BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

FILED

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KANSAS STATE BOARD OF HEALING ARTS

In the Matter of	)	
WILLIAM MALCOLM KNARR, D.O.	)	Case
Kansas License No. 19184	)	
	)	

THIRD AMENDED PETITION TO REVOKE, SUSPEND OR OTHERWISE LIMIT LICENSURE

COMES NOW, the Kansas State Board of Healing Arts and initiates these proceedings under the provisions of K.S.A. 65-2851(a) and K.S.A. 77-501 et seq. and for its cause of action, alleges and states:

The Kansas State Board of Healing Arts (hereinafter "Board") has received one or more complaints, has investigated such complaints and other matters which may result in disciplinary action, and has determined that there are reasonable grounds to believe that William Malcolm Knarr, D.O., (hereinafter "Licensee") has committed an act or acts in violation of the Kansas Healing Arts Act, K.S.A. 65-2801 et seq. The Board has requested the Disciplinary Counsel for the Board to prosecute this action. Debra L. Billingsley is the duly appointed and authorized Disciplinary Counsel for the Board.

Licensee's last known mailing address to the Board is 720 Central, Kansas City, Kansas, 66102. Additionally, Licensee has obtained legal counsel through Thomas E. Wright, Commerce Bank

Building, 100 S.E. 9th Street, Second Floor, P.O. Box 3555, Topeka, Kansas, 66601-3555.

Licensee is or has been entitled to engage in the practice of medicine and surgery in the state of Kansas having been issued license number 19184 on June 19, 1981. His license was temporarily suspended on June 12, 1993. At all times relevant to the allegations set forth in this petition, Licensee has held a current license to engage in the practice of medicine and surgery in the state of Kansas having last renewed his license on July 31, 1992 or has held a temporarily suspended license.

Since issuance of license, while engaged in the regulated profession in the state of Kansas of a physician, authorized to engage in the practice of the Healing Arts pursuant to K.S.A. 65-2801 et seq., Licensee did commit the following act(s), to wit:

COUNT I

On or around August 18, 1991, Licensee, through various acts of omission and commission, failed to provide proper medical care to patient S.E., in that Licensee (1) left the patient in the stirrups on the delivery table for a period of more than three hours, (2) prematurely injected the patient with Marcaine per the pudendal method, (3) inappropriately manipulated the perineum, (4) displayed a lack of knowledge in the use of forceps to deliver the baby, and (5) displayed a lack of knowledge regarding episiotomies and their repair. These omissions/commissions constituted a

failure to adhere to the applicable standard of care on the part of Licensee.

On or around September 27, 1990, Licensee, through various acts of omission and commission, failed to provide proper medical care to patient M.M., in that Licensee (1) failed to appropriately chart the patient's initial sonogram, (2) failed to appropriately chart the patient's initial diagnosis, (3) failed to request proper consultation on a timely basis, (4) failed to properly conduct a history and physical, (5) failed to maintain proper patient records, (6) failed to recognize abnormal laboratory test results, and (7) failed to treat the patient's hypertensive condition. The omissions/commissions constituted a failure to adhere to the applicable standard of care on the part of Licensee.

On or around January 11, 1989, Licensee, through various acts of omission and commission, failed to provide proper medical care to patient T.R., in that Licensee (1) failed to place the patient in the hospital intensive care unit, (2) failed to notify and request an obstetrical/gynecological consultant, and (3) failed to document the patient's perforated uterus in the patient's records until the transcribing of the patient's history and physical. These omissions/commissions constituted a failure to adhere to the applicable standard of care on the part of Licensee.

On or around May 10, 1991, Licensee, through various acts of omission and commission, failed to provide proper medical care to patient T.C., in that Licensee (1) failed to conduct or request

to have conducted a laparoscopic evaluation of the patient, (2) failed to obtain a gynecological consult, (3) conducted an incomplete examination prior to taking the patient into the operating room, (4) failed to rule out differential diagnoses, including but not limited to uterine rupture, and (5) was unavailable when he was responsible to respond to this type of emergency and, after being contacted, failed to respond in a timely manner. These omissions/commissions constituted a failure to adhere to the applicable standard of care on the part of Licensee.

On or around October 29, 1992, Licensee, through various acts of omission and commission, failed to provide proper medical care to patient K.P., in that Licensee (1) performed a dilation and suction and Karmen Canula on K.P. during which time Licensee perforated the uterus (2) that the Licensee performed a second dilation and suction on November 5, 1992, due to continued bleeding (3) that K.P. continued to suffer from a bacterial infection that was not treated by Licensee; and (4) Licensee failed to remove a foreign body from K.P. and she subsequently underwent a hysteroscopy with dilation and curettage. These omissions/commissions constituted a failure to adhere to the applicable standard of care on the part of Licensee.

Said acts are in violation of K.S.A. 65-2836(b) as further defined by K.S.A. 65-2837(a)(2) as said statutes existed at the time of the commission of each of said acts in that they constitute repeated instances involving failure to adhere to the

applicable standard of care to a degree which constitutes ordinary negligence, as determined by the Board.

COUNT II

That on February 20, 1981, the Board received a completed application for a license by endorsement to practice osteopathic medicine and surgery in the state of Kansas from the Licensee. Question number 17 of the application asked "Have you ever been convicted of a felony?". The Licensee answered "No" to this question.

In fact, the Licensee had been convicted of a felony in the state of Oklahoma. That on September 21, 1970, the Licensee entered a guilty plea to the crimes of possession of marijuana, the sale of marijuana and the unlawful sale of LSD in case numbers CRF-70-1346, CRF-70-1344 and CFR-70-1345 respectively in the district court of the 14th Judicial District of the state of Oklahoma, and that Licensee was committed to the custody of the Oklahoma State Department of Corrections for a term of two years in each case to run concurrently. Further, that Licensee was ordered to serve 81 days of the sentence in the state penitentiary and that the balance of the sentence was suspended, and Licensee was placed on probation.

That on June 25, 1980, the Drug Enforcement Administration received a completed application for registration under the Controlled Substance Act for a registration in the state of Missouri from the Licensee. Question number 5B of the

application asked in part "Has the applicant ever been convicted of a felony in connection with controlled substances under state or federal law ..." The Licensee answered "No" to this question. He renewed this application annually beginning in 1981 through 1983 and failed to answer appropriately on those renewal forms. That on March 8, 1981, the Drug Enforcement Administration received a completed application for registration under the Controlled Substance Act from the Licensee for registration in the state of Kansas. Question number 5B asked in part " Has the applicant ever been convicted of a felony in conviction with controlled substances under state or federal law ..." The Licensee answered "No" to this question. The Licensee renewed annually this registration in 1981, 1982 and 1983. Respondent failed to answer appropriately on all three of those applications as well.

That on June 18, 1984, the Licensee entered a guilty plea to Count I of a three count indictment for furnishing false information in an application for registration under the Controlled Substance Act in violation of Title 21, United States Code, Section 843(a)(4)(A). The Licensee was sentenced to four years and fined a sum of $5,000. The sentence was suspended and the defendant was placed on a probationary period of three years.

That on September 24, 1992, Bethany Medical Center received an application for staff privileges by the Licensee. Section four, letter D, of the application asked the question "Have you been suspended or censored by any board or committee or charged

with a felony". Licensee answered "No" to this question when in fact he had been convicted of a felony in the state of Oklahoma in 1970.

That in 1992, the Licensee applied for a Missouri Controlled Substance Registration to be used at his address at Women's Community Health Center, 1837 East Cherry, Springfield, Missouri, 65802. That the Bureau of Narcotics and Dangerous Drugs conducted an investigation regarding the Licensee's application request. Licensee failed to disclose that his Federal Controlled Substance Registration had been issued pursuant to an agreement. In fact, the Drug Enforcement Administration had revoked his Drug Enforcement Administration registration following his conviction in federal court in 1984. In 1987, the Licensee reapplied for a federal registration number and was given a license on a restricted basis, specifically the Licensee was not allowed to write any prescriptions for Controlled Substance Schedule II drugs, and he was to be monitored by the Drug Enforcement Administration. In 1991, Licensee asked to be relieved of any restrictions. He was allowed to write prescriptions for Controlled Substance Schedule II drugs, but he was to continue monitoring and to send in all copies of any Controlled Substance Schedule II drug prescriptions written. Licensee failed to report any of this to the Bureau of Narcotics and Dangerous Drugs when applying for registration in the state of Missouri.

That such act or acts are a violation of K.S.A. 65-2836(b) as further defined in K.S.A. 65-2837(a)(3), in that there has been a repeated pattern and practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine. That Licensee has continued a practice of dishonesty in reporting to state and federal agencies and that such would constitute unprofessional conduct in violation of K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(17).

COUNT III

That during the period of time Licensee was licensed to practice osteopathic medicine in the state of Kansas, he authorized the purported therapeutic exchange of a controlled substance and authorized the entries in the medical record even though he had never examined the patient who was obtaining the drug and he could not show that said drug was obtained for a valid purpose. That such authorization was granted to employees who did not have proper qualifications for obtaining said controlled substances.

That the above conduct can be evidenced by the medical records of L.B. and K.B. and Hassig Drug prescription profiles which indicate that V.B., an employee of Licensee, obtained controlled substances for her family members and entered said information in the medical records. That V.B. was authorized by the Licensee to obtain said controlled substances and that the pharmacy was authorized to fill prescriptions called in by employees. Further, that employees S.M., J.C. and D.M. have

verified that employees were authorized by the respondent to call in prescriptions and that they were not seen as patients.

Further, that Licensee exchanged prescription drugs for illicit and illegal substances with G.T. That G.T. was a patient of Licensee and that he has admitted to trading marijuana for prescription drugs. This has been verified by employee, D.M.

That the above stated conduct would be considered unprofessional conduct in violation of K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(14), in that Licensee has aided and abetted the practice of the healing arts by an unlicensed, incompetent or impaired person; and as further defined in K.S.A. 65-2837(b)(15), in that Licensee allowed another person or organization to use the Licensee's license to practice the healing arts; and as further defined in K.S.A. 65-2837(b)(23), in that Licensee has prescribed, dispensed, administered or distributed a prescription drug or substance, including a controlled substance in an excessive, improper or inappropriate manner or quantity or not in the course of Licensee's professional practice; and in violation of K.S.A. 65-2836(p), in that Licensee has prescribed, sold, administered, distributed, or given a controlled substance to any person for other than medically accepted or lawful purposes.

COUNT IV

That on or around August 7, 1991, the Licensee entered into a Stipulation with Bethany Medical Center restricting his

privileges at that health care facility in which he was to obtain a consultation with the Department of Obstetrics and Gynecology or a member of the Family Practice Department with obstetrical and gynecological privileges for all obstetrical and gynecological patients he admitted into the hospital for a period of six months. That on or around September 3, 1991, his obstetrical and gynecological privileges were revoked and all other admissions in the area of family practice were placed on 100% review for a period of six months. That on or around February 27, 1992, after final appellate review by the trustees of the Board of Bethany Medical Center, the revocation and restrictions of September 3, 1991, were upheld. That on or around May 7, 1993, Licensee's admitting privileges and privileges to order tests were revoked by Bethany Medical Center. That said sanctions or action taken by Bethany were for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action of the Healing Arts Act, and, as such, is a violation of K.S.A. 65-2836(s).

COUNT V

(Confidential)

COUNT VI

That during the period of 1991, while Licensee was licensed to practice medicine and surgery in the state of Kansas, Licensee failed to maintain a policy of professional liability insurance as required by K.S.A. 40-3402 in that during the period of time he had no insurance and he was actively practicing medicine in the state of Kansas. Such act or acts constitute a violation of K.S.A. 65-2836(y) and/or 65-2836(z).

COUNT VII

That during the year 1991, Licensee failed to continually pay the annual premium surcharge as required by K.S.A. 40-3404 in violation of K.S.A. 65-2836(z) and that during the period he failed to pay, he was actively practicing medicine in the state of Kansas.

COUNT VIII

That while practicing at the Women's Community Health Center, 1837 East Cherry Street, Springfield, Missouri, 65802, Licensee wrote a prescription for Valium #50 in the name of the Women's Community Health Center. This was on prescription #006406 and was signed by Licensee on September 30, 1992. This prescription was taken to Smitty's Grocery Store Pharmacy, 218 South Glenstone Avenue, Springfield, Missouri. The pharmacist advised that he could not fill a prescription for Women's Community Health Center. Licensee scratched through the name, Women's Community Health Center, and replaced it with employee name, Leah Guymon. That said Valium #50 was used by the clinic for

preoperative purposes. The Valium #50 was utilized for a period of one to two weeks and was administered until taken by Miss Guymon. That in writing the prescription in the name of the clinic or one of the office staff was a violation of 21 CFR 1306.04(b), and as such is in violation of K.S.A. 65-2836(q), for violation of a federal law or regulation relating to a controlled substance.

COUNT IX

That Licensee prescribed, administered, and dispensed a controlled substance, i.e. a Valium #50 prescription, written on prescription #006406 on September 30, 1992, without benefit of having first obtained a Missouri Controlled Substance Registration and without a Federal Controlled Substance Registration for his Missouri practice. Said prescription was written on a prescription pad for Women's Community Health Center, 1837 East Cherry, Springfield, Missouri, 65802. The Drug Enforcement Agency number that was listed on the prescription was in fact that of Dr. Robert Christ, M.D. That such an act is in violation of 21 CFR 1301.21 and as such is a violation of K.S.A. 65-2836(q), in that Licensee has violated a federal law or regulation relating to a controlled substance.

COUNT X

That on or around August 1992, Licensee failed to provide adequate security for controlled substances under his authority and control which resulted in the loss of five viles of Sublimaze in violation of 19 CFR 30-1.030(2)(A). That said act or acts is in

violation of K.S.A. 65-2836(q) in that Licensee has violated a federal law or regulation relating to a controlled substance.

COUNT XI

That during the period of time Licensee was licensed to practice the Healing Arts in the state of Kansas he repeatedly failed to practice the Healing Arts with the level of care, skill and treatment which is recognized by reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances. This was evidenced by his treatment of patients S.E., M.M., T.R., T.C. and K.P., and all foregoing acts. Said conduct is considered a violation of the Healing Arts Act, specifically 65-2836(b) as further defined in K.S.A. 65-2837(b)(24).

COUNT XII

That effective June 12, 1993, Licensee's Kansas license was temporarily suspended in the state of Kansas. That since this suspension date, the Licensee has continued to maintain an office in violation of a lawful Board Order. Said act is in violation of K.S.A. 65-2836(k) and K.S.A. 65-2836(f) as it applies to K.S.A. 65-2867.

WHEREFORE, Petitioner prays the Board serve the Licensee with a copy of this Petition as provided by law. Petitioner further prays that upon evidence presented at the hearing, the Board make findings and conclusions of law that Licensee has committed acts in violation of the Kansas Healing Arts Act and the

Board take such disciplinary action, assess such civil fine and impose such costs against Licensee as authorized by law as it shall deem just and proper.

KANSAS STATE BOARD OF HEALING ARTS

Debra L. Billingsley

Debra L. Billingsley
Disciplinary Counsel
Kansas State Board of Healing Arts
235 S. Topeka Blvd.
Topeka, Kansas 66603

9/3/93
Date

CERTIFICATE OF SERVICE

I, Debra L. Billingsley, hereby certify that on the 3 day of September, 1993, a true and correct copy of the above and foregoing Third Amended Petition to Revoke, Suspend or Otherwise Limit Licensure in the United States mail, first class, postage prepaid, to the following:

Randall J. Forbes, Esq.
Presiding Officer
400 S.W. 8th Street, Ste. 409
P.O. Box 639
Topeka, Kansas 66601

Thomas E. Wright, Esq.
Wright, Henson, Somers & Sebelius
P.O. Box 3555
Topeka, Kansas 66601-3555

and the original was hand-delivered to:

Lawrence T. Buening, Jr.
Executive Director
Kansas State Board of Healing Arts
235 S. Topeka Blvd.
Topeka, Kansas 66603

Debra L. Billingsley
Debra L. Billingsley

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