counsel, the Board makes the following findings of fact, conclusions of law and orders:

1. Respondent is entitled to practice medicine and surgery, having been issued license number 04-17350 on December 9, 1977. He practices gynecology in Shawnee, Kansas.

2. Respondent participates in Amway as a private enterprise separate from his practice of medicine and surgery. As a participant, he is able to make a profit from selling, purchasing or enlisting others to sell or purchase Amway products, the vast majority of which are unrelated to his practice of medine and surgery.

3. On December 1, 1997, Patient K.M. presented to Respondent's office for an annual check-up and to discuss some specific questions regarding her health history. Respondent

5-5

customarily examines patients in the examination room and then discusses the examination in his office. After the examination, Patient K.M. went to Respondent's office to discuss the examination as she had done on previous occasions. The discussion in Respondent's office lasted approximately ten minutes.

4. While in Respondent's office, Patient K.M. expected to discuss her examination and to ask questions. But the conversation immediately turned to Respondent's Amway business. Respondent gave printed information to Patient K.M. offering her the opportunity to participate in his business. He explained different options for participating. Patient K.M. did not feel pressured to join, but she had no interest in the business. Patient K.M. lost interest in the remainder of the conversation. Patient K.M.'s medical questions were not discussed as she had hoped. The Board finds that Respondent exploited Patient K.M. by using the patient visit to further his economic interest rather than address Patient K.M.'s medical issues as reasonably expected.

5. The Board is authorized by K.S.A. 1997 Supp. 65-2836(b) to revoke, suspend, or limit a license to practice the healing arts, or the Board may censure or fine a licensee, upon the finding of unprofessional conduct, dishonorable conduct, or professional incompetence. The Board does not agree with Respondent's argument that since the healing arts act fails to define Respondent's conduct as unprofessional or dishonorable, the Board lacks authority to take disciplinary action. In *Kansas State Board of Healing Arts v. Foote*, 200 Kan. 447 (1968), the Court stated:

> "Considering the entire policy expressed in the [healing arts] act, we believe the legislature, by enumerating certain acts and classifying them as unprofessional conduct, did not thereby intend

> to exclude all other acts or conduct in the practice of the healing arts which by common understanding render the holder of a license unfit to practice. It would be difficult, not to say impractical, in carrying out the purpose of the act, for the legislature to list each and every specific act or course of conduct which might constitute such unprofessional conduct of a disqualifying nature." 228 Kan. at 453.

The Board concludes that exploiting a patient by using the patient visit to further a licensee's own outside economic interest rather than addressing the patient's concerns constitutes unprofessional conduct. In light of this conclusion, the Board finds that Respondent committed an act of unprofessional conduct when he exploited the patient interview, attempting to further his own economic interest rather than address the patient's concerns.

6. In concluding that Respondent committed an act of unprofessional conduct, the Presiding Officer does not conclude that either participating in a multi-level marketing system or selling goods or services to a patient constitutes a *per se* violation of the healing arts act.

7. In this case, there was no serious patient harm, and there is not a history of prior discipline of Respondent. However, Patient K.M. was sufficiently concerned so that she terminated the physician-patient relationship with Respondent. The Board concludes that censure is the appropriate remedy.

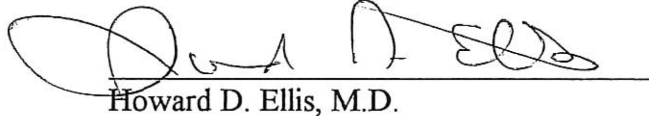
**IT IS, THEREFORE, ORDERED THAT** Respondent is publicly censured.

**PLEASE TAKE NOTICE THAT** this is an Initial Order. An Initial Order becomes effective as a Final Order 30 days after service unless reviewed by the Agency Head. A Petition

for Review may be filed with the Executive Director at 235 S. Topeka Blvd., Topeka, Kansas 6603.

**ENTERED THIS 21 DAY OF MAY, 1998.**

KANSAS STATE BOARD OF HEALING ARTS



Howard D. Ellis, M.D.

**Certificate of Service**

I certify that a copy of the foregoing Initial Order was served this 22nd day of May, 1998 by depositing the same in the United States Mail, first-class postage prepaid, and addressed to:

John T. Schroll, M.D.
89901 W. 74th Street, Ste 248
Shawnee Mission, Kansas 66204

Thomas E. Wright
Attorney at Law
Commerce Bank Bldg., 2nd Floor
100 E. 9th Street
P.O. Box 3555
Topeka, Kansas 66601

and a copy was hand-delivered to:

Kevin K. LaChance
Disciplinary Counsel
235 S. Topeka Blvd.
Topeka, Kansas 66603

FILED
JUN 08 1998
KANSAS STATE BOARD OF
HEALING ARTS

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

| | | |
|---|---|---|
| In the Matter of | ) | |
| | ) | |
| JOHN T. SCHROLL, M.D., | ) | Case No. 98-00248 |
| | ) | |
| Kansas License #04-17350 | ) | |
| | ) | |

Pursuant to K.S.A. Chapter 77

**PETITION FOR REVIEW OF INITIAL ORDER**

COMES NOW John T. Schroll, M.D., and petitions the agency head, Kansas State Board of Healing Arts, to review the Initial Order of presiding officers Donald B. Bletz, M.D., Howard D. Ellis, M.D., Christopher Rodgers, M.D., and Ronald J. Zoeller, D.C., issued May 22, 1998.

The Board of Healing Arts has already issued a Notice of Intent to Review Initial Order and has designated that the issue to be reviewed is whether respondent should be publicly censured. Dr. Schroll files this Petition because he requests that the findings of fact and conclusions of law also be reviewed by the Kansas State Board of Healing Arts.

MEMORANDUM IN SUPPORT OF PETITION

A. Evidence submitted to the presiding officers fail to support certain findings of fact.

Some findings of fact made in the Initial Order are not supported by the evidence in the record of the hearing before the presiding officers on April 22, 1998. Each finding with which Dr. Schroll takes issue will be addressed in this Petition in the order in which they are found in the Initial Order.

5-9

> Finding of Fact #1: "On December 1, 1997, Patient K.M. presented to Respondent's office for an annual check-up <u>and to discuss some specific questions regarding her health history</u>."

The underlined portion of the above statement is not supported in the record. K.M. did not have specific questions when she presented for her annual exam. <u>Transcript</u>, p. 56.

The evidence showed only that K.M. requested a "complete workup of blood and urine analysis", which was done, because of her family history of heart conditions and sugar diabetes. <u>See Transcript of Hearing</u>, p. 56.

> Finding of Fact #2: "While in Respondent's office, Patient K.M. expected to discuss her examination <u>and to ask questions</u>."

This statement is not supported by the evidence.

There is <u>no</u> evidence in this case to indicate 1) that K.M. intended to ask questions, 2) that K.M. asked questions, or 3) that K.M. did not have her questions answered.

The evidence indicates that the standard meeting in Dr. Schroll's office after a patient's medical examination is really more of an opportunity for Dr. Schroll 1) to tell the patient his impressions from the examination, 2) to advise of test results, and 3) to advise what should be done if a problem arose. <u>See Transcript</u>, p. 27 - 28. A typical "discussion" after a medical exam would not involve input from the patient unless the patient has questions. In this case, K.M.'s examination was discussed. <u>See Transcript</u>, p. 28.



5-10

> Finding of Fact #3: "But the conversation <u>immediately</u> turned to Respondent's Amway business."

This finding is not supported by the evidence.

The statement incorrectly implies that Amway was the only topic addressed during the 10-minute meeting that took place after K.M.'s physical examination. The evidence shows that 2 - 4 minutes of this meeting involved only the medical condition of K.M.. <u>Transcript</u>, p. 28, 58. K.M.'s divorce was also discussed. <u>Transcript</u>, pp. 29, 61 - 62. It was only during the remaining portion of the 10-minute meeting that Dr. Schroll told K.M. about the business opportunity available through the Amway Corporation and gave K.M. some written information about the business. <u>Transcript</u>, pp. 29, 61.

> Finding of Fact #4: "Patient K.M.'s medical questions were not discussed as she had hoped."

There is no evidence that K.M. had any questions.

<u>After</u> K.M. left Dr. Schroll's office, she decided that <u>Dr. Schroll</u> should have asked more questions. <u>Transcript</u>, p. 67 - 68. There is no other basis in the record for this finding.

> Finding of Fact #5: "The Board finds that Respondent exploited patient K.M. by using the patient visit to further his economic interest rather than address Patient K.M.'s medical issues as reasonably expected."

There is no factual basis to find that K.M. was "exploited" simply because Dr. Schroll took a few minutes to discuss business.

The statement that Dr. Schroll "used" K.M.'s visit to "further" his economic interest has no basis in the record. K.M. wasn't interested in the business opportunity presented by Dr. Schroll and did not participate in it. Therefore, Dr. Schroll's

economic interest wasn't furthered. If anything, his economic interest was hindered by explaining the business to K.M. rather than spending the same period of time doing something else that might have furthered his economic interest.

The statement that Dr. Schroll didn't address K.M.'s medical issues as "reasonably expected" has no basis in fact.

Dr. Schroll did address K.M.'s medical issues. Whether they were reasonably addressed should be viewed from an objective standard that applies equally to all physicians. Whether K.M. was "happy" and whether Dr. Schroll was able to read her mind do not matter.

B. Evidence submitted to the presiding officers fail to support their conclusion of law.

The presiding officers concluded that Dr. Schroll had committed an act of unprofessional conduct, in violation of K.S.A. 65-2836(b). This conclusion cannot be supported by the evidence.

There is no statute, regulation or policy that prevents Dr. Schroll from participating in an Amway business at the same time that he is practicing medicine. Nor is there a statute, regulation or policy which prevents Dr. Schroll from sharing this business opportunity with another person who also happens to be his patient. Dr. Schroll did not violate K.S.A. 65-2836(b) and he is not subject to discipline.

C. Conclusion.

If the Board of Healing Arts wants to prevent a physician from sharing a legitimate business opportunity, unrelated to his

practice of medicine, with a patient, the Board may pass a regulation. Until it does, an attempt to impose disciplinary action for such conduct is arbitrary and unlawful.

Respectfully Submitted,

WRIGHT, HENSON,
SOMERS, SEBELIUS, CLARK & BAKER, LLP
Commerce Bank Building, 2nd Floor
100 East 9th Street, P.O. Box 3555
Topeka, KS 66601-3555
785/232-2200

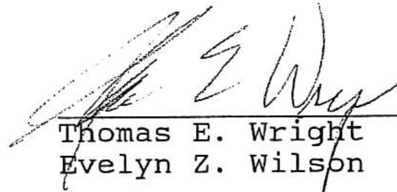
By ______________________________
Thomas E. Wright #06115
Evelyn Z. Wilson #12401
Attorneys for Respondent Robert T. Schroll, M.D.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 8th day of June, 1998, a copy of the above and foregoing document was deposited in the United States mail, postage prepaid, addressed to the following:

Lawrence T. Buening, Jr.
Executive Director
Kansas Board of Healing Arts
235 S. Topeka Blvd.
Topeka KS 66603-3068
785/296-3680

Kevin K. LaChance
Disciplinary Counsel
Kansas Board of Healing Arts
235 S. Topeka Blvd.
Topeka KS 66603-3068



Thomas E. Wright
Evelyn Z. Wilson

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5-14

FILED
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KANSAS STATE BOARD OF HEALING ARTS

**BEFORE THE BOARD OF HEALING ARTS**
**OF THE STATE OF KANSAS**

In the Matter of )
)
John T. Schroll, M.D. ) Docket No. 02-HA-30
Kansas License No.4-17350 )
)

**PETITION TO REVOKE, SUSPEND OR OTHERWISE LIMIT LICENSE**

COMES NOW the Kansas State Board of Healing Arts ("Petitioner"), by and through Stacy L. Cook, Litigation Counsel, and initiates these proceedings pursuant to the provisions of K.S.A. 65-2851a and K.S.A. 77-501 *et seq.* For its cause of action, Petitioner alleges and states:

1. John T. Schroll, M.D.'s ("Licensee") last known mailing address to the Board is 8901 W. 74th, #243, Shawnee Mission, Kansas 66204.

2. Licensee is or has been entitled to engage in the practice of medicine and surgery, having been issued License No. 4-17350 on approximately December 9, 1977. At all times relevant to the allegations set forth in the Petition, Licensee has held a current license to engage in the practice of medicine and surgery, having last renewed his license on May 16, 2001.

3. Since issuance of license, and while engaged in a regulated profession as a medical doctor in the State of Kansas, pursuant to K.S.A. 65-2801 *et seq.*, Licensee did commit the following act(s):

**COUNT ONE**

4. Petitioner incorporates herein by reference paragraphs 1 through 3.

5. On or about April 29, 1997 patient #1 presented to Licensee's office for an annual examination, which was to include a pelvic examination and a pap smear.

6. While patient #1 was disrobed and lying on the examination table, Licensee made an inappropriate sexual comment regarding the patient's vaginal area.

7. Pursuant to K.S.A. 65-2836(b), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has committed an act of unprofessional conduct by making an inappropriate sexual comment during an examination regarding the patient's vaginal area.

8. Pursuant to K.S.A. 65-2836(b), as further defined by K.S.A. 65-2837(b)(16), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has committed an act of sexual misconduct related to Licensee's professional practice.

9. Pursuant to K.S.A. 65-2836(b), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has engaged in an act of dishonorable conduct.

WHEREFORE, Petitioner prays that the Board make findings of fact and conclusions of law that Licensee committed these acts in violation of the Kansas Healing Arts Act, that Licensee's license to practice the healing arts in the State of Kansas be revoked, suspended or otherwise limited, and that the Board assess such administrative fines and impose such costs against Licensee as it shall deem just and proper and as authorized by law.

## COUNT TWO

10. Petitioner incorporates herein by reference paragraphs 1 through 9.

11. On or about December 6, 1992 patient presented to Licensee's office with various gynecologic issues.

12. Licensee performed a pelvic examination and a breast examination on patient #2.

13. While the patient was still in the examination room, Licensee took the patient's hand and inappropriately commented on the patient's appearance.

14. After the examination and while discussing treatment options, Licensee made several inappropriate comments which were sexual in nature and not necessary to any treatment issues. .

15. Pursuant to K.S.A. 65-2836(b), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has committed acts of unprofessional conduct by making unnecessary and inappropriate sexual comments immediately after a pelvic examination and while the patient was seeking treatment from Licensee.

16. Pursuant to K.S.A. 65-2836(b), as further defined by K.S.A. 65-2837(b)(16), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has engaged in an act of sexual misconduct related to Licensee's professional practice, as described above.

17. Pursuant to K.S.A. 65-2836(b), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has committed acts of unprofessional conduct as described above.

WHEREFORE, Petitioner prays that the Board make findings of fact and conclusions of law that Licensee committed these acts in violation of the Kansas Healing Arts Act, that Licensee's license to practice the healing arts in the State of Kansas be revoked, suspended or otherwise limited, and that the Board assess such administrative fines and impose such costs against Licensee as it shall deem just and proper and as authorized by law.

**COUNT THREE**

18. Petitioner incorporates herein by reference paragraphs 1 through 17.

19. From approximately May 17, 2001 through November 8, 2001, Licensee provided prenatal care to patient #3 during her pregnancy.

20. During various prenatal visits, Licensee made inappropriate comments about patient #3's appearance, including statements to the effect of "you are so beautiful" and you have the "nicest body."

21. On approximately November 8, 2001, patient #3 presented for a post-partum exam.

22. During the visit, Licensee touched patient #3's breasts in an inappropriate manner.

23. Licensee also made an inappropriate comment about the size of patient #3's breasts.

24. Pursuant to K.S.A. 65-2836(b), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has committed acts of unprofessional conduct by making inappropriate sexual comments and by inappropriately touching the patient while the patient was seeking treatment from Licensee.

25. Pursuant to K.S.A. 65-2836(b), as further defined by K.S.A. 65-2837(b)(16), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has engaged in an act of sexual misconduct related to the Licensee's professional practice, as described above.

26. Pursuant to K.S.A. 65-2836(b), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has committed acts of unprofessional conduct as described above.

WHEREFORE, Petitioner prays that the Board make findings of fact and conclusions of law that Licensee committed these acts in violation of the Kansas Healing Arts Act, that Licensee's license to practice the healing arts in the State of Kansas be revoked, suspended or otherwise limited, and that the Board assess such administrative fines and impose such costs against Licensee as it shall deem just and proper and as authorized by law.

Respectfully submitted,

Stacy L. Cook #16385
Litigation Counsel
Kelli Benintendi #16032
Associate Counsel
Kansas State Board of Healing Arts
235 S. Topeka Boulevard
Topeka, Kansas 66603
Telephone (785) 296-7413

## CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing PETITION TO REVOKE, SUSPEND OR OTHERWISE LIMIT LICENSE was served on the 7th day of December, 2001 by United States mail, first-class postage prepaid and addressed to:

John T. Schroll, M.D.
8901 W. 74th, #248
Shawnee Mission, Kansas 66204

and the original was hand-delivered to:

Lawrence T. Buening, Jr.
Executive Director
235 S. Topeka Boulevard
Topeka, Kansas 66603-3068

Stacy L. Cook

FILED
JAN 15 2002
KANSAS STATE BOARD OF
HEALING ARTS

**BEFORE THE BOARD OF HEALING ARTS**
**OF THE STATE OF KANSAS**

| | | |
|---|---|---|
| In the Matter of | ) | |
| | ) | |
| John T. Schroll, M.D. | ) | Docket No. 02-HA-30 |
| Kansas License No.4-17350 | ) | |
| | ) | |

**FIRST AMENDED**
**PETITION TO REVOKE, SUSPEND OR OTHERWISE LIMIT LICENSE**

COMES NOW the Kansas State Board of Healing Arts ("Petitioner"), by and through Stacy L. Cook, Litigation Counsel, and for its First Amended Petition to Revoke, Suspend or Otherwise Limit License, alleges and states:

1. John T. Schroll, M.D.'s ("Licensee") last known mailing address to the Board is 8901 W. 74th, #243, Shawnee Mission, Kansas 66204.

2. Licensee is or has been entitled to engage in the practice of medicine and surgery, having been issued License No. 4-17350 on approximately December 9, 1977. At all times relevant to the allegations set forth in the Petition, Licensee has held a current license to engage in the practice of medicine and surgery, having last renewed his license on May 16, 2001.

3. Since issuance of license, and while engaged in a regulated profession as a medical doctor in the State of Kansas, pursuant to K.S.A. 65-2801 *et seq.*, Licensee did commit the following act(s):

**COUNT ONE**

4. Petitioner incorporates herein by reference paragraphs 1 through 3.



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5. On or about April 29, 1997 patient #1 presented to Licensee's office for an annual examination, which was to include a pelvic examination and a pap smear.

6. While patient #1 was disrobed and lying on the examination table, Licensee made an inappropriate sexual comment regarding the patient's vaginal area.

7. Pursuant to K.S.A. 65-2836(b), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has committed an act of unprofessional conduct by making an inappropriate sexual comment during an examination regarding the patient's vaginal area.

8. Pursuant to K.S.A. 65-2836(b), as further defined by K.S.A. 65-2837(b)(16), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has committed an act of sexual misconduct related to Licensee's professional practice.

9. Pursuant to K.S.A. 65-2836(b), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has engaged in an act of dishonorable conduct.

WHEREFORE, Petitioner prays that the Board make findings of fact and conclusions of law that Licensee committed these acts in violation of the Kansas Healing Arts Act, that Licensee's license to practice the healing arts in the State of Kansas be revoked, suspended or otherwise limited, and that the Board assess such administrative fines and impose such costs against Licensee as it shall deem just and proper and as authorized by law.

**COUNT TWO**

10. Petitioner incorporates herein by reference paragraphs 1 through 9.

11. On or about December 6, 1999, patient presented to Licensee's office with various gynecologic issues.

12. Licensee performed a pelvic examination and a breast examination on patient #2.

13. While the patient was still in the examination room, Licensee took the patient's hand and inappropriately commented on the patient's appearance.

14. After the examination and while discussing treatment options, Licensee made several inappropriate comments which were sexual in nature and not necessary to any treatment issues.

15. Pursuant to K.S.A. 65-2836(b), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has committed acts of unprofessional conduct by making unnecessary and inappropriate sexual comments immediately after a pelvic examination and while the patient was seeking treatment from Licensee.

16. Pursuant to K.S.A. 65-2836(b), as further defined by K.S.A. 65-2837(b)(16), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has engaged in an act of sexual misconduct related to Licensee's professional practice, as described above.

17. Pursuant to K.S.A. 65-2836(b), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has committed acts of dishonorable conduct as described above.

WHEREFORE, Petitioner prays that the Board make findings of fact and conclusions of law that Licensee committed these acts in violation of the Kansas Healing Arts Act, that Licensee's license to practice the healing arts in the State of Kansas be revoked, suspended or otherwise limited, and that the Board assess such administrative fines and impose such costs against Licensee as it shall deem just and proper and as authorized by law.

**COUNT THREE**

18. Petitioner incorporates herein by reference paragraphs 1 through 17.

19. From approximately May 17, 2001 through November 8, 2001, Licensee provided prenatal care to patient #3 during her pregnancy.

20. During various prenatal visits, Licensee made inappropriate comments about patient #3's appearance, including statements to the effect of "you are so beautiful" and you have the "nicest body."

21. On approximately November 8, 2001, patient #3 presented for a post-partum exam.

22. During the visit, Licensee touched patient #3's breasts in an inappropriate manner.

23. Licensee also made an inappropriate comment about the size of patient #3's breasts.

24. Pursuant to K.S.A. 65-2836(b), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has committed acts of unprofessional conduct by making inappropriate sexual comments and by inappropriately touching the patient while the patient was seeking treatment from Licensee.

25. Pursuant to K.S.A. 65-2836(b), as further defined by K.S.A. 65-2837(b)(16), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has engaged in an act of sexual misconduct related to the Licensee's professional practice, as described above.

26. Pursuant to K.S.A. 65-2836(b), the Board may revoke, suspend or otherwise limit Licensee's license in that Licensee has committed acts of dishonorable conduct as described above.

WHEREFORE, Petitioner prays that the Board make findings of fact and conclusions of law that Licensee committed these acts in violation of the Kansas Healing Arts Act, that Licensee's license to practice the healing arts in the State of Kansas be revoked, suspended or otherwise limited, and that the Board assess such administrative fines and impose such costs against Licensee as it shall deem just and proper and as authorized by law.

Respectfully submitted,

Stacy L. Cook #16385
Litigation Counsel
Kelli Benintendi #16032
Associate Counsel
Kansas State Board of Healing Arts
235 S. Topeka Boulevard
Topeka, Kansas 66603
Telephone (785) 296-7413

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the foregoing FIRST AMENDED PETITION TO REVOKE, SUSPEND OR OTHERWISE LIMIT LICENSE was served on the 15th day of January, 2002 by United States mail, first-class postage prepaid and addressed to:

John T. Schroll, M.D.
8901 W. 74th, #248
Shawnee Mission, Kansas 66204

Thomas E. Wright
Evelyn V. Wilson
Wright, Henson, Somers, Sebelius, Clark & Baker, LLP
2nd Floor, 100 SE 9th Street
P.O. Box 3555
Topeka, Kansas 66601-3555

and the original was hand-delivered to:

Lawrence T. Buening, Jr.
Executive Director
235 S. Topeka Boulevard
Topeka, Kansas 66603-3068

Stacy L. Cook

FILED
JUL 11 2002
KANSAS STATE BOARD OF HEALING ARTS

**BEFORE THE BOARD OF HEALING ARTS**
**OF THE STATE OF KANSAS**

| | | |
|---|---|---|
| **In the Matter of** | ) | |
| | ) | |
| **JOHN T. SCHROLL, M.D.** | ) | **Docket No. 02-HA-30** |
| **Kansas License No. 4-17350** | ) | |
| | ) | |

**INITIAL ORDER**

NOW ON THIS twenty-fourth Day of April 2002 this matter comes on for hearing. Stacy L. Cook, Litigation Counsel, and Kelli J. Benintendi, Associate Counsel, appear for Petitioner. Thomas E. Wright and Evelyn Z. Wilson, of Wright, Henson, Somers, Sebelius, Clark & Baker, LLP appear for Respondent John T. Schroll, M.D.

Petitioner presents witnesses and exhibits, and the matter is recessed. The hearing recommences on the twenty-fifth Day of April. Petitioner presents witnesses and exhibits, and Petitioner rests. Respondent presents witnesses and exhibits, and the matter is recessed. The hearing recommences on the twenty-sixth Day of April. Respondent presents witnesses and exhibits, and Respondent rests. Counsel present closing arguments and the matter is recessed.

After hearing the testimony of the witnesses and the arguments of counsel, and having the agency record before her, the Presiding Officer finds, concludes and orders as follows:

1. Respondent is licensed to practice medicine and surgery in the State of Kansas. He is certified by the American Board of Obstetrics and Gynecology and practices in that specialty.

2. On December 6, 1999, Patient T.K. presented to Respondent's office. She had been referred to Respondent by her primary care physician to discuss mild dyspareunia symptoms.

5-26

3. During the examination and discussion that followed, Respondent made statements to Patient T.K. that caused the patient to file a written complaint with the Board. Respondent denies that he made these statements in the manner alleged. Patient T.K. testified regarding her visit to Respondent's office. The Presiding Officer finds her testimony clear and persuasive.

4. Respondent commented to Patient T.K. during the examination that she had beautiful eyes, and stated that after looking at "hips, butts, boobs and vaginas all day, it was the eyes that did it" for him. This statement was made while Respondent held the patient's hand.

5. Respondent and Patient T.K. discussed the physical examination in Respondent's office following the examination. Respondent recommended a hysterectomy. Respondent told Patient T.K. that after the surgery she would be able to have sex in every position and that her husband would enjoy it.

6. The Presiding Officer finds that Respondent did not intend to invite the patient into a sexual relationship by the comments or by holding her hand. Further, the Presiding Officer concludes that these comments and holding of the patient's hand do not constitute sexual abuse, misconduct or exploitation. But these comments were considered inappropriate by the patient. While some familiarity in communication between the physician and patient is acceptable, a patient does legitimately expect a physician to have a professional demeanor and a clinical level of communication with the patient, particularly when discussing the patient's anatomy or treatment. This is especially true in the relationship between a patient and an obstetrician. That relationship involves intimacy in the physical examination, and it involves discussion of private information about which the patient might be shy or embarrassed.

7. The Presiding Officer concludes that when Respondent used nonprofessional terms

to refer to body parts, and when he told the patient what is personally attractive to him while holding her hand, Respondent should have realized that the patient would question whether the visit is a clinical experience for the patient or a personal experience for the physician.

8. The Presiding Officer further concludes that it was not inappropriate for Respondent to tell the patient she could have intercourse in every position following a hysterectomy. But when Respondent added that the patient's husband would enjoy the sexual experience, he should realize that his statement creates confusion for the patient in understanding whether the procedure is for the patient's medical benefit or for her husband's enjoyment.

9. On November 8, 2001, Patient E.M. presented to Respondent's office for a postpartum visit. After the pelvic exam, Respondent and the patient were discussing birth control, and Respondent observed that Patient E.M.'s bra did not fit properly. The patient was wearing a shirt at the time. Respondent lifted the patient's shirt and adjusted the bra to tuck her breasts back into the bra. While he did touch the patient's breasts, Respondent did not fondle her breasts. These facts are not in dispute.

10. Respondent suggests that there was a medical purpose for adjusting the clothing of this patient. However, the precise medical purpose is not clear from the record, and the incident is not documented in the patient record.

11. A female medical student was present in the examination room with Patient E.M., and the student witnessed Respondent adjusting the patient's clothing. The student testified that she was surprised by Respondent's actions, and observed that the patient was also surprised.

12. Respondent did not ask Patient E.M. for permission to lift her shirt or to touch her clothing or her breasts, and he did not tell the patient in advance what he was doing. Respondent

did comment while he was adjusting the bra that the bra did not fit correctly.

13. The Presiding Officer finds and concludes that when Respondent touched the breasts of Patient E.M. he did not do so for his own pleasure, or that he engaged in sexual abuse, misconduct or exploitation. However, the Presiding Officer does find that Respondent confused the boundaries of the professional relationship by adjusting the patient's bra and touching the patient's breasts without first asking for the patient's permission to do so, or without explaining in advance the clinical nature of what he was about to do.

14. The Presiding Officer finds and concludes that Respondent failed to observe appropriate professional boundaries with two patients. Those failures include making inappropriate comments, even though possibly in jest, and in unauthorized touching. Dr. Bates's testimony emphasized the importance of those boundaries, and the result when the boundaries are violated. As a policy matter, the Presiding Officer finds that for the effective practice of medicine, a patient often must allow a physician to discuss matters or to touch the patient in a manner that the patient would not allow others to do as a matter of personal privacy. But when the physician makes statements or engages in conduct that crosses that personal boundary and the clinical purpose is not clear, the patient can be expected to be embarrassed, to be confused about the nature of the relationship, or even to lose trust in the professional relationship. Patients must be protected from this type of harm.

15. In mitigation, Respondent did not engage in the conduct for his own sexual gratification.

16. The Board may issue a disciplinary order upon the finding that a licensee has engaged in unprofessional, incompetent, or dishonorable conduct. The Kansas Supreme Court has

established that the Legislature did not intend an exhaustive list of actions that constitute unprofessional or dishonorable conduct when it enacted K.S.A. 65-2837. The Presiding Officer concludes boundary violations such as those committed by Respondent constitute unprofessional or dishonorable conduct.

17. Disciplinary action authorized by statute includes revocation, suspension, or limitation of a license, or censure or fine of a licensee. In light of the mitigating circumstances found above, the Presiding Officer orders that Respondent be fined $1000, and that he pay the costs of the disciplinary proceeding.

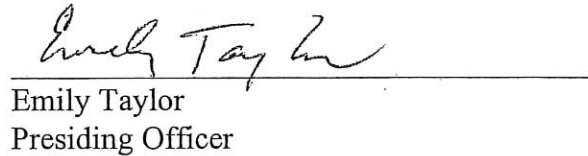
**IT IS, THEREFORE, ORDERED** that Respondent is fined $1000, and that he pay the costs of the proceeding as allowed by statute.

**PLEASE TAKE NOTICE** that this is an Initial Order. A party to an agency proceeding may seek review of an Initial Order by filing a petition for review within 15 days following service of the Initial Order. Any such petition must be filed with the Executive Director at 235 S. Topeka Blvd., Topeka, KS 66603.

**PLEASE TAKE FURTHER NOTICE** that Board will, on its own motion, review this Initial Order at its regularly scheduled meeting, August 17, 2002 at 10:30 a.m. or as soon thereafter as the matter can be heard, and at the conclusion of the review issue a Final Order. Upon conducting review, the Board may exercise all of the decision making authority as if it had heard the matter itself. Any party may file a brief with the Board's Executive Director on or before August 2, 2002.

No further notice of hearing will be given.

**Dated this 10th day of July 2002.**



Emily Taylor
Presiding Officer

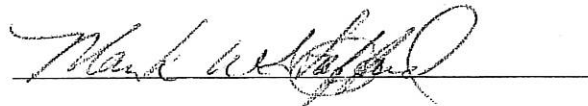
**Certificate of Service**

I certify that a true copy of the foregoing Order was served this 14th day of July 2002 by depositing the same in the United States Mail, first-class postage prepaid, and addressed to:

Thomas E. Wright
Evelyn Z. Wilson
Wright, Henson, Somers, Sebelius, Clark & Baker, LLP
2nd Floor, 100 SE 9th Street
P.O. Box 3555
Topeka, Kansas 66601-3555

and a copy was hand-delivered to the office of:

Stacy L. Cook
Kelli J. Benintendi
235 S. Topeka Blvd.
Topeka, Kansas 66603



FILED
JUL 26 2002
KANSAS STATE BOARD OF HEALING ARTS

**BEFORE THE BOARD OF HEALING ARTS**
**OF THE STATE OF KANSAS**

In the Matter of )
) Docket No. 02-HA-30
**JOHN T. SCHROLL, M.D.,** )
Kansas Licence No. 4-17350 )
)

## PETITIONER'S PETITION FOR REVIEW OF INITIAL ORDER

**COMES NOW** the Petitioner, by and through Stacy L. Cook, Litigation Counsel, and Kelli J. Benintendi, Associate Counsel, and pursuant to K.S.A. 77-527, requests that the Board review the Initial Order filed July 11, 2002. Petitioner requests the Board adopt the findings of fact and conclusions of law in the Initial Order and modify the disciplinary provisions of the Initial Order to include an additional order that Licensee be required to attend and successfully complete a course on boundary violations.

### I. The Findings of Fact and Conclusions of Law Should Be Adopted in the Final Order.

In the Initial Order, the Presiding Officer found that Respondent made inappropriate sexual comments to Patient T.K. and touched Patient E.M.'s breasts without asking her permission or telling her what he was doing. Both patients testified at the formal hearing. Respondent also testified about his recollection of the events which took place with both patients. The Presiding Officer found Respondent failed to observe appropriate professional boundaries. The Presiding Officer further concluded that Respondent's boundary violations with the two patients constitutes unprofessional or dishonorable conduct.

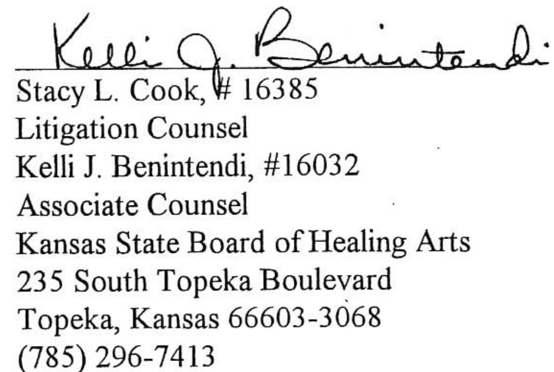
The findings of fact and conclusions of law contained in the Initial Order should be adopted by the Board in the Final Order.

## II. Respondent Should Be Ordered to Attend and Successfully Complete a Course on Boundary Violations.

The Initial Order imposes a fine of $1,000 against Respondent and orders that he pay the costs of the disciplinary proceedings. This is the second disciplinary proceeding against Respondent. The first proceeding was in 1998 and involved Respondent's solicitation of a patient to join his personal business venture. Respondent was fined $5,000 in the first proceeding. Both of these actions involve Respondent's inappropriate conduct with patients. As such, the Board should impose an additional remedial provision in the Final Order which orders Respondent to attend and successfully complete a boundary violations course to directly address Respondent's conduct with patients.

**WHEREFORE,** Petitioner prays the Board adopt the findings of fact and conclusions of law in the Initial Order in this matter. Petitioner prays the Board modify the Initial Order to impose further discipline in the form of an order that Licensee attend and successfully complete a course on boundary violations and for such additional relief as the Board deems just and proper in the circumstances.

Respectfully submitted,



Stacy L. Cook, # 16385
Litigation Counsel
Kelli J. Benintendi, #16032
Associate Counsel
Kansas State Board of Healing Arts
235 South Topeka Boulevard
Topeka, Kansas 66603-3068
(785) 296-7413

## CERTIFICATE OF SERVICE

I, Kelli J. Benintendi, Litigation Counsel, Kansas State Board of Healing Arts, hereby certify that I served a copy of the above **Petitioner's Petition for Review of Initial Order** by depositing the same in the U.S. mail, postage prepaid, on this the 26th day of July, 2002, to:

Thomas E. Wright
Evelyn Z. Wilson
WRIGHT, HENSON, SOMERS, SEBELIUS
CLARK & BAKER, L.L.P.
P.O. Box 3555
Topeka, Kansas 66601-3555

and the original was hand-delivered to:

Lawrence T. Buening, Jr.
Executive Director
Kansas State Board of Healing Arts
235 South Topeka Boulevard
Topeka, Kansas 66603-3068

Kelli J. Benintendi

**BEFORE THE BOARD OF HEALING ARTS**
**OF THE STATE OF KANSAS**

FILED
AUG 22 2002
KANSAS STATE BOARD OF HEALING ARTS

| | | |
|---|---|---|
| **In the Matter of** | ) | |
| | ) | |
| **JOHN T. SCHROLL, M.D.** | ) | **Docket No. 02-HA-30** |
| **Kansas License No. 4-17350** | ) | |
| | ) | |

## FINAL ORDER

NOW ON THIS Seventeenth Day of August 2002, this matter comes before the Board for review of the Initial Order issued July 11, 2002. Stacy L. Cook, Litigation Counsel, appears for Petitioner. Respondent John T. Schroll, M.D. appears in person and through Thomas E. Wright of Wright, Henson, Somers, Sebelius, Clark & Baker, LLP.

After hearing the arguments of counsel and the statement of Respondent, and having the record of the hearing before it, the Board adopts Paragraphs 1-17 of the Initial Order as the findings and conclusions of the Board. Those findings and conclusions are as follows:

1. Respondent is licensed to practice medicine and surgery in the State of Kansas. He is certified by the American Board of Obstetrics and Gynecology and practices in that specialty.

2. On December 6, 1999, Patient T.K. presented to Respondent's office. She had been referred to Respondent by her primary care physician to discuss mild dyspareunia symptoms.

3. During the examination and discussion that followed, Respondent made statements to Patient T.K. that caused the patient to file a written complaint with the Board. Respondent denies that he made these statements in the manner alleged. Patient T.K. testified regarding her visit to Respondent's office. The Presiding Officer finds her testimony clear and persuasive.

4. Respondent commented to Patient T.K. during the examination that she had beautiful eyes, and stated that after looking at "hips, butts, boobs and vaginas all day, it was the eyes that did it" for him. This statement was made while Respondent held the patient's hand.

5. Respondent and Patient T.K. discussed the physical examination in Respondent's office following the examination. Respondent recommended a hysterectomy. Respondent told Patient T.K. that after the surgery she would be able to have sex in every position and that her husband would enjoy it.

6. The Presiding Officer finds that Respondent did not intend to invite the patient into a sexual relationship by the comments or by holding her hand. Further, the Presiding Officer concludes that these comments and holding of the patient's hand do not constitute sexual abuse, misconduct or exploitation. But these comments were considered inappropriate by the patient. While some familiarity in communication between the physician and patient is acceptable, a patient does legitimately expect a physician to have a professional demeanor and a clinical level of communication with the patient, particularly when discussing the patient's anatomy or treatment. This is especially true in the relationship between a patient and an obstetrician. That relationship involves intimacy in the physical examination, and it involves discussion of private information about which the patient might be shy or embarrassed.

7. The Presiding Officer concludes that when Respondent used nonprofessional terms to refer to body parts, and when he told the patient what is personally attractive to him while holding her hand, Respondent should have realized that the patient would question whether the visit is a clinical experience for the patient or a personal experience for the physician.

8. The Presiding Officer further concludes that it was not inappropriate for Respondent

to tell the patient she could have intercourse in every position following a hysterectomy. But when Respondent added that the patient's husband would enjoy the sexual experience, he should realize that his statement creates confusion for the patient in understanding whether the procedure is for the patient's medical benefit or for her husband's enjoyment.

9. On November 8, 2001, Patient E.M. presented to Respondent's office for a postpartum visit. After the pelvic exam, Respondent and the patient were discussing birth control, and Respondent observed that Patient E.M.'s bra did not fit properly. The patient was wearing a shirt at the time. Respondent lifted the patient's shirt and adjusted the bra to tuck her breasts back into the bra. While he did touch the patient's breasts, Respondent did not fondle her breasts. These facts are not in dispute.

10. Respondent suggests that there was a medical purpose for adjusting the clothing of this patient. However, the precise medical purpose is not clear from the record, and the incident is not documented in the patient record.

11. A female medical student was present in the examination room with Patient E.M., and the student witnessed Respondent adjusting the patient's clothing. The student testified that she was surprised by Respondent's actions, and observed that the patient was also surprised.

12. Respondent did not ask Patient E.M. for permission to lift her shirt or to touch her clothing or her breasts, and he did not tell the patient in advance what he was doing. Respondent did comment while he was adjusting the bra that the bra did not fit correctly.

13. The Presiding Officer finds and concludes that when Respondent touched the breasts of Patient E.M. he did not do so for his own pleasure, or that he engaged in sexual abuse, misconduct or exploitation. However, the Presiding Officer does find that Respondent confused the

boundaries of the professional relationship by adjusting the patient's bra and touching the patient's breasts without first asking for the patient's permission to do so, or without explaining in advance the clinical nature of what he was about to do.

14. The Presiding Officer finds and concludes that Respondent failed to observe appropriate professional boundaries with two patients. Those failures include making inappropriate comments, even though possibly in jest, and in unauthorized touching. Dr. Bates's testimony emphasized the importance of those boundaries, and the result when the boundaries are violated. As a policy matter, the Presiding Officer finds that for the effective practice of medicine, a patient often must allow a physician to discuss matters or to touch the patient in a manner that the patient would not allow others to do as a matter of personal privacy. But when the physician makes statements or engages in conduct that crosses that personal boundary and the clinical purpose is not clear, the patient can be expected to be embarrassed, to be confused about the nature of the relationship, or even to lose trust in the professional relationship. Patients must be protected from this type of harm.

15. In mitigation, Respondent did not engage in the conduct for his own sexual gratification.

16. The Board may issue a disciplinary order upon the finding that a licensee has engaged in unprofessional, incompetent, or dishonorable conduct. The Kansas Supreme Court has established that the Legislature did not intend an exhaustive list of actions that constitute unprofessional or dishonorable conduct when it enacted K.S.A. 65-2837. The Presiding Officer concludes boundary violations such as those committed by Respondent constitute unprofessional or dishonorable conduct.

17. Disciplinary action authorized by statute includes revocation, suspension, or limitation of a license, or censure or fine of a licensee. In light of the mitigating circumstances found above, the Presiding Officer orders that Respondent be fined $1000, and that he pay the costs of the disciplinary proceeding.

The Board further finds as follows:

18. Based upon the hearing record as a whole, and based upon prior agency action involving Respondent's failure to observe a proper boundary between himself and a patient when he attempted to engage in a business transaction with that patient, the Board finds that Respondent's license should be limited with a requirement that Respondent attend a Board-approved course in professional boundaries. For purposes of this order, the Board hereby approves the program entitled Professional Renewal Medicine through Ethics, offered September 20-22, 2002 by the Robert Wood Johnson Medical School, University of Medicine and Dentistry of New Jersey.

19. The Board further concludes that the limitation imposed by this order does not reduce the scope of practice or the authority of Respondent to engage in the healing arts, and thus shall not be reported as a limitation upon Respondent's license. The Board further concludes that this order is an open public record.

20. The Board finds that Petitioner's motion for assessment of costs should be considered separately to allow Respondent time to file a written response. The motion shall be heard by Presiding Officer Emily Taylor, who is hereby authorized to issue a Final Order on that motion. Any party may seek reconsideration of that Final Order before the Board.

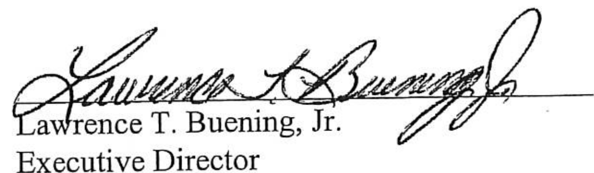
**IT IS, THEREFORE, ORDERED** that Respondent is fined $1000, and that he pay the costs of the proceeding as allowed by statute.

**IT IS FURTHER ORDERED** that Respondent attend a course on professional boundaries as approved by the Board.

**IT IS FURTHER ORDERED** that Emily Taylor is appointed as Presiding Officer and authorized to issue a Final Order on Petitioner's motion for assessment of costs.

**PLEASE TAKE NOTICE** that this is a Final Order. A Final Order is effective upon service. A party to an agency proceeding may seek judicial review of a Final Order by filing a petition in the District Court as authorized by K.S.A. 77-610, et seq. Reconsideration of the Final Order is not a prerequisite to judicial review. A petition for judicial review is not timely unless filed within 30 days following service of the Final Order. A copy of any petition for judicial review must be served upon the Board's executive director at 235 S. Topeka Blvd., Topeka, KS 66603.

**Dated this 22d day of August 2002.**



Lawrence T. Buening, Jr.
Executive Director



5-40

**Certificate of Service**

I certify that a true copy of the foregoing Order was served this 22nd day of August 2002 by depositing the same in the United States Mail, first-class postage prepaid, and addressed to:

Thomas E. Wright
Evelyn Z. Wilson
Wright, Henson, Somers, Sebelius, Clark & Baker, LLP
2nd Floor, 100 SE 9th Street
P.O. Box 3555
Topeka, Kansas 66601-3555

and a copy was hand-delivered to the office of:

Stacy L. Cook
Kelli J. Benintendi
235 S. Topeka Blvd.
Topeka, Kansas 66603

IN THE DISTRICT COURT OF JOHNSON COUNTY, KANSAS

ANGELA CADY,
11720 S. Shannon Street
Olathe, KS 66062

Plaintiff,

v.

JOHN SCHROLL, M.D. 73829
Serve at: 8901 West 74th Street, Suite 228
Shawnee Mission, KS 66204

WOMEN'S CARE, P.A. 73828
Serve: Resident Agent
Robert J. Danner
8901 W. 74th Street, Suite 248
Shawnee Mission, KS 66204

CRISTINE CARRIKER, M.D. 12749
Serve at: 8901 West 74th Street, Suite 248
Shawnee Mission, KS 66204

MAUREEN KING, M.D. 77383
Serve at: 8901 West 74th Street, Suite 248
Shawnee Mission, KS 66204

MICHAEL MAGEE, M.D. 50674
Serve at: 8901 West 74th Street, Suite 248
Shawnee Mission, KS 66204

JULIE MARTIN, M.D. 51588
Serve at: 8901 West 74th Street, Suite 248
Shawnee Mission, KS 66204

BRENDAN MITCHELL, M.D. 56626
Serve at: 8901 West 74th Street, Suite 248
Shawnee Mission, KS 66204

ANGELA PIQUARD, M.D. 65036
Serve at: 8901 West 74th Street, Suite 248
Shawnee Mission, KS 66204

and

Case No.: 06 CV 00095

Division No.: 7

07-00141 is closed. It is a dup. of 07-00011

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IN THE DISTRICT COURT OF WYANDOTTE COUNTY, KANSAS
CIVIL DEPARTMENT

| | |
|---|---|
| SANDRA GONZALEZ, Plaintiff, | 02-00268 |
| vs. | No. |
| 5710 | Cou |
| SCOTT A. MONTGOMERY, M.D., | Chapter 60 |
| and JOHN T. SCHROLL, M.D., 13829 | |
| Defendants. | |

PETITION

**Count I: Medical Negligence**

Comes now Plaintiff Sandra Gonzalez, by and through her counsel, and for her Count I claim against Defendants Scott A. Montgomery, M.D., and John T. Schroll, M.D., alleges:

1. Plaintiff Sandra Gonzalez ("Mrs. Gonzalez") is a resident of Wyandotte County, Kansas.

2. At all times relevant to this litigation, Defendant Scott A. Montgomery, M.D. ("Dr. Montgomery"), has been a physician engaged in the practice of medicine in Wyandotte and Johnson County, Kansas, and has held himself out to be a skilled and competent physician.

3. At all times relevant to this litigation, Defendant John T. Schroll,

03-00084

IN THE DISTRICT COURT OF JOHNSON COUNTY
CIVIL DIVISION

| | | |
|---|---|---|
| LAURA COOK, | ) | |
| Plaintiff, | ) | 02CV02424 |
| vs. | ) | No. ____ |
| | ) | Division: 4 |
| JOHN T. SCHROLL, M.D., | ) | |
| | ) | Chapter 60 |
| and | ) | |
| WOMEN'S CARE, P.A., | ) | |
| Defendants. | ) | |

**PETITION**
**COUNT I**
**(Claim of Medical Negligence)**

COMES NOW the plaintiff, Laura Cook, and for her cause of action in Count I of this Petition against defendant John T. Schroll, M.D., alleges and states as follows:

1. That this case was originally filed on July 2, 2001, in the District Court of Johnson County, Kansas as case number 01C4223 and was voluntarily dismissed without prejudice by stipulation against defendants pursuant to K.S.A. 60-241 on or about October 18, 2001, and pursuant to K.S.A. 60.518, is hereby re-filed within six months.

2. Plaintiff Laura Cook is a resident of the State of Kansas, residing in Olathe, Johnson County, Kansas

3. Defendant John T. Schroll, M.D. (hereinafter "defendant Schroll") is an individual, and at all times relevant hereto, practiced medicine within Johnson County, Kansas and may served at 401 S. Clairborne Road, Olathe, Kansas 66062.

4. Venue lies in this Court because the cause of action accrued within Johnson County,

CLERK OF DISTRICT COURT
JOHNSON COUNTY, KS
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IN THE DISTRICT COURT OF JOHNSON COUNTY, KANSAS AT OLATHE

**Billie R. Watkins**
1201 N.W. Warwick
Blue Springs, Missouri 64015,

Plaintiff,

vs.

**John Schroll, M.D.** 073829

Defendant

Serve at:

Georgetown Medical Building
8901 West 74th Street
Shawnee Mission, Kansas 66204

and

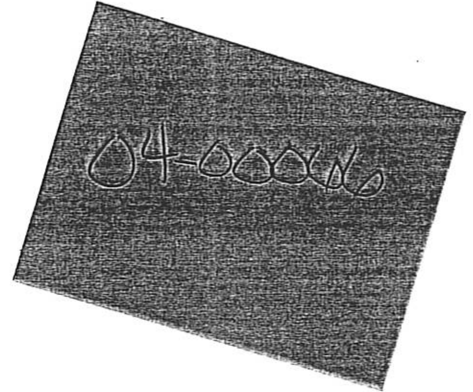
075210

**Shawnee Mission Medical Center, Inc.**

Serve:

Registered Agent
**Samuel H. Turner, Sr.,**
9100 W. 74th Street
P.O. Box 2923
Merriam, Kansas 66201

Defendants.




Case Number: 03 CV 04905

Court: 9

## PETITON FOR DAMAGES

Plaintiff Billie R. Watkins (hereinafter "Watkins"), for her Petition for Damages against John Schroll, MD (hereinafter "Schroll"), and Shawnee Mission Medical Center, Inc. (hereinafter "Medical Center"), states as follows:

## COUNT I

1. Plaintiff Watkins is an individual residing at 1201 N.W. Warwick, Blue Springs, Missouri.

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5-45

IN THE DISTRICT COURT OF JOHNSON COU[NTY, KANSAS]

04-00268

ANGELA FITZHUGH,
Individually and as the heir of
Savonna Alise Collins
18226 Springdale Road
Leavenworth, KS

DEMARIS COLLINS,
Individually and as the heir of
Savonna Alise Collins
819 Cecil Ave.
Louisville, KY

Plaintiffs,

v.

SAINT LUKE'S SOUTH HOSPITAL, INC.
Serve: Resident Agent
Julie Quirin
12300 Metcalf Avenue
Overland Park, KS 66213

WOMEN'S CARE, INC. 09NR ~~91424~~
Serve: Resident Agent
Robert J. Danner
8901 W. 47th Street, Suite 248
Merriam, KS 66204

JUDITH C. WIKA, R.N., C.N.M. NR
Serve at: 8901 W. 47th Street, Suite 248
Merriam, KS 66204

MAUREEN M. KING, M.D. 077383
Serve at: 8901 W. 47th Street, Suite 248
Merriam, KS 66204

JOHN T. SCHROLL, M.D. 07389
Serve at: 8901 W. 47th Street, Suite 248
Merriam, KS 66204

Defendants.

Case No.: 03CV08

Division: 17

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