Approved: April 2, 2008
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The meeting was called to order by Chairperson Susan Wagle at 1:30 P.M. on February 26, 2008 in Room 136-N of the Capitol.

Committee members absent:

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: Dr. Mark McCune, Member, Kansas Board of Healing Arts

Other in attendance: Please see attached Guest List

Continued hearing on Kansas Board of Healing Arts responsiveness to complaints from the public.

Upon calling the meeting to order, the Chair introduced the Board of Directors for the Kansas Board of Healing Arts: Ms. Sue Ice, Public Member from Newton, KS; Mrs. Betty McBride, President from Columbus; Dr. M. Myron Leinwetter, DO from Rossville. and Dr. Mark McCune, M.D. from Hanover.

The Chair then called on Dr. McCune, who wanted to thank the Committee for the opportunity to come before the Committee today as the delegated representative of the majority of members of the Kansas Board of Healing Arts (KBHA) and not at the request of the Board staff, but at the request of the Board members themselves. He offered a time line of Board meetings for a special session on 2-16-08, their meeting with Senator Wagle, and convening again on 2-22 & 2-23-08 for its regularly scheduled meeting of which 5 hours were devoted with staff regarding issues they needed to address and develop a plan of action to begin to resolve issues of public and legislative concern. He then went on to list the problems they have identified and the proposed corrective plan of action which included:

1. Communication Issues - agreed with the Committee that the Board has not done a good job communicating with complainants, but offered proposal remedies including: interview each complainant/closely related family members, regular follow-up communication, public use of Board website, enhanced Board, and Policy Statement No.07-02, that directs the Board Disciplinary Counsel to initiate an investigation on each complaint and reports received.

2. More Timely Processing of Cases - the Board is grateful for the legislative funding of 7 additional FTE's as it has been unable to adequately perform its functions due to being understaffed and underfunded due in part to legislative sweeping of Board funds. Their proposed remedies include: allocation of approved FTE positions, creation of: case management strategic committee, hearing officer panel, and second disciplinary panel. In addition they have increased Board meeting time, sanctioned guidelines, looking at re-vision of pre-hearing orders, develop a classification system, and drafted & submitted **HB2620**.

3..Lastly, faster processing of egregious, high-level cases using proposed remedies including the legislative revision of K.S.A. 2006 Supp. 65-2837(a) and letters of admonishment.

In summary, Dr. McCune stated that they share the Committee's concerns, hopes that this testimony makes it evident the seriousness with which the Board considers these matters, and hopes that their commitment to address and create a plan of action to resolve these concerns is transparent to this Committee and the public. A copy of his testimony and attachments, which include **HB2620** and KBHA's policy statement No.07-02, are (Attachment 1) attached hereto and incorporated into the Minutes by reference.

As there were no other conferees to appear before the Committee, the Chair asked for questions which came from Senators Brungardt, Barnett, Journey, Haley, Gilstrap and Wagle including:

- re: proposal A for communication issues, is this in response to the Post Audit Report No.07-02?

- re: additional proposals, are they forthcoming, are they more recent, are they because of Committee and public concerns?

- Are non-medical people well enough represented on the Board?

- for Mrs. McBride, are the health care providers hard enough on their own peers?

- re: 163 complaints in the last 3 months, is that a typical intake? Comment: Seems you could separate into fluff and serious stuff right away and assumes these are staff decisions that the Board wouldn't necessarily know about

- how many cases arise to the level of the full Board and is it typical?

- it would seem with this separation of duties with the Board and the difficulty in the number of members you really end up with 5 members in each of these sub-groups, that can't really co-mingle in reviewing these cases, that perhaps some more members could disperse the duties among more on the Board.

- re: a day and a half that would require an overnight commitment, do you feel you will have greater participation among your 15 members of the Board and have you considered 2 full days, however, for practicality many people may not come for that half day but may come because it is a full day?

-what are the terms of the Board members? And in view of the increase in case loads, have you considered taking on more retired doctors or citizens?

- were you in touch with the agency to know that this information was going to come out in the Post Audit? Did this surprise your Board members?

- did your disciplinary panel have access to the complete records, did it used to be that the full Board looked at every case, and how would articulate your role of overseeing the agency (ex. Meeting their obligations)?

As there were no further questions of the Board, the Chair thanked them for all they had done and offered them a packet regarding Dr. Geenens saying she hopes they have an opportunity to read them and also go meet with the U.S. Department of Justice, that they need to follow up and take a look at their legal department and see if their capabilities are up to what they need them to be. She also requested they take a look at the Schneider case and hear both sides of the legal story. She stated that if we look at the budgets of other states it just appears to her that there are several cases where Missouri was able to act on special situations, much quicker than Kansas and suggested the Board pull the report from Missouri regarding Dr. Geenens. A copy of the packet is (Attachment 2) attached.

Adjournment

As there was no further discussion, the meeting was adjourned. The time was 2:30 p.m.

The next meeting is scheduled for March 4, 2008.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Tuesday, February 26, 2008

38 in att.

NAME	REPRESENTING
Gabrielle Huckaby	Sen Dennis Pyle
LARRY MAGILL	KAIA
Tracy Russell	KHPA
Reagan Cussimanio	KHPA
Betsy Brownlee	KCCI
John Kiefhaber	Ks. Chiropractic Assn.
Michelle Peterson	Capitol Strategies
Bob Corkins	Kansas Liberty
Kathy Ostmeyer	Kansans for Life
Michael Kennedy	KAFP

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38 in att

TO: Senate Committee on Health Care Strategies
The Honorable Susan Wagle, Senator and Committee Chairwoman

FROM: Mark A. McCune, M.D.
Member, Kansas State Board of Healing Arts

RE: Response of the members of the Board of Healing Arts
to committee concerns

DATE: February 26, 2008

Good afternoon, Chairwoman Wagle and members of the committee. I am Dr. Mark McCune, a sitting member of the Kansas Board of Healing Arts. I have been in private practice in the field of dermatology and dermasurgery since 1981. I have been a member of the Board since 2001.

I want to thank Senator Wagle and the entire committee for the opportunity to come before you today as the delegated representative of the majority of the members of the Board of Healing Arts. I am here, not at the request of Board staff, but at the request of Board members themselves.

The majority of the Board met in special session on Saturday, February 16th, 2008 to discuss issues raised by the public and the legislature. A letter to this committee was drafted and signed by those members present. I, along with three other Board members including Mrs. Betty McBride, our current Board president and a public member, met with Senator Wagle last week to discuss the Board's letter. She asked if members of the Board would be willing to come before this committee to discuss the Board's thoughts and plans on how to move forward from this point.

The Board convened again on 2/22/08 and 2/23/08 for its regularly scheduled meeting. Approximately 5 hours were devoted over those two days to additional discussion with staff regarding issues we needed to address and the development of an action plan to begin to resolve issues of public and legislative concern.

I have been asked by the Board to be its representative before you today. My comments represent the concerns of the majority of Board members and our proposed plan of action going forward.

Accompanying me today is Mrs. McBride, our Board president, as well as Mrs. Sue Ice, a public Board Member.

Our letter of February 16, 2008 addressed to this committee expresses our awareness of public and legislative criticisms and concerns regarding the Board's function and performance. This committee already has received extensive testimony from Mr. Lawrence Buening, Jr., the Executive Director of the Board, Mr. Mark Stafford, General Counsel to the Board, and other Board staff regarding internal functioning of the Board's

process and procedures. Specific information regarding individual cases of interest currently under investigation by the Board has also been presented. The purpose of my appearance and testimony today is not to discuss or revisit the testimony already before the committee provided by Board staff. I am, instead, here to inform you of the Board members commitment to address the concerns of this committee and our proposed plan to move forward in a positive direction.

I wish to emphasize the seriousness with which the Board has addressed the criticism we have received, our need for self-evaluation, and the need and expectation by both the Board as well as this committee for the rapid implementation of changes to improve our ability to protect the health and welfare of the public. The Board is comprised of an exceptional group of health care professionals, public members, and board staff. All are fully committed to our shared mission of public protection with unquestioned sincerity, integrity, honesty, and dedication to fulfillment of our duties to the best of our individual and collective abilities.

The problems we have identified and the proposed corrective plan of action are as follows:

1. Communication Issues

We agree with this committee and the public that the Board has not done a good enough job to communicate with complainants. We agree that frustrations have been created by not giving them appropriate and timely feedback regarding the filing, status, and resolution of their complaints.

Proposed Remedies

A. Policy Statement No. 07-02
Attached to this testimony is Board Policy Statement No. 07-02, which was implemented October 20, 2007. This directs Board Disciplinary Counsel to initiate an investigation on each complaint received from the public and other health care professionals, and on reports of adverse findings from medical care facilities or peer review organizations.

B. Interview of Each Complainant / Closely Related Family Member
Once a complaint is received that alleges a violation, is opened for an investigation, and has been assigned to an investigator, each complainant will be interviewed regarding their complaint. Close family members will be interviewed if the person whom the complaint personally concerns is unable to be interviewed. These interviews will be in addition to other interviews being conducted in the course of the investigation.

C. Regular Follow-up Communication with Complainants
The complainant will receive a written communication from Disciplinary Counsel at the opening of the investigation. Additionally, a letter will be sent every 60 days thereafter updating the complainant of the status of the

investigation to the extent allowed due to protection of information under investigation. Any phone calls made to the Board by complainants will be answered or returned as received. Phone call communications will not alter the schedule of written communications to complainants. Outcome of the investigation will be communicated. If a disciplinary case is filed, Litigation Counsel will likewise continue bimonthly communication to the complainant until the case is resolved.

D. Public Use of Board Website
Information is currently posted on the Board website regarding licensees who have had action taken against their licenses over the last 10 – 12 years. This allows the public and other interested parties the ability to easily gain information on licensees. Additionally, the Board takes action the public may not know about. The Board website can be utilized to make this information available. Public awareness campaigns and education initiatives about Board functions can also be posted on and accessed through the website by the public.

E. Enhanced Board – Board Staff Communication
Board members have requested staff to provide as much information as possible to the full Board regarding cases under investigation and/or filed to litigate. Cases of an egregious or otherwise unusual nature will be flagged for possible designation of additional staff time and resources to speed progression of the case. As is current policy and procedure, only information will be shared that is not protected by being under investigation, that will not violate the separation of functions doctrine, and will not be an *ex parte* communication. A plan for informing the Board of pending cases has been proposed by the Board's General Counsel and will be implemented by the Board after further discussion and contemplation.
The Board will be informed by staff of developing issues of public concern from around the state regarding licensees and other matters pertaining to the Board. Notice of appearances of staff before legislative committees and the given testimony will be provided to Board members in as timely a fashion as possible.

2. More Timely Processing of Cases
The Board is grateful for the legislative funding of seven additional FTE's to enable more timely investigation of received complaints, Disciplinary Panel review, and the filing and prosecution of cases. As determined by the Post Legislative Audit Report, the Board has been unable to adequately and efficiently perform its functions due to being understaffed and underfunded due in part to legislative sweeping of Board funds.

Proposed Remedies

A. Allocation of Approved FTE Positions

All but one of the seven approved FTE positions have been filled. A new investigator started employment within the last week which will allow more timely and rapid investigation of complaints received. One of the Board Staff that assists Disciplinary Counsel will implement and facilitate written and telephone communication with complainants as outlined above. The Board has directed staff to utilize the unfilled FTE position to provide Litigation Counsel with a medically trained individual that can receive, review, coordinate, summarize, and organize documents and other information received to speed litigation case development and filing.

The Board has received 163 complaints over the last 90 days. Each complaint regarding standard of care, as outlined in the Board's new policy discussed above, and each complaint alleging some other violation of the Healing Arts Act will be investigated. Each patient or complainant with knowledge about the care provided is now being interviewed.

Disciplinary Counsel's opinion is that the optimum number of cases per investigator is 40 to 60. Some investigators currently are working 100 or more cases. Litigation Counsel can not work up and prosecute the currently pending and upcoming cases in as timely a fashion as desired by all parties concerned. It is likely that the Board will need future legislative approval for additional FTE funding to adequately and efficiently investigate and prosecute cases in a more timely fashion.

B. Creation of Case Management Strategic Committee
Mrs. McBride, the Board president, has created a new committee, the Case Management Strategic Committee, which will work with Disciplinary, Litigation, and General Counsel to expedite and triage handling of authorized cases. Administrative and low level cases will be adjudicated in a way to free Litigation Counsel to devote more time to higher priority cases. Egregious and high level priority cases will be "fast-tracked" to the extent that still allows proper due process to take place.

C. Creation of Hearing Officer Panel
At the recommendation of General Counsel, the Board has created a new Hearing Officer Panel. This will consist of a group of Board members from all disciplines and the public that can serve as hearing officers for filed cases. This group will not be involved in the disciplinary panel that reviewed the entire investigative file and authorized the case to be filed so that the proper division of functions will be preserved. This panel will establish a readily available group of hearing officers to provide direction and allow faster processing of backlogged, current, and future cases that would otherwise require full Board action at our normally scheduled bimonthly meetings.

D. Creation of a Second Disciplinary Panel
The Board is considering the establishment of a second Disciplinary Panel to review and process caseload which will double the number of cases that can be processed per given time frame. However, that will only prove to be useful if Litigation Counsel has the proper staffing and manpower to be able to file, develop, and prosecute authorized cases in a timely fashion to avoid a "bottleneck" in the progression of caseload.

E. Increased Board Meeting Time
The Board members have committed to expanding Board meeting time. Meetings are currently bimonthly, with one-day Saturday meetings alternating with one-half day Friday/ one-day Saturday meetings. Our plan is to expand each bimonthly meeting to the one and one-half day format starting with the next meeting in April, 2008. This should allow more cases to be heard and adjudicated. Case backlog should be shortened. If needed, the Board has already considered expansion to two day bimonthly meetings, monthly meetings, and a concentrated expanded several day meeting to try to help clear case backlog.

F. Sanctioning Guidelines
The Board and General Counsel continues to work on the development of sanctioning guidelines which should allow faster settlement or adjudication of cases that qualify for application of proper and consistent sanctions.

G. House Bill 2620
Board Counsel has drafted and submitted House Bill 2620 for legislative action. The bill is attached to this testimony for your review. It should allow faster disposition of non-disciplinary cases. If passed by the House, the Board would appreciate your full support for passage by the Senate.

H. Revision of Pre-Hearing Order
Litigation and General Counsel have requested that the Board look at revision of pre-hearing orders. It is felt that shorter times for discovery, use of and testimony by expert witnesses, and other pre-hearing activities can be achieved by revision of our current order. Hopefully, time to hearing dates can be shortened. Factors beyond control of the Board will continue to slow the process, such as prolonged time to hearing by outside agencies designated by the Board to function as the hearing officer.

I. Priority Classification of Disciplinary Case Priorities
Litigation Counsel is developing a classification system that defines the nature and seriousness of cases as determined by the investigative file and decision of the Disciplinary Panel. It is anticipated that such a classification will be used by the Case Management Strategic Committee as well as the Hearing Officer Panel to efficiently triage, settle, or prosecute cases appropriately and in a more timely fashion.

3. Faster Processing of Egregious, High-Level Cases
   It is well recognized by the Board that there are times when a licensee has been found by the Disciplinary Panel to have committed a single act that is of high-level concern or egregious nature, but rises only to the level of ordinary negligence. The Board currently notifies the licensee of the recommendation by the Disciplinary Panel that ordinary negligence has occurred and keeps the case on file without disciplinary action. In the absence of gross negligence, serious conduct issues, or patterns of practice or behavior which demonstrate a manifest incapacity or incompetence to practice medicine, a case will not be authorized to be filed until after the licensee is found to have committed repeated (3) instances of ordinary negligence. This is in accordance with our interpretation of K.S.A. 2006 Supp. 65-2837(a), the language of which is included in Board Policy Statement No. 07-02 which is attached to this testimony.

   Proposed Remedies

   A. Legislative Revision of K.S.A. 2006 Supp. 65-2837 (a)
      The Board voted unanimously at its meeting on February 23, 2008 to request that the legislature provide statutory ability to take disciplinary action against a licensee on the first occurrence of determined ordinary negligence. The Board only requests this remedy in the case of highly concerning, egregious ordinary negligence (as determined by the Board). The ability to proceed in a more expedited fashion in such a case should allow the Board to discipline a licensee or otherwise take action against a license without having to wait for more time to go by while waiting for repeated instances to occur. This has obvious relevance to concerns recently expressed by the public and the legislature regarding the delay in time it seems to take for the Board to act against a licensee.

   B. Letters of Admonishment
      By revision of the professional incompetency statute, the Board would have the authority to also contact the licensee after a single case of ordinary negligence with a letter of admonishment as deemed appropriate by the Board. Such a letter would give the Board a better ability to strongly advise the licensee of the Board's concerns which would hopefully enlighten and encourage the licensee to modify his/her behavior and/or patterns of practice more quickly than otherwise might occur.

In summary, the members of the Board of Healing Arts and Board staff understand and share the concerns of this committee as well as the public. My hope is that my testimony today makes it abundantly evident to you, Senator Wagle, as well as to the other esteemed members of this committee the seriousness with which the Board considers these matters. More importantly, we pray that our commitment to address and create a plan of action to resolve these concerns is transparent and obvious to this committee and the citizens of Kansas.

Along with Board president Betty McBride, Mrs. Ice, and the rest of the Board members, I wish to express our gratitude and appreciation for the opportunity to come before this committee. I stand available to answer questions you might have to the best of my knowledge and ability.

Sincerely,

Mark A. McCune, M.D.
For the members of the Kansas Board of Healing Arts

Session of 2008

HOUSE BILL No. 2620

By Special Committee on Judiciary

1-10

AN ACT concerning the state board of healing arts; relating to non-disciplinary resolution.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) The board, a committee of the board or a peer review committee established pursuant to K.S.A. 65-2840c, and amendments thereto, as a non-disciplinary resolution, may enter into a written agreement with a licensee for a professional development plan, make written recommendations to a licensee or issue a written letter of concern to a licensee if the board, committee of the board or peer review committee determines that the licensee:

(1) Seeks to establish continued competency for renewal of licensure other than through continued education requirements established pursuant to K.S.A. 65-2809, and amendments thereto;

(2) has been absent from clinical practice for an extended period of time and seeks to resume clinical practice;

(3) has failed to adhere to the applicable standard of care but not to a degree constituting professional incompetence, as defined by K.S.A. 65-2837, and amendments thereto; or

(4) has engaged in an act or practice that, if continued, would reasonably be expected to result in future violations of the Kansas healing arts act.

(b) Notwithstanding any other provision of law, a meeting of the board, a committee of the board or a peer review committee established pursuant to K.S.A. 65-2840c, and amendments thereto, for the purpose of discussing or adopting a non-disciplinary resolution authorized by this section shall not be subject to the Kansas administrative procedures act, K.S.A. 77-501 et seq., and amendments thereto, and shall not be subject to the Kansas open meetings act as provided in K.S.A. 75-4317 et seq., and amendments thereto. A non-disciplinary resolution authorized by this section shall not be deemed disciplinary action or other order or adjudication. No failure to adhere to the applicable standard of care or violation of the Kansas healing arts act may be implied by the adoption of a non-disciplinary resolution.

(c) A non-disciplinary resolution authorized by this section shall be

confidential in the manner provided by K.S.A. 65-2898a, and amendments thereto, and shall not be admissible in any civil, criminal or administrative action, except that such resolution shall be admissible in any disciplinary proceeding by the board.

(d) This section shall be part of and supplemental to the Kansas healing arts act.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 07-02

Subject: **Allegations of practice below the standard of care**
Date: **October 20, 2007**

WHEREAS:

The healing arts act grants authority to the Board, its agents and employees to investigate matters of professional incompetency. The act defines professional incompetency at K.S.A. 2006 Supp. 65-2837(a) as follows:

"Professional incompetency" means:

(1) One or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes gross negligence, as determined by the board.

(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.

(3) A pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine.

Similar definitions of professional incompetency apply to other professions the Board regulates.

Investigating allegations of practice below the standard of care includes, at a minimum, gathering pertinent patient records, communicating with the licensees involved and obtaining their statements, and presenting the records to a peer review committee.

The Board determines that alleged practice below the standard of care described in written complaints from the public, including other health care professionals, and reports of adverse findings from medical care facilities or peer review organizations warrant investigation without waiting for repeated instances or a pattern of practice to develop.

The Board projects that investigating all allegations of practice below the standard of care described in written complaints from the public, including other health care professionals, and reports of adverse findings from medical care facilities or peer review organizations would increase the number of cases opened each fiscal year by approximately 60. Investigation of these additional cases will require the addition of one FTE special investigator and the expenditure of approximately $15,000 per year to obtain medical records.

IT IS, THEREFORE, DECLARED THE POLICY OF THE BOARD THAT:

1. All alleged practice below the standard of care described in written complaints from the public, including other health care professionals, and reports of

adverse findings from medical care facilities or peer review organizations, should be investigated without regard to prior complaints against the involved licensee.

2. Investigation should include gathering pertinent patient records, communicating with the licensees involved and obtaining their statements, interviewing other witnesses as staff determine is appropriate, and presenting the records to a peer review committee, except that Board staff may terminate an investigation when there is discovery of credible and persuasive evidence establishing that a complaint lacks merit or was made in bad faith.

3. The Board will continue to pursue legislative authority for alternative means of concluding investigations suggesting practice below the standard of care but not establishing grounds to initiate disciplinary action.

4. The Board will dedicate appropriate resources, and will seek sufficient legislative appropriations of staff and expenditure limitations to implement this policy.

ADOPTED THIS 20th Day of October, 2007.

Betty McBride
President

Geenens Time Line

*10/03 - I filed my official complaint with the Board.

*11/03 - Steve French, the investigator from the Board, met with Dr. Murphy and me at Dr. Murphy's office. Dr. Murphy provided Mr. French with numerous files of information about Geenens and his unethical behavior. After meeting with each of us individually, Mr. French went to Geenens office and met with both Geenens and my wife regarding their relationship.

*12/03 - I found out about the Dilf picture. I spoke with two different psychiatrists about patients they were seeing, who were inappropriately dealt with in a sexual manner by Geenens. Geenens exposed himself to one patient. He masturbated on the phone to the other. I spoke with the second patient and her psychiatrist on the phone. I gave all of this information to Mr. French, who investigated all of this information.

*12/03 - I found out about the three teenage boys who had committed suicide while under Geenens care. The parents of two filed wrongful death lawsuits, which were settled out of court. I gave all of this information to Mr. French.

*10/04 - Fox 4 TV did a news story about my complaint and the Board's lack of action. A female patient (Patient A) who had similar problems with Dr. Geenens appeared disguised in the interview to share her story and received threatening phone calls that evening regarding the safety of her children.

* 12/04 - The Ks Board disciplined Geenens.

* 12/04 - I sent a letter to Governor Sebelius and outlined the complaints regarding Geenens that had been turned in to the Ks Board.

* 12/04 - Geenens filed a complaint against me with the Missouri Board of Psychologists.

* 7/05 – Patient A and my ex wife had words at a swim meet, where my ex-wife told Patient A confidential information only Patient A, her husband and Geenens knew. Subsequently, Patient A filed a complaint with the Board that was dismissed the following year.

* 8/05 - I was investigated by Blue Cross for insurance fraud, based on an anonymous complaint that was filed by my ex-wife at Geenens insistence. Nothing was found wrong.

* 9/05 - I settled my lawsuit out of court for $100,000.

* 12/05 - The complaint with the Missouri Board of Psychologists filed against me was dismissed with no action.

*Spring of 2006 - The Missouri Board of Healing Arts contacted me regarding an investigation they began on Geenens.

* 1/07 – New Female (Patient B) filed a complaint with the Kansas Board regarding Geenens. In this complaint, she shared information about Geenens relationship with Howard Ellis. In addition, she gave Board evidence that she was given numerous prescriptions by Dr. Geenens even though she was not his patient and how he pursued a relationship with her.

Senate Health Care Strategies
Committee
Date: February 26, 2008
Attachment 2

* Summer 2007 Dr. Murphy filed his complaint (details of which were given to the Senate Health Strategies Committee in February).

* Summer 2007, the Missouri board completed a 300 page plus investigative report and sent it to the Kansas Board of Healing Arts.

* 10/07 Geenens Missouri license was retired with agreement to not seek licensure in Missouri again.

*10/07 Patient B arranges private meeting with Larry Buening to make sure he understood how important the complaint was that she had filed back in January. Mr. Buening promised he would act on her complaint.

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

2,3

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							

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

In the Matter of)
Douglas Geenens, D.O.)
Kansas License No. 5-22577)
_____)

Docket No. 05-HA- 36

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.

2-4

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

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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

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

AGREED TO BY:

Douglas Geenens, D.O.
Licensee

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

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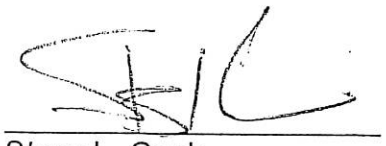
and the original was hand-delivered for filing to:

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



Stacy L. Cook

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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.

Geenens

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.

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(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

Green

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.

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

- How does KSBHA choose to define "minimal information"? Is the KSBHA...

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Monday, Feb 25, 2008

Posted on Thu, Feb. 21, 2008

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AP NewsBreak: Feds accuse Kansas of recklessness in doctor's case

By ROXANA HEGEMAN
Associated Press Writer

WICHITA, Kan. - The Kansas Board of Healing Arts is under fire for revealing that federal investigators were probing a clinic run by a Haysville physician, documents obtained by The Associated Press indicate.

Prosecutors contend the board told defense attorneys that undercover officers and informants had been placed at the clinic run by Dr. Stephen Schneider, who is facing federal charges of illegally prescribing painkillers.

"Thankfully, as far as we know, no harm came to anyone because of KBHA's reckless and unnecessary production of this information," Assistant U.S. Attorney Tanya Treadway wrote in a Jan. 28 letter to KBHA counsel Mark Stafford.

Stafford replied in a Feb. 1 letter that the board's litigation counsel had contacted the Kansas Bureau of Investigation and the Drug Enforcement Administration to discuss the discovery request. Those agencies did not object to the release of minimal information as long as no law enforcement document was released, he said.

"We didn't reveal anything that shouldn't be revealed and the people we needed to get clearance from we contacted and got clearance from," Stafford said Thursday.

A federal indictment links the clinic - described by prosecutors as a "pill mill" - to the accidental overdose deaths of 56 patients. The government charged the doctor and his wife with directly causing four deaths and contributing to the deaths of 11 other patients cited in the indictment.

Treadway also contended in a Jan. 24 letter that the board did not fully respond to all of its subpoenas. She noted that prosecutors did not find out until last month that complaints to the state agency about Schneider or physicians linked to the clinic dated as far back as 1995, and that the board still held 70 boxes of documents it had not turned over to investigators.

Schneider and his wife, nurse Linda Schneider, were indicted in December on federal charges including conspiracy, unlawful distribution of a controlled substance resulting in death, health care fraud, illegal money transactions and money laundering.

They have vehemently proclaimed their innocence.

"The U.S. attorney's office has always tried to work cooperatively with the Kansas Board of Healing Arts," U.S. Attorney Eric Melgren said Thursday in an e-mailed response to the AP. "We have different responsibilities and different tools for the job, but we share the goal of protecting the public."

Stafford said Thursday the board has tried not to impair a legal proceeding by another branch of government.

"I think some things are sounding a little strained as far as communications when you read the letters - what prompted that, I don't know," he said. "I hope our responses were accurate and were not seen as trying to escalate any problems."

But documents obtained by the AP through an open records request indicate that cooperation on the Schneider case between federal prosecutors and the state agency has deteriorated. The Board of Healing Arts is even refusing to accept faxed subpoenas in lieu of personal service.

The board asked a civil court for a seven-day extension of a subpoena deadline to produce voluminous documents demanded by prosecutors. Prosecutors chided the board for jeopardizing their criminal investigation with the publicly filed civil petition and asked the judge to seal it.

All of that came on top of a still simmering dispute between the two agencies over whether federal prosecutors asked the board to delay administrative proceedings against Schneider until the federal indictment was filed.

Documents obtained by the AP appear to bolster both sides of that argument.

In an Oct. 6, 2006, letter to the board's attorney, Treadway wrote: "By coordinating, we will avoid duplicating efforts and we will stay out of the KBHA's way in its administrative proceedings against Dr. Schneider."

After KBHA executive director Lawrence Buening Jr. testified to lawmakers that he had been asked to hold off on administrative proceedings until a federal indictment was filed, Melgren sent a letter to state Sen. Susan Wagle saying his office did not ask KBHA to defer its investigation in the interests of its federal investigation.

2-24

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

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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

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

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

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.

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;

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.

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 J. Stevens

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

Kelli J. Stevens
Signature

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

FILED

DEC 2 7 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

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

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CERTIFICATE OF SERVICE

I, Kelli J. 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 J. Stevens
Signature

2-91

FILED CAB

DEC 2 7 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.

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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

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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

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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

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Kansas State Board of Healing Arts
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(785) 296-7413

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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

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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.