

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

KS State Board of Healing Arts

In the Matter of)
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WASSE ZAFER, D.C.)
Kansas License No. 01-04097)

Docket No. 09-HA00184

JOURNAL ENTRY

NOW on this 17th day of July, 2009 the above captioned matter comes before the Kansas State Board of Healing Arts [hereinafter Board], Gary Counselman, D.C., presiding on the Board's Motion for *Ex Parte* Emergency Order of Suspension and for Emergency Proceedings. The petitioner, The Kansas State Board of Healing Arts appears by and through counsel Lori D. Dougherty, Associate Litigation Counsel, and Stacy R. Bond, Associate Litigation Counsel. The licensee, Wasse Zafer, D.C., appears in person with counsel Terri Z. Austenfeld of Sanders, Warren & Russell, LLP, Overland Park, Kansas. There are no other appearances.

WHEREFORE after reviewing the agency record, conducting a hearing in this matter, hearing the statements and arguments of counsel and being duly apprised of the premises, the Presiding Officer finds, concludes and orders as follows:

PROCEDURAL HISTORY

1. On approximately February 8, 1992, Licensee was issued license number 01-04097 to practice chiropractic by the Board.
2. Licensee last renewed his license on approximately January 7, 2009.
3. On April 30, 2009, the Board filed a Petition and Motion for *Ex Parte* Emergency Order of Suspension and for Emergency Proceedings.
4. An Emergency *Ex Parte* Order of Suspension was filed against Licensee on May 1, 2009.
5. A formal hearing was held on the Order of Suspension on May 22, 2009, and continued on June 3, 2009 and June 25, 2009.

6. At the conclusion of the formal hearing on June 25, 2009, the parties were ordered to file Proposed Findings of Facts and Conclusions of Law on or before July 17, 2009.

FINDINGS OF FACT

Count 1: Patient 1

7. Patient 1 was in an automobile accident on October 17, 2008 in Olathe, Kansas. (Tr. Vol. II p. 8, lines 18-25, p. 9 lines 5-6).
8. Patient 1 received a phone call from the Advocates of Public Safety and was referred to Licensee. (Tr. Vol. II, p. 12, lines 8-12, p. 13, lines 15-24).
9. Patient 1 appeared at Licensee's office for an evaluation on or about October 22, 2008. (Petitioner's Exhibit 4).
10. Patient 1 filled out the patient forms, except for the referral form, prior to meeting with Licensee. (Tr. Vol. II, p. 14, lines 17-20, p. 64, lines 13-18).
11. Patient 1 first spoke with Licensee at this appointment. (Tr. Vol. II, p.14, lines 24-25, p. 15, line 1).
12. Patient 1 met with Licensee in Licensee's office for his evaluation. There was another person present in the office during the evaluation. (Tr. Vol. II, p. 15, lines 2-7).
13. Patient 1 told Licensee he was referred by the Advocates of Public Safety, but he was directed by Licensee to circle "saw sign" on the referral form. (Tr. Vol. II, p. 21, lines 4-15, p. 58, lines 21-25, p. 59, lines 1-19).
14. Licensee wrote down "rear-ended over 15-20 mph" in patient 1's records. (Petitioner's Exhibit 4, p. Zafer 168).
15. Patient 1 testified that he told Licensee the other driver was "doing 10 to 15 miles an hour" and also specified, "I know that I told him my head did not hit the headrest." (Tr. Vol. II, p. 17, lines 3-6).
16. Licensee wrote, "the head struck the headrest," in Patient 1's medical record. (Tr. Vol. II,

p.17, lines 5-6, Petitioner's Exhibit 4, p. Zafer 168).

17. Patient 1 testified that it was not accurate to say he had “a great deal of anxiety, nervousness, and also a great deal of fatigue ever since the accident” as written in his patient records by Licensee. (Tr. Vol. II, p. 19, lines 18-25, Petitioner's Exhibit 4, p. Zafer 168).
18. Patient 1 testified that he was not physically examined by Licensee during the evaluation. (Tr. Vol. II, p. 21, lines 16-25, p. 22, lines 1-24).
19. Patient 1 testified that except for X-rays and pointing to spots on his back, Licensee did not touch him during the evaluation. (Tr. Vol. II, p. 23, lines 11-20).
20. Licensee testified that although he did not perform a blood pressure check on Patient 1, he circled “unremarkable” on the patient record. (Tr. Vol. I, p. 92, lines 6-16).
21. Patient 1 specifically denied being physically examined by the Licensee, having a finger to nose test performed on him, or performing any strength tests during his visit with the Licensee. (Tr. Vol. II, p. 21, lines 22-25, p. 22, lines, 1-3).
22. Licensee noted in Patient 1's record that he had antalgia on the left, head tilt to the left, left pupil sluggishness, and right pupil smaller than the left. Licensee also noted Patient 1 performed a finger to nose test with difficulty. (Petitioner's Exhibit 4, p. Zafer 166).
23. Licensee documented several tests performed on Patient 1 in the patient records, including strength testing, and noted decreased strength in the masseter, shrug, and shoulder abduction. (Petitioner's Exhibit 4, p. Zafer 164-167).
24. Patient 1 testified the majority of the time he spent with Licensee was spent discussing money and not about his injury or how he was feeling. (Tr. Vol. II, p. 23, lines 7-17).
25. Patient 1 testified that after his evaluation, X-rays were taken. Patient 1 testified that during the last X-ray, Licensee and another person, “pushed down hard enough [on my head] that my stance, my posture had to shift to the balls of my feet to overcome the downward force so that I wouldn't call over.” (Tr. Vol. II, p. 27, lines 19-25).

26. Licensee admits that either he or his associate performed flexion/extension stress view x-rays on Patient 1. (Licensee's Proposed Findings of Fact and Conclusions of Law).
27. Licensee's expert witness, Timothy D. Warren, D.C., testified that during extension views, you use "...a little bit of manual persuasion to push [the head] back some, but not very much more than just say tap someone's shoulder and say hi." (Tr. Vol. III, p. 897, lines 17-25, p. 898, lines 1-2).
28. Licensee testified that during his extension views "10-12 pounds of pressure is put on top of the head." (Tr. Vol. I, p. 61, lines 17-18).
29. Licensee opined that the concept of flexion/extension stress views is that patients are not able to fully extend to the end range of motion on their own, and unless the end range of motion is achieved, you will not be able to adequately determine if there is ligamentous laxity, instability or tearing. (Tr. Vol. III, p. 985, lines 1-25).
30. Dr. Warren testified that he had "no idea" why an x-ray would be taken when someone was forcefully pulling a patient's head back until it hurt. (Tr. Vol. III, p. 899, lines 1-14).
31. Patient 1 testified that prior to seeing Licensee his pain "wasn't real severe to where I remember, you know, I was in a lot of pain," but that, "when I left, I was in more pain than when I arrived." (Tr. Vol. II, p. 25, lines 4-6, p. 28, line 23-24).
32. Patient 1's medical records reflect Licensee noting severe tenderness on palpitation, severe para-vertebral muscle spasm, and severe edma. (Petitioner's Exhibit 4, p. Zafer 165).
33. After his appointment with Licensee, Patient 1 saw Dr. Robert Bonebrake, D.C. (Tr. Vol. II, p. 29, lines 2-4).
34. Dr. Bonebrake is a licensed chiropractor in the state of Kansas. He attended Western States Chiropractic College in Portland, Oregon and Life Chiropractic College in San Leandro, California. (Tr. Vol. II, p. 67, lines 3-8).
35. Dr. Bonebrake performed a range of motion studies and conducted a brief nuerological

examination of the patient. He testified he observed the patient's pupils, his gait, his carriage, and did a general chiropractic workup of Patient 1. (Tr. Vol. II, p. 75, lines 11-25, p. 76, lines 1-19, p. 78, lines 21-25, p. 80 lines 1-12).

36. Dr. Bonebrake did not observe any antalgic gait or head carriage. He also testified he observed a normal head position and nothing significant with Patient 1's eyes or pupils. (Tr. Vol. II, p. 79, lines 2-20).
37. Dr. Bonebrake found Patient 1 to be misaligned in a number of places in his back and neck and diagnosed Patient 1 with a mild cervical sprain and strain, mild thoracic sprain and strain, and a sacral iliac subluxation and strain. (Tr. Vol. II, p. 89, lines 7-17).
38. Dr. Bonebrake saw Patient 1 a total of eight times over a seven week period. (Tr. Vol. II, p. 86, lines 13-17).
39. Patient 1 testified he was never placed on disability by Dr. Bonebrake and never missed work due to his injuries from the car accident, yet Licensee noted in his medical records, "Total disability from 10/17/08 to 10/31/08." (Tr. Vol. II, p. 31, lines 1-7, Petitioner's Exhibit 4, p. Zafer 173).
40. Dr. Bonebrake testified that he did not consider putting Patient 1 on disability because, "he didn't appear compromised to the point where he needed to be on disability. Like I said, he was animated, he was moving normally, he was working, he was on his way back to work, he wasn't necessarily complaining that he had some real bad trouble, he was just sore and stuff." (Tr. Vol. II, p. 88, lines 9-22).
41. Dr. Bonebrake did request Patient 1 get his X-rays from Licensee. (Tr. Vol. II, p. 82, line 1, Tr. Vol. II, p. 34, lines 20-22).
42. Licensee refused to release the X-rays to Patient 1 directly. (Tr. Vol. II, p. 32, lines 8-25, p. 33, lines 1-2).
43. When shown his X-rays by Licensee, Patient 1 testified he questioned whether he needed an

MRI. Patient 1 testified Licensee said, “No, that would hurt our case.” (Tr. Vol. II, p.35, lines 19-20).

Count II:

(confidential)

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(confidential)

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Count III:
Patient 3:

84. Patient 3 was involved in a car accident on February 25, 2009 in Olathe, Kansas. Patient 3 did not seek medical treatment after the accident, although she was sore in her lower back. (Tr. Vol. 1, p. 300, lines 15-25, p. 301, lines 1-3, 17-25).
85. Patient 3 testified she received a call on March 2, 2009 from Public Safety of Kansas from a woman named Miranda, who stated Patient 3 was entitled to a free evaluation with a special kind of chiropractor who would check for soft tissue damage or neurological damage. (Tr. Vol. 1, p. 303, lines 19-23, p. 304, lines 19-24).
86. Miranda referred Patient 3 to Licensee. Patient 3 was given the name, address and phone number to make an appointment with Licensee. (Tr. Vol. 1, p. 306, lines 6-8).
87. Patient 3 testified she spoke with Licensee's receptionist and confirmed her free consultation with Licensee. She was scheduled for an appointment the next day, March 3, 2009. (Tr. Vol. 1, p. 317, lines 15-21).
88. Patient 3 testified that when she went in to see Licensee, the only symptom she had was lower back discomfort. She testified that her pain prior to seeing Licensee was "minimal.

More an annoyance . . . it just kind of getting a little better, but kind of annoying.” (Tr. Vol. 1, p. 310, lines 1-6, p. 315, lines 1-5, p. 316, lines 7-14).

89. Patient 3 testified that she was given a packet of papers to fill out. The receptionist came out into the lobby after she turned them in helped Patient 3 to “fill in the holes” she had left. (Tr. Vol. I, p. 311, lines 2-5).
90. Patient 3 testified the receptionist wrote in symptoms or answers that were inaccurate, including writing that a body part had struck the car fixtures because it could have happened, and that Patient 3 had pain daily when the patient had written “maybe.” (Tr. Vol. 1, p. 311, lines 12-22, p. 313, lines 1-25, p. 314, lines 1-3, Petitioner's Exhibit 11, p. Zafer 477).
91. Patient 3 met with Licensee for approximately 45 minutes, alone in his office.
92. Patient 3 described Licensee's reaction to her referral from the Public Safety Advocates as, “he told me not to put that on the form. He told me that I should put on the form that I drive by often because they won't question that...” (Tr. Vol. 1, p. 321, lines 5-21).
93. Patient 3 testified that talk about her insurance company took up at least half of her evaluation time with Licensee. She stated that Licensee told her she could get damages of \$25,000 for her pain and suffering and advised her not to speak to the insurance company, but “to refer them to talk to your doctor, to call me if they have any questions about your treatment.” (Tr. Vol. 1, p. 323, lines 22-25, p. 324, lines 20-25, p. 325, lines 1-5).
94. Patient 3 testified that conversations about treatment were all prior to Licensee's examination of her. (Tr. Vol. 1, p. 324, lines 4-7, p. 325, lines 7-10).
95. Patient 3 testified Licensee was going to put her on disability for two weeks, even though she told him, “I didn't think I'd need the disability and he said that after treatment and being away from work that I might need that disability.” (Tr. Vol. I, p. 632, lines 17-21).
96. Patient 3 testified Licensee did a physical examination of her, including listening to her

breath sounds, a pen light, resistance test, and the Weber test. Patient 3 describes no other testing by Licensee other than x-rays. (Tr. Vol. I, p. 325, lines 22-25, p. 327, lines 4-25, p. 328, lines 1-12).

97. Licensee lists several other neurological tests in Patient 3's chart as having been performed. (Petitioner's Exhibit 11, page Zafer 481).
98. Patient 3 testified that during Licensee's examination of her, he injured areas that were previously not sore. Patient 3 described Licensee's movement as "he held one shoulder here and put his hand on top of my skull and he pushed down hard and I ducked down to the side because it hurt and I said, that hurts, and he says, you need to stop pulling away from me . . . he did the same thing again and it hurt and I ducked away and he did it a total of three times and I hurt." Patient 3 described the movement as "Forceful. It was very forceful straight down. It, it was not a natural angle for my head to be in." (Tr. Vol. 1, p. 328, lines 18-25, p. 329, lines 1-7).
99. Patient 3 testified the pain was a lot of pressure and it felt hot, like heat down her neck and spine. Patient 3 testified she had never felt anything like that before. (Tr. Vol. I, p. 331, lines 7-14).
100. Patient 3 testified that after the procedure by Licensee, she had pain in the "neck and upper back to almost stopping where my previous discomfort had been." She also stated that she did not have neck and upper back discomfort until that procedure. (Tr. Vol. I, p. 331, lines 7-14).
101. Patient 3 testified that after he performed this movement, Licensee stated he would be surprised if she didn't have a neck injury." (Tr. Vol. I, p. 360, lines 2-5).
102. Patient 3 stated that she did not return to Licensee's office for treatment after the initial visit and received calls from Licensee and his staff, stating she needed to come in for care, that it was urgent and that Licensee told her she had a Category Three injury. (Tr. Vol. I, p.

345, lines 1-17).

Count IV:

(confidential)
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Licensee's Witnesses:

Annie McCoy:

111. Annie McCoy has worked for Licensee for four years. (Tr. Vol. II, p. 245, lines 3-5).
112. Ms. McCoy testified she “doesn't call [attorneys] and refer them [patients].” (Tr. Vol. II, p. 270, lines 8-9).
113. Ms. McCoy sent an email to John Zimmerman of Chionuma & Associates on March 3, 2009 after Patient 3's appointment about Patient 3. John Zimmerman responded, writing, “Thanks for the referral, Anne.” (Petitioner's Exhibit 11, p. Zafer 461-462).
114. Ms. McCoy's testimony is not credible and is unpersuasive.

Kenneth Downing, D.C.:

115. Dr. Downing is the Secretary for the Auto Accident Injury Help Line, an organization created by Licensee. (Respondent's Exhibit 7, p. 16).
116. Dr. Downing testified he “has no idea” whether Licensee solicits patients and does not have any knowledge whether the Licensee was or was not contacting accident victims through the Auto Accident Injury Help Line. (Tr. Vol. III, p. 833, lines 14-25).
117. Based upon his own statements as to lack of personal knowledge, Dr. Downing's testimony concerning patient solicitation by Licensee is disregarded in its entirety. (K.S.A. 60-419).
118. Dr. Downing further testified that no research has been done by the Auto Accident Injury Help Line, stating, “We toyed around with an idea of trying to put together a case study group, did some study, you know, and background and looked into it, yeah, but that was about it. (Tr. Vol. III, p. 832, lines 19-23). This portion of Dr. Downing's testimony is reliable (confidential)

Timothy D. Warren, D.C.:

119. Dr. Warren was retained by Licensee as an expert witness in this matter. Petitioner objects to admission of his testimony and is overruled.

120. Dr. Warren's review is based on the patient records provided to him by Licensee. (Tr. Vol. III, p. 884, lines 9-24).
121. Dr. Warren testified he had no way of knowing if Licensee did or did not manipulate the consultation and/or the objective findings to any degree. (Tr. Vol. III, p. 885, lines 12-17).
122. Dr. Warren opined the standard of care was met by Licensee based on Warren's review of the records. However, Dr. Warren stated it might influence his opinion if he were to be provided information that the patients all disagreed with certain aspects of their patient records and their treatment as indicated in the records Warren reviewed. (Tr. Vol. III, p. 885, lines 1-25, p. 886, line 7).
123. Since the Presiding Officer finds that the patient records as presented to Dr. Warren did not accurately reflect the conditions of the patients or what tests were performed on the patients, Dr. Warren's opinion on the standard of care is disregarded.

Other Matters:

124. Licensee's Exhibit 15 shows billing and coding problems. An E&M code was billed on every visit along with a CMT code. These should not be billed together on every visit because a CMT code already has an E&M code built into to it. When they are used together, a 25 modifier should be used.
125. Licensee testified that he and his staff do not wear any type of protection while giving x-rays despite being in front of the machine. (Tr. Vol. III, p. 1049, lines 5-25, p. 1050, lines 1-4).

CONCLUSIONS OF LAW

126. The Board presented clear and convincing evidence sufficient to prove the allegations contained in the the Board's Motion for *Ex Parte* Emergency Order of Suspension.
127. The Licensee's act or conduct caused injury and medically unnecessary pain to Patients 1 and 3.

128. Licensee has repeatedly failed to adhere to the applicable standard of care to a degree constituting ordinary negligence.
129. The Board may revoke, suspend, or limit a license upon a finding that the licensee has committed an act of professional incompetency. K.S.A. 65-2836(b).
130. Professional incompetency is defined by statute at K.S.A. 65-2837(a).
131. Repeated instances of failure to adhere to the applicable standard of care to a degree that constitutes ordinary negligence is professional incompetency, as defined by K.S.A. 65-2837(a)(2).
132. A pattern of practice or behavior that demonstrates a manifest incapacity to practice the healing arts constitutes professional incompetency, as defined by K.S.A. 65-2837(a)(3).
133. The Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(2), in that Licensee has engaged in repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the Board. Specifically, the Presiding Officer finds, relying on his own expertise, that normal flexion and extension x-ray views as taught in any chiropractic college with movement to patient tolerance are very useful to a diagnosis. However, the “stress” views as performed by Licensee are inherently dangerous and risky, especially in an acute injury situation, such as a motor vehicle accident. These x-rays as performed by Licensee are below acceptable standard of care.
134. Licensee has violated K.S.A. 65-2836(b), as further defined by K.S.A. 65-2837(a)(2), by additionally taking x-rays that are below professional quality. The x-rays of Patients 1 and 2 (Exhibits 21 and 22) are either too light or too dark to properly diagnosis the patients’ conditions. This is below the acceptable standard of care.
135. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(3), in that Licensee has engaged in a pattern of practice or other behavior which demonstrates a

manifest incapacity or incompetence to practice medicine, to wit his x-ray procedure.

136. The Licensee has not violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(1), in that the Board did not prove by clear and convincing evidence that Licensee or his agents solicited patients.
137. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(12), in that Licensee has engaged in conduct likely to deceive, defraud or harm the public, to wit Licensee caused physical injuries to Patients number 1 and 3.
138. The Board failed to prove that Licensee violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(13), by clear and convincing evidence.
139. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(17), in that Licensee engaged in the use of any false, fraudulent or deceptive any document connected with the practice of healing arts including the intentional falsifying or fraudulent altering of a patient or medical care facility record. The Presiding Officer finds that all three patients were credible in that information contained in their medical records as written down by Licensee was inaccurate.
140. The Presiding Officer concludes that the Board did not prove by clear and convincing evidence that Licensee violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(18), obtaining any fee by fraud, deceit or misrepresentation.
141. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(24), in that Licensee has engaged in repeated failure to practice healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar circumstances, to wit Licensee fails to protect himself and his staff from radiation during x-rays and his “stress” view x-rays do not measure up to the level of acceptable care.
142. Licensee has not violated K.S.A. 65-2836(b), as further defined in K.A.R. 100-22-1, by

failing upon receipt of a signed release from a patient, to furnish a copy of the patient record to the patient. To wit, the Presiding Officer, using his own expertise, concludes that no reasonable practitioner would release Patient 1's x-rays under the circumstances presented in this case.

143. The Presiding Officer concludes that Licensee's continuation in practice would constitute an immediate danger to the public health, safety, or welfare. While the Board did not prove all of its allegations by clear and convincing evidence, those allegations which were proven are egregious enough to warrant the continued suspension of Licensee.

144. Therefore, the Presiding Officer ORDERS that Licensee's license shall be suspended until a full evidentiary hearing may be held on the disciplinary petition and an initial order has been filed in the case.

145. The Presiding Officer recuses himself from any further proceedings in this matter.

IT IS SO ORDERED.



Gary L. Counselman, D.C.
Presiding Officer

Certificate of Service

I certify that the foregoing Journal Entry was served this 17th day of Sept., 2009, by depositing the same in the United States Mail, first-class postage prepaid, and addressed to:

Wasse Zafer, D.C.
450 E. Santa Fe
Olathe, KS 66061

and

Terri Z. Austenfeld
Sanders Warren & Russell
1001 E. Terrace Street, Suite 170
Kansas City, MO 64131
Attorney for Licensee

and a copy was hand-delivered to:

Lori D. Dougherty
Associate Litigation Counsel
Kansas Board of Healing Arts
235 S. Topeka Blvd.
Topeka, KS 66603

and the original delivered for filing to the Executive Director's Office.

Cathy A. Brown

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

FILED

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MAY 01 2009

KS State Board of Healing Arts

In the Matter of)
)
Wasse Zafer, D.C.)
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Kansas License No. 01-04097)

Docket No.: 09-HA 00184

EMERGENCY EX PARTE ORDER OF SUSPENSION
AND PROTECTIVE ORDER

NOW on this 1 day of May 2009, this matter comes before the Presiding Officer upon a Motion for *Ex Parte* Emergency Order of Suspension. Lori D. Dougherty, Associate Litigation Counsel, and Stacy R. Bond, Associate Litigation Counsel, filed a Motion for *Ex Parte* Emergency Order of Suspension and for Emergency Proceedings. There are no other appearances.

The Presiding Officer has reviewed the agency file in Kansas State Board of Healing Arts (KSBHA) Docket No. 09-HA 00184. The Presiding Officer finds, concludes and orders as follows:

1. This is a motion for an order pursuant to K.S.A. 65-2838 and 77-536. Under those statutes, the Presiding Officer may issue an order without notice and hearing, and may temporarily limit or suspend a license if the Presiding Officer finds an imminent danger to the public health, safety, or welfare.
2. The Presiding Officer has received and reviewed a Motion for an *Ex Parte* Order suspending Licensee license filed with KBHA on April 30, 2009. The motion requests an emergency suspension of Licensee's license.

3. The motion for an emergency order in the above captioned case alleges that Licensee has violated K.S.A. 65-2836, specifically:
- a. K.S.A. 65-2836(b), in that Licensee has committed an act of unprofessional or dishonorable conduct or professional incompetency.
 - b. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(1), in that Licensee engaged in solicitation of professional patronage through the use of fraudulent or false advertisements, or profiting by the acts of those representing themselves to be agents of the licensee.
 - c. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(2), in that Licensee has engaged in repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board
 - d. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(3), in that Licensee has engaged in a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine.
 - e. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(12), in that Licensee has engaged in conduct likely to deceive, defraud or harm the public.
 - f. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(13), in that Licensee has made a false or misleading statement regarding the licensee's skill or the efficacy or value of the drug, treatment or remedy prescribed by the licensee or at the licensee's direction in the treatment of any disease or other condition or the body or mind.

- g. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(17), in that Licensee engaged in the use of any false, fraudulent or deceptive statement in any document connected with the practice of the healing arts including the intentional falsifying or fraudulent altering of a patient or medical care facility record.
 - h. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(18), in that Licensee has obtained any fee by fraud, deceit or misrepresentation.
 - i. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(24), in that Licensee has engaged in repeated failure to practice healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances.
 - j. K.S.A. 65-2836(b), as further defined in K.A.R. 100-22-1, by failing upon receipt of a signed release from a patient, furnish a copy of the patient record to the patient.
4. The motion for an emergency order in the above captioned case includes Exhibits one (1) through six (6).

FINDINGS OF FACT

- 5. Wasse Zafer, D.C.'s ("Licensee") last known mailing address to the Board is: 450 E. Santa Fe, Olathe, Kansas 66061.
- 6. Licensee is or has been entitled to engage in the practice of chiropractic in the State of Kansas, having been issued License No. 01-04097 on approximately

February 8, 1992, and having last renewed such license on approximately January 1, 2009.

7. At all times relevant to the allegations set forth in the Motion, Licensee has held a current and active license to engage in the practice of chiropractic in the State of Kansas.
8. Licensee presently has an active and unrestricted license to practice chiropractic in the state of Kansas.
9. The Presiding Officer finds there are grounds to reasonably believe that:
 - a. Licensee examined Patient #1 on or about October 22, 2008.
 - b. **(Confidential)**
 - c. Licensee examined Patient #3 on or about March 3, 2009.
 - d. **(Confidential)**
 - e. Licensee's acts or conduct caused injury and medically unnecessary pain
(Confidential)
 - f. Licensee's act or conduct caused injury and medically unnecessary pain to Patients #1, 2, and 3.

CONCLUSIONS OF LAW

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

11. Pursuant to K.S.A. 65-2836, the Board has grounds to revoke, suspend, censure, fine or otherwise limit Licensee's license for violation of the Kansas Healing Arts Act .
12. Pursuant to K.S.A. 77-536, the Board may use emergency proceeding to protect the public from an immediate danger to the public health, safety or welfare.
13. The Presiding Officer finds there are grounds to reasonably believe that Licensee has violated that Licensee has violated K.S.A. 65-2836, in that Licensee has violated K.S.A. 65-2836, specifically:
 - a. K.S.A. 65-2836(b), in that Licensee has committed an act of unprofessional or dishonorable conduct or professional incompetency.
 - b. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(1), in that Licensee engaged in solicitation of professional patronage through the use of fraudulent or false advertisements, or profiting by the acts of those representing themselves to be agents of the licensee.
 - c. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(2), in that Licensee has engaged in repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board
 - d. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(3), in that Licensee has engaged in a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine.

- e. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(12), in that Licensee has engaged in conduct likely to deceive, defraud or harm the public.
- f. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(13), in that Licensee has made a false or misleading statement regarding the licensee's skill or the efficacy or value of the drug, treatment or remedy prescribed by the licensee or at the licensee's direction in the treatment of any disease or other condition or the body or mind.
- g. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(17), in that Licensee engaged in the use of any false, fraudulent or deceptive statement in any document connected with the practice of the healing arts including the intentional falsifying or fraudulent altering of a patient or medical care facility record.
- h. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(18), in that Licensee has obtained any fee by fraud, deceit or misrepresentation.
- i. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(24), in that Licensee has engaged in repeated failure to practice healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances.
- j. K.S.A. 65-2836(b), as further defined in K.A.R. 100-22-1, by failing upon receipt of a signed release from a patient, furnish a copy of the patient record to the patient.

14. The Presiding Officer finds that Licensee's continuation in practice would constitute an immediate danger to the public health, safety or welfare.

15. The Presiding Officer further concludes that Licensee's license to practice of chiropractic should be immediately suspended until such time as an evidentiary hearing can be scheduled.

IT IS THEREFORE, ORDERED that the license of Wasse Zafer, D.C. is hereby immediately suspended.

IT IS FURTHER ORDERED that a Protective Order is hereby entered to protect the identity of patients and their records. Records that identify a patient shall not be disclosed to any third person except as authorized by this order or by further order of the Presiding Officer or the Board. To the extent practicable, patients shall be referred to in arguments, testimony and pleadings by the reference number listed in the Petition. This protective order shall not prohibit a party from disclosing such information to a person who has been engaged as an expert witness, or from otherwise using this information in this case and in any subsequent appeals.

IT IS FURTHER ORDERED that board counsel shall serve this order in the manner provided by law, and shall complete and file a proof of service.

PLEASE TAKE NOTICE that a hearing on this matter will be scheduled as soon as practicable at the Board office, 235 S.W. Topeka Blvd., Topeka, Kansas. The issue to be determined is whether the emergency order of suspension should remain in place, be modified or terminated. A Notice of Hearing will be issued.

PLEASE TAKE NOTICE that this is an emergency order. An emergency order is effective when rendered. A party to an agency proceeding may seek judicial review of an emergency order by filing a petition in the District Court as authorized by K.S.A. 77-601, et seq.

A petition for judicial review is not timely unless filed within 30 days following service of the order. A copy of any petition for judicial review must be served upon Board's Executive Director at 235 S.W. Topeka Blvd., Topeka, Kansas 66603.

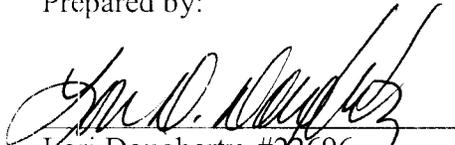
Dated this 1 day of ~~April~~^{May} 2009.

Kansas State Board of Healing Arts



Presiding Officer

Prepared by:



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CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that I served a true and correct copy of the *Ex Parte* Emergency Order of Suspension by United States mail, postage prepaid, on this 1st day of May, 2009, to the following:

Wasse Zafer, D.C.
Licensee
450 E. Santa Fe
Olathe, Kansas 66061

Terri Z. Austenfeld
Attorney for Licensee
Sanders Warren & Russell
1001 E. Terrace, Suite 170
Kansas City, MO 64131

And a copy was hand-delivered to:

Lori D. Dougherty
Stacy R. Bond
Kansas Board of Healing Arts
235 S Topeka Blvd
Topeka, KS 66603

And the original was hand-delivered for filing with:

Jack Confer
Executive Director
Kansas Board of Healing Arts
235 S. Topeka Boulevard
Topeka, Kansas 66603-3068

