

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

FILED JUNE 21 2004 KANSAS STATE BOARD OF HEALING ARTS
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In the Matter of)
)
ALAN E. ORGAN, M.D.)
)
Kansas License No. 04-17107)
_____)

Docket No. 04-HA-51

FINAL ORDER

NOW ON THIS Nineteenth Day of June 2004, this matter comes before the Board to review the Initial Order Proposing Default. Stacy L. Cook, Litigation Counsel, appears for the Board. Respondent Alan E. Organ, M.D. does not appear in person or through counsel.

Having the agency record before it, the Board adopts the Initial Order as the Final Order, and finds, concludes and orders as follows:

1. Respondent was served with proper notice of the prehearing conference. Board staff made attempts to contact Respondent by telephone at his home and at his office, but were unable to reach him. Respondent is in default. The facts alleged in the Petition are deemed not to be disputed, and are the facts upon which the Board issues this Final Order.
2. Respondent's last known mailing address on file with the Board is 4601 W. 109th Street, #112, Overland Park, Kansas 66211.
3. Respondent is licensed to practice medicine and surgery in this state, having first been licensed on July 1, 1977. That license has been in effect continuously, and was last renewed on June 3, 2003.
4. Respondent practices in the specialty of pediatrics.
5. From approximately December 1998 through July 1999, Respondent prescribed drugs, including controlled substances, to Patient #1 [REDACTED], and who was then approximately 18 to 20 years old.
6. Respondent prescribed at least 65 cans of Stadol to Patient #1.

7. Respondent did not perform an adequate assessment and evaluation of Patient #1.

8. In prescribing Stadol to Patient #1, Respondent failed to adhere to the applicable standard of care to a degree constituting ordinary negligence.

9. Respondent failed to create and maintain documentation of his prescriptions for Stadol and other controlled substances to Patient #1.

10. In 1999, Respondent requested that his partner prescribe Stadol to Patient #1. This partner was a former resident whom Respondent trained.

11. From July to December 1999, Respondent used another physician's DEA number to obtain Stadol for Patient #1 without that other physician's knowledge.

12. On December 3, 1999, Respondent prepared a prescription for Stadol for Patient #1 using another physician's name and DEA number, without that physician's knowledge.

13. From approximately January 17, 1997 through December 24, 1998, Respondent prescribed Stadol and other controlled substances to Patient #2, [REDACTED]. Between those times, Respondent prescribed approximately 308 cans of Stadol for Patient #2.

14. On December 1, 1998, Respondent prescribed 14 cans of Stadol for Patient #2.

15. Respondent did not conduct an adequate assessment and examination of Patient #2 for the prescriptions for Stadol.

16. The manner in which Respondent prescribed Stadol for Patient #2 failed to adhere to the applicable standard of care to a degree constituting ordinary negligence.

17. Respondent failed to create and maintain adequate documentation of his prescriptions for Stadol and other controlled substances for Patient #2.

18. From approximately January 9, 1997 through February 12, 1998, Respondent prescribed approximately 36 cans of Stadol for himself.

19. From January 9, 1997 through February 2000, Respondent also prescribed other controlled substances, including Demerol, for himself.

20. Respondent failed to document these prescriptions for himself.

21. The manner in which Respondent prescribed Stadol and other controlled substances for himself failed to adhere to the applicable standard of care to a degree constituting ordinary negligence.

22. From at least October 1997 through May 2000, Respondent treated Patient #3, a 25 or 26 year-old female.

23. During that time, Respondent prescribed Stadol and other controlled substances for Patient #3.

24. Respondent prescribed Stadol for Patient #3 without an adequate assessment and examination of the patient.

25. From approximately February 1, 1999 through May 15, 2000, Respondent prescribed approximately 128 cans of Stadol for Patient #3.

26. The manner in which Respondent prescribed Stadol for Patient #3 failed to adhere to the applicable standard of care to a degree constituting ordinary negligence.

27. Respondent failed to create and maintain documentation of all of the prescriptions he ordered for Patient #3.

28. From approximately January 23, 1998 through August 21, 2000, Respondent prescribed approximately 60 cans of Stadol and other controlled substances to Patient #4.

29. Respondent prescribed the Stadol without an adequate assessment and examination of Patient #4.

30. The manner in which Respondent prescribed Stadol for Patient #4 failed to adhere to the applicable standard of care to a degree constituting ordinary negligence.

31. Respondent failed to create and maintain documentation of all of the prescriptions he ordered for Patient #4.

32. The Board finds and concludes that these prescriptions were excessive, improper, and for other than a lawful medical purpose.

33. The Board finds and concludes that Respondent has repeatedly engaged in conduct that is below the standard of care to a degree constituting ordinary negligence.

34. The Board finds and concludes that Respondent has repeatedly failed to adequately document the patient record.

Certificate of Service

I certify that a true copy of the foregoing was served this 21st day of June 2004 by depositing the same in the United States Mail, first-class postage prepaid, and addressed to:

Alan E. Organ, M.D.
4601 W. 109th Street, #122
Overland Park, KS 66211

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

Stacy L. Cook
235 S. Topeka Blvd.
Topeka, KS 66603

____ Sheryl Snyder _____