BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
	)	
Pravin G. Sampat, M.D.	)	Docket No. 09-HA-00049
Kansas License No. 04-18013	)	
	)	

JOURNAL ENTRY

NOW this March 6, 2009 the above captioned matter comes before the Board of Healing Arts, Merle Hodges, M.D., Presiding Officer, on the motion of the petitioner for an Emergency Hearing pursuant to K.S.A. 77-518 et seq. The petitioner appears by and through Janith Davis, Associate Litigation Counsel and Stacy Bond, Assistant Litigation Counsel. The respondent appears in person and by Pedro Irigonegaray and Elizabeth R. Herbert of Irigonegaray and Associates, Attorneys at Law. There are no other appearances.

WHEREUPON, the respondent moved the Presiding Officer for an Order to close the hearing to the public to maintain patient privacy. Without objection from the petitioner, the hearing was closed to the public.

WHEREUPON, the respondent moved the Presiding Officer for an Order limiting the use of hearsay evidence reportedly made by Gloria Query, now deceased. The Presiding Officer took the Motion in Limine under advisement. The Presiding Officer later sustained the Motion in Limine and will disregard any information attributed to Gloria Query.

WHEREUPON, upon conclusion of the hearing, the respondent moved the Presiding Officer to take administrative notice of a document in the Board's file. FURTHER, the respondent moved the Presiding Officer to consider evidence in the form of an affidavit from the

respondent. The petitioner opposes the Motion. The Presiding Officer DENIES the respondent's Motion.

WHEREUPON, the Presiding Officer made the following FINDINGS OF FACT:

1. Respondent was issued license number 04-18013 to practice medicine and surgery by the Board on approximately February 1, 1979, and having last renewed such license on approximately July 1, 2008.

2. This matter was initiated on October 2, 2008, when a Petition and Motion for Ex Parte Emergency Order of Suspension and for Emergency Proceedings and Proposed Order were filed by the Board, which included allegations that Respondent violated the Healing Arts Act, specifically: K.S.A. 65-2836(b), in that Respondent has committed acts of unprofessional and dishonorable conduct; K.S.A. 65-2836(p) in that he has prescribed, sold, administered, distributed, or given a controlled substance to any person for other than medically accepted or lawful purpose; K.S.A. 65-2837(b)(12) in that he committed conduct likely to deceive, defraud, or harm the public; and K.S.A. 65-2837(b)(23) by 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 Respondent's professional practice.

3. Respondent currently holds a suspended medical license and at all times relevant to this proceeding, the Board has retained jurisdiction over Respondent's licensure in this State.

4. The Board of Healing Arts staff investigated multiple cases regarding Respondent which led to the filing of a disciplinary action against Respondent's medical license in Kansas.

5. Carol Baldwin is a special investigator for the Kansas Board of Healing Arts. (Tr. p. 185, lines 3-12).

6. Ms. Baldwin investigated this matter involving the Respondent. (Tr. p. 185, lines 22-25; p. 186, line 1).

7. This matter was continued by mutual agreement until March 6, 2009.

8. A formal hearing on the emergency suspension was held March 6, 2009, and the proceedings were conducted by Presiding Officer, Merle Hodges, M.D. During the hearing, Petitioner presented evidence in support of its allegations in the form of documents and testimony of several witnesses.

9. Petitioner's witnesses included Carol Baldwin, Special Investigator II, Patient #1, **(Confidential)** and Respondent, Pravin Sampat, M.D. The respondent cross-examined each of the Petitioner's witnesses.

10. Respondent testified on his own behalf, as well as offering documents and testimony of witnesses including Brenda Bingham and Eleanor Reams.

Patient #1

11. Respondent provided medical care and treatment to Patient #1, including prescribing medications, between January 1, 2007 and May 2008. (Tr. p. 102, line 25; p. 103, lines 1-4, 17-25; p. 287, lines 18-22).

12. Patient #1 was seen in Respondent's office. (Exhibit 8c).

13. Respondent made house calls to Patient #1 to provide her medical care and treatment. (Exhibit 8c).

14. Respondent's primary diagnosis of Patient #1 were migraine headaches and anxiety. (Tr. p. 103, lines 5-9).

15. Darvocet® and Percocet® were the primary medications that Respondent prescribed to Patient #1 between January 1, 2007 and May 2008. (Tr. p. 104, line 3).

16. The dosage strengths of the Darvocet and Percocet the respondent prescribed to Patient #1 did not vary substantially from January 1, 2007 through May 2008. (Tr. p. 106, lines 13-17).

17. Respondent's medical records indicate that Patient #1 continued to complain about migraines and other consistent pain between January 1, 2007 and May 2008. Patient #1 testified that her pain was "overwhelming" and "devastating". (Exhibit 8c; Tr. p. 305, lines 2-7).

18. In spite of respondent's efforts, Patient #1's continued in pain. Respondent acknowledged that the Darvocet and Percocet prescribed to patient #1 is a short-acting pain medication, with analgesic effects between six to eight hours. The respondent testified he did not prescribe Patient #1 any longer-acting pain medications. (Tr. p. 118, lines 6-25; p. 119, lines 1-4).

19. Pursuant to an investigative subpoena issued by the Board in June 2008, Respondent produced a handwritten ledger card for Patient #1, hereinafter described as "ledger #1." (Exhibit 8b).

20. Respondent testified that he created ledger #1 with the help of his assistant Brenda Bingham. (Tr. p. 121, lines 4-25).

21. Ms. Bingham testified that she was not involved in the creation of ledger #1 and that she had never seen ledger #1. Ms. Bingham stated that she recognized the handwriting on ledger #1 as Respondent's handwriting. (Tr. p. 281, lines 15-25; p. 282, lines 1-4).

22. The Presiding Officer concludes that Ledger #1 was created solely by the Respondent without the help of Brenda Bingham.

23. The respondent testified whenever he received a payment from Patient #1, whether cash, or check, it would be documented on the ledger card. (Tr. p. 125, lines 7-15).

24. Ledger #1 does not reflect whether the payments the respondent received from Patient #1 were in the form of cash or checks. (Tr. p. 125, lines 16-18; Exhibit 8b).

25. Ledger #1 reflects that Patient #1 nearly always maintained a zero balance. (Tr. p. 123, lines 4-25; p. 124, lines 1-14; Exhibit 8b).

26. Ledger #1 details that Respondent saw Patient #1 in his office on January 15, 2007. Ledger #1 states Patient #1 was charged $55 for the visit. Patient #1 paid $55 to respondent. Patient #1 did not owe Respondent any previous amounts, and she had a zero balance. (Tr. p. 128, lines 1-25; p. 129, lines 7-12; Exhibit 8b, Sampat 1196).

27. Respondent's medical chart for Patient #1 details that he made a house call to Patient #1 on January 15, 2007. The medical chart reflects that Patient #1 was diagnosed with a migraine and was given a prescription for 25 tablets of 5mg Percocet. (Tr. p. 129, lines 21-25; p. 130, lines 1-10; Exhibit 8c, Sampat 1242).

28. Patient #1's bank statement, details that she wrote a check in the amount of $300 to Respondent, on January 15, 2007, which Respondent endorsed. (Tr. p. 130, lines 11-25; p. 131, lines 1-6; Exhibit 7, Sampat 853).

29. Respondent acknowledged that ledger #1 indicates that Patient #1 paid him $300 more than she owed him on January 15, 2007. (Tr. p. 133, lines 15-25; p. 134, lines 1-9; p. 131, lines 7-10).

30. The Presiding Officer concludes Respondent charged $300 to Patient #1 on January 15, 2007 for a prescription to purchase 25 tablets of 5mg Percocet. The Presiding Officer further concludes Patient #1 paid the Respondent $300 for the prescription to purchase 25 tablets of 5mg Percocet on January 15, 2007.

31. Ledger #1 details that Respondent saw Patient #1 in his office on February 6, 2007, that she was charged $75 for the office visit, she paid $75, and she did not owe him any previous amounts. Nothing appears in the balance column. (Tr. p. 134, lines 10-25; p. 135, lines 1-7; Exhibit 8b, Sampat 1196).

32. Respondent's medical chart for Patient #1 detail's that he made a house call to Patient #1 on February 6, 2007. The medical chart reflects that Patient #1 was diagnosed with acute migraine headache, chronic anxiety, intolerance to medications and was given a prescription for 21 tablets of Percocet 5mg/325mg. (Tr. p. 134, lines 10-25; p. 135, lines 1-23; Exhibit 8c, Sampat 1240).

33. Patient #1's bank statement, details that she wrote a check in the amount of $660 to Respondent, on February 6, 2007, which Respondent endorsed. (Tr. p. 136, lines 1-21; Exhibit 7, Sampat 846).

34. Respondent acknowledged that ledger #1 indicates that Patient #1 paid him $660 more than she owed him on February 6, 2007. (Tr. p. 136, lines 22-25; p. 137, lines 1-6).

35. The Presiding Officer concludes Respondent charged $660 to Patient #1 on February 6, 2007 for a prescription to purchase 21 tablets of 5mg Percocet 5mg/325 mg. The Presiding Officer further concludes Patient #1 paid the Respondent $660 for the prescription to purchase 21 tablets of 5mg/325 mg Percocet on February 6, 2007.

36. Patient #1's bank statement, details that she wrote a check in the amount of $1000 to Respondent, on May 16, 2007, which Respondent endorsed. (Tr. p. 140, lines 1-16; Exhibit 7, Sampat 830).

37. Ledger #1 does not indicate that Respondent provided any medical care or treatment to Patient #1 on May 16, 2007, and Respondent testified that Patient #1 was not seen on May 16, 2007. (Tr. p. 137, lines 7-10; p. 138, line 15; Exhibit 8b).

38. Ledger #1 indicates that Patient #1 was seen in Respondent's office on May 19, 2007, that she was charged $75 for the visit, and she paid $75. (Exhibit 8b).

39. To the contrary, Respondent's medical chart for Patient #1 details that he made a house call to Patient #1 on May 16, 2007. The medical chart reflects that Patient #1 was diagnosed with back pain, status post surgery, migraine headaches, left knee pain, history of chronic anxiety and stress, and was given a prescription for 60 tablets of Darvocet N, 25mg. (Tr. p. 138, lines 20-25; p. 139, lines 1-6; Exhibit 8c, Sampat 1234).

40. The Presiding Officer concludes the Respondent made a house call to Patient #1 on May 16, 2007. The Presiding Officer further concludes the respondent charged Patient #1 $1000 on May 16, 2007 for a prescription to purchase 60 tablets of Darvocet N, 5mg. The Presiding Officer further concludes Patient #1 paid the Respondent $1000 for the prescription to purchase 60 tablets of Darvocet N, 25 mg on May 16, 2007.

41. Ledger #1 also indicates that Patient #1 was seen in Respondent's office on May 21, 2007, that she was charged $55 for this visit, and she paid $55. (Exhibit 8b, Sampat 1196).

42. Respondent's medical chart for Patient #1 indicates that he saw Patient #1 in his office on May 21, 2007. The respondent diagnosed Patient #1 with acute anxiety, stress, back pain, and history of migraines. Patient #1 was given a prescription for 30 pills of Xanax 0.25mg. (Tr. p. 139, lines 8-24; Exhibit 8c, Sampat 1233).

43. Ledger #1 does not indicate Patient #1 had any balance or owed him any amounts in May 2007. (Tr. p. 137, lines 16-20).

44. Ledger #1 indicates that Patient #1 paid Respondent $1000 more in May 2007 than she owed him. (Tr. p. 136, lines 22-25; p. 137, lines 1-6).

45. Ledger #1 does not indicate that Respondent gave Patient #1 any refunds. (Tr, p. 131, lines 7-10).

46. The Presiding Officer concludes the Respondent saw Patient #1 at his office on May 21, 2007. The Presiding Officer further concludes the respondent charged Patient #1 $1000 on May 21, 2007 for a prescription to purchase 30 tablets of Xanax 0.25 mg. The Presiding Officer further concludes Patient #1 paid the Respondent $1000 for the prescription to purchase 30 tablets of Xanax, 0.25 mg on May 21, 2007.

47. Patient #1's bank statement, details that she wrote a check in the amount of $100 to Respondent, on September 6, 2007, which Respondent endorsed. (Tr. p. 143, lines 24-25; p. 144, lines 1-7; Exhibit 7, Sampat 800).

48. Ledger #1 does not indicate that Respondent provided any medical care or treatment to Patient #1 on September 6, 2007. Ledger #1 does not reflect any appointment for Patient #1 on September 6, 2007. (Tr. p. 141, lines1-8; Exhibit 8b).

49. Respondent's medical chart for Patient #1 indicates that Patient #1 was seen by Respondent in his office on September 6, 2007. The medical chart reflects that Patient #1 was diagnosed with acute migraine headaches, tachycardia, rule out supraventricular tachycardia, and was given a prescription for 25 tablets of Percocet 5mg. (Tr. p. 141, lines 19-25; p. 142, lines 1-14; Exhibit 8c, Sampat 1226).

50. The Presiding Officer concludes the Respondent saw Patient #1 at his office on September 6, 2007. The Presiding Officer further concludes the respondent charged Patient #1 $100 on September 6, 2007 for a prescription to purchase 25 tablets of Percocet, 5mg. The

Presiding Officer further concludes Patient #1 paid the Respondent $100 for the prescription to purchase 25 tablets of Percocet, 25 mg on September 6, 2007.

51. Ledger #1 also indicates that Patient #1 was seen in Respondent's office on September 15, 2007, that she was charged $55 for the visit, and she paid $55. (Exhibit 8b).

52. Respondent's medical record for Patient #1 indicates that Patient #1 was seen by Respondent in his office on September 15, 2007. Patient #1 was diagnosed with acute migraine headaches. The respondent ruled out acute sinusitis, meningitis and was given a prescription for 30 Percocet 5mg. (Tr. p. 143, lines 2-10, Exhibit 8c, Sampat 1225).

53. Patient #1's bank statement, details that she wrote a check to herself for cash on September 15, 2007 in the amount of $500. (Tr. p. 145, lines 8-20; p. 146, lines 4-20, Exhibit 7, Sampat 805).

54. Ledger #1 does not indicate Patient #1 owed any balance or any prior amounts to the Respondent in September 2007. (Tr. p. 141, lines 15-18; Exhibit 8b).

55. The Presiding Officer concludes the Respondent saw Patient #1 at his office on September 15, 2007. The Presiding Officer further concludes the respondent charged Patient #1 $500 on September 15, 2007 for a prescription to purchase 30 tablets of Percocet, 5mg. The Presiding Officer further concludes Patient #1 paid the Respondent $500 for the prescription to purchase 25 tablets of Percocet, 25 mg on September 15, 2007.

56. Ledger #1 indicates that Respondent made a house call to Patient #1 on March 25, 2008, that she was charged $300 for the house call, that she paid $273.80, and owed a balance of $26.20. (Tr. p. 147, lines 11-22; Exhibit 8b).

57. Respondent's medical chart for Patient #1 indicates that Respondent made a house call to Patient #1 on March 25, 2008. Patient #1 was diagnosed with acute migraine

headaches, status post auto accident, and was given a prescription for Percocet. (Tr. p. 149, lines 5-19; Exhibit 8c, Sampat 1207).

58. Respondent did not record the dosage amount or the quantity given of the Percocet to Patient #1. (Tr. p. 149, lines 20-25; p. 150, lines 1-4).

59. Patient #1's bank statement details that she wrote a check in the amount of $100 to Respondent, on March 25, 2008, which Respondent endorsed. (Tr. p. 150, lines 14-20; Exhibit 7, Sampat 778).

60. The Presiding Officer concludes the Respondent saw Patient #1 at her home on March 25, 2008. The Presiding Officer further concludes the respondent charged Patient #1 $100 on March 25, 2008 for a prescription to purchase Percocet. The Presiding Officer further concludes Patient #1 paid the Respondent $100 for the prescription to purchase Percocet, 25 mg on March 25, 2008.

61. Patient #1's bank statement also details that she wrote a check to herself for cash, on March 25, 2008, in the amount of $500. (Tr. p. 151, lines 2-14; Exhibit 7, Sampat 778).

62. Respondent acknowledged that ledger #1 does not indicate Patient #1 owed any balance or any amounts prior to owing $26.20 on March 25, 2008. (Tr. p. 147, lines 23-25; p. 148, line 1).

63. The Presiding Officer concludes the Respondent made a house call to Patient #1 on March 25, 2008. The Presiding Officer further concludes the respondent charged Patient #1 $800 on March 25, 2008 for a prescription to purchase an unknown quantity of Percocet, 5mg. The Presiding Officer further concludes Patient #1 paid the Respondent $800 for the prescription to purchase an unknown quantity of Percocet on March 25, 2008.

64. Ledger #1 indicates that Respondent made a house call to Patient #1 on the next day, March 26, 2008. Ledger #1 does not indicate whether Patient #1 was charged for that house call. (Tr. p. 151, lines 15-25; p. 152, line 1; Exhibit 8b).

65. Respondent's medical chart for Patient #1 indicates s that Respondent made a house call to Patient #1 on March 26, 2008. Patient #1 was diagnosed with acute migraine headaches and status post auto accident, other diagnoses same like depression and chronic stress and she was given a prescription for 20 tablets of Percocet 5mg. (Tr. p. 153, lines 4-15; Exhibit 8c, Sampat 1206).

66. The March 26, 2008 prescription for Percocet was the second Percocet prescription Respondent had written to Patient #1 in two days.

67. Respondent's March 26, 2008, medical chart for Patient #1 details that Respondent gave Patient #1 instruction's to go to the hospital but she stated that she could not afford to go to the hospital. (Tr. p. 153, lines 16-18; Exhibit 8c, Sampat 1206)

68. Respondent also testified that he told Patient #1 to go to the hospital, on March 26, 2008, and she responded that she could not afford to go to the hospital. (Tr. p. 154, lines 3-10).

69. In spite of Patient #1's inability to afford to go to the hospital on March 26, 2008, her bank statement details that she wrote two separate checks to the Respondent, in the amount of $400 each, on that date. (Tr. p. 154, lines 17-25; p. 155, lines 1-11; Exhibit 7, Sampat 778).

70. Respondent acknowledged cashing both of these checks, on the same day they were received from Patient #1, and getting $800. (Tr. p. 418, lines 2-5).

71. The Presiding Officer concludes the Respondent made a house call to Patient #1 on March 26, 2008. The Presiding Officer further concludes the respondent charged Patient #1

$800 on March 26, 2008 for a prescription to purchase an unknown quantity of Percocet, 5mg. The Presiding Officer further concludes Patient #1 paid the Respondent $800 for the prescription to purchase twenty tablets of Percocet on March 26, 2008 by writing two checks to the Respondent in the amount of $400 each.

72. Ledger #1 details that Respondent saw Patient #1 in his office on December 5, 2007, and that she was charged $45 for the visit and paid $45. There is no indication of any balance owing or any previous balance. (Tr. p. 156, lines 23-25; p. 157, lines 1-16; Exhibit 8b, Sampat 1197).

73. Respondent's medical chart for Patient #1 indicates that Patient #1 was seen at Respondent's office on December 5, 2007. Patient #1 was diagnosed with acute migraine and chronic anxiety and was given a prescription for 25 tablets of 50mg Darvocet. (Tr. p. 158, lines 2-15; Exhibit 8c, Sampat 1216).

74. Patient #1's bank statement details that she wrote a check to herself for $900 cash on December 5, 2007, the same day that she received the Darvocet prescription from Respondent. (Tr. p. 159, lines 3-13; Exhibit 7, Sampat 790).

75. The Presiding Officer concludes Patient #1 saw the respondent on December 5, 2007. The Presiding Officer further concludes the respondent charged Patient #1 $900 on December 5, 2007 for a prescription to purchase a prescription for 25 tablets of 50mg Darvocet. The Presiding Officer further concludes Patient #1 paid the Respondent $900 for the prescription to purchase a prescription for 25 tablets of 50mg Darvocet on December 5, 2007.

76. Ledger #1 details that Respondent saw Patient #1 in his office on December 7, 2007, and that she was charged $55 for the visit and paid $55. There is no indication of any

balance owing or any previous balance. (Tr. p. 159, lines 14-25; p. 160, lines 1-2; Exhibit 8b, Sampat 1197).

77. Respondent's medical chart for Patient #1 details that Respondent made a house call to Patient #1 on December 7, 2007. The medical chart reflects that Patient #1 was diagnosed with acute migraine and chronic anxiety and was given a prescription for 30 tablets of Darvocet N 100mg. (Tr. p. 160, lines 8-15; Exhibit 8c, Sampat 1215).

78. Patient #1's bank statement details that she wrote a check to herself for $1,050 cash on December 7, 2007, the same day that she received the Darvocet prescription from Respondent. (Tr. p. 160, lines 16-25; p. 161, lines 1-4).

79. The Presiding Officer concludes Patient #1 saw the respondent on December 7, 2007 at his office. The Presiding Officer further concludes the respondent charged Patient #1 $1,050 on December 5, 2007 for a prescription to purchase a prescription for 30 tablets of Darvocet N 100 mg. The Presiding Officer further concludes Patient #1 paid the Respondent $1,050 for the prescription to purchase a prescription for 30 tablets of Darvocet N 100 mg. on December 7, 2007.

80. Ledger #1 details that Respondent saw Patient #1 in his office on December 12, 2007, and that she was charged $55 for the visit, and paid $55. Ledger #1 indicates there was a zero balance on December 12, 2007. (Tr. p. 161, lines 5-20; Exhibit 8b, Sampat 1197).

81. Contrary to ledger #1, Respondent's medical chart for Patient #1 details that Respondent made a house call to Patient #1 on December 12, 2007. The medical chart reflects that Patient #1 was diagnosed with migraine headaches, intolerant to other medications like NSAID's, Tylenol, could not get help from Ultram, and was given a prescription for 30 tablets of Darvocet N. (Tr. p. 161, lines 21-25; p. 162, lines 1-12; Exhibit 8c, Sampat 1214).

82. Patient #1's bank statement details that she wrote a check to herself for $800 cash on December 12, 2007, the same day that she received the Darvocet prescription from Respondent. (Tr. p. 162, lines 16-25; p. 163, lines 1-2; Exhibit 7, Sampat 791).

83. The Presiding Officer concludes Patient #1 saw the Respondent for medical treatment on December 12, 2007, however, it is unclear where the medical treatment was rendered to Patient #1. The Presiding Officer further concludes the respondent charged Patient #1 $800 on December 12, 2007 for a prescription to purchase a prescription for 30 tablets of Darvocet N. The Presiding Officer further concludes Patient #1 paid the Respondent $800 for the prescription to purchase a prescription for 30 tablets of Darvocet N mg. on December 12, 2007.

84. Ledger #1 contains an entry for Patient #1 for December 17, 2007. This entry details that Patient #1 was charged $55 and paid $55, however there is no indication whether Patient #1 had an office visit or received a house call on December 17, 2007. Further, there is no indication of any balance owing or any previous balance. (Tr. p. 163, lines 11-24; Exhibit 8b, Sampat 1197).

85. Respondent's medical chart for Patient #1 indicates that Respondent made a house call to Patient #1 on December 17, 2007. During this house call, Patient #1 was diagnosed with acute migraine headaches, history of left knee replacement, chronic anxiety, stress, and was given a prescription for 30 tablets of Darvocet N 100mg. (Tr. p. 164, lines 6-15; Exhibit 8c, Sampat 1213).

86. Patient #1's bank statement details that she wrote a check to herself for $800 cash on December 17, 2007, the same day that she received the Darvocet prescription from Respondent. (Tr. p. 164, lines 18-25; p. 165, lines 1-6, Exhibit 7, Sampat 792).

87. The Presiding Officer concludes Patient #1 saw the Respondent for medical treatment on December 17, 2007, however, it is unclear where the medical treatment was rendered to Patient #1. The Presiding Officer further concludes the respondent charged Patient #1 $800 on December 17, 2007 for a prescription to purchase a prescription for 30 tablets of Darvocet N. The Presiding Officer further concludes Patient #1 paid the Respondent $800 for the prescription to purchase a prescription for 30 tablets of Darvocet N mg. on December 17, 2007.

88. On October 12, 2008, Respondent created a ledger card. (Petitioner's Exhibit 9). Exhibit 9 was created by Respondent to show what the correct charges were to Patient #1. (Tr. p. 170, lines 1-5).

89. At an undisclosed time later in October 2008, Respondent created a ledger sheet, hereinafter referred to as "ledger #2." (Petitioner's Exhibit 10).

90. Ledger #2 was created by Respondent in anticipation of a meeting during late October 2008, between Respondent and his attorney, and board attorneys. (Tr. p. 166, lines 10-25; p. 167, lines 1-22; Exhibit 10).

91. Respondent created ledger #2, "to show that [ledger #1] was wrong and this one, you know, was accurate reflecting all the charges." (Tr. p. 168, lines 1-4).

92. Respondent further testified that he created ledger #2 using his medical charts and established charges for office visits and house calls. (Tr. p. 168, lines 5-22; p. 169, lines 1-7).

93. Respondent later said that ledger #2 was "probably" created from Exhibit 9. (Tr. p. 170, lines 6-12).

94. Respondent acknowledged that the medical charts he referred to in creating ledger #2, in October 2008, were the same medical charts that he submitted to the Board, pursuant to subpoena, back in June 2008. (Tr. p. 169, lines 8-13).

95. Respondent acknowledged that neither ledger #2 (Exhibit 10) nor Exhibit 9 reflect any payments made by Patient #1. (Tr. p. 115, lines 4-6; p. 170, lines 14-17).

96. Respondent testified that a few days before the hearing he created yet another document, a chart, related to his care and treatment of Patient #1. (Tr. p. 116, lines 1-3)

97. This chart was admitted into evidence as Petitioner's Exhibit 15. It details date, place of service, medicine prescribed, milligram amount, dosage per day amount, amount of charges, payments received from Patient #1, and PDR recommended. (Tr. p. 116, lines 1-3).

98. Respondent testified that the column, on Exhibit 15, reflecting payments received from Patient' #1 came from copies of Patient #1's checks that the Board provided to him during discovery in this matter. (Tr. p. 115, lines 15-25).

99. Respondent asserts that Patient #1 owed him money for care and treatment between January 1, 2007 and May 2, 2008, (Tr. p. 178, lines 24-25). Respondent is uncertain how much Patient #1 owed him and has no verification of how much Patient #1 paid to him. (Tr. p. 177, lines 19-25; p. 178, lines 19-23).

100. Respondent never sent Patient #1 a bill for any charges, although she owed him money. (Tr. p. 171, lines 2-5).

101. Respondent never stopped treating Patient #1, even though she owed him money. (Tr. p. 173, lines 18-21).

102. Patient #1 testified that she never received a statement from Respondent because she paid Respondent every time she saw him. (Tr. p. 296, lines 1-4). Patient #1 further testified

that she was never told during any office visit or any house call, by either Respondent or his staff, that she owed any money to Respondent. (Tr. p. 296, lines 9-19).

103. Patient #1 testified that on the dates she wrote checks to Respondent and also received prescriptions from Respondent, those checks were given to the Respondent for the prescriptions he had written to her. (Tr. p. 306, lines 3-9).

104. Patient #1 also testified that on the dates she wrote checks to herself for cash, and saw Respondent and received prescriptions from him, the cash was given to Respondent for the prescriptions he had written to her. (Tr. p. 306, lines 10-16).

105. Respondent never gave Patient #1 receipts for any cash or checks that she gave to him. (Tr. p. 300, lines 6-13).

106. From January 1, 2007 through May, 2008, Patient #1 had medical insurance coverage through Humana and her insurance premiums were automatically deducted from her bank account every month. (Tr. p. 291, lines 13-25; p. 292, lines 1-7; Exhibit 7).

107. Respondent knew Patient #1 had insurance and Respondent was aware that she was insured, but Respondent did not want to be bothered with Patient #1's insurance. (Tr. p. 363, lines 23-25; p. 364, lines 1-5; p. 352, lines 1-2).

108. Respondent never called Patient #1's prescriptions directly in to the pharmacy, but always gave her a written paper prescription. (Tr. p. 300, lines 17-25).

109. Respondent would not make a house call to Patient #1 unless Respondent knew that Patient #1 had money at her house ready to give to him. (Tr. p. 298, lines 16-18).

110. Brenda Bingham testified that she prepared four written notations of phone messages that had been left for the Respondent, including two phone messages from Patient #1

to Respondent on April 10, 2008. (Tr. p. 283, lines 13-20; Exhibit 8a, Sampat 1185). One of those phone messages left by Patient #1 read, "Please call, she has the money".

111. Patient #1 testified that the money she was referencing in that message was money to purchase a prescription from Respondent. (Tr. p. 297, lines 12-23).

WHEREUPON, the Presiding Officer made the following CONCLUSIONS OF LAW AND OF FACT:

112. The Board must prove its allegations by a preponderance of the evidence. "In all civil actions, the party asserting the affirmative of an issue is entitled to prevail upon the production by him of a preponderance of evidence." *People's Bank of Minneapolis v. Reid* et al. 86 Kan. 245, 120 P. 339 (1912).

113. Clear and convincing evidence is where the "fact finder believes that the truth of the facts asserted is highly probable." *In re B.D.- Y.,* 286 Kan. 686, 187 P.3d 594, (2008).

114. The Presiding Officer finds the Board presented clear and convincing evidence sufficient to prove the allegations contained in the Board's Motion for *Ex Parte* Emergency Order of Suspension.

115. The Respondent's testimony that payments from Patient #1 were for amounts owed for office visits and house calls were self-serving, unpersuasive and lacked credibility.

116. Patient #1 gave payments to Respondent above and beyond the reasonable amount of any care and treatment she received.

117. Patient #1 had medical insurance coverage from January 1, 2007 through May 2008, which covered office visits and house calls, in whole or in part.

118. Respondent created ledger #1 and submitted it pursuant to an investigative subpoena from the Board in June 2008 as part of Patient #1's medical records.

119. After an investigation began and Respondent's license had been suspended by emergency *ex parte* order, Respondent created subsequent ledgers.

120. The Presiding Officer finds that Patient #1's testimony, regarding cash and check payments she made to Respondent for the purchase of written prescriptions, is credible, persuasive, clear and convincing.

121. The Presiding Officer concludes the evidence is clear and convincing that from January 1, 2007, through May 2008, Respondent sold prescriptions to Patient #1, in exchange for checks and cash.

122. Pursuant to K.S.A. 65-2838(c), the Board has the authority to temporarily suspend Respondent's license to practice medicine and surgery to address an imminent threat to the health, safety or welfare of the public.

123. Pursuant to K.S.A 65-2836, the Board has grounds to revoke, suspend, censure, fine or otherwise limit Respondent's license to practice medicine and surgery for violation of the Kansas Healing Arts Act.

124. Pursuant to K.S.A. 77-536, the Board may use an emergency proceeding to protect the public from an immediate danger to the public health, safety or welfare.

125. Respondent has violated the Healing Arts Act, specifically:

a. K.S.A. 65-2836(b), in that he has committed acts of unprofessional or dishonorable conduct;

b. K.S.A. 65-2836(p), in that he has prescribed, sold, administered, distributed or given a controlled substance to any person for other than medically accepted or lawful purpose;

c. K.S.A. 65-2837(b)(12), in that he has committed conduct likely to deceive, defraud or harm the public;

d. K.S.A. 65-2837(b)(23), by 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 his professional practice.

126. Respondent violated K.S.A 65-2836(b), by committing acts of unprofessional or dishonorable conduct, as defined by statute at K.S.A 65-2837(b).

127. Respondent violated K.S.A 65-2837(b)(12), in that he committed conduct likely to deceive, defraud or harm the public, when he sold written prescriptions for Darvocet and Percocet to Patient #1 for various sums of money.

128. Respondent violated K.S.A. 65-2837(b)(23), in that he prescribed a prescription drug in an improper or inappropriate manner, when he sold written prescriptions for Darvocet and Percocet to Patient #1 for various sums of money.

129. Respondent violated K.S.A. 65-2836(p), in that he prescribed a controlled substance to Patient #1 for other than a medically accepted or lawful purpose.

130. Respondent's return to unrestricted practice of medicine and surgery would constitute an immediate danger to the public heath, safety or welfare.

WHEREFORE, the Respondent's license to practice medicine and surgery is SUSPENDED until a full evidentiary hearing is held on the disciplinary petition and the Presiding Officer has issued an Initial Order in the case.

IT IS SO ORDERED.

DATED: May ___, 2009.

Merle Hodges, M.D.
Presiding Officer
Kansas State Board of Healing Arts
235 S. Topeka Blvd.
Topeka, KS 66603

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that I served the forgoing Journal Entry on this 14th day of May, 2009, was mailed by United States Mail to:

Elizabeth Herbert
Pedro Irigonegaray
IRIGONEGARAY & ASSOCIATES
1535 SW 29th Street
Topeka, Kansas 66611-1901

And HAND DELIVERED to the following:

Janith A. Davis, #18115
Stacy R. Bond, #17673
Attorneys for the Petitioner
Kansas State Board of Healing Arts
235 SW Topeka Blvd.
Topeka, KS 66603-3068

And the original was hand-delivered for filing with:

Jack Confer
Executive Director
Kansas State Board of Healing Arts

Cathy A. Brown