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KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of)
CHESTER W. STONE, M.D.)
) **KSBHA Docket No. 18-HA00053**
Kansas License No.: 04-20987)

FINAL ORDER REVOKING LICENSURE

On June 8, 2018, the Kansas State Board of Healing Arts ("Board") held the conference hearing on the Petition for discipline filed against the medical license of Chester W. Stone, M.D. ("Licensee"). Courtney E. Manly, Associate Litigation Counsel appeared on behalf of the Respondent Board. Licensee appeared in person and *pro se*.

Pursuant to the authority granted to the Board by the Kansas Healing Arts Act, K.S.A. 65-2901, *et seq*., and in accordance with the provisions of the Kansas Administrative Procedure Act, K.S.A. 77-501, *et seq*., the Board hereby enters this Final Order in the above-captioned matter. After reviewing the agency record, hearing the arguments of the parties, and being duly advised in the premises, the Board makes the following findings, conclusions and orders.

FINDINGS OF FACT

Licensee is or has been entitled to practice medicine and surgery in the State of Kansas, having been issued License No. 04-20987 on approximately June 14, 1985. Licensee maintained Active status from June 14, 1985, until June 30, 2009, at which point he changed is licensure status to Federal Active. Licensee has continually held a Federal Active license since that time.

On or about [redacted], between 4:32 a.m. and 4:52 a.m., a patient of Licensee patient, ("Patient 1"), sent text messages to Licensee that were suicidal in nature. Around 6:00 a.m. on [redacted], law enforcement officers from [redacted] were dispatched to perform a welfare check on Patient 1, [redacted].

Law Enforcement found Patient 1 unresponsive in the backseat of her vehicle. Law Enforcement observed that she did not appear to be breathing, and her ankles were exposed and vary pale in color. Upon checking for a pulse, Law Enforcement noted Patient 1's skin felt cold to the touch, and colder than the outside temperature, which was approximately 57 degrees Fahrenheit. Law Enforcement was unable to locate Patient l's pulse. However, upon further investigation, Law Enforcement determined Patient 1 was alive and breathing. Ultimately, Patient 1 was provided life-saving treatment at two Kansas hospitals and survived.

Upon a search of the vehicle, Law Enforcement found empty pill bottles, including:

Tizanidine, 4 mg, 120 pills; Alprazolam 0.5 mg, 120 pills; Acetaminophen, 500 mg, 225 pills; and Naproxen Sodium, 220 mg, 300 pills. Licensee had prescribed Patient 1 the Alprazolam 0.5 mg, 120 pills, on or about October 7, 2015.

On [redacted], the [redacted] Office notified the Board that it obtained evidence that Licensee was inappropriately prescribing medication to Patient 1; that Licensee and Patient 1 were having [redacted]; and that on or about [redacted], Patient 1 had attempted suicide by overdosing, and had used, in part, medications prescribed by Licensee. The Board initiated an investigation.

The evidentiary record establishes that, during the time Licensee and Patient 1 had an active licensee-patient relationship, Licensee engaged in a sexual and romantic relationship with Patient 1. The romantic relationship [redacted] during the time that Patient 1 [redacted] received treatment for anxiety from Licensee. [redacted]. The agency record includes a series of text messages in [redacted], which showed Licensee and Patient 1 were [redacted] intimate relationship and that Licensee was inappropriately prescribing medication to Patient 1 at that time. Licensee failed to keep any medical records related to his care and treatment of Patient 1.

On or about December 1, 2015, Licensee provided a response to the Board regarding the Board's investigation of Licensee's conduct. In his response, Licensee reported that Patient 1 had been previously [redacted]. Licensee admitted they had "a romantic liason." Licensee also admitted he had treated her for anxiety [redacted], and later referred her to a psychiatrist. He admitted that he continued treating Patient 1 by prescribing medications to her as late as [redacted]

Additionally, Licensee admitted to prescribing medication to [redacted]. Licensee reported there are no medical records for [redacted] from the times he prescribed them medication.

Licensee's KTRACS Report shows he prescribed controlled substances to Patient 1 and [redacted] on multiple occasions. Examples of this include: Licensee prescribed Lorazepam 1 mg, 30 pills, to [redacted], on or about [redacted], 2015; Licensee prescribed Hydrocodone-Acetaminophen 5-500, 10 pills, to another [redacted], on or about [redacted] 2010. Licensee failed to keep any medical records related to his care and treatment of [redacted].

Licensee's December 1, 2015, response to the Board also revealed that from January 2015 through May 2015, Licensee worked on a regular basis as a weekend Hospitalist Physician at Mercy Hospital in Manhattan, Kansas. At the June 8, 2018 hearing, Licensee stated that he continued to do locum tenens work and "moonlight[ing] in various places periodically."

Additionally, while holding a Federally Active license, Licensee's KTRACS Report shows he prescribed controlled substances seventeen (17) times, to twelve (12) different individuals, from on or about December 26, 2010, through June 8, 2015.

CONCLUSIONS

The Board has reviewed the entire agency record and considered the briefs, oral arguments, and comments of the parties at the hearing. The Board bases its conclusions on the agency record and the facts, law, and policy described above and below.

Licensee's conduct violated the Kansas Healing Arts Act as follows:

- Licensee violated K.S.A. 65-2836(b), in that Licensee committed acts of unprofessional or dishonorable conduct, as further described below.

- As defined by K.S.A. 65-2837(b)(16), Licensee committed acts of sexual abuse, misconduct or other improper sexual contact, which exploited the licensee-patient relationship, when he engaged in a romantic and/or sexual relationship with Patient 1.

- As defined by K.S.A. 65-2837(b)(23), Licensee prescribed, dispensed, administered or distributed a prescription drug or substance, including a controlled substance, in an improper or inappropriate manner.

- As defined by K.S.A. 65-2837(b)(25), Licensee failed to keep written medical records which accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results and test results, when Licensee failed to make a written medical record when he provided care and treatment to Patient 1 and [redacted].

- Licensee violated K.S.A. 65-2836(k), in that Licensee violated K.A.R. 100-24-1 by failing to maintain adequate medicals records, as described above.

- Licensee violated K.S.A. 65-2809(h)(l), in that Licensee was issued a federally active license and failed to engage in only limited practice outside of the course of federal employment consistent with the scope of practice of exempt licensees, as Licensee worked on a regular basis as a weekend Hospitalist Physician at Mercy Hospital in Manhattan, Kansas, and prescribed controlled substances seventeen (17) times to twelve (12) different patients. Further, licensee's statements at the hearing indicated that he continued to work outside the scope of his license up to the time of the hearing.

- As described above and below, Licensee violated K.S.A. 65-2836(f), in that Licensee willfully and/or repeatedly violated the Healing Arts Act.

SANCTIONS

Based on the agency record, the findings described above, the policy mandate given to the Board by the Kansas legislature to protect patient safety, and the aggravating factors described below, the Board concludes that the appropriate sanction is revocation of Licensee's license. The Board, after considering the agency record in light of potential mitigating or aggravating factors, finds the following aggravating factors in this case:

- Licensee's thorough lack of genuine remorse and refusal to take responsibility for his actions. This was reflected both in his written response to the Board investigator and his comments at the June 8, 2018 hearing. In his written response, Licensee blamed , as well as Patient 1's for Licensee's initial decision to enter into an inappropriate relationship with Patient 1. Licensee blamed multiple other individuals for his inappropriate and unlawful prescribing, including pharmacists and DEA employees. He also repeatedly blamed circumstances for his decisions, although his behavior reflected a pattern of unlawful and egregiously unprofessional conduct that spanned a long period of time and occurred under diverse circumstances. Licensee exhibited a disturbing level of lack of awareness of the severity of his conduct, particularly in regard to his wrongful sexual relationship with a patient and his wrongful prescribing behavior in regard to that patient.

- The severity of Licensee's conduct. Licensee had a wrongful relationship with a patient, and, knowing the Patient's psychiatric condition and/or symptoms, unlawfully prescribed a large amount of a powerful benzodiazepine to her. Thus, Licensee both abused the fundamental trust between patient and physician and the power dynamics inherent in such a relationship. The Board also notes that Licensee's conduct contributed to Patient 1's nearly fatal overdose. This incident demonstrates that Licensee's conduct constituted a serious threat to patient safety.

- The vulnerability of Patient 1. As described above, Patient 1 was a psychiatric patient who had both a physician-patient relationship with Licensee and romantic relationship with Licensee. Licensee was in a position of significant power over Patient 1 and he abused that power.

- Licensee has practiced for approximately 35 years. He knew, or should have known, the wrongfulness of his conduct in all respects described in this Order. His claims of lack of awareness did not ameliorate the Board's serious concerns; they aggravated those concerns. The Board finds that, contrary to Licensee's repeated attribution of some of his wrongful conduct to not "reading the fine print," a practitioner of 35 years should have a basic awareness of the laws and rules that apply to his practice in Kansas.

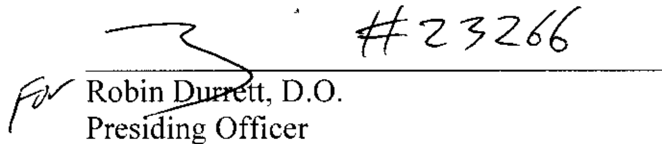
- The length of time over which Licensee's unlawful conduct occurred. Licensee's unlawful conduct spanned over many years. This was not a case of a brief and isolated period of poor judgment. Licensee's violations reflect a lengthy and sustained period of multiple serious violations of the Healing Arts Act.

ORDERS

IT IS THEREFORE ORDERED, BY THE KANSAS STATE BOARD OF HEALING ARTS that Chester Stone, M.D.'s license No. 04-20987, to practice medicine and surgery in the State of Kansas is hereby **REVOKED**.

IT IS SO ORDERED THIS 12th DAY OF JULY, 2018, IN THE CITY OF TOPEKA, COUNTY OF SHAWNEE, STATE OF KANSAS.

KANSAS STATE BOARD OF HEALING ARTS



for Robin Durrett, D.O.
Presiding Officer

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, Respondent 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.

NOTICE REGARDING DUTY TO MAINTAIN PATIENT RECORDS

PLEASE TAKE NOTICE that pursuant to K.A.R. 100-24-2, you are required to maintain each of your patients' records for a minimum of 10 years from the last date of service. Because you cannot actively practice, K.A.R. 100-24-3 requires that you notify the Board on or before June 11, 2018, of the location of your patients' records, the name of the designated agent to maintain the records, along with the telephone number and mailing address of the agent. If you will be maintaining the records yourself, you shall give your contact information instead. This information will be provided to former patients who contact the Board to inquire as to the location of their records. You should also be aware that if you are unable or refuse to allow patients access to their records, the Board may petition the court for appointment of a custodian of the records pursuant to K.S.A. 65-28,128.

CERTIFICATE OF SERVICE

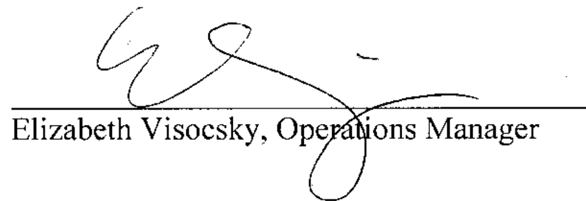
I, the undersigned, hereby certify that a true and correct copy of the above and foregoing **FINAL ORDER REVOKING LICENSURE** was served this 13th day of July, 2018, by depositing the same in the United States Mail, first-class, postage prepaid, and addressed to:

Chester Stone, MD
Licensee

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

Courtney E. Manly, Associate Litigation Counsel
Kansas State Board of Healing Arts
800 SW Jackson Lower Level, Ste A
Topeka, KS 66612

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



Elizabeth Visocsky, Operations Manager