BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

IN THE MATTER OF PETER LEE, D.O. Kansas License, No. 05-22558	}	DOCKET NOS. KSBA DKT NO.: 07 HA 00012 OAH DKT. NO.: 07 HA 0002

FINAL ORDER

NOW THIS August 16, 2008, the above captioned matter comes before the Board on the respondent's motions for a continuance and stay of initial order; the Initial Order of Presiding Officer Steve Good; and the petitioner's motion for an Emergency Order. Respondent, Peter Lee, D.O., appears by and through Gwen Birzer and Randy J. Troutt. Kathleen Lippert, Litigation Counsel, appears for the Board.

WHEREUPON, the Board hears argument on the respondent's Motion for a Continuance. The Board, having considered the statements of counsel, **DENIES** the respondent's Motion for a Continuance.

WHEREUPON, the Board hears argument on the petitioner's Motion to Stay the Initial Order. The Board, having considered the statements of counsel, **DENIES** the respondent's Motion to Stay the Initial Order.

WHEREUPON, the Board considers the Initial Order of Presiding Officer Steve Good. Having the agency record before it, and after hearing the arguments of counsel, 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 petitioner's Motion for an Emergency Order is declared MOOT.

IT IS, THEREFORE, ORDERED the license of Peter Lee, D.O. is hereby revoked.

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 18th day of August, 2008.

Kansas State Board of Healing Arts

Jack Confer
Acting Executive Director

CERTIFICATE OF SERVICE

I certify that a true copy of the foregoing Final Order was served this 18th day of August, 2008, by depositing the same in the United States Mail, first class postage prepaid, and addressed to:

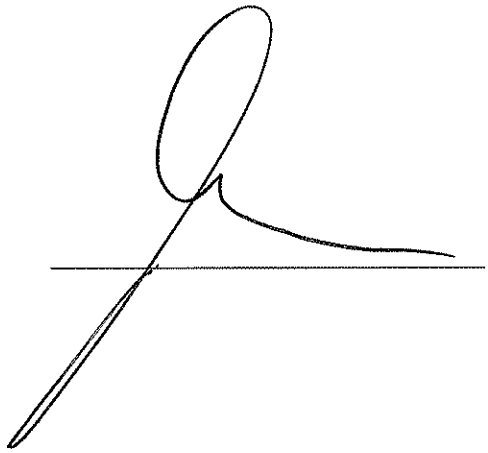
Peter Lee, D.O.
P.O. Box 620
Liberal, KS 67909

Peter Lee, D.O.
23 E. 11th Street
Liberal, KS 67901

Randy J. Troutt
Gwynne E. Birzer
Attorneys at Law
100 N. Broadway, Ste. 950
Wichita, KS 67202

And a copy was hand-delivered to the office of

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



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KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS
STATE OF KANSAS

IN THE MATTER OF	)	Docket No.: 07 HA 00012
Peter Lee, D.O.	)	
Kansas License No. 05-22558	)	OAH No.: 07HA0002

INITIAL ORDER

Statement of Case

Peter Lee D.O., the respondent, appeals from the Board's petition of August 11, 2006. The petition alleges violations of the standard of care, inappropriate prescribing, inadequate medical record documentation, sexual misconduct, unprofessional conduct and **(Confidential)** The petition contains 14 counts, regarding 12 patients.

Proceedings conducted by the Board are governed by the Kansas Administrative Procedure Act at K.S.A. 77-501 *et. seq.* See also, K.S.A. 65-2851a.

The Board appointed a presiding officer from the Office of Administrative Hearings, which assigned Stephen E. Good.

A formal hearing was held April 29, 2008 through May 5, 2008 at the Office of the Board of Healing Arts in Topeka, Kansas. Testifying for the Board were **(Confidential)** patient number 10, patient number 11, patient number 12, Timothy Scott Webb D.O., Sergeant Gene Ward, Ian Yeats, M.D., E. James Fitzgerald, M.D., Paul W. Murphy M.D., Myrna McCarl, Scott Bond, Stephanie Durban, Maria Franco, and Lori Denk. The Board offered the deposition of Gupreet S. Randhawa, M.D., in lieu of his testimony. Testifying on behalf of the respondent was Peter Lee, D.O. The following gave their testimony for the respondent by video deposition: Nathan Kitchens, Brenda Mayes, and patients number 9, 6, 7 and 4.

Findings of Fact

By clear and convincing evidence the presiding officer finds the following facts:

1. Peter Lee, D.O., is licensed by the Kansas Board of Healing Arts to practice osteopathic medicine and surgery. The allegations giving rise to the Board's petition to revoke Dr. Lee's license occurred while he was practicing in Liberal, Kansas.

Exhibit A

2. In 1984 Dr. Lee obtained his D.O. degree from the University of Health Sciences College of Osteopathic Medicine in Kansas City, Missouri. In 1985 he became board certified in Osteopathic medicine and surgery. He worked for the United States Army. In December 1988, the Kansas Board of Healing Arts granted him a license. In about 1989 or 1990, Dr. Lee started work with Dr. E. James Fitzgerald in an emergency room department in Manhattan, Kansas. In December 2001 Dr. Lee was granted privileges to practice at Southwest Medical Center in Liberal, Kansas. Dr. Lee came to Liberal to work in the emergency department with Dr. Fitzgerald, at his urging. Dr. Lee's contract with the medical center was not renewed, and Dr. Lee opened up a private practice in Liberal in about 2003.

Count Number 1

3. When patient number 1 was first seen by Dr. Lee on January 4, 2004, he was 25 years old. He was an over weight police officer with borderline high blood pressure. On his first visit he complained of acute back pain caused by putting his daughter in a car seat. On later visits he complained of falling asleep on the job and told Dr. Lee he had a history of narcolepsy.

4. Dr. Lee treated patient number 1's back pain, neck pain and sciatica through August 27, 2005 by using pain medication, muscle relaxants, narcotic injections, and OMT (osteopathic manipulation treatments). Dr. Lee assessed patient number 1's pain by clinical examination. He did not take X-rays, MRIs, nor did he refer patient number 1 to a pain specialist. Dr. Lee testified he suggested these tests and a diagnostic workup to patient number 1, but the patient refused. Dr. Lee did not document his suggestions and the patient's refusal in the patient record.

5. Patient number 1 received 150 injections of Demerol at Dr. Lee's office. The quantities range from 150 to 200 milligrams. One hundred milligrams is the top end for most people. The Board's expert, Timothy Scott Webb, D.O., described these injections as "over the top". The cumulative effects of narcotics, muscle relaxants and Valium (also prescribed) which patient number 1 received, would have a depressive effect on the CNS (central nervous system).

6. Patient number 1 complained of falling asleep at work. Dr. Webb believed the CNS depressant drugs he was taking may have been a cause of patient number 1's drowsiness. Without doing any workup, such as sleep apnea testing or sleep latency testing, Dr. Lee diagnosed patient number 1 with narcolepsy and prescribed Adderall, a stimulant. It is not the standard of care to use stimulants to counteract the effect of depressants, according to Dr. Webb.

7. Dr. Lee also prescribed patient number 1 with Phenermine, which is an amphetamine, because of his obesity. However Dr. Lee never calculated a BMI (body mass index). Nor did he conduct a cardiovascular exam before prescribing

Phenermine, a side effect of which is to increase blood pressure. In fact, patient number 1's weight and blood pressure both increased while he took Phenermine. Dr. Lee's notes show no indication he ever addressed the blood pressure issue.

8. In August 2005 patient number 1 was fired for sleeping on the job. His supervisor, Gene Ward, described patient number 1 as appearing glassy eyed and half asleep at work. In October 2005 patient number 1 wrote an email to Mr. Ward stating "I was taking way too many pills and fucking up my life.... Dr. Lee giving us and everybody else too much medication." He writes that he is clean and doing a lot better.

Count Number 2

9. Patient number 2 is the wife of patient number 1, and was seen by Dr. Lee from April 2004 through September 2005. She was seen for neck pain, back pain, malaise, narcolepsy, depression, migraines, severe colds and obesity. Dr. Lee used over 60 OMT, Demerol shots, Valium, Oxycodone, Hydrocodone and other medications.

10. Dr. Lee did not take X-rays, MRIs or refer the patient to specialists to evaluate her pain. For several months she received prescriptions for a combination of Oxycodone and Hydrocodone in excess of 200 pills per month. She was prescribed Soma, a muscle relaxant, at the rate of 160 to 200 pills per month. The maximum normal dosage for Soma is 120 pills per month. In March 2005 alone, patient number 2 received 220 Soma, 120 Oxycodone, 120 Hydrocodone and several Demerol shots. Dr. Webb testified the amount of pain medications she received was comparable for a patient with end-stage cancer pain, not for one with general complaints of back and neck pain.

11. Patient number 2 was treated for depression, although the medical record did not document any symptoms. Dr. Lee prescribed Valium at twice the recommended dosage. Valium is not indicated for depression, unless there is an anxiety component. According to Dr. Webb, Valium can worsen depression. Dr. Lee did not document patient number 2's response to Valium, or to the other two medications he prescribed for her depression (Fluoxatine and Lexapro).

12. Dr. Lee appropriately treated patient number 2 for migraines with Imitrex and Maxalt, but he failed to document her response. Then, he shifted her to narcotics, even though she was already taking them for her back pain. According to Dr. Webb, if a patient has frequent migraines that require narcotics, a neurologic consultation is a standard of care. Dr. Lee made no such referral.

13. The patient records for patient number 2 listed little symptomatology or discussion about narcolepsy. Dr. Webb believed the diagnosis of narcolepsy may not have been justified; patient number 2 was just over sedated from the narcotics.

14. Although Dr. Lee claimed he was seeing patient number 2 for obesity, he did not record her height or weight. He did not calculate her BMI. He prescribed Tenuate, a weight loss medication, but he did not document this prescription in the patient record.

Count Number 3

15. Patient number 3, a 34 year old female, had chronic pain with multiple sclerosis and fibromyalgia, as well as neck and back pain. She also had a history of abusing prescription drugs. An MRI of her spine showed mild disc bulging at L4–L5 and at L5–S1. Dr. Lee saw her from October 2003 through October 2005.

16. From May 2004 to July 2004, Dr. Lee increased patient number 3's prescription for Oxycontin, a narcotic, from 10mg to 40mg, although he knew she had a drug problem. In December 2004, patient number 3 reported that she accidentally threw her pain medications in the sink. Nevertheless Dr. Lee gave her a prescription for 30mg of Oxycontin. In March 2005 he prescribed three 40mg pills of Oxycontin per day, but the actual prescription was enough for four 40mg pills per day. Oxycontin is considered "long lasting", and is supposed to be taken every twelve hours.

17. Dr. Webb believed that Dr. Lee deviated from the standard of care by prescribing more medications than he told the patients to take, which runs the risk of increasing drug usage and the chance the drugs will be diverted. The standard of care is to escalate dosages of medication more slowly and to try other avenues to control the pain, particularly when the patient exhibits drug-seeking behavior.

Count Number 4

18. Patient number 4, age 40, was seen for mid to lower back pain from May 2003 through October 2005. When she first went to Dr. Lee, patient number 4 showed him a previous MRI. In addition to OMT, Dr. Lee prescribed Hydrocodone as well as the CNS depressant Tramadol and Alprazolam. During an eight month period, the Hydrocodone exceeded the recommended dosage. Dr. Webb believed Dr. Lee should have more fully evaluated the patient instead of beginning a treatment with narcotics and muscle relaxants. Dr. Webb's opinion is that Dr. Lee prescribed controlled substances in an inappropriate manner.

Count Number 5

19. Patient number 5, a 46 year old man, started seeing Dr. Lee for neck and shoulder pain, with radiating right arm pain, following a work injury. From May 2004 through October 2005, Dr. Lee performed OMT and prescribed medications for pain. Although patient number 5 was seen by a surgical specialist, Dr. Lee's records do not refer to any recommendations the specialist may have made. Dr. Lee increased

patient number 5's pain medications with minimal to no documentation explaining his rationale.

20. Although patient number 5 swears he's never been addicted to pain medication, he also admitted to having been jailed for being caught with meth, and that he'd been in substance abuse treatment in 1988 and possibly 2001. He was caught in September 2004 getting narcotic prescriptions from Dr. Robert Sager, and other doctors at the same time.

21. In May 2004 Dr. Lee prescribed 100 tablets of 20mg Oxycontin by taking two a day. This is enough for 50 days. Yet 22 days later, on June 8, 2004, Dr. Lee refilled the prescription. Dr. Lee also prescribed patient number 5 Soma and Caristrodol in excess of 4 pills per day, which exceeds the dosage guidelines. On March 28, 2005 Dr. Lee prescribed 40 10mg Lortab. Two days later, on March 30, 2005, he prescribed another 40 Lortab, with no notation in the chart as to why.

22. Dr. Webb's opinion is that Dr. Lee prescribed controlled substances in an inappropriate manner. Dr. Webb saw no effort to limit the patient from escalating dosages, and it appeared to Dr. Webb that Dr. Lee was swapping an office visit fee for medications.

Count Number 6

23. Patient number 6, a 42 year old man, suffered a back injury when he fell off scaffolding while painting. He had a history of disc disease in his lumbar spine. Dr. Lee saw him from July 2003 through October 2005 for back pain, neck pain, sciatica, depression and malaise. Patient number 6 was treated with OMT and the muscle medications Tramadol and Tylenol with Codeine. Over one 6-day period (October 15 through 21, 2004) Dr. Lee prescribed 300 Tramadol tablets, without documenting his reasons for doing so. The recommended maximum dosage per day is 400mg, or 8 tablets.

24. Dr. Webb testified Dr. Lee, by prescribing excessive amounts of medication, failed to meet the standard of care. Dr. Lee prescribed Tramadol well in excess of the maximum recommended dosage. Further, Tramadol and Tylenol with Codeine have a cumulative CNS depressive effect.

Count Number 7

25. Patient number 7 has Sjogren's disease, in addition to rheumatoid arthritis, back and neck pain, fibromyalgia and anxiety. Sjogren's is a rheumatologic disease causing joint problems and chronic pain. Before seeing Dr. Lee patient number 7 had neck surgery and was addicted to her medication.

26. According to patient number 7, no other doctors in Liberal would see her because she had too many problems, was in to much pain, and had no money. But, Dr. Lee "took care of welfare people and didn't even charge them." Actually, on July 22, 2005 Dr. Lee charged patient number 7 $40.00 for an office visit for which she was not present. Her husband was present to get prescriptions for her.

27. Although patient number 7 was pretty close to the maximum dosage of about 18 medications when she first Dr. Lee on January 27, 2004, and was only on three medications when she stopped treatment in October 2005, she was receiving more medications overall. For example, she was taking one Soma per day when she first presented for care. By October 2005 she was taking almost twelve per day, or 3 to 4 times the recommended dosage. She received Soma refills every three to five days.

28. On most visits – which started as several per month, and ended as almost every three days – she received a prescription for the narcotic Hydrocodone, as well as for Soma, and for generic Xanax. She was prescribed Hydrocodone in excess of the manufacturer's recommended dosage of 6 per day. The high doses of Soma and generic Xanax (and Hydrocodone) cause significant CNS depression.

29. Dr. Webb believed that the use of Hydrocodone was inappropriate because patient number 7 was already addicted. Dr. Lee did not document trying other types of medication like Prozac (an SSRI) to treat her chronic anxiety. Dr. Webb testified the standard of care was not met.

Count Number 8

30. Patient number 8 was a 25 year old policeman seen by Dr. Lee from October 2003 through March 2005 for back pain, neck pain, sciatica, weight loss, malaise, and fatigue. After OMT failed the work, Dr. Lee started prescribing narcotic pain medications. No X-rays or MRIs were taken, nor was patient number 8 evaluated to determine the underlying condition. According to Dr. Webb, the standard of care in treating back pain, neck pain and sciatica would be to initially use nonsteriodal anti-inflammatory drugs. Dr. Lee failed to document why he chose narcotics as a first line of treatment.

31. For example, from December 24, 2004 through January 11, 2005, patient number 8 had nine office visits. At each visit he was given a shot of Demerol. During this time he received prescriptions for 80 Oxycodone, 160 Hydrocodone and 160 Valium. Dr. Webb's opinion is that Dr. Lee's treatment of patient number 8 did not meet the standard of care.

Count Number 9

32. Forty-eight year old patient number 9 had a history of drug and substance abuse, of which Dr. Lee was aware. He saw her from December 2003 through October 2005 for back and neck pain. For the majority of these visits, he prescribed narcotics, including on the first visit. On the patient intake form, she indicated she was allergic to Morphine. Dr. Lee had some of her medical records from Dr. Mark V. Pace, M.D., which also reflected an allergy to Morphine. In addition, there are entries in the right hand column of Dr. Lee's progress notes reflecting the patient was allergic to Morphine.

33. Yet on September 9, 2005 patient number 9 was prescribed MSIR (morphine sulfate immediate release). On September 12, 2005 patient number 9 indicated she didn't want the MSIR because it made her vomit. However, on September 16, 2005, MSIR was again prescribed. Shortly after this visit, patient number 9 was hospitalized for six days due to a reaction to and overdose of MSIR.

34. Patient number 9 also appeared to have an allergic reaction to Tylox, a brand name for Hydrocodone or Oxycodone. On August 1, 2005 she complained to Dr. Lee of a rash and reported that Tylox made her itch. Dr. Lee described the rash as an allergic reaction, yet on August 2, 2005 he prescribed more Tylox.

35. Dr. Webb's opinion is that Dr. Lee prescribed drugs in an excessive and inappropriate manner. There appeared to be no effort, as indicated in the medical records, by Dr. Lee to attempt to find the cause for the patient's pain, or any effort to limit narcotics, until patient number 9 overdosed on the MSIR. Dr. Webb observed that there were multiple entries in the record that patient number 9 came back into the office for refills every three or four days, which equates to taking 10 Hydrocodone pills per day.

Count Number 10

36. Dr. Lee saw patient number 10 for three months, from August through October 2005. She was 10 years old at the time. She is the sister of patient number 11 and the daughter of patient number 12. The girl apparently had an acute asthma attack associated with bronchitis. She received intramuscular injections of Rocephin, an antibiotic, on two of the five visits; on four visits she received nebulized Albuterol.

37. Dr. Webb questioned the use of an intramuscular injection for a 10 year old, but he ultimately concluded that Dr. Lee's care for patient number 10 was appropriate. Dr. Webb concluded that Dr. Lee's medical records on this patient – indeed, on all twelve patients – were inadequate. Dr. Lee agrees and concedes his patient records were inadequate. In fact, during the hearing, one of his counsel described his medical records as "lousy".

Count Number 11

38. This nine year old girl was seen by Dr. Lee from August 9, 2005 through September 29, 2005. Although the patient history sheet did not state the patient had asthma or was on any medications, Dr. Lee saw her for five visits. On three of these visits she received intramuscular Rocephin.

39. Dr. Webb believed the use of intramuscular Rocephin on three occasions in a two month period for a nine year old child was "odd", particularly since there was no documentation why this was used over oral medication. Nevertheless Dr. Webb concluded patient number 11 did not receive less than appropriate care.

Count Number 12

40. Dr. Lee saw thirty year old patient number 12 from April 5, 2005 to October 15, 2005, primarily for migraines and asthma; but also for back and neck pain, bronchitis and an abscess. She brought medical records from previous doctors she had seen in Oklahoma City. For example, she had seen a neurologist from May 2003 through April 2004 who gave trigger point injections, but no narcotic medications had been prescribed. In fact, her complete medication list from Oklahoma was devoid of any narcotics.

41. On her first visit, Dr. Lee gave her no physical exam, but did give her a prescription for Maxalt, for migraines and Restorial, to help with her sleep. About a week later, she returned to Dr. Lee complaining of headaches. She received Percocet and Oxycodone to try. On her third visit, she needed a refill and she received it. Even though patient 12 testified the medications helped her headaches, she felt drugged and out of her mind. At one point Dr. Lee diagnosed number 12 with bi-polar and gave her Symbyax, Seroquel and Xanax.

42. Dr. Lee saw patient number 12 two to four times per month. In this six and half month period, he gave her twelve intramuscular Demerol shots, six of those in August 2005 alone. In addition, he gave her a prescription for injectable Demerol, and one for 100 10mg Oxycodone. She received seven doses of IM Rocephin in six months. He also provided OMT and trigger point injections.

43. Dr. Webb's opinion is that Dr. Lee deviated from the standard of care by almost immediately beginning the use of narcotics, and by showing a pattern of increasing the narcotic dosage. (The neurologist who saw patient number 12 for a year treated her migraines with no narcotics.) Also, Dr. Lee's records do not reflect why he chose to aggressively treat bronchitis and asthma with IM Rocephin, as opposed to oral medications.

Count Number 13

44. Dr. Lee had a sexual relationship with patient number 12 while she was his patient. It started during her second office visit. While she was lying down on the exam table, he put his hand on her leg and sang "Love Me Tender" to her. On her third visit, he asked her for a hug. He rubbed her thighs. He kissed her with his tongue in her mouth.

45. On the fourth visit, Dr. Lee gave patient number 12 a 150mg Demerol shot at the beginning of the visit. Her headache was gone, but she felt tired and drugged while lying on the examination table. Dr. Lee put his hand on her bottom and started kissing her mouth. "I was just out of it. I wasn't struggling. I was completely pliant," she testified on April 29, 2008.

46. While still out of it, Dr. Lee rolled patient number 12 on to her back, lifted her shirt, pulled down her bra, and groped and squeezed her breasts. Patient number 12 asked him, "Aren't you married?" Dr. Lee answered, "My wife is having sex with the gardener, and she's having sex with the pool man and she doesn't care who I have sex with." He pulled her pants down, stuck his fingers in her vagina and said her problem was she wanted sex.

47. After leaving the office on this fourth visit, Dr. Lee took patient number 12 to dinner, then to his home where they had sex until 2:00 a.m. At his insistence, she saw him again the next night. He came by Hastings, where she was employed. They went out to eat, then back to his place for sex.

48. Early on in the relationship Dr. Lee drove patient number 12 home. They were seen kissing **(Confidential)** . Patients number 10, 11, and 12 lived with **(Confidential)** until about August 1, 2005 when Dr. Lee allowed the three to live in the basement of his home, rent free until about January 2006. **(Confidential)** saw Dr. Lee kiss her **(Confidential)** on a couch in her home. **(Confidential)** described the kiss as "sexual": Dr. Lee wrapped his legs around patient number 12 and was deep kissing her.

49. Others who observed the sexual nature of Dr. Lee and patient number 12's relationship were her children. The girls were 12 and 13 years old when they testified on April 29, 2008. Patient number 11, the younger girl, told her **(Confidential)** she heard "moans" from the basement bedroom that Dr. Lee and patient number 12 shared. Patient number 11 saw Dr. Lee hug and kiss her mother, and observed him come down to their basement apartment every night. She saw Dr. Lee and her mother sleeping in her mother's bed; and on two or three occasions she slept on the floor while the adults slept in the bed.

50. Patient number 10 saw Dr. Lee kiss her mother on the lips in public and in the basement apartment. She knew that Dr. Lee had bought her mother a new car (2005 Toyota Corolla). Patient number 10 testified that Dr. Lee and her mother acted "like they were a couple", holding hands and she (patient number 12) put her head on his shoulder. Patient number 10 also saw Dr. Lee give her mom shots in the bedroom.

51. Dr. Lee took patients number 10, 11, and 12 on a trip to Amarillo, Texas. The two girls stayed in one room and Dr. Lee and patient number 12 stayed in another at the hotel. Dr. Lee bought the girls swim suits and towels. In addition to the car, Dr. Lee bought patient number 12 watches, a handbag, perfumes and a cell phone, including the monthly charges.

52. **(Confidential)** a co-worker with patient number 12 at Hastings, saw Dr. Lee and patient number 12 kissing at Hastings. Although Dr. Lee denied having a sexual relationship with patient number 12 he testified he moved her and her children in to the basement of his home, and paid the extra rent of $675.00 per month. He acknowledged taking her out to dinner. He agreed he let her use a car and a cell phone up until January 2007. He admitted making other purchases for patient number 12 and her children.

53. On October 19, 2005 Lori Denk, an investigator with the Kansas Board of Healing Arts, met with Dr. Lee at his office in Liberal. She obtained copies of patient records. In response to the Board's inquiry, Dr. Lee dictated his response (Board Exhibit number 51) word-for-word to patient number 12, who then typed it. Patient number 12 knew that some of the information contained in exhibit number 51 was false, but Dr. Lee threatened to shoot her mother if he lost his medical license. **(Confidential)** had filed a complaint with the Board of Healing Arts.) Patient number 12 wrote her own letter dated November 3, 2005 to the Board (Board Exhibit number 13), wherein she denied having an intimate relationship with Dr. Lee. Patient number 12 wrote another letter to the Board in January 2007 (Board Exhibit number 14) wherein she admitted to previously lying and wherein she discussed her relationship with Dr. Lee.

Count Number 14

54. After working with Dr. Lee in Manhattan, Kansas, Dr. Fitzgerald believed Dr. Lee had good skills and judgment and his skills would be valuable to the Liberal medical community. But once Dr. Lee came to Liberal, Dr. Fitzgerald saw a "drastic change" in him. Dr. Lee exhibited grandiose thoughts, like he was "the best doctor" and that "all women want me". Dr. Fitzgerald noticed Dr. Lee spoke rapidly, had flights of ideas and was drinking alcohol. Dr. Lee told Dr. Fitzgerald he only slept one or two hours a night. **(Confidential)**
(Confidential)

55. In November 2004 Dr. Fitzgerald called in an anonymous complaint to the Board of Healing Arts. **(Confidential)**
(Confidential)

56. Stephanie Durban and Maria Franco worked in the X-ray department of Southwest Medical Center in 2003. In January 2003 while at work, Dr. Lee grabbed Ms. Durban. He said that if he was drunk, he'd "do this" to her. He then kissed her on the lips. This occurred in the waiting room full of people. Ms. Franco was present and observed this. Dr. Lee then turned to Ms. Franco and said, "If the lights were off, I'd kiss you."

57. Ian Yeats is a medical doctor in Liberal, Kansas. He filed a complaint with the Board of Healing Arts because Dr. Lee threatened to kill the doctors in his (Dr. Yeats) building. Dr. Yeats and his colleges obtained a restraining order against Dr. Lee preventing him from coming on to their property.

58. Gupreet Randhawa is a medical doctor in Liberal. In August 2005 he approached Dr. Lee in a parking lot to discuss a patient they had in common. Dr. Lee briefly discussed the patient and then went off on a tangent saying, "I am the best physician in this town" and "all the people love me." Dr. Lee went on to say, "I am going to kill a few doctors in this medical community", and "They are all out to get me." Dr. Randhawa filed a police report.

59. On August 14, 2005 **(Confidential)** was returning patients number 10 and 11 to **(Confidential)** (patient number 12) who lived in Dr. Lee's basement. As she pulled in the driveway, Dr. Lee came rushing out and told **(Confidential)** "You're serious bi-polar and you've been misdiagnosed for thirty years at least." **(Confidential)** was stunned while sitting in her car. He told her not to worry about patient number 12 because he would take care of her. He said he bought her a car and pointed to a Toyota Corolla and said "I paid cash". Patient number 12 came outside and her eyes looked funny, not focusing. This incident spurred **(Confidential)** to write a letter of concern to the Board of Healing Arts in September 2005.

60. **(Confidential)**

61. **(Confidential)**

(Confidential)

62. **(Confidential)**

63. Lori Denk, a Board investigator, met with Dr. Lee in person on October 19, 2005 and discussed some of his patients. Dr. Lee told Ms. Denk that if he did not provide the pain medication to all these patients they would just die. He stated that he turned away five to six patients a day because he wouldn't give them narcotics. Dr. Lee told Ms. Denk that he had to trust his patients when they told him they are in pain and he could not ignore that. Dr. Lee stated that he was a very good doctor and he could just look at a patient and know immediately what was wrong with them. Dr. Lee stated that all of his patients are bi-polar.

64. In his testimony on May 5, 2008 Dr. Lee stated the following individuals were bipolar: patient number 8, patient number 9, Dr. Fitzgerald, Bill O'Reilly, Rush Limbaugh and Hillary Clinton. Regarding patient number 8, Dr. Lee testified: "He's a bipolar cop. That's never been diagnosed by any psychiatrist." Regarding patient number 9, he testified: "Nobody knows she's schizophrenia and bipolar. I was the only one that first discovered she's bipolar." Regarding Dr. Fitzgerald, Dr. Lee testified: "He's fired from place to place because he's bipolar, severe bipolar." **(Confidential)**

Applicable Law

1. The Kansas Board of Healing Arts has the authority to revoke a license it has issued based upon: unprofessional conduct, professional incompetency, inability to practice due to mental illness and for violating the Board's rules. K.S.A. 65-2836(b),(i), and (k). The Board has the authority to fine a licensee for violations. K.S.A. 65-2863a.

2. Professional incompetency is defined at K.S.A. 65-2837(a)(2)and (3) as:

> (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.

3. Unprofessional conduct has several definitions under K.S.A. 65-2837(b), but the four applicable here are:

> (16) commission of any act of sexual abuse, misconduct or exploitation related to the licensee's professional practice.
>
> . . . .
>
> (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 reasonable 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.

4. The Board's cites violations of two regulations: K.A.R. 100-23-1, which concerns treating obese patients; and K.A.R. 100-24-1, which deals with maintaining adequate medical records.

Discussion

1. As Dr. Webb opined, Dr. Lee appears to use narcotics as a first line of treatment to cover up pain, with no attempt to find the cause and perhaps correcting it; with no attempt to rehabilitate the patients so they no longer need pain medication or as much. Patient number 1, for example, went for months with daily or every other day injections of large doses of Demerol. Patient number 1's firing was almost certainly connected with all of the medications Dr. Lee prescribed. It also appeared to Dr. Webb that medications were given at the patient's request, and that patients chose when to see the doctor, rather than Dr. Lee controlling the return visits. Dr. Webb's opinion on patients numbered 1 through 9, and patient number 12 is that Dr. Lee deviated from the standard of care, and that he prescribed medicine inappropriately.

2. Dr. Lee testified on May 5, 2008 that "everybody needs some kind of pain pill." However, he said he never takes pain pills. Instead, he suffers "so I can appreciate my patients' pain." When asked how he knew the amount of pain a patient had, Dr. Lee did not respond by saying he asked the patient to rate it on a scale of one to ten, for example. He testified, "Because they told, they told – if they said 5mg, it doesn't help the pain, it doesn't work, then I give them 10mg." His automatic response was to prescribe pain pills and to give the patient what he/she wanted.

3. **(Confidential)**

4. Dr. Lee stated he was aware that clinical obesity was defined as having a BMI of 30 or greater. But he testified on May 5, "We are doctors, we don't need to follow all these guidelines. A lot of guidelines are wrong. A lot of books are wrong." Although the prescribing guidelines for Phentermine require a BMI over 30, Dr. Lee testified, "Yes, they require, but doesn't necessarily mean, mean I can not use my judgment, because I am an experienced doctor. Medicine is an art. You don't follow rigidly the regulations."

5. Through his testimony, Dr. Lee demonstrated he was not amenable to change. He often interrupted the questions of counsel. He was reminded by his own counsel to "stick to what we are talking about," and to "let me finish my sentence", and to "just answer the questions." His answers were often phrased in absolute terms, with no appreciation for nuance. As Dr. Murphy observed in his testimony on May 1, 2008, those with Dr. Lee's personality profile are "extremely reluctant to listen to the advice of others." As Dr. Murphy's July 12, 2005 letter states, Dr. Lee is "completely closed off to interventions."

6. Dr. Lee's denials about a sexual relationship with patient number 12 are utterly and wholly unconvincing. The evidence went way beyond clear and convincing to establish the sexual nature of the relationship. Dr. Lee has no credibility on this point.

Conclusions of Law

1. Dr. Lee's treatment of patients' number 1 through number 9, and number 12 has deviated from the standard of care to a degree that constitutes negligence. His treatment of these same 10 patients demonstrates an incapacity to practice medicine. This violates K.S.A. 65-2837(a)(2) and (3), and constitutes professional incompetency.

2. Dr. Lee has prescribed and administered prescription drugs including controlled substances in an inappropriate and excessive manner or quantity to patients one through nine, and patient number 12. For the same 10 patients, he also failed to practice with a level of skill recognized by a reasonably prudent similar practitioner. This violates K.S.A. 65-2837(b)(23) and (24), and constitutes unprofessional conduct.

3. Dr. Lee failed to maintain adequate medical records for all twelve patients. This violates K.S.A. 65-2837(b)(25) and K.A.R. 100-24-1(b), and constitutes unprofessional conduct.

4. Dr. Lee's sexual contact with patient number 12 constitutes sexual abuse, misconduct or exploitation and is a violation of K.S.A. 65-2837(b)(16), and constitutes unprofessional conduct.

5. Dr. Lee violated K.A.R. 100-23-1 by failing to adequately examine and counsel patient numbers 1 and 2 before treating them for obesity with controlled substances.

6. **(Confidential)**

7. Based on the totality of circumstances presented at the hearing ranging from over prescribing narcotics, to sexual involvement with a patient, to threatening to kill doctors in Liberal, Kansas, **(Confidential)** it is clear that Dr. Lee can not safely practice medicine.

ORDER

Based on Dr. Lee's repeated violations of the Kansas Healing Arts Act, Dr. Lee's license to practice osteopathic medicine and surgery is revoked. The costs of this proceeding are assessed against him. K.S.A. 65-2846. The amount of the costs has yet to be determined.

IT IS SO ORDERED.

Pursuant to K.S.A. 77-527, either party may appeal this initial order. A petition for review must be filed within 15 days from date of this initial order. Failure to timely request review may preclude further judicial review. If neither party requests a review, this initial order becomes final and binding on the 30th day following its mailing. Petitions for review shall be mailed or personally delivered to: Jack Confer, Acting Executive Director, Kansas Board of Healing Arts, 235 South Topeka Boulevard, Topeka, Kansas 66603.

Stephen E. Good
Presiding Officer

CERTIFICATE OF SERVICE

On Thurs 7/31, 2008, I mailed by U.S. mail, a copy of this initial order to:

Peter Lee, D.O.
P. O. Box 620
Liberal, KS 67909

Randy J. Troutt
Gwynne E. Birzer
Attorney at Law
100 N. Broadway, Ste. 950
Wichita, KS 67202

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

Courtney Tilton
Staff Person
1020 S. Kansas Ave.
Topeka, KS 66612