FILED
KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
	)	
ANN K. NEUHAUS	)	KSBHA Docket No. 10-HA00129
Kansas License No. 04-21596	)	OAH Docket No. 10HA0014
	)	

PETITIONER'S BRIEF ON THE REMANDED ISSUES CONCERNING SANCTION OR SANCTIONS TO BE IMPOSED FOR RESPONDENT'S VIOLATION OF K.S.A. 65-2836(k) AND K.A.R. 100-24-1

COMES NOW Petitioner, Kansas State Board of Healing Arts, by and through Reese H. Hays, Litigation Counsel, and Jessica A. Bryson, Associate Litigation Counsel, and submits its brief on The Remanded Issues Concerning the Sanctions to be Imposed for Respondent's Violation of K.S.A. 65-2836(k) and K.A.R. 100-24-1. Petitioner respectfully requests the Board find the appropriate sanction in this matter to be Revocation of Respondent's license to practice medicine and surgery and order Respondent to pay the costs of the proceedings as set forth in Petitioner's Statement of Costs. Petitioner requests sufficient time to present its oral argument at the time of this matter's upcoming Conference Hearing.

I. BACKGROUND

I A. Summary of the Procedural History for the Above-Numbered Case

This matter was initiated when Petitioner filed a Petition, seeking disciplinary action against Licensee's license to practice medicine and surgery on April 16, 2010. A formal hearing on the Petition was held before Presiding Officer Edward Gaschler of the Office of Administrative Hearings on September 12, 2011, through September 16, 2011, and concluded on November 4,

2011. On February 17, 2012, the Presiding Officer issued an Initial Order making findings of fact, conclusions of law, and recommendations as to the appropriate sanction.

The Kansas State Board of Healing Arts ("Board") reviewed the Presiding Officer's Initial Order on June 22, 2012. On that date, the Board accepted, adopted, and incorporated by reference, each Finding of Fact and Conclusion of Law set forth in the Initial Order. Furthermore, the Board found, upon full consideration of all relevant facts, arguments, and circumstances, that for her violations of the Kansas Healing Arts Act, the appropriate sanction was for Respondent's license to practice medicine and surgery in Kansas to be immediately revoked with the full costs of the proceeding being assessed against Respondent.

The Board's Final Order was the subject of an appeal in the District Court of Shawnee County, Kansas, Division Seven pursuant to the Kansas Judicial Review Act, as amended, K.S.A. 77-601 *et seq.* The result of that appeal to the District Court of Shawnee County, Kansas, Division Seven was a judgment sustaining in part and reversing in part the Final Order of the Board. The Judge of the District Court Division Seven issued a written order on March 7, 2014, vacating the Board's order of revocation of licensure and its order assessing costs. His order further remanded the matter "for [a] further hearing concerning the sanction or sanctions, if any, to be imposed upon [Respondent] for her violation of K.S.A. 65-2836(k) by her violation of K.A.R. 100-24-1."

I B. Summary Regarding Respondent's Previous History With the Board

This is not Respondent's first occurrence of being the subject of a disciplinary action by this Board. Respondent has previously been the subject of two (2) disciplinary actions taken by this Board against her license to practice medicine and surgery in the State of Kansas. The first

disciplinary Board action taken against Respondent occurred when Respondent agreed to a Stipulation and Enforcement Order in Case No. 00-HA-00020 on October 18, 1999. This disciplinary action was taken because:

> [Respondent] violated federal regulations concerning controlled substances, including the **failure to maintain complete and accurate records** of controlled substances received, dispensed, delivered or otherwise disposed of, and failure to maintain a dispensing administration log. In addition, [Respondent] entered into a Memorandum of Agreement with the Drug Enforcement Agency ("DEA"), which constitutes a limitation of [Respondent's] DEA registration
>
> *Stipulation and Agreement and Enforcement Order*, Case No. 00-HA00020, dated October 18, 1999. (Emphasis added).

Respondent was the subject of a second disciplinary action by this Board in Case No. 01-HA00014. In that case, the Board found that Respondent violated the applicable standard of care in the intra-and post-procedure monitoring of five (5) separate patients. *Agreed Initial Order*, 01-HA00014, para. 20, dated June 15, 2001. Further, the Board found that she committed unprofessional conduct when she intentionally, knowingly, or recklessly failed to provide written notice of the gestational age of the fetus in compliance with the then applicable Woman's Right to Know Act. *Id.* at 22. The Board found Respondent committed further unprofessional conduct when she failed to provide an adequate informed consent to sedation. *Id.* at 23. Finally, the Board found Respondent's "**lack of documentation** regarding sedation and pre-, intra- and post-procedure monitoring for [five (5)] patients...constitute[d] a **failure to maintain an adequate patient record as required by K.A.R. 100-24-1.**" *Id.* at 24. (Emphasis Added). Furthermore, in that Agreed Initial Order, Respondent was ordered, in part, to "comply with **all provisions of K.A.R. 100-24-1, with respect to medical record keeping.**" *Id.* at 33. (Emphasis Added). The

Final Order resulting from the Agreed Initial Order of the Board in Case No. 01-HA00014 has not been rescinded or modified in any way and is currently in effect.

II. ARGUMENT AND AUTHORITIES

The practice of the healing arts is a "privilege granted by legislative authority and is not a natural right of individuals . . . ." Kan. Stat. Ann. § 65-2801 (1957). "The whole purpose and tenor of the healing arts act is the protection of the public against unprofessional, improper, unauthorized and unqualified practice of the healing arts. The goal is to secure to the people the services of competent, trustworthy practitioners." *Kansas State Bd. of Healing Arts v. Foote*, 200 Kan. 447, 453, 436 P.2d 828, 833 (1968). The Kansas Healing Arts Act does not require a finding of actual harm to a patient in order for a licensee's acts and/or conduct to be grounds for disciplinary action under the provisions of the act. *Fieser v. Kansas State Bd. of Healing Arts,* 281 Kan. 268, 130 P.3d 555 (2006).

"A licensee of the healing arts holds a respected and elevated position in society, with responsibility not only to patients, but also to the public, to colleagues, to the profession, to self and to the health care system in general. The mission of the Board of Healing Arts is to protect the public by authorizing only those persons who meet and maintain certain qualifications to engage in the health care professions regulated by the Board, and to protect the integrity of the professions." Guidelines for the Imposition of Disciplinary Actions, Section I, page 2 (August 2008).

"When presented with a doctor who poses a possible threat to his patients, the Board must act in accordance with the interests of the public before the interests of the doctor. Therefore, the

Board's responsibility is not to weigh the benefit and harm of this agency action as it pertains to [Respondent] and [her] personal life, but to the benefit and harm to the public and the public's perception of the Board as a regulatory agency. If the Board is to perform its regulatory function, the public must perceive the Board as acting in the public's best interest, rather than catering its decision to the benefit of the doctors it is tasked with regulating." *Zoeller v. State Bd. Of Healing Arts*, Case No. 12-C-50, slip opinion at p. 12 (Shawnee County District Court July 2, 2012).

II A. RESPONDENT'S MISCONDUCT

Respondent admitted in her testimony that she intentionally failed to document within her patient records for Patients #1 through #11 and that she could have documented more extensively. (Tr. p. 871, lines 1-25; p. 872, lines 1-25; p. 873, lines 1-5). The Presiding Officer found Respondent's argument that she intentionally failed to document within her patient records to protect patients' privacy to have "no merit since each patient was clearly identified." *Initial Order*, Docket No. 10-HA000129, Conclusions, para 6, dated February 20, 2012. He further stated, "How the nonexistence of specific patient documentation protects patients is not clear and is without merit." *Id.*

Respondent explained during her testimony that she utilized the Psychmanger Lite computer software, DTREE Positive DX Report and the GAF Report, for the purpose of patient record documentation. (Tr. p. 785, lines 12-25; Tr. p. 786, lines 1-8; Tr. p. 931, lines 12-15; Tr. p. 1057, lines 9-16). The Presiding Officer found that the DTREE and GAF reports were the only documents in the files for Patients #1 through #11 for which Respondent claimed ownership and none of those documents had been authenticated by her. *Initial Order* at para 17. Moreover, the

Presiding Officer found the DTREE Positive DX Report and the GAF Report computer printouts failed to document any specific information about the functioning of any of the patients; but rather, the computer printouts merely reflected answers to specific "Yes" or "No" questions. *Id.* at para 19. Furthermore, Honorable Judge Franklin R. Theis agreed with the Presiding Officer when he stated, "It is clear here that [Respondent's] maintenance of records as to each of patients #1-#11 fell below the requirements of K.A.R. 100-24-1 and below any reasonably required standard of care for their maintenance…." *Neuhaus v. Kansas State Bd of Healing Arts*, No. 12-C-50, slip op. at p. 79-80 (Shawnee County District Court March 7, 2014).

II A.i. Patient #1

Respondent's patient record for Patient #1 consists of six (6) pages. (Exhibit 23). Within that six (6) page patient record, there are only two (2) documents that Respondent created. *Id.* The first of Respondent's created documents is the DTREE Positive DX Report, which consists of a single page with nine (9) lines of text. *Id.* The second document is the GAF Report which consists of one (1) and half (1/2) pages of large font double spaced text. *Id.* at pages 4-6.

The Presiding Officer found that "[t]here is nothing in Patient #1's file bearing the name or leading to the identity of [Respondent] with the exception of an Authorization to Disclose Protected Health Information form." *Initial Order* at para 26. Furthermore, the Presiding Officer found Respondent's patient record for Patient #1 to contain inaccurate information; that being, "[t]he computer forms generated by [Respondent] conflict with [Respondent's] testimony in that [Respondent] reports that the face sheet of Dr. Tiller's containing the examination date of July 22,

2003 would be the appropriate appointment date when the DTREE and GAF reports generated by [Respondent] bear the date of June 21, 2003. *Id.* at para 29.

In sum, the Presiding Officer found that "there is certainly no 'pertinent and significant information concerning the patient's condition.' There are merely computer generated documents that in no way provide for a meaningful record of Patient #1." *Id.* at 31. He further found that Respondent's patient record for Patient #1 to be in violation of K.S.A. 65-2836(k) and K.A.R. 100-24-1. *Id.*

II A.ii. Patient #2

Respondent's patient record for Patient #2 consists of seven (7) pages. (Exhibit 24). Within that seven (7) page patient record, there record are only two (2) documents that Respondent created. *Id.* The first document of Respondent's created documents is the GAF Report, which consists of one and a quarter (1 1/4) pages of large font double spaced text. *Id.* at 4-5. The second document is the DTREE Positive DX Report, which consists of one and half (1 1/2) pages of large font text. *Id.* at 6-7.

The Presiding Officer found "[w]hile there is an Authorization to Disclose Protected Health Information form with the Licensee's name on it in Exhibit 24, there is nothing in the file to indicate who the treating physician is." *Initial Order* at para 34. The Presiding Officer further found that "[t]he date of any mental health examination conducted by [Respondent] is also unclear." *Id.* at 35. He goes further to find that "[f]rom the Licensee's testimony, one would believe that the examination date would be July 8, 2003, which is the date on the face sheet from Dr. Tiller's office. However, the two computer generated reports bear the date of July 9, 2003.

Therefore, it is unclear as to when [Respondent] might have actually seen the patient." *Id.* The Presiding Officer also found that Respondent did not "document…the physical appearance of the patient, the affect or mood of the patient, or anything specific to this patient." *Id.* at para 38. He further found that Respondent's GAF Report and DTREE Diagnosis Report contained conflicting information in that "the GAF report shows the patient had not been suicidal or in danger of intentionally hurting herself, [whereas] the DTREE Diagnosis report shows that there had been recurrent thoughts of death (not just fear of dying), recurrent suicide ideation without specific plan, or suicide attempt or specific plan for committing suicide." *Id.* at 39.

In sum, the Presiding Officer found that Respondent "violated K.S.A. 65-2836(k) and K.A.R. 100-24-1(b) in that the patient record is absolutely void of any 'pertinent and significant information concerning the patient's condition,' does not contain dates on which [Respondent] allegedly performed services for the patient, and does not reflect any treatment recommended or any other records reviewed." *Id.* at 45.

II A.iii. Patient #3

Respondent's patient record for Patient #3 consists of ten (10) pages. (Exhibit 25). Within that ten (10) page document, there are only two (2) documents that Respondent created. *Id.* The first document of Respondent's created documents is the DTREE Positive DX Report, which consists of one and half (1 1/2) pages of large font text. *Id.* at pages 6-7. The second document is the GAF Report, which consists of one and an eighth (1 1/8) pages of large font double spaced text. *Id.* at pages 9-10.

The Presiding Officer found that "[t]he only thing in the patient's file that refers to [Respondent] is an Authorization to Disclose Protected Health Information form. Nothing identifies [Respondent] as the treating physician." *Initial Order* at para 47. Additionally, the Presiding Officer found that "[t]here [was] nothing in the patient record specific to Patient #3 that was created by [Respondent]." *Id.* at para 49. The Presiding Officer also noted that there was a document entitled MI Statement (a.k.a. mental illness statement) and another statement regarding Patient #3 located within Respondent's patient record for Patient #3; however, these documents were not created by Respondent; but rather, another physician's staff. *Id.*

In sum, the Presiding Officer found Respondent's patient record for Patient #3 to be "wholly ineffective" and that she violated K.S.A. 65-2836(k) and K.A.R. 100-24-1. *Id.* at para 55. The Presiding Officer further explained that "[t]he appointment date of [Respondent's] appointment with Patient #3 was not evident. There [was] nothing in the [Respondent's] handwriting or any notation by her as to any examination of Patient #3. In the mental health statement [a.k.a. MI Statement] that was reviewed, there [was] no indication that [Respondent] relied upon [that] information and, if she did, how [Respondent] relied upon [that] information." *Id.* Moreover, he found "[t]he patient documentation in this case [to be] wholly inadequate." *Id.*

II A.iv. Patient #4

Respondent's patient record for Patient #4 consists of ten (10) pages. (Exhibit 26). Within that ten (10) page document, there are only two (2) documents that Respondent created. *Id.* The first document of Respondent's created documents is the DTREE Positive DX Report, which

consists of two and an eighth (2 1/8) pages of large font text. *Id.* at pages 7-9. The second document is the GAF Report, which consists of one (1) page of large font text. *Id.* at page 10.

The Presiding Officer found that "[o]ther than the Authorization to Disclose Protected Health Information form which contains [Respondent's] name, there is nothing contained in Exhibit 26 identifying [Respondent] as the treating physician." *Initial Order* at para 58.

In sum, the Presiding Officer found that Respondent "violated K.S.A. 65-2836(k) and K.A.R. 100-24-1 in that the documentation contained in Patient #4's chart does not designate a date that [Respondent's] professional service were provided, it does not contain whatsoever any pertinent, significant information that [Respondent] obtained from the patient's condition, it does not reflect the examination that [Respondent] conducted, nor does it contain the reason for the patient seeking [Respondent's] services." *Id.* at 63. The Presiding Officer goes on to find that Respondent does not document "any treatment that was recommended or whether [Respondent] relied upon any information that was provided to her from Dr. Tiller's office, such as the mental illness statement [a.k.a. MI statement]. The file does not even show [Respondent] as the treating physician." *Id.*

II A.v. Patient #5

Respondent's patient record for Patient #5 consists of eight (8) pages. (Exhibit 27). Within that eight (8) page document, there are only two (2) documents that Respondent created. *Id.* The first document of Respondent's created documents is the DTREE Positive DX Report, which consists of one and a fourth (1 1/4) pages of large font text. *Id.* at pages 6-7. The second document is the GAF Report, which consists of one (1) page of double spaced large font text. *Id.* at page 8.

The Presiding Officer found that "[t]he GAF report was completed on August 7, 2003[; however,] [t]he DTREE report shows a completion date of August 7, 2003, which has been drawn through and it appears [Respondent] has initialed new dates of August 12 and August 13, 2003. The report date from Dr. Tiller's office was August 12, 2003. There is no explanation in [Respondent's] files as to why [those] dates are inconsistent." *Initial Order* at para 67.

Overall, the Presiding Officer found Respondent's "file of Patient #5 [to be] wholly inadequate." *Id.* at para 71. Furthermore, he found Respondent to be in violation of K.S.A. 65-2836(k) and K.A.R. 100-24-1. In explaining his finding, the Presiding Officer stated, "There [was] no clear date of any examination of Patient #5, there [was] no evidence of what led to [Respondent's] diagnosis for [Patient #5], there [was] no evidence of any personal evaluation or specific clinical information concerning [Patient #5]. Further, there [was] nothing in the patient record to indicate that [Respondent] reviewed the mental health statement that was prepared by Dr. Tiller's office. [Furthermore], [t]he file does not even show [Respondent] as the treating physician." *Id.*

II A.vi. Patient #6

Respondent's patient record for Patient #6 consists of twenty (20) pages. (Exhibit 28). Within that twenty (20) page patient record, there are only two (2) types of documents that Respondent created, the DTREE Positive DX Report and the GAF Report. *Id.* at pages 9-13 and 16-20. The Presiding Officer found that within that patient record, "[t]here are two DTREE Positive DX Reports...[One] DTREE report has a report date of September 5, 2003 [and the other has a report date of August 26, 2003]. [One] GAF computer generated report has a rating date of

August 26, 2003 and a report date of August 26, 2003 [and the other has report date of September 5, 2003]. There is no explanation for the difference in the...report dates." *Initial Order* at para 75.

Overall, the Presiding Officer found that Respondent's patient record for Patient #6 "wholly fails to satisfy the requirements of K.A.R. 100-24-1." *Id.* at 80. Further, he found that Respondent "violated K.S.A. 65-2836(k) and K.A.R. 100-24-1 in that she failed to maintain an adequate record for Patient #6." *Id.* He explained, "The record maintained does not identify [Respondent] as a treating physician, does not contain a single pertinent or significant item concerning the patient's condition, and does not reflect any type of examination conducted by [Respondent] other than the computer generated tests." *Id.*

II A.vii. Patient #7

Respondent's patient record for Patient #7 consists of seven (7) pages. (Exhibit 29). Within that seven (7) page document, there are only two (2) documents that Respondent created. *Id.* The first document of Respondent's created documents is the DTREE Positive DX Report, which consists of one and a half (1 1/2) pages of large font text. *Id.* at pages 5-6. The second document is the GAF Report, which consists of one half (1/2) page of large font text. *Id.* at page 7.

The Presiding Officer found Respondent's patient record to contain conflicting information when he stated: "The mental health statement obtained by Dr. Tiller's office denied that Patient #7 had suicidal tendencies. Yet, the GAF report generated by [Respondent's] computer and the DTREE Positive DX report both suggested that Patient #7 was suicidal." *Initial Order* at para 86.

The Presiding Officer found Respondent's patient record for Patient #7 to be "totally inadequate." Further, he found that "[t]he medical records of Patient #7 completed by [Respondent] violate K.S.A. 65-2836(k) and K.A.R. 100-24-1." *Id.* at para 90. He explained that "[t]here is not one instance where pertinent and significant information concerning the patient's condition was provided. There is nothing to document what examination was performed other than the computerized examination...The record fails to identify [Respondent] as the treating physician. The patient record fails to comply with K.A.R. 100-24-1." *Id.*

II A.viii. Patient #8

Respondent's patient record for Patient #8 consists of five (5) pages. (Exhibit 30). Unlike the other patient records in this matter, Respondent's patient record does not contain a DTREE Positive DX Report or a GAF Report. *Id.* Therefore, this patient record does not contain any documentation that can be attributed to Respondent. *Id.* Moreover, the Presiding Officer found that there was "no documentation of anything by [Respondent]." *Initial Order* at para 98. Further, "[o]f the five pages, [Respondent's] name appears at the top of a face sheet [and] there is an Authorization to Disclose Protected Health Information form which bears [Respondent's] name printed at the very top of the document." *Id.* at para 92.

In sum, the Presiding Officer found that "[t]he documentation in Patient #8's file [did] not meet the requirements of K.A.R. 100-24-1 and, therefore, [Respondent was] in violation of K.S.A. 65-2836(k)." *Id.* at para 98. Specifically, the Presiding Officer found that "[t]here [was] no date of any service provided, there [was] nothing in the record containing pertinent and significant information concerning the patient's condition, and there [was] nothing concerning any type of

examination [Respondent] performed. [Furthermore,] [t]here is no authentication by [Respondent] of anything in the file nor does the file indicate any recommended treatment or whether any records were reviewed by [Respondent]." *Id.*

II A.ix. Patient #9

Respondent's patient record for Patient #9 consists of ten (10) pages. (Exhibit 31). Within that ten (10) page document, there are only two (2) documents that Respondent created. *Id.* The first document is the DTREE Positive DX Report, which consists of one and a half (1 1/2) pages of large font text. *Id.* at pages 7-8. The second document is the GAF Report, which consists of one and a half (1 1/2) pages of large font text. *Id.* at page 9-10. The Presiding Officer found that Respondent documented conflicting information in her patient record for Patient #9 in that "[Respondent] completed the computerized GAF report and the computerized DTREE Positive DX report. Both of these reports bear a date of November 5, 2003. [However,] [t]he appointment date as set forth in the face sheet provided by Dr. Tiller' office sets the appointment date to be November 4, 2003. It is unclear what day the appointment was for Patient #9." *Initial Order* at para 101-102. The Presiding Officer further found that "[w]hile [Respondent's] name appears twice in Patient #9's record, nowhere does it indicate that [Respondent] [was] Patient #9's treating physician." *Id.* at para 101.

Overall, the Presiding Officer found Respondent "violated K.S.A. 65-2836(k) and K.A.R. 100-24-1." *Id.* at para 106. "The patient records for Patient #9 do not contain a date certain when professional service were provided to the patient and it contains absolutely no pertinent and significant information concerning the patient's condition. Further, the record does not reflect

what, if any, type of examination was performed upon the patient nor does it indicate the reason for the patient seeking out the services of [Respondent]...[T]here is nothing in the record to indicate treatment recommended or whether other patient records were reviewed. [Finally,] [t]he record does not identify [Respondent] as the treating physician." *Id.*

II A.x. Patient #10

Respondent's patient record for Patient #10 consists of ten (10) pages. (Exhibit 32). Within that ten (10) page document, there are only two (2) documents that Respondent created. *Id.* The first document is the DTREE Positive DX Report, which consists of two (2) pages of large font text. *Id.* at pages 8-9. The second document is the GAF Report, which consists of one (1) page of large font text. *Id.* at page 10.

The Presiding Officer found that Respondent documented conflicting information in her patient record for Patient #10; in that, "[t]he face sheet from Dr. Tiller's office shows the appointment with Patient #10 was October 4, 2003...However, the computerized forms completed by [Respondent]...are both dated November 13, 2003. Obviously, the date that [Respondent] had any contact with Patient #10 is uncertain." *Initial Order* at para 110.

Furthermore, the Presiding Officer found that "[t]he name of [Respondent] appears twice on the records of Patient #10. The first time is in a handwritten form on the face sheet prepared by Dr. Tiller's office. The second is in a printed version on an Authorization to Disclose Protected Health Information form. However, it is not clear from the record maintained by [Respondent] that [Respondent] was treating physician of Patient #10." *Id.* at para 109.

Overall, the Presiding Officer found Respondent to have "violate[d] K.S.A. 65-2836(k) and K.A.R. 100-24-1 in that the patient record is wholly inadequate and contains no specific clinical information generated by [Respondent] as to Patient #10." *Id.* at para 118. The Presiding Officer explained that "[t]he file does not indicate which date [Respondent] provided professional services to Patient #10 and does not contain any pertinent and significant information concerning the patient's condition, what examinations were performed, or the reason the patient sought out the services of [Respondent]. [Also,] [t]he record does not indicate what patient records from other health care providers were reviewed in forming [Respondent's] diagnosis." *Id.*

II A.xi. Patient #11

Respondent's patient record for Patient #11 consists of five (5) pages. (Exhibit 33). Within that five (5) page document, there are only two (2) documents that Respondent created. *Id.* The first document of Respondent's created documents is the DTREE Positive DX Report, which consists of one and a half (1 1/2) pages of large font text. *Id.* at pages 3-4. The second document is the GAF Report, which consists of a one half (1/2) page of large font text. *Id.* at page 5.

The Presiding Officer found that Respondent documented conflicting information in her patient record for Patient #11. *Initial Order* at para 122-124. More specifically, the Presiding Officer found "[t]he face sheet as contained in Patient #11's records shows the appointment date to be November 18, 2003." *Id.* at para 122. "Both of [Respondent's DTREE Positive DX Report and GAF Report] bear the date of November 20, 2003." *Id.* "It is unclear what date [Respondent] had any contact with Patient #11." *Id.* "Further complicating the issue of when [Respondent] may

have seen Patient #11 is the fact the patient's pregnancy termination was on November 19, 2003, the day before the date on the computerized reports." *Id.* at para 124.

The Presiding Officer further found that "[t]here [was] nothing in the patient record of Patient #11 to support [Respondent's] DTREE Positive DX report or the GAF report. There is only one specific piece of clinical information contained in the patient's record and that is found on the intake form provided by Dr. Tiller." *Id.* at para 125.

Furthermore, the Presiding Officer found "[a]n Authorization to Disclose Protected Health Information form has [Respondent's] name printed on this document. Nowhere else in the patient record is [Respondent's] name found. Nowhere in the patient record does it show that [Respondent] is the treating physician for Patient #11." *Id.* at para 121.

In all, the Presiding Officer found Respondent violated "K.A.R. 100-24-1 and K.S.A. 65-2836(k)...in that the documentation contained in Patient #11's record did not reflect any specific clinical information about the patient, the evaluation process, or how the diagnosis was reached. In addition, the date of any examination is unknown, there is nothing signed by [Respondent] and there is no reason for the patient seeking out the services of [Respondent]." *Id.* at para 130.

II B. APPROPRIATE SANCTION

When considering Applicant's current intentional misconduct in addition to the two (2) previous disciplinary actions that the Board has taken against her license, the only appropriate sanction in this case is the revocation of Respondent's license to practice medicine and surgery in Kansas.

"The purposes for maintaining patient records include: (1) to furnish documentary evidence of the patient's history, symptoms and treatment; (2) to serve as a basis for review, study and evaluation of the care rendered; (3) to ensure that the records provide meaningful health care information to other practitioners should the patient have his or her care transferred to another provider; and (4) to assist in protecting the legal interests of the patient, and responsible practitioner... The interest of the patient is paramount. Failure to perform these duties regarding patient care has the potential to cause patient harm." Disciplinary Sanctioning Guidelines, Section II, Paragraph 10, page 15. In addition, Dr. Gold testified during the Formal Hearing that the importance of patient record documentation is "so that concurrent care providers or subsequent care providers have a clear understanding of the doctor's thought process[,]...the treatment provided and the patient responses to [that treatment]. It [is]...a quality of care issue." (Transcript (Tr.) p. 314, lines 6-18).

How a licensee documents in a patient's record is critically important. Adequate documentation in a patient's record is not just about documenting the patient's personally identifiable information, i.e., name, date of birth, social security number, contact information, etc. Instead, an adequate patient record is required to contain significant and pertinent information so, in part, the record (1) facilitates good care; (2) provides documentation for later review; (3) provides methods of communicating between providers; (4) shows adherence to policies and procedures; (5) provides evidence that care was necessary; and (6) acts as a source of reliable evidence of the licensee's care for a patient because it shows events as they happen; rather than, being left to the whims of patients' and providers' memories years after the events occur.

Furthermore, proper documentation in the patient record both protects the patient and the licensee. However, failing to document within a patient's record could result in grave consequences for a patient. For example, if the patient has an allergic reaction to a medication and the doctor does not document that allergy, the patient is at risk for harm due to re-exposure to the medication by future treatment providers. (*See* Tr. p. 314, lines 19-25; p. 315, lines 1-24). Applying that to this situation, information that a patient has been suicidal in the past needs to be documented so it can be communicated to a concurrent or subsequent treating provider so it can be appropriately addressed to ensure the patient does not act upon those suicidal thoughts and/or intentions. *See Id.* Thusly, intentionally failing to document in the patient record, or documenting the patient's record in a haphazard manner, could have devastating effects upon the patient, including death of the patient.

Pursuant to K.S.A. 65-2836(k), disciplinary action may be taken against a licensee if the licensee "has violated any lawful rule and regulation promulgated by the board . . .." Kan. Stat. Ann. § 65-2836(k) (2011). Furthermore, K.A.R. 100-24-1 sets out the minimum requirements for what constitutes an adequate patient record. The minimum requirements include; but are not limited to, containing adequate identification of the patient; indicating dates any professional service was performed; containing pertinent and significant information regarding the patient's condition; reflecting what examinations, vital signs, and tests were obtained, performed, or ordered and the findings and results of each; indicating the initial diagnosis and the patient's initial reason for seeking the licensee's services; reflecting treatment performed or recommended; and including

all patient records received from other health care providers if those records formed the basis for a treatment decision. *See* Kan. Admin. Regs. § 100-24-1 (1998).

Upon reviewing the patient records for Patients #1 through #11, the Presiding Officer found that the patient records in three (3) cases were "wholly inadequate." *Initial Order* at para 55, 71, and 118. In one case, he found the patient record to be "totally inadequate." *Id.* at para 90. In eight cases, the Presiding Officer found that the records failed to contain "pertinent and significant" information. *Id.* at para 31, 44, 63, 71, 80, 90, 98, and 118. In one case, he found that there was no "meaningful record." *Id.* at para 31. In two cases, the Presiding Officer found that the patient records contained conflicting information: specifically, the documentation showed that each patient was both having recurrent thoughts of death, recurrent suicide ideation without specific plan, or suicide attempt or specific plan for committing suicide as well as documentation denying being suicidal or in danger of intentionally harming themselves. *Id.* at para 39, 86. Despite the conflicting information, there is no documentation showing resolution of the conflicting information. *Id.* Finally, in at least one case, the Presiding Officer found that the patient record lacked specific clinical information about the patient, the evaluation process, and how the patient's diagnosis was reached. *Id.* at para 130.

Respondent's misconduct may be placed in either one of two Board Sanctioning Guideline Grid Categories. Her misconduct may be placed into the General Misconduct category in that her misconduct was potentially harmful to patients and was disruptive to board processes. *See* Board Sanctioning Guidelines, Section II, Category 2A, page 6. However, her misconduct may also be placed into the Patient Record Category regarding an intentional act of a failure to create

documentation. *See* Board Sanctioning Guidelines, Section II, Category 10A, page 14. Regardless of which of the two categories Respondent's misconduct is considered, the result is the same: revocation of Respondent's license to practice medicine and surgery in the State of Kansas. Revocation of Respondent's license is the appropriate sanction because it is the presumed sanction as modified for prior board actions, prior to adjustment for aggravating/mitigating factors in both categories. *See Id.* at Section V: Sanctioning Grid, Category of Offense 2A, page 2; and Category of Offense 10A, page 5.

Furthermore, "[a]fter it has been established that a violation has occurred, then the Board should consider the facts and circumstances unique to the case to determine whether the presumptive sanction is appropriate in light of any aggravating and/or mitigating factors." *Id.* at Section III: Aggravating and Mitigating Factors – policy considerations, page 15-16. Even when considering aggravating and mitigating factors, revocation of licensure continues to be the appropriate sanction in this case.

Respondent's failure to maintain an adequate patient record, as required by K.S.A. 65-2836(k) and K.A.R. 100-24-1, for Patients #1 through #11, was not inadvertent or by mistake. Instead, Respondent consciously decided to not document in the patients' records. Simply stated, it was an intentional act. While Respondent has asserted that she left information out in an attempt to protect patients' privacy, no explanation was provided as to how patient privacy was protected when the patient record contained personally identifiable information such as name, date of birth, social security number, and addresses. The Presiding Officer concluded that Respondent's argument had "no merit since each patient was clearly identified. How the nonexistence of specific

patient documentation protects patients is not clear and is without merit." *Initial Order*, Conclusions para 6.

Respondent's intentional act of leaving out pertinent and significant information regarding her patients' conditions as well as information regarding what examinations were performed did not protect her patients; rather, her intentional act placed her patients' current and future health in jeopardy. Her patients' concurrent and/or subsequent providers were deprived of relevant and material information that was necessary to facilitate them providing the patients quality care and treatment.

Another aggravating factor in this matter is the young age and vulnerability of the patients involved. Respondent's patients in this matter were between 10 and 18 years of age. Thusly, Respondent's patients were not adults who had the benefit of experience and age to address their conditions; but rather, they were young and inexperienced children who she diagnosed with significant mental illnesses. Respondent had a duty to ensure that her patients had an adequate patient record so that they would be able to have access to that record for future healthcare that addressed their needs wholly, completely, and sufficiently.

Furthermore, Respondent's intentional failure to adequately document in her patients' record is not an isolated event. Instead, all eleven (11) patient records addressed in this case were inadequate and found to be in violation of K.S.A. 65-2836(k) and K.A.R. 100-24-1. Therefore, this shows it was a pattern of misconduct that was perpetrated in each one of these patient's cases.

Unfortunately, this is not the first time in which Respondent has had to face potential disciplinary action against her license to practice medicine and surgery in Kansas, in part, for her

failure to properly document. Instead, this is Respondent's third case in which she has had to appear before the Board. In KSBHA Docket No. 00-HA00020, a Stipulation and Enforcement Order found, in part, that Respondent failed to maintain complete and accurate records. In her second case before the Board, KSBHA Docket No. 01-HA00014, the Board once again found, in part, that Respondent failed to properly document and that Respondent failed to "maintain an adequate patient record as required by K.A.R. 100-24-1." *Agreed Initial Order*, 01-HA00014 at para. 24. Furthermore, in that Agreed Initial Order, Respondent was ordered to "comply with all provisions of K.A.R. 100-24-1, with respect to medical record keeping." *Id.* at 33.

As shown by those two previous disciplinary actions, the Board has attempted to remediate and rehabilitate Respondent's conduct to no avail. In the first action, the Board attempted to remediate her by limiting Respondent's license in regard to her prescribing controlled substances and requiring additional documentation to be created in relation to her prescribing of controlled substances. *See Stipulation and Agreement And Enforcement Order* Docket 00-HA00020. The Board made its second attempt to remediate Respondent's conduct when it approved the Agreed Initial Order in Docket Number 01-HA00014. In that Agreed Initial Order, the Board once again attempted to remediate Respondent by limiting her license to practice medicine and surgery and specifically ordering her to comply with her statutory and regulatory duties including complying with "all provisions of K.A.R. 100-24-1, with respect to medical record keeping."

Another aggravating factor is the fact Respondent was an experienced practitioner who knew of her duty to document within a patient's medical record, and who intentionally chose not to carry out that duty. Respondent's intentional premeditated failure to document causes the nature

and the gravity of her misconduct to be one that is much more egregious than an inexperienced licensee who merely unintentionally documented inadequately, accidently documented inadequately, or who had not been subject to prior attempts by this Board to remediate their inability to document properly.

While Respondent has admitted to her misconduct, she has shown neither remorse nor any consciousness of the wrongfulness of her misconduct. Clearly, Respondent knew of her duty to properly document; however, her conduct and testimony shows that she believes that she was justified in her wrongful conduct. As once stated by Aristotle, "Our characters are the result of our conduct." Aristotle, *Nicomachean Ethics*, Book 3, chapter 5, section 12 (c. 335 BC). Here, by choosing to ignore the Board's attempt to remediate her behavior in the two previous actions, Respondent's conduct shows that she believes her way is better than the Board's way, and as such, Respondent has shown that her character is one that cannot be rehabilitated. Therefore, in the future if Respondent feels justified in her behavior, no matter how clearly wrong that conduct is, she will disregard any regulation or order of this Board that mandates her to do otherwise. This is clearly evident in the fact that, at the time she committed her misconduct in this matter, she was not only required to adhere to K.A.R. 100-24-1 as a licensee of this Board, she was also specifically mandated to adhere to K.A.R. 100-24-1 by Board Order. *See Agreed Initial Order* Docket No. 01-HA00014 at para 33.

Furthermore, this is Respondent's third strike. She was given not one, but two, second chances to fix her documentation issues. "Those who cannot remember the past are condemned

to repeat it." George Santayana, *Life of Reason, Reason in Common Sense*, Scribner's, p. 284, 1905. That is no truer than in this situation.

III. CONCLUSION

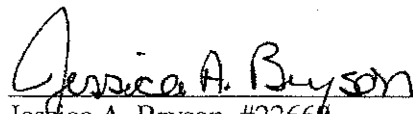
In conclusion, Respondent has shown that, when presented with a situation where she believes that she knows best, she will disregard any attempt of this Board to regulate her otherwise. Respondent's intentional lack of documentation in this matter, in conjunction with her previous Board disciplinary action for similar misconduct, demonstrates the fact that she cannot be regulated or be remediated by this Board, and as a result, the facts and circumstances in this case necessitate the revocation of Respondent's license to practice medicine and surgery in the State of Kansas. Furthermore, when the aggravating factors are considered with the fact that Licensee has been previously disciplined for her misconduct on two (2) previous occasions by this Board, it becomes clear that the only sanction that is appropriate for the Board to take in this matter is Revocation of Respondent's license to practice medicine and surgery in the State of Kansas.

WHEREFORE, Petitioner requests the Board find that the only appropriate sanction that can be taken in this matter by the Board is to Revoke Respondent's license to practice medicine and surgery.

FURTHER, Petitioner requests that they be allowed to present oral argument on these matters.

Respectfully submitted,

Reese H. Hays, #22700
Litigation Counsel
Kansas State Board of Healing Arts
800 SW Jackson
Lower Level-Suite A
Topeka, Kansas 66612
(785) 296-0961



Jessica A. Bryson, #22669
Associate Litigation Counsel
Kansas State Board of Healing Arts
800 SW Jackson
Lower Level-Suite A
Topeka, Kansas 66612
(785) 296-8022

CERTIFICATE OF SERVICE

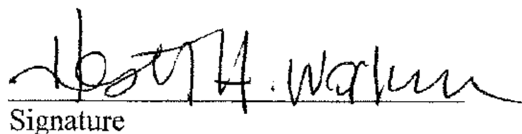
I, the undersigned, hereby certify that I served a true and correct copy of the **PETITIONER'S BRIEF ON THE REMANDED ISSUES CONCERNING SANCTION OR SANCTIONS TO BE IMPOSED FOR RESPONDENT'S VIOLATION OF K.S.A. 65-2836(k) AND K.A.R. 100-24-1** by United States mail, postage prepaid, on this 17th day of November, 2014 to the following:

Robert V. Eye
Kelly J. Kauffman
Robert V. Eye Law Office, L.L.C.
The Dibble Building
123 S.W. 6th Avenue, Suite 200
Topeka, Kansas 66603

Mark A. Ferguson
Gates, Shields & Ferguson
10990 Quivira, Suite 200
Overland Park, KS 66210

And the original was hand-delivered for filing to:

Kathleen Selzler Lippert
Executive Director
Kansas State Board of Healing Arts
800 SW Jackson
Lower Level-Suite A
Topeka, Kansas 66612



Signature