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

In the Matter of	)	
Daniel K. Frye, M.D.	)	
	)	
Ks. License No. 04-30064	)	**Docket No. 18-HA00023**
	)	

FINAL ORDER ON REVIEW OF INITIAL ORDER

On April 12, 2019, the above-captioned matter came before the Kansas State Board of Healing Arts ("Board") for review of the Initial Order filed with the Board on February 18, 2019. Respondent, Dr. Frye, appeared in person and through counsel, Bruce Keplinger. The Petitioner appeared through Susan Gering, Deputy Litigation Counsel. Dr. Myron Leinwetter recused himself from participating in the Board deliberations and decision in this matter because he served on the Board's Disciplinary Panel for this matter.

Pursuant to the authority granted to Board by the Kansas Healing Arts Act, K.S.A. 65-2801 *et seq.*, and in accordance with the provisions of the Kansas Administrative Procedure Act ("KAPA"), K.S.A. 77-501 *et seq.*, specifically K.S.A. 77-527, the Board enters this Final Order.

SUMMARIZED BACKGROUND, PROCEDURAL POSTURE, AND CONCLUSIONS

A Petition for discipline was filed against Dr. Frye's license on October 5, 2017. The Petition alleged Dr. Frye's care and treatment of Patient 1 constituted unprofessional and/or dishonorable conduct and/or professional incompetency. The Office of Administrative Hearings ("OAH") was appointed to conduct a formal hearing and issue an Initial Order.

After the OAH held a formal hearing the administrative law judge ("ALJ") issued the Initial Order, which found Dr. Frye violated the Kansas Healing Arts Act in that his care and treatment of Patient 1 demonstrated "conduct or practice that if continues will reasonably be expected to constitute the inability to practice the healing arts with reasonable skill and safety . . . [and] ordinary negligence." (Initial Order, p. 7). Further, the ALJ found Dr. Frye's recordkeeping failed to meet the standard of care. The ALJ also found two instances of dishonorable conduct due to Dr. Frye's failure to inform Patient 1 of a bladder injury and his failure to be forthright with the ALJ on certain issues. As a result of these violations, the ALJ held that Dr. Frye's license to practice medicine and surgery should be subject to: (1) an eighty-nine day suspension; (2) "probation as the Board deems necessary"; (3) a fine totaling $2,998; (4) completion of a records keeping course; (5) completion of an ethics course; and (6) payment of costs for the proceeding.

The Board filed a Notice of Intent to Review the Initial Order, the matter was fully briefed by both parties, and the Board held a hearing on review of the Initial Order on April 12, 2019 at which the parties were given an additional opportunity to be heard on the matter.[1]

Now, the Board enters this Final Order on review of Initial Order finding Dr. Frye violated the Kansas Healing Arts Act in his care and treatment of Patient 1. Dr. Frye demonstrated conduct or practice that, if continued, will reasonably be expected to constitute the inability to practice the healing arts with reasonable skill and safety. Further, Dr. Frye's recordkeeping failed to meet the standard of care. As further described herein, the Board orders the following sanctions and costs in this case: (1) a fine totaling $2,998; (2) completion of a records keeping course; (3) completion of an ethics course; and (4) payment of costs for the proceeding.

FINDINGS OF FACT

1. Dr. Frye owns and operates the Center for Women's Health and Wellness for Obstetrics and Gynecology in Wyandotte County, Kansas.

2. Patient 1 was referred to Dr. Frye by a colleague for follow-up after Patient 1 had an [redacted] result on a specimen collected on [redacted] 2013.

3. Patient 1 was seen by Dr. Frye [redacted] 2013. Documentation of this office visit by Dr. Frye states, "Doing a [redacted] can[sic] out Abnormal... Doing a [redacted]". This office note is not signed and the author cannot be identified.

4. A [redacted] was also performed [redacted] 2013 but is not documented in the office note.

5. Patient 1 returned to Dr. Frye's office [redacted] 2013 for the results of her [redacted]. The office note made at this office visit is also unsigned and the author of the note cannot be identified.

6. The findings of the [redacted] include: [redacted]

7. Dr. Frye determined further testing was needed. This is not documented in an office note. However, there is an illustration on the [redacted] report. There is more than one unidentified hand writing on the report. Neither the illustration nor the handwritings are signed. The identity of the author cannot be ensured.

[1] In advance of the April 12, 2019 oral arguments, the Board was provided the entire agency record to facilitate a comprehensive understanding of the underlying matter, including the hearing transcript and all exhibits, briefs, and motions filed by the parties in advance of oral arguments. The entire agency record was considered by the Board in rendering its decision. As required by K.S.A. 77-527(d), the Board gave due regard to the Presiding Officer's opportunity to observe the witnesses and determine their credibility during the formal hearing.

8. A [redacted] was performed at Providence Medical Center [redacted] 2013. Patient 1 returned to Dr. Frye's office [redacted] 2013 for the results of the [redacted]. The note of this visit contains incorrect information. Again, this office note is not signed, and the author cannot be identified.

9. At the [redacted] 2013 office visit it was recommended Patient 1 have a [redacted]. The office note documents "R/B/I/A discussed in detail. [Patient 1] understands and agrees the [redacted] possible [redacted]." The note is silent on the specific risks, benefits, alternatives, and indications that were discussed with Patient 1.

10. Patient 1 speaks only Spanish. She recalled [redacted] was the translator during the [redacted] 2013 visit when the [redacted] was discussed. She testified she did not recall that risk of infection or damage to nearby organs was discussed at this time. She also testified she did not recall that she was advised that an alternative to a [redacted] was to wait 3-6 months.

11. On [redacted] 2013 Patient 1 presented to Providence Medical Center for a [redacted]. She was given consent forms to sign, including Consent to Operation, Anesthesia and Other Medical Procedures, in English and Spanish. There was no translator present at Providence Medical Center when she signed these consents.

12. Dr. Frye did not see Patient 1 on [redacted] 2013, prior to the [redacted] being performed.

13. Shortly after starting the [redacted] Dr. Frye encountered friable tissue. The tissue was thin and tore easily. The nurse in the operating room testified that she witnessed the Dr. Frye injure Patient 1's [redacted]. She also testified Dr. Frye cut into Patient 1's [redacted] with scissors. However, Dr. Frye testified that the nurse physically could not have observed the relevant portion of the surgical field during the procedure and did not have a view of the relevant surgical field in this case.

14. After the [redacted] and [redacted] injury, Dr. Frye left the operating room to talk to Patient 1's husband. Dr. Frye told Patient 1's husband that Patient 1's [redacted] was injured. He failed to tell the husband that Patient 1's [redacted] was also injured. The conversation with Patient 1's husband was not documented anywhere in Patient 1's medical record. At this point, Dr. Frye called consults into the surgery.

15. Dr. Frye's post-operative report includes the diagnosis of severe [redacted] and the post-operative diagnosis as inadvertent injury to both [redacted] and [redacted]. He also documented the procedure was difficult due to additional inflammation secondary to her previous procedures, a [redacted] and [redacted]. This operative report was not signed until Patient 1's discharge from Providence Medical Center on [redacted]

16. Throughout Patient 1's stay at Providence Medical Center ([redacted]), Patient 1 had post-operative consults with cardiology, hospitalist, internal

medicine, nephrology, pulmonology, and urology, all due to the iatrogenic injury suffered during the [redacted], 2013 [redacted].

17. In anticipation of another procedure to be performed by Dr. Frye, Patient 1 terminated her patient-physician relationship with Dr. Frye. Patient 1 indicated she did this because she was afraid to have another surgery by Dr. Frye. Dr. Frye did not document that Patient 1 terminated the patient-physician relationship in any medical record.

18. Once discharged from Providence Medical Center, Patient 1 received additional care from the University of Kansas Hospital. She was treated there for [redacted], complication of [redacted] with [redacted] and [redacted].

19. The Medical Staff Executive Committee at Providence Medical Center reviewed the Dr. Frye's care of Patient 1. [redacted]

20. The negative impact this event has had on Patient 1 include permanent [redacted]. She is subject to [redacted]. Her family member testified she is withdrawn and less active than she was prior to the surgery.

21. Dr. Frye settled a malpractice case related to this matter in the amount [redacted]

22. Except as otherwise described and/or clarified herein, and to the extent to which the Initial Order does not conflict with this Final Order, the Board adopts the findings described in the Initial Order.

CONCLUSIONS OF LAW AND POLICY

I. Applicable statutes and regulations.

K.S.A. 65-2836 provides, in part:

> A licensee's license may be revoked, suspended or limited, or the licensee may be publicly or privately censured or placed under probationary conditions...upon a finding of the existence of any of the following grounds:
>
> (b) The licensee has committed an act of unprofessional or dishonorable conduct or professional incompetency, except that the board may take appropriate disciplinary action

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

(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.

(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.

(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.

K.S.A. 65-2837 provides, in part:

(a) "Professional incompetency" means:

(2) Repeated instances involving failure to adhere to the applicable standard of care to a degree that constitutes ordinary negligence, as determined by the board.

Kansas Administrative Regulation (K.A.R.) 100-24-1 addresses minimal requirements record keeping. It provides, in part:

(a) Each licensee of the board shall maintain an adequate record for each patient for whom the licensee performs a professional service.
(b) Each entry shall be authenticated by the person making the entry unless the entire patient record is maintained in the licensee's own hand-writing.

II. Conclusions.

Except as otherwise described and/or clarified herein, and to the extent to which the Initial Order does not conflict with this Final Order, the Board adopts the conclusions described in the Initial Order.

Pursuant to K.S.A. 65-2836(b), Dr. Frye engaged in conduct that would reasonably be expected to constitute an inability to practice the healing arts with reasonable skill and safety to patients

Dr. Frye encountered an operating situation that should have caused him concern and he should have considered changing the course of Patient 1's surgery. He did not. Patient 1 had friable tissue resulting in Dr. Frye causing a [redacted] injury. After causing an injury, Dr. Frye failed to change his approach or abandon the procedure. Consequently, Dr. Frye caused a second

injury to Patient 1's [redacted]. At this point, Dr. Frye called in two additional physicians in an attempt to remedy the state of the Patient 1's situation. Unfortunately, Patient 1 suffered permanent damage. This is the type of conduct or practice that (combined with the other findings and conclusions in this order) will, if continued, reasonably be expected to constitute an inability to practice the healing arts with reasonable skill and safety in violation of K.S.A. 65-2836(b).

Pursuant to K.S.A. 65-2836(w) Dr. Frye settled a medical liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under The Healing Arts Act

As a result of the events described above, Dr. Frye settled a medical liability claim against him in the amount [redacted] Under the facts of this case, K.S.A. 65-2836(w) applies because the Board finds that the medical liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under the Healing Arts Act.

Dr. Frye's care of Patient 1 constitutes ordinary negligence but does not rise to the level of gross negligence.

Gross negligence is a conscious, wanton act or omission in reckless disregard for the foreseeable outcome. See *MacDougall v. Walthall*, 174 Kan. 663, 667 (1953). According to Dr. Hague, Dr. Frye encountered a situation which should have caused him to change course or abandon the procedure, and this constitutes a reckless disregard for the foreseeable outcome. However, because of the nature of his practice, Dr. Frye regularly sees patients who present similar to Patient 1. The Board does not believe proceeding in this particular case demonstrates a complete indifference to probable consequences, despite its imprudence. Rather, Dr. Frye's actions demonstrate ordinary negligence under Kansas law.

Pursuant to K.S.A. 65-2836(k), Dr. Frye's documentation did not meet the standard of care.

Dr. Frye violated the standard described in K.S.A. 65-2836(k) as follows:

a. K.A.R 100-24-1(a) requires a licensee of the Board to maintain an adequate record for an individual when the licensee performs a professional service. Dr. Frye failed to do this. His medical documentation is cryptic. He failed to document what was discussed with Patient 1 in his documentation of risks, benefits, indications, and alternatives. What was said, or not said, can never be known. However, Patient 1 testified that she was not presented with risks or alternative.

b. Further, Dr. Frye's documentation on the pathology report of a conversation he had with Patient 1 contains incorrect information. LEEP is documented twice on this paper, in two different handwritings. A LEEP procedure was not performed on Patient 1.

c. Dr. Frye failed to document any examination of July 12, 2013, July 18, 2013, or July 24, 2013.

d. K.A.R. 100-24-1 (c) requires each entry shall be documented by the person making the entry unless the entire record is maintained in the licensee's own handwriting. Notes made concerning Patient 1 had the handwriting of more than one individual, but no signatures were made on them.

Sanctions

The Board approaches every case according to the totality of the evidentiary record and the circumstances and facts unique to the case. Based on the above findings, the Board concludes a wide range of sanctions could be justified in this case. The Board's sanctioning authority is limited only by Kansas law and the bounds of due process.

Here, the Board departs from and does not adopt the ALJ's sanctions. The Board finds the appropriate sanctions to be as follows:

1. **A civil fine of $2998. This fine shall be paid in full within 30 days of the filing of this Final Order, or, in the alternative, Licensee may submit a proposed payment schedule for the Board's consideration and approval within that time frame.**

2. **Successful completion of all subject areas of the Ethics and Boundaries Assessment Service Essay Examination on or before August 1, 2019, or the substantial equivalent as determined and pre-approved by the Board.**

3. **Successful completion of the Center for Personalized Education for Professionals ("CPEP") Medical Record Keeping Seminar, or the substantial equivalent as determined and pre-approved by the Board, on or before August 1, 2019.**

The Board does not order a suspension and does not impose any additional probation.

Costs

This Final Order, finding multiple violations of the Healing Arts Act, is adverse to Licensee. Therefore, it is appropriate to assess costs against him pursuant to K.S.A. 65-2846. Based on consideration of the circumstances described in this order and review of the Petitioner's statement of costs, and Dr. Frye's Response to the Petitioner's Statement of Cost, **the costs of the proceedings are assessed against Licensee in the amount of $29,446.25.** This determination of costs reflects the reductions to the Petitioner's filed statement of costs discussed at the April 12, 2019 hearing on review of the Initial Order. These costs shall be paid in full within 30 days of the filing of this Final Order, or, in the alternative, Licensee may submit a proposed payment schedule for the Board's consideration and approval within that time frame.

All communications, payments, evidence of completion, etc., related to this matter shall be sent to the following address:

Kansas Board of Healing Arts
Attn: Compliance Coordinator
800 SW Jackson, Lower Level Suite A
Topeka, Kansas 66612
KSBHA_ComplianceCoordinator@ks.gov

IT IS SO ORDERED THIS 13 DAY OF May, 2019, IN THE CITY OF TOPEKA, COUNTY OF SHAWNEE, STATE OF KANSAS.

KANSAS STATE BOARD OF HEALING ARTS

Kathleen Selzler Lippert
Executive Director

NOTICE OF APPEAL RIGHTS

PLEASE TAKE NOTICE that this is a Final Order. A Final Order is effective upon service, and service of a Final Order is complete upon mailing. Pursuant to K.S.A. 77-529, Parties may petition the Board for Reconsideration of a Final Order within fifteen (15) days following service of the final order. Additionally, 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 Kathleen Selzler Lippert, Executive Director, Kansas State Board of Healing Arts, 800 SW Jackson, Lower Level-Suite A, Topeka, KS 66612.

CERTIFICATE OF SERVICE

I certify that a true copy of the foregoing Order was served this 21 day of May, 2019, by depositing the same in the United States Mail, first-class postage prepaid, and addressed to:

Daniel K. Frye, M.D.
[redacted]
Shawnee, KS 66216

Bruce Keplinger
Norris & Keplinger
9225 Indian Creek Parkway, Suite 750
Overland Park, KS 66210

and a copy was hand-delivered to the office of:

Susan Gering, Deputy Litigation Counsel
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

and the original was filed with the office of the Executive Director.

Jennifer Cook, Legal Assistant