BEFORE THE BOARD OF HEALING ARTS
FOR THE STATE OF KANSAS

IN THE MATTER OF	)	Docket No.: 10-HA00129
	)	
ANN K. NEUHAUS, M.D.	)	OAH No.: 10HA0014
Kansas License No. 04-21596	)	
	)	

Pursuant to K.S.A. Chapter 77

INITIAL ORDER

NOW on this 12th day of September, 2011, this matter comes on for formal proceedings upon the Petition filed by the Kansas State Board of Healing Arts (Board or Petitioner) on or about April 16, 2010. Reese H. Hays, Litigation Counsel, and Jessica A. Bryson, Associate Litigation Counsel, appeared for the Board. Ann K. Neuhaus, M.D. (Respondent or Licensee) appeared in person and by and through Robert V. Eye and Kelly J. Kauffman.

The Board and the Respondent presented witnesses and exhibits.

At the conclusion of the hearing, the parties were given until January 17, 2012 to file Proposed Findings of Fact and Conclusions of Law.

Applicable Law

1. Kansas Statutes Annotated (K.S.A.) 65-2836 provides as follows:

> Revocation, suspension, limitation or denial of licenses; censure of licensee; grounds; consent to submit to mental or physical examination or drug screen, or any combination thereof, implied. A licensee's license may be revoked, suspended or limited, or the licensee may be publicly or privately censured or placed under probationary conditions, or an application for a license or for reinstatement of a license may be denied upon a finding of the existence of any of the following grounds:
>
> (a) The licensee has committed fraud or misrepresentation in applying for or securing an original, renewal or reinstated license.
>
> (b) The licensee has committed an act of unprofessional or dishonorable conduct or professional incompetency, except that the board may take appropriate disciplinary action or enter into a non-disciplinary resolution when a licensee has

engaged in any conduct or professional practice on a single occasion that, if continued, would reasonably be expected to constitute an inability to practice the healing arts with reasonable skill and safety to patients or unprofessional conduct as defined in K.S.A. 65-2837, and amendments thereto.

(c) The licensee has been convicted of a felony or class A misdemeanor, whether or not related to the practice of the healing arts. The board shall revoke a licensee's license following conviction of a felony occurring after July 1, 2000, unless a 2/3 majority of the board members present and voting determine by clear and convincing evidence that such licensee will not pose a threat to the public in such person's capacity as a licensee and that such person has been sufficiently rehabilitated to warrant the public trust. In the case of a person who has been convicted of a felony and who applies for an original license or to reinstate a canceled license, the application for a license shall be denied unless a 2/3 majority of the board members present and voting on such application determine by clear and convincing evidence that such person will not pose a threat to the public in such person's capacity as a licensee and that such person has been sufficiently rehabilitated to warrant the public trust.

(d) The licensee has used fraudulent or false advertisements.

(e) The licensee is addicted to or has distributed intoxicating liquors or drugs for any other than lawful purposes.

(f) The licensee has willfully or repeatedly violated this act, the pharmacy act of the state of Kansas or the uniform controlled substances act, or any rules and regulations adopted pursuant thereto, or any rules and regulations of the secretary of health and environment which are relevant to the practice of the healing arts.

(g) The licensee has unlawfully invaded the field of practice of any branch of the healing arts in which the licensee is not licensed to practice.

(h) The licensee has engaged in the practice of the healing arts under a false or assumed name, or the impersonation of another practitioner. The provisions of this subsection relating to an assumed name shall not apply to licensees practicing under a professional corporation or other legal entity duly authorized to provide such professional services in the state of Kansas.

(i) The licensee has the inability to practice the healing arts with reasonable skill and safety to patients by reason of physical or mental illness, or condition or use of alcohol, drugs or

controlled substances. In determining whether or not such inability exists, the board, upon reasonable suspicion of such inability, shall have authority to compel a licensee to submit to mental or physical examination or drug screen, or any combination thereof, by such persons as the board may designate either in the course of an investigation or a disciplinary proceeding. To determine whether reasonable suspicion of such inability exists, the investigative information shall be presented to the board as a whole, to a review committee of professional peers of the licensee established pursuant to K.S.A. 65-2840c, and amendments thereto, or to a committee consisting of the officers of the board elected pursuant to K.S.A. 65-2818, and amendments thereto, and the executive director appointed pursuant to K.S.A. 65-2878, and amendments thereto, or to a presiding officer authorized pursuant to K.S.A. 77-514, and amendments thereto. The determination shall be made by a majority vote of the entity which reviewed the investigative information. Information submitted to the board as a whole or a review committee of peers or a committee of the officers and executive director of the board and all reports, findings and other records shall be confidential and not subject to discovery by or release to any person or entity. The licensee shall submit to the board a release of information authorizing the board to obtain a report of such examination or drug screen, or both. A person affected by this subsection shall be offered, at reasonable intervals, an opportunity to demonstrate that such person can resume the competent practice of the healing arts with reasonable skill and safety to patients. For the purpose of this subsection, every person licensed to practice the healing arts and who shall accept the privilege to practice the healing arts in this state by so practicing or by the making and filing of a renewal to practice the healing arts in this state shall be deemed to have consented to submit to a mental or physical examination or a drug screen, or any combination thereof, when directed in writing by the board and further to have waived all objections to the admissibility of the testimony, drug screen or examination report of the person conducting such examination or drug screen, or both, at any proceeding or hearing before the board on the ground that such testimony or examination or drug screen report constitutes a privileged communication. In any proceeding by the board pursuant to the provisions of this subsection, the record of such board proceedings involving the mental and physical examination or drug screen, or any combination

thereof, shall not be used in any other administrative or judicial proceeding.

(j) The licensee has had a license to practice the healing arts revoked, suspended or limited, has been censured or has had other disciplinary action taken, or an application for a license denied, by the proper licensing authority of another state, territory, District of Columbia, or other country, a certified copy of the record of the action of the other jurisdiction being conclusive evidence thereof.

(k) The licensee has violated any lawful rule and regulation promulgated by the board or violated any lawful order or directive of the board previously entered by the board.

(l) The licensee has failed to report or reveal the knowledge required to be reported or revealed under K.S.A. 65-28,122, and amendments thereto.

(m) The licensee, if licensed to practice medicine and surgery, has failed to inform in writing a patient suffering from any form of abnormality of the breast tissue for which surgery is a recommended form of treatment, of alternative methods of treatment recognized by licensees of the same profession in the same or similar communities as being acceptable under like conditions and circumstances.

(n) The licensee has cheated on or attempted to subvert the validity of the examination for a license.

(o) The licensee has been found to be mentally ill, disabled, not guilty by reason of insanity, not guilty because the licensee suffers from a mental disease or defect or incompetent to stand trial by a court of competent jurisdiction.

(p) The licensee has prescribed, sold, administered, distributed or given a controlled substance to any person for other than medically accepted or lawful purposes.

(q) The licensee has violated a federal law or regulation relating to controlled substances.

(r) The licensee has failed to furnish the board, or its investigators or representatives, any information legally requested by the board.

(s) Sanctions or disciplinary actions have been taken against the licensee by a peer review committee, health care facility, a governmental agency or department or a professional association or society for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(t) The licensee has failed to report to the board any adverse action taken against the licensee by another state or licensing jurisdiction, a peer review body, a health care facility, a

professional association or society, a governmental agency, by a law enforcement agency or a court for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(u) The licensee has surrendered a license or authorization to practice the healing arts in another state or jurisdiction, has surrendered the authority to utilize controlled substances issued by any state or federal agency, has agreed to a limitation to or restriction of privileges at any medical care facility or has surrendered the licensee's membership on any professional staff or in any professional association or society while under investigation for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(v) The licensee has failed to report to the board surrender of the licensee's license or authorization to practice the healing arts in another state or jurisdiction or surrender of the licensee's membership on any professional staff or in any professional association or society while under investigation for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(w) The licensee has an adverse judgment, award or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(x) The licensee has failed to report to the board any adverse judgment, settlement or award against the licensee resulting from a medical malpractice liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(y) The licensee has failed to maintain a policy of professional liability insurance as required by K.S.A. 40-3402 or 40-3403a, and amendments thereto.

(z) The licensee has failed to pay the premium surcharges as required by K.S.A. 40-3404, and amendments thereto.

(aa) The licensee has knowingly submitted any misleading, deceptive, untrue or fraudulent representation on a claim form, bill or statement.

(bb) The licensee as the responsible physician for a physician assistant has failed to adequately direct and supervise the physician assistant in accordance with the physician assistant licensure act or rules and regulations adopted under such act.

(cc) The licensee has assisted suicide in violation of K.S.A. 21-3406, prior to its repeal, or K.S.A. 21-5407, and amendments thereto, as established by any of the following:

(A) A copy of the record of criminal conviction or plea of guilty for a felony in violation of K.S.A. 21-3406, prior to its repeal, or K.S.A. 21-5407, and amendments thereto.

(B) A copy of the record of a judgment of contempt of court for violating an injunction issued under K.S.A. 60-4404, and amendments thereto.

(C) A copy of the record of a judgment assessing damages under K.S.A. 60-4405, and amendments thereto.

2. K.S.A. 65-2837 provides as follows:

Definitions. As used in K.S.A. 65-2836, and amendments thereto, and in this section:

(a) "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 the healing arts.

(b) "Unprofessional conduct" means:

(1) Solicitation of professional patronage through the use of fraudulent or false advertisements, or profiting by the acts of those representing themselves to be agents of the licensee.

(2) Representing to a patient that a manifestly incurable disease, condition or injury can be permanently cured.

(3) Assisting in the care or treatment of a patient without the consent of the patient, the attending physician or the patient's legal representatives.

(4) The use of any letters, words, or terms, as an affix, on stationery, in advertisements, or otherwise indicating that such person is entitled to practice a branch of the healing arts for which such person is not licensed.

(5) Performing, procuring or aiding and abetting in the performance or procurement of a criminal abortion.

(6) Willful betrayal of confidential information.

(7) Advertising professional superiority or the performance of professional services in a superior manner.

(8) Advertising to guarantee any professional service or to perform any operation painlessly.

(9) Participating in any action as a staff member of a medical care facility which is designed to exclude or which results in the exclusion of any person licensed to practice medicine and surgery from the medical staff of a nonprofit medical care facility licensed in this state because of the branch of the healing arts practiced by such person or without just cause.

(10) Failure to effectuate the declaration of a qualified patient as provided in subsection (a) of K.S.A. 65-28,107, and amendments thereto.

(11) Prescribing, ordering, dispensing, administering, selling, supplying or giving any amphetamines or sympathomimetic amines, except as authorized by K.S.A. 65-2837a, and amendments thereto.

(12) Conduct likely to deceive, defraud or harm the public.

(13) Making a false or misleading statement regarding the licensee's skill or the efficacy or value of the drug, treatment or remedy prescribed by the licensee or at the licensee's direction in the treatment of any disease or other condition of the body or mind.

(14) Aiding or abetting the practice of the healing arts by an unlicensed, incompetent or impaired person.

(15) Allowing another person or organization to use the licensee's license to practice the healing arts.

(16) Commission of any act of sexual abuse, misconduct or other improper sexual contact, which exploits the licensee-patient relationship, with a patient or a person responsible for health care decisions concerning such patient.

(17) The use of any false, fraudulent or deceptive statement in any document connected with the practice of the healing arts including the intentional falsifying or fraudulent altering of a patient or medical care facility record.

(18) Obtaining any fee by fraud, deceit or misrepresentation.

(19) Directly or indirectly giving or receiving any fee, commission, rebate or other compensation for professional services not actually and personally rendered, other than through the legal functioning of lawful professional partnerships, corporations or associations.

(20) Failure to transfer patient records to another licensee when requested to do so by the subject patient or by such patient's legally designated representative.

(21) Performing unnecessary tests, examinations or services which have no legitimate medical purpose.

(22) Charging an excessive fee for services rendered.

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

(24) Repeated failure to practice 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.

(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.

(26) Delegating professional responsibilities to a person when the licensee knows or has reason to know that such person is not qualified by training, experience or licensure to perform them.

(27) Using experimental forms of therapy without proper informed patient consent, without conforming to generally accepted criteria or standard protocols, without keeping detailed legible records or without having periodic analysis of the study and results reviewed by a committee or peers.

(28) Prescribing, dispensing, administering or distributing an anabolic steroid or human growth hormone for other than a valid medical purpose. Bodybuilding, muscle enhancement or increasing muscle bulk or strength through the use of an anabolic steroid or human growth hormone by a person who is in good health is not a valid medical purpose.

(29) Referring a patient to a health care entity for services if the licensee has a significant investment interest in the health care entity, unless the licensee informs the patient in writing of such significant investment interest and that the patient may obtain such services elsewhere.

(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.

(31) Violating K.S.A. 65-6703 and amendments thereto.

(32) Charging, billing or otherwise soliciting payment from any patient, patient's representative or insurer for anatomic pathology services, if such services are not personally rendered by the licensee or under such licensee's direct supervision. As used in this subsection, "anatomic pathology services" means the gross or microscopic examination of histologic processing of human organ tissue or the examination of human cells from fluids, aspirates, washings,

brushings or smears, including bloodbanking services, and subcellular or molecular pathology services, performed by or under the supervision of a person licensed to practice medicine and surgery or a clinical laboratory. Nothing in this subsection shall be construed to prohibit billing for anatomic pathology services by a hospital, or by a clinical laboratory when samples are transferred between clinical laboratories for the provision of anatomic pathology services.

(33) Engaging in conduct which violates patient trust and exploits the licensee-patient relationship for personal gain.

(c) "False advertisement" means any advertisement which is false, misleading or deceptive in a material respect. In determining whether any advertisement is misleading, there shall be taken into account not only representations made or suggested by statement, word, design, device, sound or any combination thereof, but also the extent to which the advertisement fails to reveal facts material in the light of such representations made.

(d) "Advertisement" means all representations disseminated in any manner or by any means, for the purpose of inducing, or which are likely to induce, directly or indirectly, the purchase of professional services.

(e) "Licensee" for purposes of this section and K.S.A. 65-2836, and amendments thereto, shall mean all persons issued a license, permit or special permit pursuant to article 28 of chapter 65 of the Kansas Statutes Annotated.

(f) "License" for purposes of this section and K.S.A. 65-2836, and amendments thereto, shall mean any license, permit or special permit granted under article 28 of chapter 65 of the Kansas Statutes Annotated.

(g) "Health care entity" means any corporation, firm, partnership or other business entity which provides services for diagnosis or treatment of human health conditions and which is owned separately from a referring licensee's principle practice.

(h) "Significant investment interest" means ownership of at least 10% of the value of the firm, partnership or other business entity which owns or leases the health care entity, or ownership of at least 10% of the shares of stock of the corporation which owns or leases the health care entity.

3. Kansas Administrative Regulation (K.A.R.) 100-24-1 provides as follows:

Adequacy; minimal requirements.

(a) Each licensee of the board shall maintain an adequate record for each patient for whom the licensee performs a professional service.

(b) Each patient record shall meet these requirements:

(1) Be legible;
(2) contain only those terms and abbreviations that are or should be comprehensible to similar licensees;
(3) contain adequate identification of the patient;
(4) indicate the dates any professional service was provided;
(5) contain pertinent and significant information concerning the patient's condition;
(6) reflect what examinations, vital signs, and tests were obtained, performed, or ordered and the findings and results of each;
(7) indicate the initial diagnosis and the patient's initial reason for seeking the licensee's services;
(8) indicate the medications prescribed, dispensed, or administered and the quantity and strength of each;
(9) reflect the treatment performed or recommended;
(10) document the patient's progress during the course of treatment provided by the licensee; and
(11) include all patient records received from other health care providers, if those records formed the basis for a treatment decision by the licensee.

(c) Each entry shall be authenticated by the person making the entry unless the entire patient record is maintained in the licensee's own hand-writing.

(d) Each patient record shall include any writing intended to be a final record, but shall not require the maintenance of rough drafts, notes, other writings, or recordings once this information is converted to final form. The final form shall accurately reflect the care and services rendered to the patient.

(e) For purposes of implementing the healing arts act and this regulation, an electronic patient record shall be deemed a written patient record if the electronic record cannot be altered and if each entry in the electronic record is authenticated by the licensee.

Findings of Fact
Applicable to All Counts

1. The Licensee has been licensed by the Board since approximately December 5, 1986 to practice medicine and surgery in the state of Kansas.

2. The Licensee is a general practitioner and is not board-certified in any specialty. The Board has previously disciplined the Licensee and imposed limitations on the Licensee's practice of medicine and surgery.

3. The Board, through its investigators, subpoenaed records for Patients #1 through #11 that were in the Licensee's possession. The Licensee had provided reports on all

these patients to George R. Tiller, M.D. The purpose of obtaining the Licensee's reports was to allow Dr. Tiller to perform abortions on Patients #1 through #11.

4. Eliza H. Gold, M.D. has been licensed to practice medicine and surgery in Virginia, the District of Columbia, New Jersey, and New York. Dr. Gold has been licensed to practice medicine since 1986, is board-certified in psychiatric medicine, and has a subspecialty certification for forensic psychiatry.

5. Dr. Gold has written for a variety of publications dealing with psychiatric medicine.

6. Dr. Gold testified regarding the Licensee's practice of medicine as it relates to the Licensee's treatment of Patients #1 through #11.

7. In evaluating the Licensee's care of Patients #1 through #11, Dr. Gold reviewed the records maintained by the Licensee, the medical records of Dr. Tiller, inquisition testimony and court testimony of the Licensee, applicable Kansas statutes, and the Licensee's expert report provided by K. Allen Greiner, Jr., M.D. Additionally, Dr. Gold reviewed the American Academy of Child and Adolescent Psychiatric Practice Parameters and other written materials as well as the Diagnostic and Statistical Manual 4th Edition with Text Revisions (hereafter DSM-IV-TR).

8. Dr. Gold is a highly qualified expert in the field of psychiatric medicine.

9. The Licensee presented expert testimony from Dr. Greiner, a medical doctor who practices at the University of Kansas Medical Center.

10. It is somewhat unclear but there appears to be some type of relationship between Dr. Greiner and the Licensee. For example, prior to the Licensee submitting an application to be a fellow with the University of Kansas Medical Center Primary Care Research Development Program, Dr. Greiner had notified the Licensee that she had been selected as a fellow. Similarly, the Licensee submitted an incomplete application for the Fellowship Program and Primary Care Research Development Program at the University of Kansas and even though the application was incomplete in that it lacked character references and a letter of recommendation from a department chairperson, the application was accepted. Why Dr. Greiner accepted an incomplete application from the Licensee is unknown.

11. After the Licensee's acceptance into the program, Dr. Greiner became the Licensee's mentor.

12. Prior to viewing the records of the Licensee, Dr. Greiner agreed to provide expert testimony for the Licensee without charging the Licensee for his expert opinion.

13. Dr. Greiner, before reaching an opinion as to the Licensee's practice, had to verbally discuss what occurred with regard to these patients because he could not determine

this from the medical records he reviewed. The testimony of Dr. Greiner is not persuasive and is not credible.

14. In each count of the Board's petition, the Board alleges that the Licensee committed an act of unprofessional or dishonorable conduct or professional incompetency in violation of K.S.A. 65-2836(b). The Board further alleges that the practice of the Licensee was professionally incompetent and was unprofessional conduct as set forth in K.S.A. 65-2837(a)(2) and K.S.A. 65-2837(b). Additionally, the Board alleges that the Licensee's practice was in violation of K.S.A. 65-2836(k) in that the Licensee violated K.A.R. 100-24-1 in failing to meet the minimum requirements for maintaining adequate patient records.

15. The DSM-IV-TR is the "current taxonomy of psychiatric disorders" in the words of Dr. Gold. The DSM-IV-TR recommends that you collect all the information needed for a standard psychiatric examination. This information is listed below at paragraph 22. The DSM-IV-TR is used nationally and internationally.

16. In her treatment of Patients #1 through #11, the Licensee utilized computer based programs that are based upon the DSM-IV-TR.

17. The Licensee, in her care of Patients #1 through #11, utilized computer programs from Psychmanager Lite computer software. These programs utilized by the Licensee were the DTREE Positive DX and the GAF reports. DTREE and the GAF reports are the only documents in the files for Patients #1 through #11 for which the Licensee claims ownership. None of these documents are authenticated by the Licensee.

18. The DSM-IV-TR and the Psychmanager Lite DTREE modules provide cautionary statements for practitioners. These cautionary statements require a practitioner to have and use the proper clinical training and skills in using either the DSM-IV-TR or the Psychmanager Lite programs.

19. In the patients' records containing computer printout material from the Licensee, there is nothing specific about the patients listed that was generated by the Licensee. The computer printouts do not contain any specific information about the functioning of any of the patients. The computer printouts merely reflect answers to specific "Yes" or "No" questions.

20. It was Dr. Gold's professional opinion that utilizing the Psychmanager Lite DTREE Positive DX and GAF modules standing alone does not meet the applicable standard of care because there is not sufficient information regarding specific behavioral information regarding the patients as presented at the time of the examination.

21. Nothing in the computerized programs as utilized by the Licensee establishes that the Licensee performed a mental health evaluation within the applicable standard of care for these patients.

22. In conducting mental health evaluations or examinations, it is necessary for the physician to review the patient's presenting problems, the duration and frequency of the problems, the intensity of symptoms, the patient's past history, including treatment and any response to the treatment, family history, social history, occupational history, as well as past medical history, and an examination of past medical records. Additionally, based upon the condition of the patient, if a medical problem is suspected, a medical evaluation may be needed.

23. The applicable standard of care for mental health evaluations is basically a nationwide standard of care. While there might be slight regional or geographical variations, the standard of care is substantially the same nationwide.

24. The Licensee testified that her appointment date for the patients would be the date listed on Dr. Tiller's face sheet.

Count I

25. Patient #1 was a 14-year-old single white female who was 26 weeks plus pregnant.

26. The Licensee's patient records for Patient #1 are set forth in Exhibit 23. There is nothing in Patient #1's file bearing the name or leading to the identity of the Licensee with the exception of an Authorization to Disclose Protected Health Information form.

27. In Patient #1's file, there is no evidence that the Licensee conducted any type of personal evaluation of Patient #1 and the only evidence consists of the computer reports generated by the Licensee. There is no review of Patient #1's psychiatric, medical or developmental history, no review of prior medical treatment or symptoms, and no review of family history or review of any medical documentation by the Licensee.

28. The Licensee did not provide a review of the patient's psychiatric, medical, or developmental history, prior psychiatric treatment or symptoms, family history, family relationships, physical or sexual abuse, substance abuse, or any other possible cause of distress. The Licensee did not document the patient's physical appearance, affect, mood, or anything personal to Patient #1. There is no evidence of any type of mental status examination.

29. The computer forms generated by the Licensee conflict with the Licensee's testimony in that the Licensee 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 the Licensee bear a date of June 21, 2003.

30. In the care and treatment of Patient #1, the Licensee departed from the applicable standard of care in that the Licensee failed to conduct a mental health evaluation. There is nothing to establish that any specific evaluation was performed by the Licensee. Further, there is nothing in the record to establish that the Licensee did anything other than subjecting the patient to the computerized programs the Licensee utilized. This is in violation of K.S.A. 65-2836(b) and K.S.A. 65-2837(a).

31. In Patient #1's records, except for the computer printouts, there is absolutely no evidence of any examination by the Licensee of Patient #1 nor is there any evidence whatsoever of what transpired between Patient #1 and the Licensee. Notwithstanding the claims of the Licensee, the date of the contact between the Licensee and Patient #1 is not clear and 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. This is in violation of K.S.A. 65-2836(k) and K.A.R. 100-24-1.

Count II

32. Patient #2 was a 10-year-old incest, rape victim who became pregnant at the age of 9.

33. The Licensee's patient records for Patient #2 are set forth in Exhibit 24 and consist of seven total pages.

34. While 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.

35. The date of any mental health examination conducted by the Licensee is also unclear. From 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 the Licensee might have actually seen the patient.

36. Again, there are two computer generated reports in Patient #2's file, but nothing else from the Licensee that leads to any possible diagnosis.

37. There is nothing in the patient's record to show that the Licensee reviewed the patient's psychiatric, medical, or developmental history, prior psychiatric treatment or symptoms, the family history and family relationships of the patient, or any physical or sexual abuse of the patient. There is no evidence of any type of mental status examination.

38. There is nothing in the record showing that the Licensee documented the physical appearance of the patient, the affect or mood of the patient, or anything specific to this patient.

39. The Licensee's file of Patient #2 contains the GAF report and the DTREE Diagnosis report. While the GAF report shows the patient had not been suicidal or in danger of intentionally hurting herself, 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. Notwithstanding this, it does not appear that the Licensee did anything to determine which of her computerized programs were correct. She did nothing to determine whether or not Patient #2 was suicidal.

40. Conducting a mental health evaluation for a 10-year-old incest, rape victim such as Patient #2 would have been complex, requiring specialized skills. It was Dr. Gold's opinion that the Licensee should have referred this type of patient to a specialist.

41. The examination of Patient #2 would require an extensive period of time as well as input from other caregivers. Additionally, evidence of the performance of a specialized intensive child evaluation would be needed. There is no evidence in the Licensee's file that this type of process ever occurred.

42. There is not one piece of evidence in the file generated by the Licensee that establishes a mental health examination was conducted with any specific information related to the patient.

43. The Licensee, in her care and treatment of Patient #2, violated K.S.A. 65-2836(b) and K.S.A. 65-2837(a) in that the Licensee failed to adhere to the applicable standard of care. The Licensee's total failure to conduct an examination of Patient #2 and to obtain personalized clinical information specific to the patient was not met. The Licensee did not obtain psychiatric, medical, or developmental histories, prior psychiatric treatment symptoms, family history, family relationships, physical or sexual abuse, or anything remotely personal to the patient. There is no indication that the Licensee addressed the conflict between the two computerized reports.

44. The Licensee, in her treatment of Patient #2, 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 the Licensee allegedly performed services for the patient, and does not reflect any treatment recommended or any other records reviewed.

Count III

45. Patient #3 was a 15-year-old white female who was approximately 26 weeks pregnant.

46. The Licensee's patient records for Patient #3 are set forth in Exhibit 25.

47. The only thing in the patient's file that refers to the Licensee is an Authorization to Disclose Protected Health Information form. Nothing identifies the Licensee as the treating physician.

48. The Licensee utilized two computer programs to diagnose Patient #3 with Major Depressive Disorder, Single Episode, Psychotic Features.

49. There is nothing in the patient record specific to Patient #3 that was created by the Licensee. There is a mental illness statement and a statement regarding the patient that was completed by Dr. Tiller's staff.

50. There is no evidence that the Licensee conducted any type of personal evaluation of Patient #3 in that the Licensee's file for Patient #3 contained documents sent over from Dr. Tiller's file and then the computer generated checklist based upon the DSM-IV-TR criteria. There is nothing supporting any type of diagnosis concerning Patient #3 with personal information.

51. There is no review of Patient #3's psychiatric, medical, or developmental history, no prior psychiatric treatment or symptoms, personal or family history, or a review of any other medical documentation concerning Patient #3. There is no evidence of any type of mental status examination.

52. There is nothing in the record for Patient #3 reflecting that the Licensee observed her physical appearance, her affect and mood, or anything personally specific to Patient #3.

53. There is nothing to indicate that the Licensee had any involvement whatsoever with this patient other than the completion of the two computer program items.

54. The Licensee, by failing to provide any specific clinical information that would substantiate a comprehensive mental health evaluation, is in violation of K.S.A. 65-2836(b) and K.S.A. 65-2837(a).

55. The Licensee violated K.S.A 65-2836(k) and K.A.R. 100-24-1 in that her documentation for Patient #3 was wholly ineffective. The appointment date of the Licensee's appointment with Patient #3 is not evident. There is nothing in the Licensee's handwriting or any notation by her as to any examination of Patient #3. In the mental health statement that was reviewed, there is no indication that the Licensee relied upon this information and, if she did, how the Licensee relied upon this information. The patient documentation in this case is wholly inadequate.

Count IV

56. Patient #4 was a 15-year-old African American female who was 28 weeks pregnant.

57. Patient #4's file as maintained by the Licensee is set forth in Exhibit 26 and consists of 10 pages.

58. Other than the Authorization to Disclose Protected Health Information form which contains the Licensee's name, there is nothing contained in Exhibit 26 identifying the Licensee as the treating physician.

59. The Licensee diagnosed Patient #4 with Acute Stress Disorder, Moderate. This diagnosis requires that the patient has "experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to physical integrity of self or others" (DSM-IV-TR). Nowhere in the record of Patient #4 is there any evidence as to any traumatic event that would support this diagnosis.

60. There is no evidence that the Licensee conducted any type of personal evaluation of Patient #4 in that the Licensee's file for Patient #4 contained documents sent over from Dr. Tiller's file and then the computer generated checklist based upon the DSM-IV-TR criteria. There is nothing supporting any type of diagnosis concerning Patient #4 with personal information.

61. There is no review of Patient #4's psychiatric, medical, or developmental history, no prior psychiatric treatment or symptoms, personal or family history, or a review of any other medical documentation concerning Patient #4. There is no evidence of any type of mental status examination.

62. The Licensee, by failing to obtain any specific clinical information that would substantiate a comprehensive mental health evaluation, is in violation of K.S.A. 65-2836(b) and K.S.A. 65-2837(a).

63. The Licensee has 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 the Licensee's professional services were provided, it does not contain whatsoever any pertinent, significant information that the Licensee obtained from the patient's condition, it does not reflect the examination that the Licensee conducted, nor does it contain the reason for the patient seeking the Licensee's services. Further, there is no evidence of any treatment that was recommended or whether the Licensee relied upon any information that was provided to her from Dr. Tiller's office, such as the mental illness statement. The file does not even show the Licensee as the treating physician.

Count V

64. Patient #5 was a 15-year-old female who was approximately 25 weeks pregnant.

65. Patient #5's file as maintained by the Licensee is set forth in Exhibit 27 and consists of eight pages.

66. Only one page has any indication that the Licensee was involved with the care of this patient. That document is an Authorization to Disclose Protected Health Information form that bears the Licensee's name. There is nothing to indicate who the treating physician for this patient was.

67. There is a two-page DTREE Positive DX report and a GAF report. The GAF report was completed on August 7, 2003. The DTREE report shows a completion date of August 7, 2003, which has been drawn through and it appears the Licensee 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 the Licensee's files as to why these dates are inconsistent.

68. In the computer generated reports, the diagnosis is Major Depressive Disorder, Single Episode. Other than the computer printout, there is nothing to indicate the basis for this diagnosis. There is no review of the patient's presenting problems, duration, frequency, or intensity of the current symptoms, or any past history, including treatment and any response treatment. There is no family history, social history, or anything personal or specific to this patient.

69. There is no evidence in the Licensee's file that she performed an adequate mental health examination. There is no evidence that the Licensee explored the symptoms and findings contained in the mental health statement prepared by Dr. Tiller's office or that she obtained any of the patient's psychiatric history or anything specific to this patient.

70. The Licensee violated K.S.A. 65-2836(b) and K.S.A. 65-2837(a).

71. The medical documentation contained in the Licensee's file of Patient #5 is wholly inadequate. There is no clear date of any examination of Patient #5, there is no evidence of what led to the Licensee's diagnosis for this patient, there is no evidence of any personal evaluation or specific clinical information concerning this patient, there is no pertinent and significant information concerning the patient's condition contained in the file, nor are there any specific treatment recommendations for this patient. Further, there is nothing in the patient record to indicate that the Licensee reviewed the mental health statement that was prepared by Dr. Tiller's office. The file does not even show the Licensee as the treating physician. This is in violation of K.S.A. 65-2836(k) and K.A.R. 100-24-1.

Count VI

72. Patient #6 was a 16-year-old female approximately 25 weeks pregnant.

73. The Licensee's record for Patient #6 is set forth in Exhibit 28.

74. There is nothing in Patient #6's file which indicates who the treating physician is. The Licensee's name is printed on an Authorization to Disclose Protected Health Information form.

75. There are two DTREE Positive DX reports, one with a rating date of August 26, 2003. The DTREE report has a report date of September 5, 2003. The GAF computer generated report has a rating date of August 26, 2003 and a report date of August 26, 2003. There is no explanation for the difference in the DTREE report dates.

76. From the DTREE Positive DX report, the Licensee shows a diagnosis of Acute Stress Disorder and shows that the patient has "experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to physical integrity."

77. Nothing in the patient record shows any traumatic event involving the patient that would lead to a diagnosis of Acute Stress Disorder. The Licensee did not identify any traumatic event in the patient's chart.

78. There is nothing to establish that the Licensee conducted a mental health examination involving an interview of the patient concerning the presenting problems, duration, frequency, and intensity of the current symptoms, any past history of the patient, family history of the patient, prior medical conditions and current medical conditions, as well as social history and occupational history. There is no evidence that the Licensee performed a mental health evaluation or that any mental health evaluation was ever done.

79. The Licensee, in the care and treatment of Patient #6, violated K.S.A. 65-2836(b) and K.S.A. 65-2837(a) by failing to meet the applicable standard of care in the treatment of Patient #6.

80. The Licensee 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. The record maintained does not identify the Licensee 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 the Licensee other than the computer generated tests. This wholly fails to satisfy the requirements of K.A.R. 100-24-1.

Count VII

81. Patient #7 was a 15-year-old female approximately 25 weeks pregnant.

82. The Licensee's medical records for Patient #7 are contained in Exhibit 29 and consist of a total of seven pages.

83. Other than the Licensee's name printed on an Authorization to Disclose Protected Health Information form, there is nothing in Patient #7's file to indicate that the Licensee is the treating physician.

84. The patient's file consists of a total of seven pages. The Licensee generated three of the pages of the patient record through her computer generated DTREE report and her GAF report.

85. Other than the computerized reports generated by the Licensee, there is nothing contained in the record for Patient #7 to show that a mental health evaluation was conducted. There is nothing specific about Patient #7 generated by the Licensee concerning the patient's presenting problems, the duration of these problems, the frequency of the problems, the intensity of the current symptoms, any past history, any treatment, or any response to treatment. There is no family history, social history, or occupational history in the patient's file. Nothing about this patient is included in the Licensee's record to establish that an adequate mental health examination was conducted by the Licensee.

86. The mental health statement obtained by Dr. Tiller's office denied that Patient #7 had suicidal tendencies. Yet, the GAF report generated by the Licensee's computer and the DTREE Positive DX report both suggested that Patient #7 was suicidal. Yet, nothing is contained in the Licensee's medical record to show that she ever addressed which was the correct position. That is, she never addressed whether Patient #7 had or did not have suicidal ideation. She simply ignored this conflicting information.

87. There is nothing contained in Patient #7's record to show that the Licensee ever reviewed the patient's presenting problems, the duration of those problems, the frequency and intensity of the patient's current symptoms, any past history, any family history, any social history, any medical history, or anything about the patient. There is nothing in the Licensee's work that identifies any specific detail about Patient #7. There is no evidence of any type of mental status examination.

88. There is no significant clinical data contained in the medical records of Patient #7 that would lead to the diagnosis rendered by the Licensee.

89. The Licensee violated K.S.A. 65-2836(b) and K.S.A. 65-2837(a) in that she did not meet the applicable standard of care in her care and treatment of Patient #7. The Licensee failed to adequately conduct a mental health evaluation. The Licensee

failed to document any specific information concerning Patient #7. The Licensee failed to address the apparent inconsistency between her computer generated tests and the mental health statement prepared by Dr. Tiller's office.

90. The medical records of Patient #7 completed by the Licensee violate K.S.A. 65-2836(k) and K.A.R. 100-24-1 in that they are totally inadequate. There 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. Additionally, there was no treatment performed or recommended which, in light of the Licensee's computerized reports that the patient was suicidal, is troubling. The record fails to identify the Licensee as the treating physician. The patient record fails to comply with K.A.R. 100-24-1.

Count VIII

91. Patient #8 was a 13-year-old female who was approximately 25 weeks pregnant.

92. The Licensee's records for Patient #8 are contained in Exhibit 30 and consist of five pages. Of the five pages, the Licensee's name appears at the top of a face sheet. Additionally, there is an Authorization to Disclose Protected Health Information form which bears the Licensee's name printed at the very top of the document.

93. Unlike the prior patients, there is no DTREE computer report or GAF computer report contained in Patient #8's file.

94. Although it is not in the patient's file, the Licensee testified during an inquisition or court hearing that she diagnosed Patient #8 with Suicide Ideation and Acute Stress Disorder. This diagnosis is not found in the patient's record maintained by the Licensee.

95. In order to make a diagnosis of Suicide Ideation and Acute Stress Disorder, it would be necessary for a mental health evaluation to be performed by the attending physician.

96. There is nothing in Patient #8's file that would establish that the Licensee performed any type of mental health evaluation whatsoever on this patient.

97. The Licensee, in treatment of Patient #8, violated K.S.A. 65-2836(b) and K.S.A. 65-2837(a) by failing to adhere to the applicable standard of care. There is no evidence that there was a standard child psychiatric evaluation or a standard psychiatric evaluation of any kind performed by the Licensee for Patient #8. Further, there is nothing in the chart generated by the Licensee that would lead to a diagnosis.

98. The documentation in Patient #8's file does not meet the requirements of K.A.R. 100-24-1 and, therefore, the Licensee is in violation of K.S.A. 65-2836(k). There is no documentation of anything by the Licensee. There is no date of any service provided, there is nothing in the record containing pertinent and significant information concerning the patient's condition, and there is nothing concerning any type of examination the Licensee performed. There is no authentication by the Licensee of anything in the file nor does the file indicate any recommended treatment or whether any records were reviewed by the Licensee.

Count IX

99. Patient #9 was a 15-year-old female who was approximately 25 weeks pregnant.

100. The Licensee's patient record for Patient #9 is contained in Exhibit 31 and consists of a total of ten pages.

101. While the Licensee's name appears twice in Patient #9's record, nowhere does it indicate that the Licensee is Patient #9's treating physician.

102. The Licensee completed the computerized GAF report and the computerized DTREE Positive DX report. Both of these reports bear a date of November 5, 2003. The appointment date as set forth in the face sheet provided by Dr. Tiller's office sets the appointment date to be November 4, 2003. It is unclear what day the appointment was for Patient #9.

103. The records maintained by the Licensee do not anywhere indicate that a mental health evaluation was conducted on Patient #9 other than the two computerized reports. There is nothing indicating that the Licensee reviewed the patient's presenting problems, the duration of the problems, the frequency of the problems, and the intensity of any current symptoms. There is no indication that the Licensee reviewed the patient's past history, her family history, social history, or occupational history. There is nothing in the patient record to establish that a mental health evaluation was completed by the Licensee.

104. The Licensee violated K.S.A. 65-2836(b) and K.S.A. 65-2837(a) by failing to properly conduct a mental health evaluation of Patient #9. There is no specific clinical information contained in the record generated by the Licensee as to what were the specific conditions of Patient #9. Only computer generated reports based upon "Yes" and "No" answers, which are inadequate to establish a mental evaluation.

105. The Licensee violated K.S.A. 65-2836(b) and K.S.A. 65-2837(a) in that she did not meet the applicable standard of care. The Licensee failed to adequately conduct a mental health examination.

106. The patient records for Patient #9 do not contain a date certain when professional services 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 the Licensee. Finally, there is nothing in the record to indicate treatment recommended or whether other patient records were reviewed. The record does not identify the Licensee as the treating physician. The Licensee violated K.S.A. 65-2836(k) and K.A.R. 100-24-1.

Count X

107. Patient #10 was an 18-year-old female who was approximately 25 weeks pregnant.

108. The Licensee's patient record for Patient #10 consists of 10 pages set out in Exhibit 32.

109. The name of the Licensee appears twice on the records of Patient #10. The first time it 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 the Licensee that the Licensee was a treating physician for Patient #10.

110. The face sheet from Dr. Tiller's office shows the appointment with Patient #10 was October 4, 2003. This is generally in accordance with testimony provided by the Licensee that the appointment date on Dr. Tiller's face sheet was the appointment date for the patient. However, the computerized forms completed by the Licensee, the DTREE Positive DX report and the GAF report, are both dated November 13, 2003. Obviously, the date that the Licensee had any contact with Patient #10 is uncertain.

111. In the Licensee's computerized DTREE Positive DX report and the GAF report, the Licensee reaches a diagnosis of Acute Stress Disorder, Severe.

112. Under the DSM-IV-TR diagnostic criteria, it is necessary for a patient to have this diagnosis to have "experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to physical integrity."

113. The records of Patient #10 do not have any indication whatsoever that Patient #10 "experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to physical integrity."

114. The Licensee testified that the traumatic event in Patient #10's life was an unintended pregnancy. This would lead to a conclusion that any unintended pregnancy causes the mental health condition of the pregnant woman to be Acute Stress Disorder.

There is nothing in the patient file to support this. The Licensee did not document this in Patient #10's file.

115. Patient #10 had a history of past psychiatric treatment. Patient #10 was taking 40 milligrams of Paxil per day and had last suffered an anxiety attack approximately six months prior to her involvement with the Licensee. The Licensee did not in any way review the psychiatric treatment history of Patient #10 nor is there any evidence that the Licensee contacted Patient #10's treating physician to review the patient's records and discuss with the treating physician Patient #10's care.

116. The Licensee did not perform an adequate mental health evaluation on Patient #10 in that there was no review of the patient's presenting problems, the duration, frequency, or intensity of any current symptoms, any past history, or any treatment. There is no evidence that the Licensee reviewed the family history, medical history, social history, or occupational history of Patient #10. There is no evidence of any type of mental status examination.

117. As a result of the Licensee's failure to conduct a meaningful mental health examination, the Licensee has violated K.S.A. 65-2836(b) and K.S.A. 65-2837(a).

118. The Licensee's treatment of Patient #10 violates 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 the Licensee as to Patient #10. The file does not indicate which date the Licensee 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 the Licensee. The record does not indicate what patient records from other health care providers were reviewed in forming the Licensee's diagnosis.

Count XI

119. Patient #11 was a 16-year-old female who was approximately 29 weeks pregnant.

120. The Licensee's patient file for Patient #11 is identified as Exhibit 33 and consists of five pages.

121. An Authorization to Disclose Protected Health Information form has the Licensee's name printed on this document. Nowhere else in the patient record is the Licensee's name found. Nowhere in the patient record does it show that the Licensee is the treating physician for Patient #11.

122. The face sheet as contained in Patient #11's record shows the appointment date to be November 18, 2003.

123. The Licensee generated her computerized DTREE Positive DX report and GAF report. Both of these reports bear the date of November 20, 2003. It is unclear what date the Licensee had any contact with Patient #11.

124. Further complicating the issue of when the Licensee may have seen Patient #11 is the fact that the patient's pregnancy termination was on November 19, 2003, the day before the date on the computerized reports.

125. There is nothing in the patient record of Patient #11 to support the 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.

126. The care of Patient #11 by the Licensee did not meet the applicable standard of care. There is no clinical information within the Licensee's record for Patient #11 that supports any type of psychological diagnosis. There is no documentation that the Licensee completed a mental health evaluation that included the presenting problems of the patient, the duration, frequency, or intensity of any current symptoms, any past history of the patient, or any medical history, family history, social history, or occupational history of the patient. There is absolutely nothing specific about this patient other than what is contained in Dr. Tiller's face sheet.

127. The patient record of Patient #11 indicates that she might be in danger of hurting herself and yet there is nothing contained in the record to assess this situation. The Licensee ignored this.

128. The Licensee did not meet the applicable standard of care and is in violation of K.S.A. 65-2836(b) and K.S.A. 65-2837(a).

129. Further, there was a deviation from the applicable standard of care in the treatment of Patient #11 in that the Licensee did not refer Patient #11 to a specialist for an adolescent psychiatric evaluation. Based upon documentation in Dr. Tiller's records, there was a need for a specialized examination because of the patient's history.

130. K.A.R. 100-24-1 and K.S.A. 65-2836(k) were violated by the Licensee 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 the Licensee, and there is no reason for the patient seeking out the services of the Licensee.

Conclusions

1. Based upon the above findings and conclusions, it is clear that the Licensee has held herself out as a specialist in the field of psychiatric medicine in making mental health

evaluations. It is equally clear that the Licensee has failed in the cases cited above to make competent mental health evaluations that meet the applicable standard of care for the 11 patients listed above.

2. In each of the cases listed above, the only thing that is clear that the Licensee did was have patients answer "Yes" or "No" questions and plug these answers into a computer. There is no indication that the Licensee on any occasion actually conversed with a patient concerning the items necessary for a competent mental health examination to be completed.

3. The testimony of Dr. Greiner is largely discounted. This is based upon his relationship with the Licensee as well as the inability to find him credible. This is because despite the fact that even in the Licensee's treatment of Patient #8, where there was absolutely nothing done by the Licensee to reach a diagnosis, Dr. Greiner testified he believed the Licensee met the standard of care. There is no documentation whatsoever of the Licensee ever seeing Patient #8, or treating Patient #8, or performing any examination, or having any contact with Patient #8 at all. Yet, Dr. Greiner was of the opinion that the Licensee's care and treatment of Patient #8 met the applicable standard of care and that the documentation of the care for Patient #8 was adequate and met the applicable standard of care. The question then becomes, if there is absolutely nothing in the file from the Licensee, how could it possibly meet the applicable standard of care? Clearly it could not.

4. It must be noted that in each of the 11 cases above the Licensee diagnosed each patient as having a major mental illness. In some cases, the patients were, according to the Licensee's diagnosis, suicidal. Yet, in not one single case did the Licensee make any recommendations that the patient be seen by a psychiatrist, a psychologist, or any other type of mental health worker. The Licensee simply referred each patient for a pregnancy termination. If the Licensee sincerely believed that the patients were seriously mentally ill, it would seem likely that a treating physician would recommend treatment for these rather serious mental illnesses. Yet, the Licensee ignored these alleged mental illnesses.

5. Based upon the evidence, the Licensee simply completed yes/no questions and answers and whatever diagnosis the computer gave, she assigned that diagnosis. This method of practicing medicine does not meet the applicable standard of care.

6. The Licensee attempts to explain why there is nothing of hers in these patient files. She argues that was to protect the patients. This argument has no merit since each patient was clearly identified. How the nonexistence of specific patient documentation protects patients is not clear and is without merit.

7. Based upon the history of the Licensee with the Board and based upon the findings of fact contained herein and based upon the disciplining policy of the Board, the license

of the Licensee is revoked. The care and treatment of the 11 patients in question was seriously jeopardized by the Licensee's care.

Conclusions of Law

The license of Ann K. Neuhaus, M.D. is hereby revoked and the costs of this action are hereby taxed to her. The Board shall file an Affidavit of Cost in this matter.

IT IS SO ORDERED.

Pursuant to K.S.A. 77-527, either party may appeal this initial order. A petition for review must be filed within 15 days from date of this initial order. Failure to timely request review may preclude further judicial review. If neither party requests a review, this initial order becomes final and binding on the 30th day following its mailing. Petitions for review shall be mailed or personally delivered to: Kathleen Selzler Lippert, Executive Director, Kansas State Board of Healing Arts, 800 SW Jackson, Lower Level, Suite A, Topeka, KS 66612.

Edward J. Gaschler
Administrative Law Judge/Presiding Officer

CERTIFICATE OF SERVICE

On Feb. 17, 2012, I mailed a copy of this Initial Order to:

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