

FILED *CAB*

OCT 14 2008

KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS  
OF THE STATE OF KANSAS

IN THE MATTER OF }  
AMIR FRIEDMAN, M.D. }  
Kansas License, No. 04-28095 }  
}

DOCKET NOS.  
KSBA DKT NO.: 07 HA 00007  
OAH DKT. NO.: 07 HA 0008 BHA

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Pursuant to K.S.A. Chapter 77

FINAL ORDER

NOW THIS October 10, 2008, the above captioned matter comes before the Kansas State Board of Healing Arts (Board) on the respondent's motions for Summary Judgment; the Initial Order of Presiding Officer Ed Gaschler; and the petitioner's motion for the assessment of costs. Respondent, Amir Friedman, M.D., appears by telephone *pro se*. Kathleen Lippert, Litigation Counsel, appears for the Board. There are no other appearances.

WHEREUPON, the Board hears argument and considers the respondent's Motion for Summary Judgment. The Board, having reviewed the file, being familiar with the premises and having considered the statements of counsel, **DENIES** the respondent's Motion for Summary Judgment.

WHEREUPON, the Board considers the Initial Order of the Board's Presiding Officer, Ed Gaschler.

WHEREUPON, the respondent objects to members of the Board's Disciplinary Panel considering the Initial Order. The Board grants the respondent's objection and Dr. Ray Conley, D.C., Dr. Michael Beezley, M.D., and public member Betty McBride recuse themselves from participating in the review of the Initial Order.

WHEREUPON, the Board, upon its own motion, appoints Dr. Vinton K. Arnett, D.C., Dr. Gary Counselman, D.C., Public Member Sue Ice, Dr. M. Myron Leinwetter, D.O., Dr. Kimberly J. Templeton, M.D., Dr. Nancy J. Welsh, M.D., and Dr. Ronald N. Whitmer, D.O. as the Board's designees to hear this matter pursuant to K.S.A. 77-527(d).

WHEREUPON, the board's designees, being duly informed of the premises, having the agency record before it, and after hearing the arguments of the respondent *pro se* as well as counsel for the Board, the Board adopts the findings of fact, conclusions of law and order as stated in the Initial Order. A copy of the Initial Order is attached to this Final Order as Exhibit "A" and is incorporated by reference.

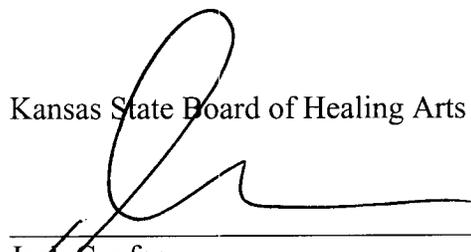
WHEREUPON, the Board's designee hears the petitioner's Motion to Assess Costs pursuant to K.S.A. 65-2846(b) in the amount of \$35,635.27 as set forth in petitioner's motion. The Board designee's, having the agency record before it and being duly apprised of its premises, finds costs should be assessed to Amir Friedman, M.D. in the amount of \$35,635.27.

**IT IS, THEREFORE, ORDERED** the license of Amir Friedman is hereby revoked with costs in the amount of \$35,635.27 assessed to the respondent.

**PLEASE TAKE NOTICE** that this is a final order. A final order is effective upon service. A party to an agency proceeding may seek judicial review of a final order by filing a petition in the District Court as authorized by K.S.A. 77-601, et seq. Reconsideration of a final order is not a prerequisite to judicial review. A petition for judicial review is not timely unless filed within 30 days following service of the final order. A copy of any petition for judicial review must be served upon Jack Confer, the Board's Acting Executive Director, at 235 SW Topeka Blvd., Topeka, KS 66603.

DATED this 14<sup>th</sup> day of October, 2008.

Kansas State Board of Healing Arts



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Jack Confer  
Acting Executive Director

CERTIFICATE OF SERVICE

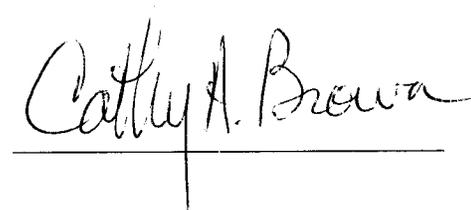
I certify that a true copy of the foregoing Final Order was served this 14th day of October, 2008, by depositing the same in the United States Mail, first class postage prepaid, and addressed to:

Edward Gaschler  
Presiding Officer  
Office of Administrative Hearings  
1020 S. Kansas Avenue  
Topeka, KS 66612

Amir M. Friedman  
310 Hunters Rd.  
Swedesboro, NJ 08085  
Pro Se

And a copy was hand delivered to:

Kathleen Selzler Lippert  
Kansas Board of Healing Arts  
235 SW Topeka Blvd.  
Topeka, KS 66603



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*J. Confer*

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

**FILED**

SEP 08 2008

KS State Board of Healing Arts

IN THE MATTER OF )  
)  
AMIR M. FRIEDMAN, M.D. )  
Kansas License No. 04-28095 )  
\_\_\_\_\_)  
Pursuant to K.S.A. Chapter 77

Docket No.: 07 HA00007

OAH No.: 07HA0008 BHA

**INITIAL ORDER**

NOW on this 11<sup>th</sup> day of June, 2008, this matter comes on for formal proceedings upon the First Amended Petition filed by the Kansas State Board of Healing Arts (Board or Petitioner) on November 3, 2006. Kelli J. Stevens and Kathleen Selzler Lippert, Litigation Counsel, appear for the Board. The Respondent appeared pro se.

The Board and the Respondent presented witnesses and exhibits.

At the conclusion of the hearing, the parties were given until August 1, 2008, to file Proposed Findings of Fact and Conclusions of Law. The date for filing the Proposed Findings of Fact and Conclusions of Law was extended to August 12, 2008.

Preliminary Matters

Subpoenas

At the conclusion of the evidentiary hearing of this matter, the Respondent was granted leave to enforce certain subpoenas that were issued. The Respondent was given until July 11, 2008, to file appropriate pleadings establishing that the Respondent was enforcing these subpoenas. From the matters submitted by the Respondent, the Respondent has not taken appropriate action to enforce the subpoenas and it does not appear that any appropriate action has been taken by the Respondent to enforce these subpoenas.

Motion to Extend Filings

On August 8, 2008, the Respondent filed a Bias and Prejudice Against Defendant and His Request for Twelve Days in Order to Respond to Petitioner's Closing Arguments.

In this document, the Respondent argues that the deadline for filing Proposed Findings of Fact and Conclusions of Law should not have been extended and requested that he be given 12 days to respond to Petitioner's closing arguments. In as much as it does not appear that the Respondent utilized the transcripts that were previously unavailable to file his Proposed Findings of Fact and Conclusions of Law (see Respondent's Proposed Findings of Fact and Conclusions of Law wherein no citations to the transcripts are made), this request is denied.

### Exhibits

At the conclusion of the evidentiary hearing of the matter, the Respondent offered a large number of exhibits. The Respondent neither specifically identified any of the exhibits nor provided any foundation for the exhibits. The Petitioner objected to the admission of the exhibits based upon lack of foundation and relevancy.

The exhibits were reviewed and the Petitioner's objection to lack of foundation is sustained.

### Findings of Fact

1. The Respondent formerly practiced medicine in the state of Kansas. The Respondent was issued License No. 04-28095 by the Board. This license was not renewed and was cancelled by the Petitioner on August 1, 2006. The status of the Respondent's license is cancelled.
2. Jonathan Daniels, M.D., certified by the American Board of Obstetrics and Gynecology, provided expert testimony for the Petitioner regarding Patients No. I through V.
3. Dr. John D. Pfeifer, Associate Professor in the Department of Pathology and Immunology at Washington University's School of Medicine in St. Louis, Missouri, provided expert testimony on behalf of the Petitioner regarding Patient No. IV.
4. William Manion, M.D., and Michael Gold, M.D., provided expert testimony on behalf of the Respondent concerning the Respondent's care of Patient No. IV.
5. The Respondent did not provide any expert testimony for Patients No. I, II, III, or V.

Applicable Law

1. Kansas Statutes Annotated (K.S.A.) 65-2838 provides:

**65-2838. Disciplinary action against licensee; procedure; stipulations; temporary suspension or limitation; emergency proceedings; guidelines for use of controlled substances for treatment of pain; written advisory opinions.** (a) The board shall have jurisdiction of proceedings to take disciplinary action authorized by K.S.A. 65-2836 and amendments thereto against any licensee practicing under this act. Any such action shall be taken in accordance with the provisions of the Kansas administrative procedure act.

- (b) Either before or after formal charges have been filed, the board and the licensee may enter into a stipulation which shall be binding upon the board and the licensee entering into such stipulation, and the board may enter its findings of fact and enforcement order based upon such stipulation without the necessity of filing any formal charges or holding hearings in the case. An enforcement order based upon a stipulation may order any disciplinary action authorized by K.S.A. 65-2836 and amendments thereto against the licensee entering into such stipulation.
- (c) The board may temporarily suspend or temporarily limit the license of any licensee in accordance with the emergency adjudicative proceedings under the Kansas administrative procedure act if the board determines that there is cause to believe that grounds exist under K.S.A. 65-2836 and amendments thereto for disciplinary action authorized by K.S.A. 65-2836 and amendments thereto against the licensee and that the licensee's continuation in practice would constitute an imminent danger to the public health and safety.
- (d) The board shall adopt guidelines for the use of controlled substances for the treatment of pain.
- (e) Upon request of another regulatory or enforcement agency, or a licensee, the board may render a written advisory opinion indicating whether the licensee has prescribed, dispensed, administered or distributed controlled substances in accordance with the treatment of pain guidelines adopted by the board.

2. K.S.A. 65-2851a provides:

**65-2851a. Administrative proceedings; procedure, review and civil enforcement.** (a) All administrative proceedings provided for by article 28 of chapter 65 of the Kansas Statutes Annotated and

affecting any licensee licensed under that article shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

(b) Judicial review and civil enforcement of any agency action under article 28 of chapter 65 of the Kansas Statutes Annotated shall be in accordance with the act for judicial review and civil enforcement of agency actions.

3. K.S.A. 77-501 provides:

**77-501. Title.** K.S.A. 77-501 through 77-541 shall be known and may be cited as the Kansas administrative procedure act.

4. K.S.A. 65-2837 provides:

**65-2837. 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 medicine.

(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 exploitation related to the licensee's professional practice.
- (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.
- (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.

5. K.S.A. 65-2836 provides:

**65-2836. 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 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.
- (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 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 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. 2002 Supp. 60-4404 and amendments thereto.
  - (C) A copy of the record of a judgment assessing damages under K.S.A. 2002 Supp. 60-4405 and amendments thereto.

#### Findings of Fact – Count I

1. The Respondent provided obstetric services to Patient No. I. On July 8, 2004, the Respondent called Coffeyville Regional Medical Center (CRMC) in Coffeyville, Kansas, to advise that Patient No. I would be admitted for an induction on July 9, 2004.
2. At the time the Respondent called CRMC to inform them that Patient No. I would be seen for an induction on July 9, 2004, he advised that he was in Tulsa, Oklahoma, and he provided some Tulsa phone numbers to the CRMC. (See Exhibit 46 and the report made by Laura J. Robson [FRI00830].)
3. In the early morning hours of July 9, 2004, Patient No. I presented herself at CRMC. Patient No. I was in labor and the Respondent was contacted.
4. The Respondent immediately began driving toward Coffeyville, Kansas, and attempted to manage the care of Patient No. I via cell phone.
5. During Patient No. I's labor, the nursing staff at CRMC had concerns regarding the baby developing signs of fetal distress. Ultimately, another physician was contacted to deliver Patient No. I's baby.

6. At no time did the Respondent advise CRMC that he was not available for delivery of the baby nor did the Respondent advise CRMC to contact another physician because he was too far away.
7. The Respondent appeared at CRMC shortly after the other physician delivered the baby.
8. Dr. Jonathan Daniels testified that the Respondent did not adhere to the applicable standard of care. Dr. Daniels testified that the Respondent attempted to manage the care of Patient No. I via phone and that he should have "immediately turned her care over to another physician."
9. Regarding the Respondent's assertion that he only had courtesy privileges at CRMC, Dr. Daniels still was of the opinion that regardless of the courtesy status of the Respondent's privileges, the Respondent did not meet the standard of care because he did not have a specific physician covering for this patient.
10. The actions of the Respondent also belie his assertion that as a courtesy physician he did not have to have another physician covering him. The actions of the Respondent clearly show that he was the only physician providing medical care to Patient No. I until it was necessary for CRMC to contact another physician because the Respondent was not available.
11. Dr. Daniels also testified that the Respondent's medical notes were misleading. The notes indicate that the Respondent was present and providing care to Patient No. I.

#### Conclusions of Law

1. The action of the Respondent regarding Patient No. I constitutes a failure to adhere to the applicable standard of care. The Respondent's medical records were misleading. Pursuant to K.S.A. 65-2836 and K.S.A. 65-2837, departure from the applicable standard of care constitutes ordinary negligence. The Respondent's medical records were misleading and constitute unprofessional conduct.
2. The Respondent's arguments that he was never contacted by CRMC and that it was only when he called CRMC that he learned that Patient No. I had been admitted is totally without merit. The Respondent would have the Presiding Officer believe that he was sitting around his residence in Independence, Kansas, during the early morning hours of July 9, 2004, and that he contacted CRMC on a mere whim to see if any of his patients appeared for treatment. This defies logic and is not credible.

3. The Board has established that the Respondent did not adhere to the applicable standard of care and that his medical records were misleading.

#### Findings of Fact - Count II

1. Count II of the Petition concerns the Respondent's care and treatment of Patient No. II at Mercy Hospital in Independence, Kansas.
2. The Respondent ordered a Pitocin induction for Patient No. II who was pregnant at Mercy Hospital. While Patient No. II was induced, the Respondent was performing elective surgery at Wilson County Hospital in Neodesha, Kansas.
3. The Respondent ordered the induction of Patient No. II at 8:00 a.m. Patty Fienen, a registered nurse, was providing care for Patient No. II during the induction. Ms. Fienen was aware that the Respondent was going to be in surgery, but believed he would be performing surgeries at Mercy Hospital and not at Wilson County Hospital.
4. During the induction of Patient No. II, the baby experienced deceleration and after contact was made with the Respondent, he ordered a Cesarean Section for Patient No. II.
5. The reason for Patient No. II's induction was due to expected intrauterine growth retardation (IUGR) and the recommended treatment for this is to have the baby delivered.
6. During the course of Patient No. II's treatment, Ms. Fienen learned that the Respondent was performing surgeries not in Mercy Hospital but at Wilson County Hospital. During the course of preparing Patient No. II for surgery, Nurse Fienen was directed to get an ultrasound for the baby's fluid and fetal weight.
7. There is nothing in the record to indicate that any other physician would be providing medical care for Patient No. II.
8. Because the Respondent ordered a Cesarean Section, Patient No. II was prepared for that Cesarean Section even though the Respondent was at Wilson County Hospital in Neodesha, Kansas, and not at Mercy Hospital in Independence, Kansas.
9. This matter was reported to the administration at Mercy Hospital and an Adverse Finding Report was made as a result of the Respondent's care of Patient No. II.

10. Dr. Jonathan Daniels reviewed the medical records concerning Patient No. II. Dr. Daniels testified:

“My opinion that he did not meet the standard of care in this case doesn’t have to do with the fact that he chose to do a C-Section; that was appropriate. What it had to do with was the fact that he was inducing a patient very likely to develop fetal distress when he was not available.”

11. Dr. Daniels also testified there was no indication in the patient’s file that the Respondent had turned over care of the patient to another physician.
12. Dr. Daniels also was of the opinion that the fact there was a family physician available to provide care for Patient No. II did not establish that the Respondent met the applicable standard of care. The family physician would not have been able to do a Cesarean Section, if that was necessary, and the Respondent was the physician who was actively managing the care of Patient No. II and therefore he had a duty to be available.

#### Conclusions of Law

1. The action of the Respondent regarding Patient No. II constitutes a failure to adhere to the applicable standard of care. Pursuant to K.S.A. 65-2836 and K.S.A. 65-2837, the Respondent’s departure from the applicable standard of care constitutes ordinary negligence.
2. The Respondent continually argued that in this case there was another physician available who could perform the Cesarean Section. First, the Respondent had the opportunity to obtain some evidence concerning this, but refused to pay the necessary copying costs for the documents. Thus, there is no evidence other than the Respondent’s statement that there was another physician available to perform the surgery. Second, the records from Mercy Hospital would indicate otherwise. Mercy Hospital, as a result of the care and treatment of Patient No. II, entered an Adverse Finding Report. Finally, even if this was so, the record clearly indicates that the Respondent was the physician who was actively managing the care of Patient No. II. The testimony of Dr. Daniels indicates that if this is the case, then the Respondent needed to be available. He was not. Thus, the Respondent has not met the applicable standard of care.
3. The Respondent testified that he never spoke to Nurse Fienen. This is in direct conflict to what he told the Board during the investigation of this case. During the investigation of this matter, the Respondent stated:

"In my communication with the OB nurse, the message conveyed was one of a fetal heart rate present after deceleration...I did ask the nurse if Drs. Atwood or Sohaei needed to be called and her response was the fetal strip looked good...I did inform the nurse to let the OR know...and that we may be doing a C/S at a later date." (See Exhibit No. 8.)

4. The statements made by the Respondent in Exhibit No. 8 confirm the testimony of Nurse Fienen. The statements made by the Respondent in Exhibit No. 8 totally conflict with his sworn testimony.

#### Findings of Fact - Count III

1. Count III of the Petition involves the Respondent's care and treatment of Patient No. III.
2. Patient No. III presented herself at Mercy Hospital on October 2, 2005. Patient No. III had report of amniotic fluid leaking and some vaginal bleeding. Patient No. III was 20 weeks pregnant.
3. The Respondent was contacted regarding the patient and the Respondent refused to come into the hospital. Debra Clemens, a registered nurse at Mercy Hospital, provided care for Patient No. III on the day in question. Nurse Clemens received an order by way of telephone from the Respondent to admit Patient No. III to the Obstetrics Unit for observation. The Respondent also had additional orders including lab work, doppler for fetal heart tones, and Nitrazine. Nitrazine is used to determine if there is amniotic fluid being discharged.
4. During the time that Patient No. III was in the hospital, Patient No. III spoke on the phone with the Respondent. The patient wanted an ultrasound. At the time, an ultrasound was not available at Mercy Hospital.
5. At 12:30 p.m., the Respondent ordered that Patient No. III could be discharged.
6. Ultimately, Patient No. III was seen at Wesley Medical Center in Wichita, Kansas. At that time, it was determined that the patient's baby was not viable and Patient No. III proceeded to have labor induced.
7. As a result of the Respondent's care of Patient No. III, Mercy Hospital issued an Adverse Finding Report concerning the care Patient No. III received through the Respondent.

8. Dr. Jonathan Daniels reviewed the medical records of Patient No. III. Dr. Daniels is of the opinion that the Respondent did not meet the applicable standard of care because the standard of care requires the physician to perform a sterile speculum examination to diagnose a premature rupture of the membranes. Dr. Daniels testified that the sterile speculum examination is a very definitive way of determining whether there is amniotic fluid present in the vagina. Dr. Daniels further quoted the American College of Gynecology Practice Bulletin No. 1, dated June 1998, as establishing the sterile speculum examination as a standard of care. Finally, Dr. Daniels opined that having the patient travel from Independence, Kansas, to Wichita, Kansas, without being examined, "could be very dangerous for the patient."
9. Dr. Daniels found a note made by the Respondent some 19 days after the patient was admitted to Mercy Hospital. Dr. Daniels believes this note was extremely misleading in that it contained information that the Respondent could not have known since he did not perform an examination. The Respondent wrote the note as if he had performed the examination, which he failed to do.

#### Conclusions of Law

1. The action of the Respondent regarding Patient No. III constitutes a failure to adhere to the applicable standard of care and the medical records were misleading. Pursuant to K.S.A. 65-2836 and K.S.A. 65-2837, the Respondent's departure from the applicable standard of care constitutes ordinary negligence. The Respondent's note made 19 days following the patient's admission was unprofessional conduct.
2. The Respondent and Patient No. III both testified at the hearing of this matter. Both alleged that the Respondent did come to Mercy Hospital to examine Patient No. III. This testimony of the Respondent and Patient No. III flies in the face of Exhibit No. 18A, which is a letter from the Respondent to the Board's inspector. In this letter, the Respondent deals with the care of Patient No. III on the day in question. In this letter, the Respondent writes:

"My not coming in did not result in physical injury to the patient or her fetus."
3. Similarly, in Exhibit No. 21, which is Mercy Hospital's review of the care of Patient No. III, the Respondent writes:

"The patient left upset because a sonogram could not be obtained. She wrote me a letter complaining of this, and I recommended the MEC ask the patient for a copy of this letter. I also suggest the MEC clarify the patient's real concern as

both the patient and her husband have conveyed to me upon direct questioning that they were not upset that I did not come in.”

4. Finally, the Respondent alleges that he came to Mercy Hospital to examine a patient. No one saw the Respondent there. It would seem highly unusual that a physician would go to a hospital and see a patient, but not ask the nursing staff or the medical records staff for the patient's chart. Yet, the Respondent alleges that he did so. As stated above, this flies in the face of his written statements to both the Board and to Mercy Hospital regarding his care of Patient No. III.

#### Findings of Fact - Count IV

1. Count IV of the Petition concerns the Respondent's care and treatment of Patient No. IV.
2. Patient No. IV was a female patient of the Respondent's. Patient No. IV first saw the Respondent in August of 2002. At that time, Patient No. IV had a pap smear done. However, the results of the 2002 pap smear are not in the patient's chart.
3. On February 11, 2003, the Respondent performed a pap smear and cultures on Patient No. IV. Patient No. IV was pregnant at the time and on the specimen source it was listed as "vaginal." The February 11, 2003, pap smear was negative.
4. During the course of the Respondent's care and treatment of Patient No. IV, Patient No. IV complained of pain and vaginal bleeding. She also complained of post-coital bleeding.
5. On July 15, 2004, the Respondent saw Patient No. IV, who complained of post-coital bleeding. This was approximately one and one-half years since the patient's last pap smear. Patient No. IV was seen 15 times by the Respondent from October of 2004 through November of 2005. During each of the visits, Patient No. IV complained of vaginal bleeding and/or vaginal pain or discharge. Patient No. IV was not bleeding from the vagina on February 10, 2005, but no pap smear was done. The last pap smear was approximately two years prior to February 10, 2005.
6. In December of 2005, Patient No. IV presented to a different physician. Her complaints were of vaginal bleeding and she had lost weight. A pap smear was done and the cervix was examined.

7. The pathology report that followed the December 2005 pap smear indicated “high grade squamous intraepithelial lesion encompassing moderate to severe dysplasia.” Patient No. IV was referred to Douglas Horbelt, M.D., in Wichita, Kansas. Dr. Horbelt performed a cervical biopsy as well as a pap smear. Patient IV received treatment for cervical cancer, but ultimately treatment was not successful and Patient No. IV is now deceased.
8. Dr. Jonathan Daniels reviewed the Respondent’s care and treatment of Patient No. IV.
9. Dr. John D. Pfeifer, an Associate Professor at the Department of Pathology and Immunology at Washington University’s School of Medicine in St. Louis, Missouri, was retained by Patient No. IV’s estate or family to testify in a malpractice action against the Respondent. Dr. Pfeifer had the opportunity to review slides from Patient No. IV and concluded as follows:

“Therefore, based on my training and expertise, in my opinion there is a reasonable degree of medical certainty that (name deleted) had squamous cell carcinoma of primary cervical origin rather than of bladder (or any other) primary site of origin. I note that the histopathologic findings indicative of invasive squamous cell carcinoma of cervical origin match her clinical history and presentation.”
10. Dr. Jonathan Daniels was of the opinion that the Respondent’s care and treatment of Patient No. IV did not meet the applicable standard of care. Dr. Daniels opined that the Respondent did not perform pap smears and did not do cervical cytology screenings according to the current guidelines. Dr. Daniels quoted the American College of Obstetrics and Gynecology guidelines. Additionally, Dr. Daniels opined that the Respondent failed to perform other testing to determine what was the cause of Patient No. IV’s persistent vaginal bleeding. For example, Dr. Daniels testified that the Respondent could have done cervical biopsies, endometrial sampling, or endometrial biopsy. Finally, Dr. Daniels addressed the Respondent’s assertion that because the patient had two previously normal pap smears that the standard of care did not require her to have another. Dr. Daniels opined that if the two normal pap smears are documented, then that might be the case. However, to rely upon the patient’s “memory is a tricky thing.” Dr. Daniels also testified that post-coital bleeding is a well known symptom of cervical cancer. Since Patient No. IV had this symptom, this should have alerted the Respondent to the need for cervical cancer screening. Finally, Dr. Daniels testified that based upon a reasonable degree of medical certainty, the Respondent’s action or inaction delayed in the diagnosis of the patient’s cancer and affected the patient’s prognosis.

11. Dr. Daniels also reviewed Dr. Manion's report based upon Dr. Manion's review of slides. Dr. Daniels testified that a more accurate way for a pathologist to determine the origin of a cancer would be through immunohistochemical analysis and that through staining techniques, the true origin of the cancer type can be determined.
12. Dr. Manion did not do an immunohistochemical analysis.
13. Dr. John D. Pfeifer did the immunohistochemical analysis as described by Dr. Daniels.

#### Conclusions of Law

1. The action of the Respondent regarding Patient No. IV constitutes a failure to adhere to the applicable standard of care. Pursuant to K.S.A. 65-2836 and K.S.A. 65-2837, the Respondent's departure from the applicable standard of care constitutes ordinary negligence.
2. While the Respondent presented expert testimony as to Count IV from Dr. Manion and Dr. Gold, the effectiveness of the testimony of Dr. Manion and Dr. Gold is diminished. In light of the evidence before the Presiding Officer, it is clear that the Respondent has been less than truthful. (See Count No. II and Count No. III. The fact that the Respondent writes letters acknowledging certain matters and then he comes to this hearing and testifies in direct opposition to the writings casts serious doubt to the Respondent's credibility.) In light of that, what representations the Respondent has made to both Dr. Manion and Dr. Gold must be questioned.

#### Findings of Fact - Count V

1. Count V of the Petition involves the Respondent's care and treatment of Patient No. V.
2. Patient No. V was a pregnant female who began seeing the Respondent in June of 2005.
3. This was the second pregnancy for Patient No. V. There were no complications with the first pregnancy.
4. Patient No. V had blood testing done as part of the obstetrics panel of blood tests that are normally done. This test showed that the patient had positive antibodies for anti-D and anti-C. However, when the Respondent charted the test results, it was charted that Patient No. V had a negative antibody screen.

5. At the Respondent's direction, Patient No. V went to Mercy Hospital to get a Rhogam shot. This was done in November of 2005.
6. Patient No. V last saw the Respondent on December 14, 2005. At that time, Patient No. V was scheduled for a future appointment.
7. When Patient No. V returned to the Respondent's office, she learned that it had been closed. Patient No. V was not informed as to how to obtain her medical records.
8. Patient No. V sought out a new physician and found Daniel Chappell, M.D. Dr. Chappell saw Patient No. V on January 9, 2006, when she was approximately 36 weeks into her pregnancy.
9. During Dr. Chappell's examination of Patient No. V, heart tones for the fetus could not be obtained. Based upon an ultrasound performed in the office, the baby was deceased.
10. Thereafter, the patient was induced at CRMC and gave birth to a stillborn son.
11. Dr. Jonathan Daniels testified concerning the Respondent's care and treatment of Patient No. V. Dr. Daniels testified that his review of the records was consistent with the diagnosis of hydrops fetalis.
12. Dr. Daniels testified that it was the responsibility of the Respondent to review and be aware of abnormal laboratory tests that he orders. In reviewing the prenatal records of Patient No. V, there is no indication that the Respondent reviewed the lab results showing that the patient did have a positive antibody and was positive for anti-D and anti-C.
13. A further review of the patient's records indicates that Patient No. V's records show a negative antibody screen when in fact it was positive.
14. The records reviewed were obtained from the Respondent's office through Dr. Chappell's office.
15. The records further indicate that on June 28, 2005, a specimen was collected by Lab One and it indicates antibody-C was identified.
16. Dr. Daniels believes that the Respondent did not meet the applicable standard of care because he failed to properly transcribe the results of the test on Patient No. V and that there did not appear there was any method of double-checking for test results.

17. As a result of the Respondent's failure to properly treat Patient No. V, Dr. Daniels believes that within a reasonable degree of medical certainty the stillbirth of Patient No. V's child was caused by the mother's desensitization to the antibodies.
18. In reviewing the Respondent's records, Dr. Daniels said it appeared that the Respondent had initial lab results and therefore should have been aware of these results.

#### Conclusions of Law

1. The action of the Respondent regarding the care and treatment of Patient No. V constitutes a failure to adhere to the applicable standard of care. Pursuant to K.S.A. 65-2836 and K.S.A. 65-2837, the Respondent's departure from the applicable standard of care constitutes ordinary negligence.
2. At various times regarding Patient No. V, the Respondent suggested, argued, or otherwise stated that this file had been either tampered with or had been changed. While perhaps that is an interesting theory, it ignores the fact that the lab report was provided back to the Respondent on July 8, 2005. He continued to treat the patient through November of 2005. The Respondent offered nothing to explain why he ignored these lab results.

#### Findings of Fact - Count VI

1. Count VI of the Petition concerns the surrender of privileges.
2. Prior to April 22, 2005, the Respondent had privileges at CRMC in Coffeyville, Kansas.
3. During the time in which the Respondent had these privileges, he had been called before the Medical Executive Committee on a number of occasions.
4. On April 18, 2005, the Credentialing Committee for CRMC met regarding the Respondent's reappointment to the CRMC staff. At that meeting, the committee voted unanimously not to renew the Respondent's staff status and privileges that he had at CRMC. The committee considered various concerns as well as a Level 3 violation in making its decision not to reappoint the Respondent.
5. A letter was mailed to the Respondent on April 20, 2005, advising him of the committee's decision recommending non-renewal to the Medical Executive Committee. On April 22, 2005, the Respondent sent a letter resigning his privileges at CRMC.

### Conclusions of Law

1. By surrendering his privileges at CRMC while under an investigation for various acts and conduct, the Respondent violated K.S.A. 65-2836(u).
2. The Respondent argues that he was not under any investigation at the time he submitted his resignation. That is not true. It is clear that he was under investigation. Further, it is highly questionable that he was not aware of the fact that he was under investigation since he was notified by letter on April 20, 2005, and his resignation is dated April 22, 2005.

### Conclusions

1. Throughout the hearing of this matter, the Respondent argued that various individuals; doctors; hospital employees; nurses; CRMC in Coffeyville, Kansas; and Mercy Hospital in Independence, Kansas, were making everything up. He argues that all the complaints made were bogus. While it does appear to be correct that the Respondent was not popular with some individuals in Independence, Kansas, and Coffeyville, Kansas, there is no evidence that this was some type of vast conspiracy of the medical community of Montgomery County to harm the Respondent.
2. The Respondent threw around the words liar, perjury, and so forth concerning a good number of individuals, including nurses and doctors. The only evidence before the Presiding Officer as presented at this hearing of anyone lying or being less than candid is that of the Respondent. As noted in Count No. II and Count No. III, the Respondent makes certain statements when responding to investigators and then he testifies completely opposite. One way or another, the Respondent has lied. That is clear. The testimony of the Respondent and the Respondent's witnesses is in direct conflict to written statements made by the Respondent.
3. Additionally, examining certain medical records completed by the Respondent, especially concerning Patient No. I and Patient No. III, clearly suggest that he is attempting to mislead. Why does he need to mislead? Dr. Daniels was quite clear in that the Respondent's documentation was misleading and was written to represent facts other than they were.
4. Both the Board and the Presiding Officer gave the Respondent great latitude in conducting his own defense. A pro se litigant is required to follow the same rules and procedures as an attorney. (See *In the Matter of the Estate of Esther R. Broderick*, 34 Kan. App.2d 695.) Despite the leniency granted

the Respondent, he continually and habitually violated rules and conducted himself inappropriately.

5. In two of the cases before the Presiding Officer, one patient lost an infant and one patient lost her life. In each of these cases, the Respondent departed from the applicable standard of care. In the three other cases involving patients, the Respondent also departed from the applicable standard of care.
6. Because the Respondent denies any wrongdoing and shows no remorse for his conduct, the potential for future injury to other individuals is clear. Perhaps the best example of the Respondent's inability to recognize the injury caused was after asking Patient No. V whether her stillborn baby had been given an autopsy, she replied, "No," the Respondent persisted and asked the crying witness, "What did you...did you bury your son?" To which a tearful Patient No. V replied, "That's none of your business." Thereafter, the Respondent pursued the question even though it had been ruled irrelevant since no autopsy had been performed.
7. The above simply highlights the Respondent's failure to acknowledge any conduct that is inappropriate.
8. Based upon the totality of the record, as well as the Board sanctioning guidelines, it is clear that the Respondent has repeated and multiple violations of the Kansas Healing Arts Act. Based upon those violations, the Respondent's license, although cancelled, is hereby revoked with the cost of this proceeding to be assessed against the Respondent. The Board shall file a statement of cost under affidavit.
9. Finally, although not relevant to the revocation of the Respondent's license, note must be made of the Respondent's behavior throughout the hearing of this matter. To say that the Respondent's behavior was bizarre would be kind. His behavior was largely, if not totally, out of control. While certainly it is understandable that a licensee who is faced with discipline by the Board would be upset or angry, a licensee should be able to maintain control and composure over one's self at least a majority of the time. The Respondent could not. The Respondent's behavior was, as stated above, at best bizarre.  
**(Confidential)**

**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 30<sup>th</sup> day following its mailing. Petitions for review shall be mailed or personally delivered to: Jack Confer, Acting Executive Director, Kansas Board of Healing Arts, 235 S. Topeka Blvd., Topeka, KS 66603.

  
\_\_\_\_\_  
Edward J. Gascher  
Presiding Officer

CERTIFICATE OF SERVICE

On Sept. 8, 2008, I mailed by U.S. mail, a copy of this initial order to:

Amir M. Friedman  
310 Hunters Rd.  
Swedesboro, NJ 08085

✓ Jack Confer, Acting Executive Director  
Kathleen Seizler Lippert, Litigation Counsel  
Kansas Board of Healing Arts  
235 S. Topeka Blvd.  
Topeka, KS 66603

  
\_\_\_\_\_  
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