BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
	)	Docket No.: 15-HA00090
Pat Dinh Do, M.D.	)	
Kansas License No. 04-28594	)	

CONSENT ORDER

COMES NOW, the Kansas State Board of Healing Arts, ("Board"), by and through Susan R. Gering, Associate Litigation Counsel, and Anne Barker Hall Associate Litigation Counsel ("Petitioner"), and Pat Dinh Do, M.D. ("Licensee"), by and through his attorney Mark R. Maloney of Gilliland & Hayes, LLC, and move the Board for approval of a Consent Order affecting Licensee's license to practice medicine and surgery in the State of Kansas. The Parties stipulate and agree to the following:

1. Licensee's last known mailing address to the Board is: 1923 North Webb Road, Wichita, Kansas 67206.
2. Licensee is or has been entitled to engage in the practice of medicine and surgery in the State of Kansas, having been issued License No. 04-28594 on approximately April 8, 2000. Licensee's license is active.
3. The Board is the sole and exclusive administrative agency in the State of Kansas authorized to regulate the practice of the healing arts, specifically the practice of medicine and surgery . K.S.A. 65-2801 *et seq.*, and K.S.A. 65-2869.
4. This Consent Order and the filing of such document are in accordance with applicable law and the Board has jurisdiction to enter into the Consent Order as provided by K.S.A. 77-505

and 65-2838. Upon approval, these stipulations shall constitute the findings of the Board, and this Consent Order shall constitute the Board's Final Order.

5. The Kansas Healing Arts Act is constitutional on its face and as applied in the case. Licensee agrees that, in considering this matter, the Board is not acting beyond its jurisdiction as provided by law.
6. Licensee voluntarily and knowingly waives his right to a hearing. Licensee voluntarily and knowingly waives his right to present a defense by oral testimony and documentary evidence, to submit rebuttal evidence, and to conduct cross-examination of witnesses. Licensee voluntarily and knowingly agrees to waive all possible substantive and procedural motions and defenses that could be raised if an administrative hearing were held.
7. The terms and conditions of the Consent Order are entered into between the undersigned parties and are submitted for the purpose of allowing these terms and conditions to become an Order of the Board. This Consent Order shall not be binding on the Board until an authorized signature is affixed at the end of this document. Licensee specifically acknowledges that counsel for the Board is not authorized to sign this Consent Order on behalf of the Board.
8. The Board has received information and investigated the same, and has reason to believe that there may be grounds to take action with respect to Licensee's license under the Kansas Healing Arts Act, K.S.A. 65-2801 *et seq.*
9. This Consent Order incorporates herein by reference the facts as stated in the Petition that was filed on April 13, 2015. Exhibit 1, Petitioner in the Matter of Pat Dinh Do, M.D. 15-HA00090.

10. Licensee acknowledges that if formal hearing proceedings were conducted and Licensee presented no exhibits, witnesses, or other evidence, the Board has sufficient evidence to prove that Licensee has violated the Kansas Healing Arts Act with respect to the above allegations. Licensee further waives his right to dispute or otherwise contest the allegations contained in the above paragraphs in any further proceeding before this Board.
11. Licensee's acts, if proven, constitute conduct or professional practice, that if continued, would reasonably be expected to constitute an inability to practice the healing arts with reasonable skill and safety to patients as set forth in K.S.A. 65-2836.
12. Licensee violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(2), in that Licensee has engaged in conduct or professional practice with repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board;
13. Licensee violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(3), in that Licensee has committed a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice the healing arts;
14. Licensee violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(12), in that Licensee's conduct in the care and treatment of Patient 2 was likely to harm the public;
15. Licensee violated K.S.A. 65-2836(b), as furthered defined in K.S.A. 65-2837(b)(24), in that Licensee has had a repeated failure to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;
16. Licensee violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(25), in that Licensee failed to keep written medical records that accurately reflect the services

rendered, including patient histories, pertinent findings, examination results and test results; and

17. Licensee violated K.S.A. 65-2836(k), in that Licensee has violated a lawful regulation promulgated by the Board, specifically, K.A.R. 100-24-1 by failing to meet the minimum requirements for an adequate patient record.
18. Pursuant to K.S.A. 65-2836, the Board may revoke, suspend, limit, censure or place under probationary conditions Licensee's license and pursuant to K.S.A. 65-2863a the Board has the authority to impose administrative fines for violations of the Kansas Healing Arts Act.
19. According to K.S.A.65-2838(b) and K.S.A. 77-505, the Board has authority to enter into this Consent Order without the necessity of proceeding to a formal hearing.
20. All pending investigation materials in KSBHA Investigation Numbers 11-00312, 11-00313, 11-00400, 12-00169, and 14-00531 regarding Licensee were fully reviewed and considered by the Board members who serve on the Board's Disciplinary Panel No. 27. Disciplinary Panel No. 27 authorized and directed Board counsel to seek settlement of this matter with the provisions contained in this Consent Order.
21. Licensee further understands and agrees that if the Board finds, after due written notice and an opportunity for a hearing, that Licensee has failed to comply with any of the terms of this Consent Order, the Board may immediately impose any sanction provided for by law, including but not limited to suspension or revocation of Licensee's license to practice medicine and surgery in the State of Kansas. Licensee hereby expressly understands and agrees that, at any such hearing, the sole issue shall be whether or not Licensee has failed to comply with any of the terms or conditions set forth in this Consent Order. The Board acknowledges that at any such hearing, Licensee retains the right to confront and examine

all witnesses, present evidence, testify on his own behalf, contest the allegations, present oral argument, appeal to the courts, and all other rights set forth in the Kansas Administrative Procedures Act, K.S.A. 77-501 *et seq.*, and the Kansas Healing Arts Act, K.S.A. 65-2801 *et seq.*

22. Nothing in this Consent Order shall be construed to deny the Board jurisdiction to investigate alleged violations of the Kansas Healing Arts Act, or to investigate complaints received under the Risk Management Law, K.S.A. 65-4921 *et seq.*, that are known or unknown and are not covered under this Consent Order, or to initiate formal proceedings based upon known or unknown allegations of violations of the Kansas Healing Arts Act.
23. Licensee hereby releases the Board, its individual members (in their official and personal capacity), attorneys, employees and agents, hereinafter collectively referred to as "Releasees", from any and all claims, including but not limited to those alleged damages, actions, liabilities, both administrative and civil, including the Kansas Judicial Review Act, K.S.A. 77-601 *et seq.* arising out of the investigation and acts leading to the execution of this Consent Order. This release shall forever discharge the Releasees of any and all claims or demands of every kind and nature that Licensee has claimed to have had at the time of this release or might have had, either known or unknown, suspected or unsuspected, and Licensee shall not commence to prosecute, cause or permit to be prosecuted, any action or proceeding of any description against the Releasees.
24. Licensee further understands and agrees that upon signature by Licensee, this document shall be deemed a public record and shall be reported to any entities authorized to receive disclosure of the Consent Order.

25. This Consent Order, when signed by both parties, constitutes the entire agreement between the parties and may only be modified or amended by a subsequent document executed in the same manner by the parties.
26. Licensee agrees that all information maintained by the Board pertaining to the nature and result of any complaint and/or investigation may be fully disclosed to and considered by the Board in conjunction with the presentation of any offer of settlement, even if Licensee is not present. Licensee further acknowledges that the Board may conduct further inquiry as it deems necessary before the complete or partial acceptance or rejection of any offer of settlement.
27. Licensee, by signature to this document, waives any objection to the participation of the Board members, including the Disciplinary Panel and General Counsel, in the consideration of this offer of settlement and agrees not to seek the disqualification or recusal of any Board member or General Counsel in any future proceedings on the basis that the Board member or General Counsel has received investigative information from any source which otherwise may not be admissible or admitted as evidence.
28. Licensee acknowledges that he has read this Consent Order and fully understands the contents.
29. Licensee acknowledges that this Consent Order has been entered into freely and voluntarily.
30. All correspondence or communication between Licensee and the Board relating to the Consent Order shall be by certified mail addressed to:

Kansas State Board of Healing Arts
Attn: Compliance Coordinator
800 SW Jackson, Lower Level-Suite A,
Topeka, Kansas 66612

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

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

33. Licensee shall immediately notify the Board or its designee of any citation, arrest or charge filed against him or any conviction for any traffic or criminal offense excluding speeding and/or parking violations.

34. Licensee shall immediately notify the Board or its designee of any complaint filed, or investigation opened, by the proper licensing authority of another state, territory, District of Columbia, or other country, or by a peer review body, a health care facility, a professional association or society, or by a governmental agency.

35. Licensee shall at all times keep Board staff informed of his current practice locations addresses and telephone numbers. Licensee shall provide the above information in writing to the Board within ten (10) days of any such change.

36. This Consent Order constitutes public non-disciplinary action.

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

38. In lieu of conducting a formal proceeding, Licensee, by signature affixed to this Consent Order, hereby voluntarily agrees to the following non-disciplinary action against his license to engage in the practice of medicine and surgery:

EDUCATION

39. Licensee shall attend and successfully complete the following continuing medical education (CME) course(s)/seminar(s):

    a. Licensee shall attend and successfully complete all sessions of the in-person 2015 *4th Annual Shoulder Course* put on by the International Congress for Joint Reconstruction (ICJR) from November 5-7, 2015, unless otherwise approved by the Board and/or the Appointed Disciplinary Member.

        i. Licensee shall provide proof of successful completion for the ICJR course within thirty (30) calendar days of successfully completing the course.

    b. Licensee shall successfully complete the *Physician Supervision of Non-Physician Providers* webinar, put on by KaMMCO, unless otherwise approved by the Board and/or the Appointed Disciplinary Member.

        i. Licensee shall complete the approved webinar on or before December 11, 2015.

        ii. Licensee shall provide proof of successful completion for the approved webinar to the Compliance Coordinator within thirty (30) calendar days of successfully completing the approved webinar.

40. These hours shall be in addition to those hours required for renewal of licensure.

41. All foreseen and unforeseen costs associated with the aforementioned course(s)/seminar(s) shall be at Licensee's own expense to include, but not be limited to, the cost of the course(s)/seminar(s), travel, lodging, program fee(s), meals, etc.

BOARD COSTS

42. Licensee agrees to pay the Board's incurred COSTS in conducting these proceedings under the Kansas Administrative Procedure Act in the amount that is put forth by the Board in a Statement of Costs.

43. Such COSTS shall be paid in the form of a Cashier's Check or Money Order to the "Kansas State Board of Healing Arts" in full on or before December 30, 2015.

44. All monetary payments to the Board relating to this Consent Order shall be mailed to the Board by certified mail addressed to:

Kansas State Board of Healing Arts
Attn: Compliance Coordinator
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

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

IT IS SO ORDERED on this 3 day of NOV, 2015.

FOR THE KANSAS STATE BOARD OF HEALING ARTS:

Kathleen Selzler Lippert
Executive Director

9-11-15
Date

Pat Dinh Do, M.D.
Licensee

9-11-15
Date

PREPARED AND APPROVED BY:

Susan R. Gering, #25582
Associate Litigation Counsel
Anne Barker Hall, #23672
Associate Litigation Counsel
Kansas State Board of Healing Arts
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ahall@ksbna.ks.gov

APPROVED BY:

Mark R. Maloney
Attorney for Licensee
Gilliland & Hayes, LLC
1300 Epic Center
301 N. Main
Wichita, Kansas 67202
mmaloney@gh-ks.com

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that I served a true and correct copy of the Consent Order by United States mail, postage prepaid, on this 2 day of Nov., 2015, to the following:

Pat Dinh Do, M.D.
Licensee
1923 N. Webb Rd.
Wichita, Kansas 67206

Mark R. Maloney
Attorney for Licensee
Gilliland & Hayes, LLC
1300 Epic Center
301 N. Main
Wichita, Kansas 67202

And the original was hand-filed with:

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

And a copy was hand-delivered to:

Susan R. Gering
Associate Litigation Counsel
Anne Barker Hall
Associate Litigation Counsel
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

Compliance Coordinator
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

Cathy A. Brown

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
	)	**Docket No.: 15-HA** 00090
Pat Dinh Do, M.D.	)	
Kansas License No. 04-28594	)	

PETITION

COMES NOW the Petitioner, the Kansas State Board of Healing Arts ("Board"), by and through Susan R. Gering, Associate Litigation Counsel, and Anne Barker Hall, Associate Litigation Counsel, ("Petitioner") and initiates these proceedings against Pat Dinh Do, M.D. ("Licensee") pursuant to the provisions of K.S.A. 65-2836, K.S.A. 65-2851a, and K.S.A. 77-501 *et seq.* For its cause of action, Petitioner alleges and states:

FACTS COMMON TO ALL COUNTS

1. The Board is the sole and exclusive administrative agency in the State of Kansas authorized to regulate the practice of the healing arts, specifically the practice of medicine and surgery. K.S.A. 65-2801 *et seq.*
2. Licensee's last known mailing address to the Board is: 1923 North Webb Road, Wichita, Kansas 67206.
3. Licensee is or has been entitled to engage in the practice of medicine and surgery in the State of Kansas, having been issued original and permanent license No. 04-28594 on or about April 8, 2000, and having renewed such license on or about June 23, 2014.

4. At all times relevant to the allegations set forth in the Petition, Licensee has held a current and active license to engage in the practice of medicine and surgery in the State of Kansas.

5. Since issuance of licensure in a regulated profession as a medical doctor in the State of Kansas, pursuant to K.S.A. 65-2836 *et seq.*, Licensee did commit the following acts:

COUNT I

6. Petitioner incorporates herein, by reference, paragraphs one (1) through five (5) as fully restated and re-alleged herein.

7. On or about January 18, 2006, Patient 1, an eighty (80) year old male presented to Licensee's office as a referral from Dr. Michael Treweeke, M.D. for left shoulder pain. Patient 1 indicated he had been experiencing pain for approximately one (1) week. Patient 1 had previously had an MRI performed on January 10, 2006. The findings included a complete tear of the supraspinatus muscle tendon with retraction of the muscle.

8. At the January 18th appointment, Patient 1's evaluation and review of the January 10, 2006 MRI was performed by Licensee's Nurse Practitioner, Tennille Greb, ARNP-C. Ms. Greb's initial visit notes indicate Patient 1 had been experiencing pain for one (1) week. That same day, Ms. Greb scheduled Patient 1's left subacromial decompression and rotator cuff repair surgery for January 25, 2006, and noted that Patient 1 would have a pre-op visit with Licensee. Ms. Greb also ordered pre-operative laboratory work, requested medical clearance from Patient

1's primary care physician, and performed an EKG. Licensee did not see Patient 1 at the time of the scheduling of Patient 1's surgery.

9. The January 18th progress note was electronically signed by Ms. Greb the same day at 2:00 p.m. Licensee made revisions to the record on January 19, 2006, at 8:10 a.m. It is unclear what revisions to Patient 1's record were made by Licensee.

10. On or about January 19, 2006, a progress note indicated Patient 1 was "seen and examined with [Licensee]." The note also states "please see H & P." No history and physical dated on January 19, 2006, appears in the records. Patient 1 was also prescribed forty (40) 7.5mg Lortab by Ms. Greb. No mention of this prescription appears in the January 19th progress note for Patient 1.

11. A history and physical (H&P) examination, dictated January 24, 2006, at 8:36 p.m., the night prior to Patient 1's surgery, appears in the records. The H&P was transcribed the following morning at 7:12 a.m., and at 9:35 a.m., an electronic notation of "Signature on File" was inserted into the signature line above Licensee's name. There is no indication this H&P was performed on January 19, 2006. The H&P indicates Patient 1 was experiencing pain for approximately four (4) weeks. This information is different from that documented by Licensee's nurse practitioner and different from what Patient 1 documented on the Medical History Form at the January 18th appointment. Also, it is unclear whether the history and physical was actually dictated by Licensee as it contains the following language: "THE PATIENT WAS SEEN AND EXAMINED WITH DR. PAT DO. ADDIE GREB, ARNP FOR PAT DO, MD."

12. On or about January 25, 2006, Licensee performed a left shoulder arthroscopy with extensive debridement of the labrum, synovium, rotator cuff and chondroplasty of the humeral head and glenoid; left shoulder arthroscopic subacromial decompression; mini open rotator cuff repair; and transcatheter pain placement. Licensee's postoperative plan for Patient 1 included: abduction pillow for two (2) weeks; passive range of motion week zero (0) to three (3); active and active assisted range of motion from week three (3) to week eight (8); and gentle strengthening from week eight (8) on. Licensee's plans also indicated "no matter what we do [Patient 1] will still have residual pain and weakness . . . [o]ne of these days he may need joint replacement."

13. On or about March 14, 2006, Patient 1 presented to Licensee's office for a six (6) week post-operative status appointment reporting "some pain and weakness." Patient 1's documented treatment plan was to continue therapy and begin strengthening in two (2) weeks with a follow-up in four (4) weeks. The record was electronically signed by Barry Kentopp, P.A. and Licensee that same day.

14. On or about April 10, 2006, Patient 1 presented to Licensee's office for a three (3) month post-operative status appointment. Patient 1 was still experiencing pain and indicated that physical therapy was not helping. At this time, Patient 1 was told the only surgical option would be to consider shoulder replacement. Two (2) more weeks of physical therapy was ordered, and Patient 2 was scheduled for a recheck in two (2) weeks. Ms. Greb also wrote a prescription for forty (40) 5/325mg Percocet. No mention of this prescription was mentioned in Patient 1's April 10th progress note.

15. On or about April 21, 2006, a phone message was documented indicating Patient 1 wanted a refill on his pain medication last filled on April 10, 2006. A prescription for forty (40) 5/325mg Percocet was written by Dr. Hufford that same day.

16. On or about April 25, 2006, Patient 1 presented to Licensee's office and saw Dr. David Hufford, M.D. for a reassessment of his left shoulder pain. Based on the lack of Patient 1's improvement and widespread, diffuse disease of Patient 1's left shoulder, Dr. Hufford referred Patient 1 for an opinion regarding shoulder replacement.

17. On or about May 18, 2006, a progress note was documented indicating Patient 1 wanted Licensee's office to refill his oxycodone. The note indicates Patient 1 was left a message stating that they could not refill his prescription as he was referred to another doctor and had not been seen in the office in approximately a month.

18. On or about May 22, 2006, Patient 1 contacted Licensee's office for a prescription for Percocet after having seen Dr. Hagan and being told there was nothing Dr. Hagan could do for Patient 1, and Patient 1 was being referred back to Dr. Do. Dr. Hufford provided Patient 1 a prescription for forty (40) 5/325mg Percocet.

19. On or about May 25, 2006, Patient 1 returned to Licensee's office for a reassessment of left shoulder pain and saw Dr. Hufford. Dr. Hufford indicated he injected Patient 1's right shoulder with 40mg Depo-Medrol and 4cc Marcaine/lidocaine mix. Also, Dr. Hufford discussed that as a last resort Patient 1 might need to have a shoulder arthroplasty.

20. On or about June 2, 2006, Patient 1 presented to Licensee's office for therapy. It was documented that Patient 1 was going to run out of Percocet, and a prescription was written for Patient 1 by Dr. Hufford for forty (40) 5/325mg Percocet.

21. On June 6, 2006, Dr. Hagan sent a letter discussing his treatment and care of Patient 1. In the letter, Dr. Hagan indicated that based on the size of Patient 1's tear and the "prior attempted repair", Dr. Hagan had informed Patient 1 that any additional surgical intervention would best be pursued by Licensee as Licensee was the last surgeon to evaluate tissue quality and "chronicity of the tear."

22. On or about June 13, 2006, Patient 1 presented to Licensee's office with complaints of shoulder pain. Licensee's record indicates Patient 1 was educated regarding risks and still wanted the surgery as an attempt at perhaps helping some of his pain. Licensee documented a plan for a left shoulder hemiarthroplasty.

23. On or about June 14, 2006, Patient 1 contacted Licensee's office stating he wanted something for pain relief until his surgery. A prescription for forty (40) 50mg Ultram was prescribed.

24. A left shoulder hemiarthroplasty was scheduled by Licensee for June 30, 2006, but was canceled on June 21, 2006, after Licensee's staff was informed that Patient 1 was at Wesley Medical Center for an infected and ruptured femoral artery in his left leg.

25. In the treatment of Patient 1, Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence, specifically including, but not limited to, each of the following acts or omissions:

a. Licensee failed to utilize conservative treatment prior to surgical intervention;

b. Licensee allowed Patient 1 to be scheduled for surgery by Licensee's Nurse Practitioner prior to Licensee's evaluation and examination of Patient 1; and

c. Licensee performed a subacromial decompression on Patient 1, who had an irreparable rotator cuff tear, making the shoulder less stable and increasing the chance for a superior escape.

26. Licensee's acts and conduct during the course of treating Patient 1 constitute violations of the Kansas Healing Arts Act as follows:

a. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(2), in that Licensee has committed an act of professional incompetency with repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board;

b. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(3), in that Licensee has committed a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice the healing arts;

c. Licensee has violated K.S.A. 65-2836(b), as furthered defined in K.S.A. 65-2837(b)(24), in that Licensee has had a repeated failure to practice the healing arts with that level of care, skill and treatment which is

recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

d. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(25), in that Licensee failed to keep written medical records that accurately reflect the services rendered to Patient 1, including patient histories, pertinent findings, examination results and test results; and

e. Licensee has violated K.S.A. 65-2836(k), in that Licensee has violated a lawful regulation promulgated by the Board, specifically, K.A.R. 100-24-1 by failing to meet the minimum requirements for an adequate patient record for Patient 1.

27. Pursuant to K.S.A. 65-2836, the Board has grounds to revoke, suspend, place on probation, censure, or otherwise limit the Licensee's license to practice medicine and surgery in the state of Kansas for his violations of the Kansas Healing Arts Acts.

COUNT 2

28. Petitioner incorporates herein, by reference, paragraphs one (1) through twenty-seven (27) as fully restated and re-alleged herein.

29. On or about April 13, 2006, Patient 2, a forty-four (44) year old female, presented to Licensee's office as a consult from Patient 2's primary care physician, Dr. Saleem Shahzad, M.D. Patient 2's chief complaint was left shoulder pain that had been on-going for approximately eighteen (18) months. Licensee documented discussing with Patient 2 indications, risks and options for her left shoulder

impingement and rotator cuff tear. Patient 2 is noted to have elected to undergo a left subacromial decompression and rotator cuff repair.

30. On the same day as Patient 2's initial consult, she was scheduled to have surgery on or about April 24, 2006.

31. On or about April 24, 2006, Licensee performed a left shoulder arthroscopy with extensive debridement; left shoulder arthroscopic subacromial decompression; mini-open rotator cuff repair; and transcatheter pain placement.

32. No documentation appears in Patient 2's medical records showing Licensee saw Patient 1 for post-surgery follow-up care and treatment. Instead, Patient 2 returned to Licensee's office on or about April 26, 2006, because her pain catheter leaked out. Patient 2 saw Dr. David Hufford, M.D. Dr. Hufford indicated that Patient 2's pain catheter and dressing was removed that day. He further documented that Patient 2 was to continue physical therapy with a reassessment to occur at her two (2) week visit.

33. Also, on or about April 26, 2006, Patient 2 was evaluated by a physical therapist.

34. On or about April 28, 2006, Patient 2 returned to the physical therapist. At that time, it was noted that Patient 2 had a prescription for a pillow sling, but was still in a regular sling post-surgery.

35. Patient 2 continued physical therapy with appointments occurring on or about May 2, 4, 8, 9, 12, 15, and 25 of 2006.

36. Patient 2 did not see Licensee for any other appointments. Patient 2 instead continued to see Dr. Hufford for her post-surgical follow-up care.

37. Patient 2 returned to Licensee's office in or around June 2006 and saw Dr. Gerard Librodo, M.D. for back pain and leg pain. Patient 2 saw Dr. Librodo for her back pain on three (3) separate occasions: June 2, 2006; June 16, 2006; and June 23, 2006. No other visits to Licensee's office are documented after her June 23, 2006, appointment.

38. On or about July 26, 2010, Patient 2 sought treatment from Dr. Chan for the return of pain in her left shoulder. At this point, Patient 2 indicated her shoulder hurt for approximately one (1) month. Dr. Chan recommended a cortisone injection, which Patient 2 received the same day.

39. Patient 2 underwent a subsequent left shoulder arthroscopy with subacromial decompression with rotator cuff repair on or about September 8, 2010, performed by Dr. Chan.

40. During the procedure, Dr. Chan noticed only one stitch, parallel to the tear, was used by Licensee to repair the rotator cuff, and there appeared to have been no attempt to reattach the cuff down to the greater tuberosity.

41. Based on Dr. Chan's observations during his care and treatment of Patient 2, he submitted a complaint regarding Patient 2's previous surgical care and treatment by Licensee.

42. In the treatment of Patient 2, Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence, specifically including, but not limited to, each of the following acts or omissions:

    a. Licensee performed a side-to-side repair and failed to properly attach the tendon to the bone; and

b. Licensee failed to see Patient 2 post-surgery.

43. Licensee's acts and conduct during the course of treating Patient 2 constitute violations of the Kansas Healing Arts Act as follows:

a. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(2) in that Licensee has committed an act of professional incompetency with repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence;

b. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(3), in that Licensee has committed a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice the healing arts;

c. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(12), in that Licensee's conduct is likely to harm the public;

d. Licensee has violated K.S.A. 65-2836(b), as furthered defined in K.S.A. 65-2837(b)(24), in that Licensee has had a repeated failure to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances; and

e. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(25), in that Licensee failed to keep written medical records that accurately reflect the services rendered to Patient 2, including patient histories, pertinent findings, examination results and test results.

f. Licensee has violated K.S.A. 65-2836(k), in that Licensee has violated a lawful regulation promulgated by the Board, specifically, K.A.R. 100-24-1 by failing to meet the minimum requirements for an adequate patient record for Patient 2.

44. Pursuant to K.S.A. 65-2836, the Board has grounds to revoke, suspend, place on probation, censure, or otherwise limit the Licensee's license to practice medicine and surgery in the state of Kansas for his violations of the Kansas Healing Arts Acts.

COUNT 3

45. Petitioner incorporates herein, by reference, paragraphs one (1) through forty-four (44) as fully restated and re-alleged herein.

46. On or about May 21, 2008, Patient 3, a sixty-three (63) year old female, presented to Licensee's office as a referral from Dr. Mike McClintick, D.O., with complaints of neck and left shoulder pain that she had been experiencing for approximately three (3) months. Patient 3 had reported undergoing physical therapy for approximately six (6) weeks with minimal improvement.

47. Patient 3 was documented as being seen and examined by Licensee at the May 21st appointment. Patient 3 was also documented with the following assessments: left shoulder rotator cuff syndrome with possible rotator cuff tear; impingement; type II acromion; and cervicalgia. The treatment plan indicates advantages and disadvantages of treatment options were discussed, an MRI of Patient 3's left shoulder was scheduled, and Patient 3 was to have a follow-up once the diagnostic

studies were completed for results and recommendations. The documentation fails to show what treatment options were discussed with Patient 3.

48. A signature and revision by Kent Hoffman, P.A. dated May 22, 2008, appears in Patient 3's May 21st progress note. It is unclear from the record what revisions were made to Patient 3's medical record. Licensee did not electronically sign the record until June 2, 2008.

49. Patient 3 returned to Licensee's office on or about June 4, 2008, with continued complaints of left shoulder pain. Patient 3 was documented to have had physical therapy without relief. The objective examination of Patient 3 documents that an MRI of the left shoulder showed "bone spur with impingement. No rotator cuff tear visualized." In Patient 3's documented treatment plan, cortisone injections versus a subacromial decompression with possible rotator cuff repair were discussed with Patient 3. Patient 3 is noted to have elected to have surgery and was prescribed twenty (20) 7.5/325mg Percocet at this appointment.

50. Patient 3's progress note for the June 4, 2008, appointment was initially written and signed by John McCaig, P.A. on or about June 4, 2008. Licensee did not electronically sign the record until June 27, 2008.

51. Patient 3 was subsequently scheduled for a left subacromial decompression with possible rotator cuff repair.

52. On or about June 11, 2008, Patient 3 presented to Susan B. Allen Memorial Hospital for the scheduled procedure. Licensee's operative report documents Patient 3 underwent a left shoulder arthroscopy with extensive debridement of the labrum and undersurface of the rotator cuff; chondroplasty of the humeral head; left

shoulder arthroscopic subacromial decompression; mini open rotator cuff repair; and transcatheter pain placement for postoperative pain control. Licensee's postoperative plans for Patient 3 consisted of passive range of motion only from week zero (0) to week three (3); active and active assisted range of motion from week three (3) to week eight (8); and gentle range of motion and strengthening as tolerated from week eight (8) on.

53. On or about June 12, 2008, Patient called Licensee's office reporting that she was itching all over despite taking two (2) Benadryl every six (6) hours with her Percocet. A new prescription of forty (40) 7.5/500mg Lortab was called to Patient 3's pharmacy. The progress note was electronically signed by Sharon Treto, LPN and electronically co-signed by Mr. McCaig.

54. On or about June 25, 2008, Patient 3 presented to Licensee's office for a postoperative visit. Patient 3 was noted to be doing well with a plan to continue physical therapy with a follow-up in four (4) weeks. A prescription for forty (40) 5/325mg of Percocet was prescribed to Patient 3. The progress note was electronically signed by Mr. McCaig and electronically co-signed by Licensee that same day.

55. On or about July 11, 2008, Patient 3 called requesting a refill on her Percocet prescription. A prescription of forty (40) 5/325mg pills of Percocet was written and left for Patient 3 at the front desk. The progress note was electronically signed by Ms. Treto and electronically co-signed by Mr. McCaig.

56. Patient 3 continued with physical therapy and saw Licensee on or about August 5, 2008. She was noted to have some residual pain eight (8) weeks post-surgery and

was given an injection of 40mg Depo-Medrol, 2cc Marcaine, 2cc lidocaine into left trigger points by Mr. Hoffman. It was also documented that Patient 3 would continue with physical therapy with a follow-up to occur in one (1) month. Mr. Hoffman electronically signed the record on or about August 6, 2008. Licensee did not electronically sign the record until on or about August 7, 2008.

57. On or about August 25, 2008, a Discharge Summary from Greenwood County Hospital Rehabilitation Department documented Patient 3's physical therapy was to be discontinued after sixteen (16) physical therapy visits based on Patient 3 indicating that she was pain free, had 5/5 strength and had reached all of her personal goals.

58. On or about September 3, 2008, Patient 3 presented to Licensee's office for an appointment. Patient 3 is documented as doing well and indicated that the trigger point injections administered last month helped. Patient 3's documented treatment plan was to continue home exercises, and Patient 3 was administered an injection of 40 mg Depo-Medrol, 2cc Marcaine, 2cc lidocaine into left trigger points. Follow-up was to occur as needed. Patient 3's progress note was electronically signed by Mr. McCaig that same day. Licensee did not electronically sign the record until on or about September 7, 2008.

59. On or about November 14, 2008, approximately five (5) months postoperatively, Patient 3 returned to Licensee's office with complaints of posterior left shoulder pain. Patient 3's documented treatment plan was to undergo physical therapy for scapular strengthening, and Patient 3 was given an injection of 40mg Depo-Medrol, 2cc Marcaine, 2cc lidocaine into two left trigger point areas. Patient 3 was also

given a prescription for forty (40) 50mg Ultram, 1-2 tabs every 4-6 hours with a follow-up requested in four (4) weeks. Patient 3's progress note was electronically signed by Mr. McCaig on or about that same day. Licensee did not electronically co-sign the progress note until on or about November 23, 2008.

60. Also, on November 14, 2008, Patient 3 was referred for physical therapy for scapular strengthening. There is no documentation of Patient 3 receiving physical therapy after this date in Licensee's records.

61. Patient 3 returned to Licensee's office and was documented to have been seen and examined by Licensee on or about June 16, 2009, with complaints of neck, shoulder, and arm pain. Patient 3 indicated she had been experiencing this pain for approximately three (3) to six (6) months with most of the pain being reported in the trapezius and scapular regions. An examination was performed, and Patient 3 was scheduled for up-to-date x-rays of her cervical spine and an MRI with gadolinium of her cervical spine with a follow-up to discuss the results and future treatment considerations. Patient 3 was also billed for a trigger point injection, but no documentation showing Patient 3 was administered an injection appears in Licensee's records for this date.

62. The Progress Note for June 16, 2009, was signed and revised by Mr. Hoffman on June 17, 2009. It is unclear from the record what revisions were made to Patient 3's medical record. Licensee did not electronically sign the record until June 28, 2009.

63. On or about June 30, 2009, Patient 3 returned to Licensee's office and saw Mr. McCaig to discuss her MRI C-spine. Patient 3's chief complaint was left upper

shoulder pain. Patient 3 was administered a trigger point injection of 20mg Depo-Medrol, 1cc Marcaine, 1cc lidocaine into the left scapulothoracic bursa. Patient 3 was noted to have tolerated the procedure with a follow-up recommended in 3-4 weeks for a possible repeat injection.

64. On or about July 12, 2010, Patient 3 presented to Dr. Philip F. Hagan, M.D.'s office with complaints of continued pain in her left periscapular border. This pain was documented as being persistent after her 2008 surgery performed by Licensee. Further, Patient 3's pain was documented as having increased since the surgery. Dr. Hagan's review of the prior arthroscopic photos from the surgery performed by Licensee showed no signs of rotator cuff repair.

65. After examining Patient 3, Dr. Hagan administered a trigger point injection at Patient 3's July 12th appointment. Patient 3 was documented to have "improved relief of her discomfort post injection." Dr. Hagan's treatment plan included maintaining Patient 3 on a low dose nonsteroidal anti-inflammatory and to have her participate in physical therapy. Dr. Hagan scheduled Patient 3 for a follow-up in four (4) to six (6) weeks.

66. On or about August 18, 2010, Patient 3 returned to Dr. Hagan's office indicating her pain was "much improved" and relief of the discomfort she had experience over the past 2-3 years.

67. In the treatment of Patient 3, Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence, specifically including, but not limited to, each of the following acts or omissions:

a. Licensee failed to perform and document an examination of Patient 3's cervical spine despite Patient 3's past surgical history;

b. Licensee failed to perform a thorough physical examination and history involving Patient 3;

c. Licensee failed to document that Patient 3 was given a trigger point injection on June 16, 2009, despite billing Patient 3's insurance for the injection; and

d. Licensee's MRI findings by themselves do not support a clear indication for surgery.

68. Licensee's acts and conduct during the course of treating Patient 3 constitute violations of the Kansas Healing Arts Act as follows:

a. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(2), in that Licensee has committed an act of professional incompetency with repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence;

b. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(3), in that Licensee has committed a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice the healing arts;

c. Licensee has violated K.S.A. 65-2836(b), as furthered defined in K.S.A. 65-2837(b)(24), in that Licensee has had a repeated failure to practice the healing arts with that level of care, skill and treatment which is

recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances;

d. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(25), in that Licensee failed to keep written medical records that accurately reflect the services rendered to Patient 3, including patient histories, pertinent findings, examination results and test results; and

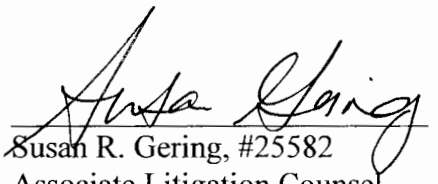
e. Licensee has violated K.S.A. 65-2836(k), in that Licensee has violated a lawful regulation promulgated by the Board, specifically, K.A.R. 100-24-1 by failing to meet the minimum requirements for an adequate patient record for Patient 3.

69. Pursuant to K.S.A. 65-2836, the Board has grounds to revoke, suspend, place on probation, censure, or otherwise limit the Licensee's license to practice medicine and surgery in the state of Kansas for his violations of the Kansas Healing Arts Act.

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

WHEREFORE, Petitioner further requests this matter to have a Presiding Officer be appointed and be set for a Formal Hearing pursuant to K.S.A. 77-513.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I, Jennifer Alberg the undersigned, hereby certify that I served a true and correct copy of the PETITION by United States mail, postage prepaid, on this 14th day of April, 2015 to the following:

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Jennifer K Alberg
Staff Member