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

KS State Board of Healing Arts

In the Matter of)	
)	Docket No. 10-HA00147
Robert T. Tenny, M.D.)	OAH Docket No. 11-HA0003
Kansas License No. 04-19156)	

CONSENT ORDER

COMES NOW, the Kansas State Board of Healing Arts, (“Board”), by and through Reese Hays, Litigation Counsel, Seth Brackman, Associate Litigation Counsel, and Jane Weiler, Associate Litigation Counsel (“Petitioner”), and Licensee-Respondent Robert T. Tenny, M.D. (“Licensee”), by and through Benoit M.J. Swinnen, Swinnen & Associates, LLC and move the Board for approval of a Consent Order affecting Licensee’s license to practice medicine and surgery in the State of Kansas. The Parties stipulate and agree to the following:

1. Licensee’s last known mailing address to the Board is: **Confidential**
Leawood, Kansas 66209.
2. Licensee is or has been entitled to engage in the practice of medicine and surgery in the State of Kansas, having been issued License No. 04-19156 on or about June 19, 1981. Licensee’s license is active and was last renewed on or about June 26, 2013.
3. The Board is the sole and exclusive administrative agency in the State of Kansas authorized to regulate the practice of the healing arts, specifically the practice of medicine and surgery. K.S.A. 65-2801 *et seq.* and K.S.A. 65-2869.

4. This Consent Order and the filing of such document are in accordance with applicable law and the Board has jurisdiction to enter into the Consent Order as provided by K.S.A. 77-505 and 65-2838. Upon approval, these stipulations shall constitute the findings of the Board, and this Consent Order shall constitute the Board's Final Order.
5. The Kansas Healing Arts Act is constitutional on its face and as applied in this case. Licensee agrees that, in considering this matter, the Board is not acting beyond its jurisdiction as provided by law.
6. Licensee voluntarily and knowingly waives his right to a hearing. Licensee voluntarily and knowingly waives his right to present a defense by oral testimony and documentary evidence, to submit rebuttal evidence, and to conduct cross-examination of witnesses. Licensee voluntarily and knowingly agrees to waive all possible substantive and procedural motions and defenses that could be raised if an administrative hearing were held.
7. The terms and conditions of the Consent Order are entered into between the undersigned parties and are submitted for the purpose of allowing these terms and conditions to become an Order of the Board. This Consent Order shall not be binding on the Board until an authorized signature is affixed at the end of this document. Licensee specifically acknowledges that counsel for the Board is not authorized to sign this Consent Order on behalf of the Board.
8. The Board has received information and investigated the same, and an Amended Petition was filed with the Board in this matter on or about November 17, 2010,

alleging grounds for disciplinary action under the Kansas Healing Arts Act, K.S.A. 65-2801, *et seq.*

9. All investigative information, specifically information related to KSBHA Investigation No. 07-00463 and the status of the pending administrative action in KSBHA Docket No. 10-HA00147/OAH Docket No. 11-HA0003, was fully reviewed and considered by the Board members who serve on the Board's Disciplinary Panel. Disciplinary Panel No. 23, through their appointed member, authorized and directed Board counsel to seek settlement of this matter with the provisions contained in this Consent Order.
10. Licensee does not admit nor deny the allegations in the Amended Petition. Licensee acknowledges that if formal hearing proceedings were conducted and Licensee presented no exhibits, witnesses, or other evidence, the Board has sufficient evidence to prove that Licensee has violated the Kansas Healing Arts Act with respect to the allegations contained in the Amended Petition. Licensee further waives his right to dispute or otherwise contest these allegations in any future proceeding before this Board.
11. This Consent Order incorporates herein by reference the facts as stated in the Amended Petition that was filed on November 17, 2010. In addition, the following facts are presented:
 - a. On or about February 26, 2007, a female patient, age seventy-seven (77) years old, had a magnetic resonance imaging (MRI) performed which revealed a left-side subdural hematoma. The patient was admitted to the

Shawnee Mission Medical Center (“SMMC”) where she was examined by Licensee.

- b. On February 27, 2007, the patient underwent surgery for evacuation of a left parietal and frontal subdural hematoma through a burr-hole procedure performed by Licensee.
- c. Licensee, as the attending physician and supervisor for all medical personnel assisting with the burr hole procedure, is responsible to the patient and the public for all his actions as well as those whom assist with the procedure, known or unknown, and during the above surgery, a traumatic injury into the substance of the patient’s brain occurred, which resulted in hemorrhaging of her brain.
- d. Following surgery, the patient exhibited aphasia and right-sided hemiparesis. A computed tomography (CT) scan was performed on February 27, 2007, which showed new areas of Pneumocephalus and hemorrhage in the brain.
- e. The operative report dictated by Licensee on February 27, 2007, which is the same day the surgery took place, described Licensee’s placement of two burr holes and the draining of fluid from each. It also described the placing of a Jackson-Pratt drain and what was variously described as gentle or careful irrigation of the sites. However, an addendum typed by Licensee on June 5, 2007, stated that a surgical technician directed what was termed as a “forceful irrigation” into the left-frontal burr hole site while Licensee had his back turned. It also stated that when Licensee

inspected the left parietal burr hole site for placement of the drain, he noted a small piece of brain tissue draining out of the site with the residual irrigation. The addendum further stated that the subdural space was nearly absent when it had been open moments before and Licensee did not believe he could safely place the drain into that site. The addendum noted Licensee's observation of what was termed "small amount of bleeding" from the surface of the underlying brain. Finally, the addendum stated that Licensee believed there was no injury to, or penetration of, the substance of the brain by Licensee.

- f. On February 27, 2007, after the surgery, Licensee advised the family of the patient that "everything went great."
- g. On February 27, 2007, after the surgery, a CT scan was ordered by Licensee, which indicated a Pneumocephalus and associated hemorrhage had developed in the parenchyma of the patient's left frontal region of the brain. Licensee failed to timely advise concurrent and subsequent treatment providers or the patient's family about the injury to the patient and he failed to document that an injury had occurred until Licensee filed his Addendum to the Operative Report filed on June 5, 2007. Furthermore, he failed to timely advise concurrent and subsequent treatment providers or the patient's family about a Pneumocephalus and associated hemorrhage that had developed in the parenchyma of the patient's left frontal region of the brain.

- h. On February 28, 2007, an MRI was ordered by Licensee, which indicated a large hematoma in the left frontal lobe. Later that day, Licensee ordered a second post-operative CT scan, which confirmed a Pneumocephalus deep in the parenchyma and a growing area of hemorrhage. Licensee failed to timely advise subsequent treatment providers or the patient's family about the injury to the patient and he failed to timely document that an injury had occurred.
- i. On February 28, 2007, Licensee advised the patient's family that her condition, which was deteriorating, was likely caused by a stroke. Licensee did not mention the incident later described in his own addendum to the operative report or alternative causes for the patient's deterioration.
- j. Also on February 28, 2007, the patient was seen by Hassan Saradih, M.D. Upon observing the patient's condition, Dr. Saradih suggested the patient be seen by a neurologist. On March 1, 2007, the patient was seen by a neurologist. Upon reviewing the imaging scans and examining the patient, the neurologist suspected an injury to the brain had occurred and discussed his suspicion with Licensee. Thereafter, the neurologist's concerns were submitted to risk management in an incident report stating that after surgery there was evidence of Pneumocephalus inside the parenchyma of the brain which showed progressive hemorrhage. The incident report requested the Surgery Department to review the case.

- k. During, and despite of, his conversation with the neurologist, Licensee failed to advise any of the patient's concurrent and subsequent treatment providers about the injury and Licensee still did not document that an injury or an incident during surgery had occurred until he wrote his addendum on June 5, 2007.
- l. On or about March 2, 2007, the Risk Manager at SMMC and Licensee had a conversation about the patient's surgery. The Risk Manager directed Licensee to inform the patient's family of the injury that occurred during surgery. Later that day, Licensee informed the patient's son about the injury that had occurred three (3) days earlier.
- m. On April 26, 2007, the Licensee's clinical privileges at SMMC were suspended by the president of the medical staff. **Confidential**
Confidential Licensee's privileges were subsequently reinstated by the staff medical executive committee on July 23, 2007, but were ultimately suspended by the SMMC professional affairs committee on August 1, 2007, **Confidential**
Confidential The suspension by the professional affairs committee was upheld by the SMMC Board of Trustees.
- n. Licensee's care and treatment of the patient was the subject of a medical malpractice lawsuit in Johnson County Court Case Docket No. 07CV04979, that was settled for a monetary amount, through a confidential agreement, on or about August 13, 2009.

12. Licensee acknowledges that the Board has sufficient evidence to prove that Licensee has violated the following provisions of the Kansas Healing Arts Act with respect to the above facts:

- a. Licensee's acts and conduct constitute a violation of K.S.A. 65-2836(b) as further defined by K.S.A. 65-2837(b)(12), involving conduct likely to deceive, defraud or harm the public, in that Licensee failed to timely advise the patient's family about the injury that occurred to the patient during surgery.
- b. Licensee's actions and conduct constitute a violation of K.S.A. 65-2836(b), as further defined by K.S.A. 65-2837(a)(3), for committing other behavior which demonstrates a manifest incapacity or incompetence to practice the healing arts, in that:
 - i. Licensee failed to recognize the significance of the injury that had occurred to the patient during the operation, especially after reviewing the first post-operative CT scan on February 27, 2007, as well as the CT scans and MRI that occurred on February 28, 2007, and March 1, 2007.
 - ii. Licensee failed to timely advise the patient's concurrent and subsequent treatment providers of the injury that had occurred during the burr hole evacuation surgery;
 - iii. Licensee failed to timely advise the patient's family about the injury to the patient.

- iv. Licensee failed to document within the patient's medical record that a surgical incident had occurred during the burr hole evacuation surgery that he performed.
- c. Licensee's actions and conduct constitute a violation of K.S.A. 65-2836(b), as further defined by K.S.A 65-2837(b)(17), for the use of any false, fraudulent or deceptive statement in any document connected with the practice of the healing arts including the intentional falsifying of a patient or medical care facility record, in that Licensee maintained false records in the following way:
 - i. Licensee failed to document within his Operative Report dated February 27, 2007, that was placed within the patient's medical record that a surgical incident had occurred during the burr hole evacuation surgery that he performed;
 - ii. On June 5, 2007, Licensee documented within the patient's medical record that that a surgical technician directed what was termed as a "forceful irrigation" into the left-frontal burr hole site while Licensee had his back turned.
 - iii. Licensee failed to document within the patient's medical record that the surgical incident that had occurred during the burr hole evacuation surgery was causing the patient's neurological deficits.
- d. Licensee's actions and conduct constitute a violation of K.S.A. 65-2836(b) as further defined by K.S.A 65-2837(b)(25), for 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.

- e. Licensee has violated K.S.A. 65-2836(s), in that sanctions or disciplinary actions have been taken against Licensee by a peer review committee, health care facility, a governmental agency or department or a professional association or society for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.
- f. Licensee's acts and conduct during the course of treating the patient constitute violations of K.S.A. 65-2836(w) of the Kansas Healing Arts Act, in that Licensee has an adverse judgment, award or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

13. Licensee further waives his right to dispute or otherwise contest the allegations contained in the above paragraphs in any further proceeding before this Board.

14. Pursuant to K.S.A. 65-2836 the Board has grounds to deny, revoke, suspend, limit, and/or censure Licensee's license. Pursuant to K.S.A. 65-2863a the Board has the authority to impose administrative fines for violations of the Kansas Healing Arts Act.

15. According to K.S.A.65-2838(b), the Board has authority to enter into this Consent Order without the necessity of proceeding to a formal hearing.

16. Nothing in this Consent Order shall be construed to deny the Board jurisdiction to investigate alleged violations of the Kansas Healing Arts Act, or to investigate

complaints received under the Risk Management Law, K.S.A. 64-4921 *et seq.*, that are known or unknown and are not covered under this Consent Order, or to initiate formal proceedings based upon known or unknown allegations of violations of the Kansas Healing Arts Act.

17. Licensee hereby releases the Board, its individual members (in their official and personal capacity), attorneys, employees and agents, hereinafter collectively referred to as "Releasees", from any and all claims, including but not limited to those alleged damages, actions, liabilities, both administrative and civil, including the Kansas Act for Judicial Review and Civil Enforcement of Agency Actions, K.S.A. 77-601 *et seq.*, arising out of the investigation and acts leading to the execution of this Consent Order. This release shall forever discharge the Releasees of any and all claims or demands of every kind and nature that Licensee has claimed to have had at the time of this release or might have had, either known or unknown, suspected or unsuspected, and Licensee shall not commence to prosecute, cause or permit to be prosecuted, any action or proceeding of any description against the Releasees.
18. This Consent Order, when signed by both parties, constitutes the entire agreement between the parties and may only be modified or amended by a subsequent document executed in the same manner by the parties.
19. Licensee agrees that all information maintained by the Board pertaining to the nature and result of any complaint and/or investigation may be fully disclosed to and considered by the Board in conjunction with the presentation of any offer of settlement, even if Licensee is not present. Licensee further acknowledges that

- the Board may conduct further inquiry as it deems necessary before the complete or partial acceptance or rejection of any offer of settlement.
20. Applicant, by signature to this document, waives any objection to the participation of the Board members, including the Disciplinary Panel and General Counsel, in the consideration of this offer of settlement and agrees not to seek the disqualification or recusal of any Board member or General Counsel in any future proceedings on the basis that the Board member or General Counsel has received investigative information from any source which otherwise may not be admissible or admitted as evidence.
 21. Licensee acknowledges that he has read this Consent Order and fully understands the contents.
 22. Licensee acknowledges that this Consent Order has been entered into freely and voluntarily.
 23. Licensee acknowledges and agrees that Licensee's failure to comply with any of the provisions of this Consent Order is a violation of a Board order and grounds for disciplinary action against Licensee's license pursuant to K.S.A. 65-2836(k).
 24. Licensee further understands and agrees that upon signature by Licensee, this document shall be deemed a public record and shall be reported to the National Practitioner Data Bank, Federation of State Medical Boards, and any other entities authorized to receive disclosure of the Consent Order.
 25. Licensee shall obey all federal, state and local laws and rules governing the practice of medicine and surgery in the State of Kansas that may be in place at the

- time of execution of the Consent Order or may become effective subsequent to the execution of this document.
26. Upon execution of this Consent Order by affixing a Board authorized signature below, the provisions of this Consent Order shall become an Order under K.S.A. 65-2838. This Consent Order shall constitute the Board's Order when filed with the office of the Executive Director for the Board and no further Order is required.
27. This Consent Order constitutes disciplinary action.
28. The Board may consider all aspects of this Consent Order in any future disciplinary matter regarding Licensee to include any request for termination of the suspension of his license to practice medicine and surgery in the State of Kansas.
29. In lieu of conducting a formal proceeding, Licensee, by signature affixed to this Consent Order, hereby voluntarily agrees to the following disciplinary action on his license to engage in the practice of medicine and surgery:

SUSPENSION

30. Licensee's license shall be suspended for a period of at least two (2) years. Such suspension will be effective upon approval of this Consent Order with the Board.
31. After the elapse of at least two (2) years from the effective date of this Consent Order, Licensee agrees that a request to terminate the suspension of his license will be considered in accordance with the provisions of K.S.A. 65-2844. Further, Licensee's request will be governed by *Vakas v. The Kansas Board of Healing*

Arts, 248 Kan. 589 (Kan. 1991), and all applicable statutes, law, rules and regulations regarding qualifications for licensure and reinstatement.

32. Licensee agrees that in the event he requests termination of the suspension of his license, the allegations contained in the Amended Petition and this Consent Order will be considered as findings of fact and conclusions of law.
33. All proceedings conducted on a request for termination of the suspension shall be in accordance with the provisions of the Kansas Administrative Procedure Act, K.S.A. 77-501, *et. seq.* and shall be reviewable in accordance with the Kansas Judicial Review Act, K.S.A. 77-601, *et. seq.*
34. If, at the time of Licensee's request to terminate the suspension of his license, he has not been actively, clinically practicing medicine and surgery in another jurisdiction of the United States of America for at least the preceding two (2) years, he agrees to submit to a clinical skills assessment at the Center for Personalized Education of Physicians (CPEP), 14001 E. Liff Avenue, Suite 206, Aurora, Colorado 80014, (303) 750-7150, fax: (303) 750-7171. The results of the clinical skills assessment shall be made available to the Board to review and consider at any and all hearings pertaining to the termination of the suspension of his license. The parties stipulate and agree that the Assessment Report will be admitted into evidence to be considered fully by the Board. Both parties may provide relevant information to CPEP for consideration as part of the clinical skills assessment. In order to permit the Board to provide such relevant information, Licensee shall immediately notify Board Counsel of the assessment dates once the assessment is scheduled. Licensee shall travel to CPEP and

complete the assessment as scheduled, at his own expense. Licensee also agrees that any and all of CPEP's recommendations will be followed and become a part of the Board Order that terminates the suspension of his license.

35. Both parties will be provided a copy of the draft Assessment Report for their review. Licensee shall complete any necessary waiver/release so that the Board may receive a copy of the draft Assessment Report for review. However, CPEP will issue its formal Assessment Report, in accordance with its internal policies.

COSTS

36. Licensee is hereby ordered to pay the Board's incurred COSTS in conducting these proceedings under the Kansas Administrative Procedure Act in the amount that is put forth by the Board in a Statement of Costs not to exceed Twenty Thousand Dollars and Zero Cents (\$20,000.00). These costs shall be paid in full prior to the Board's consideration to reinstate Licensee's license to practice medicine and surgery in the State of Kansas.
37. Licensee shall make all payments to the "Kansas State Board of Healing Arts" and send all payments to the attention of: Compliance Coordinator, Kansas State Board of Healing Arts, 800 SW Jackson, Lower Level-Suite A, Topeka, Kansas 66612.
38. Licensee agrees to submit to a competency evaluation, at his own expense, at the time in which he requests termination of the suspension of his medical license. Such competency evaluation, in full, shall be presented to the Board in connection with his request to terminate the suspension of his license.

IMMEDIATE PROCEDURAL SUSPENSION

39. In consideration of presentation of this Consent Order to the Board at the regularly scheduled February Board Meeting, Licensee also agrees to enter into an order by the Presiding Officer for IMMEDIATE PROCEDURAL SUSPENSION of his license to practice medicine and surgery and such procedural suspension shall continue until this Consent Order is approved by the Board or a Final Order is issued by the Board in this matter.

PATIENT RECORDS

40. Licensee shall keep his patient records in accordance with applicable statutes and regulation or place his patients' records in the custody of another licensed physician or records maintenance facility in compliance with K.A.R. 100-24-2 and 100-24-3. Licensee shall notify the Board on or before December 1, 2013, of the specific measures taken and the appropriate contact information so that the Board can respond to questions from patients about the location of their medical records and how they can obtain them.

41. Licensee shall ensure that all patients and any other person or entity authorized by law to obtain patient records have access to medical records. Specifically, Licensee will comply with K.S.A. 65-4970, 65-4971, 65-4972, 65-4973 and K.A.R. 100-22-1, 100-24-2 and 100-24-3 and all other applicable statutes, rules, or regulations.

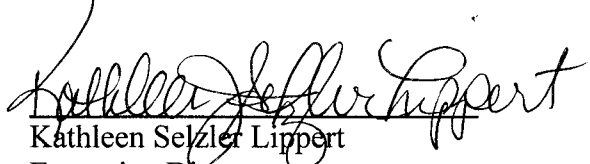
42. All correspondence or communication between Licensee and the Board relating to the Consent Order shall be by certified mail addressed to the Kansas State Board

of Healing Arts, Attn: Compliance Coordinator, 800 SW Jackson, Lower Level Suite A, Topeka, Kansas 66612.

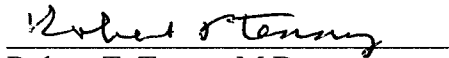
IT IS THEREFORE ORDERED that the Consent Order containing the agreement of the parties contained herein is hereby adopted by the Board as findings of fact and conclusions of law.

IT IS SO ORDERED on this 14 day of Feb, 2014.

FOR THE KANSAS STATE BOARD OF HEALING ARTS:



Kathleen Selzler Lippert
Executive Director

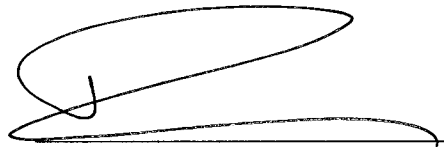
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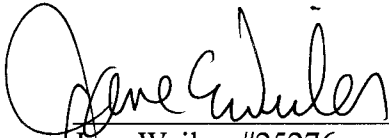

Robert T. Tenny, M.D.
Licensee

November 15, 2013
Date

PREPARED AND APPROVED BY:


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APPROVED BY:



Benoit M.J. Swinnen, #18919
Counsel for Respondent
Swinnen & Associates, LLC
921 SW Topeka Boulevard
Topeka, KS 66612
(785) 272-4878

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that I served a true and correct copy of the Consent Order by United States mail, postage prepaid, on this 17th day of Feb., 2013, to the following:

Robert T. Tenny, M.D.
Licensee
Confidential
Leawood, KS 66209

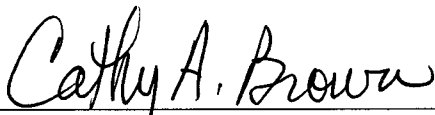
Benoit M.J. Swinnen, #18919
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And the original was filed with:

Kathleen Selzler Lippert
Executive Director
Kansas State Board of Healing Arts
800 SW Jackson
Lower Level- Suite A
Topeka, KS 66612

And copies were hand-delivered to:

Reese Hays, Litigation Counsel
Seth Brackman, Associate Litigation Counsel
Jane Weiler, Associate Litigation Counsel
Katy Lenahan, Licensing Administrator
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Staff Member