FILED

AUG 0 7 2024

KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
	)	Docket No.: 23-HA00012
Trent J. Timson, DPM	)	
Kansas License No. 12-00301	)	

FINAL ORDER

On this 7th day of August 2024, the Kansas State Board of Healing Arts ("Board") enters the following Final Order for the above captioned case.

On or about March 19 and 20, 2024, Board member Thomas Estep M.D., ("Presiding Officer"), presided at the formal hearing in the above cited case. Disciplinary Panel #37 ("Petitioner") was represented by Matthew Gaus, Deputy Litigation Counsel, and Brad Taylor, Associate Litigation Counsel. Brad Taylor has since withdrawn as counsel of record. Trent J. Timson, D.P.M. ("Licensee") appeared in person and was represented by Kelli J. Stevens and Monica Doffing of Stevens Law, LLC.

Pursuant to the authority granted to Board by K.S.A. 65-2801 *et seq.* and K.S.A. 65-2001 *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 statements, testimony, and arguments of the parties, receiving evidence, and being otherwise advised in the premises, the Board makes the following findings, conclusions, and order:

I. Findings of Fact

1. On or about February 22, 2023, the Board filed a Qualified Protective Order ("QPO") that continues in effect for the duration of this matter.

2. The hearing in this matter was closed to the public pursuant to K.S.A. 77-523(f) for the presentation of confidential medical information under K.S.A. 65-2839a(d). Transcript Volume 1 ("TV1"), p. 5.

3. Licensee holds an active and current Kansas podiatry license (#12-00301) that was initially issued on August 15, 1998. Agency Record ("AR"), p. 4.

4. On or about November 2, 2022, a Petition was filed against Licensee alleging three violations:

> Count I: From 2018 to 2020, Licensee had a sexual relationship with an individual that was his patient ("Patient 1") and throughout the time of the sexual relationship continued to provide medical treatment to Patient 1 in violation of K.S.A. 65-2006(a)(2) engaging in unprofessional or dishonorable conduct and K.S.A. 65-2837(b)(16) engaging sexual misconduct or other improper sexual contact that exploits the licensee-patient relationship with a patient. AR, pp. 5-7.
>
> Count II: From 2018 to 2020, Licensee provided medical treatment to Patient 1 without keeping adequate medical records of such treatment in violation of K.S.A. 65-2006(a)(2) engaging in unprofessional or dishonorable conduct and K.S.A. 65-2837(b)(25) failure to keep written medical records that accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results and test results. AR, pp. 7-8.
>
> Count III: On or about December 4, 2006, Licensee entered into a Consent Order with the Board. From 2002 to 2005, Licensee had a sexual relationship with his patient ("2006 Patient CONFIDENTIAL :. Licensee was disciplined for sexual misconduct and failure to keep written medical records in violation of the same statutes listed above in Count I and Count II. Licensee's actions from 2018 to 2020 as listed in Counts I and II violate K.S.A. 65-2006(a)(6) as Licensee has willfully or repeatedly violated the podiatry act. AR, pp. 8-10.

Licensee's History of Discipline by the Board

2006 Consent Order

5. In 2006, Licensee entered into a Consent Order with the Board. Licensee engaged in a sexual relationship with a patient from 2002 to 2005 in the course of the physician-patient relationship and while the patient was his employee. Licensee violated: (1) K.S.A. 65-2006(a)(2), as set forth in K.S.A. 65-2837(b)(16), in that Licensee committed acts of sexual misconduct related to Licensee's professional practice; and (2) K.S.A. 65-2006(a)(2), as set forth in K.S.A. 65-2837(b)(25), and K.A.R. 100-24-1, in that Licensee failed to keep medical records which accurately describe the services rendered to the patient. The Board ordered discipline against Licensee including:

(1) Kansas DPM license suspended two weeks;

(2) Must successfully complete sexual boundary course;

(3) Must successfully complete education courses in record keeping and prescribing;

CONFIDENTIAL

(8) Kansas DPM license limitations:

(a) Licensee is prohibited from ordering, prescribing, dispensing or administering medications to any employee, family member, significant other, or any person Licensee has a personal relationship; and

(b) Licensee shall only prescribe, order, dispense or administer prescriptions with whom he has a physician-patient relationship and maintains a medical record.

Licensee completed the requirements of the 2006 Consent Order. AR, pp. 2469 and TVI, p. 130.

2014 Consent Order

6. In 2014, Licensee entered into a Consent Order with the Board for having engaged professional incompetency to the degree of ordinary negligence regarding the treatment/surgery of a patient. Licensee violated: (1) K.S.A. 65-2006(c), as further defined by K.S.A. 65-2837, to include K.S.A. 65-2837(b)(25) in that Licensee failed to keep medical records which accurately describe the services rendered to the patient. The Board ordered discipline against Licensee including:

(1) public censure; and

(2) Must successfully complete education courses in record keeping. AR, p. 2486.

Three Relationships Between Licensee and Patient 1

7. The agency record contains a thousand plus pages of text messages between Licensee and Patient 1 documenting the three relationships License and Patient 1 carried on simultaneously (podiatrist/patient, CONFIDENTIAL , and sexual) from June 2018 to October 2020. AR, pp. 909-2296.

Licensee's Physician-Patient Relationship with Patient 1

8. The agency record includes Licensee's medical records for Patient 1 that document six office appointments beginning April 19, 2018, and ending February 9, 2019. AR, pp. 202-208.

First Appointment – Initial Exam

9. On or about April 19, 2018, Licensee first met Patient 1 at an office appointment at his practice, CONFIDENTIAL for treatment of a ganglion cyst. Patient 1 was referred to Licensee by Patient 1's primary care physician. AR, p. 204 and TV1, pp. 22-23.

Second and Third Appointment – Surgery on Cyst

10. On or about May 3, 2018, Patient 1 returned for a second office appointment and a third appointment to surgically excise the ganglion cyst. Because Patient 1 is a registered nurse with experience in surgical wounds, the next follow up appointment would be in two weeks to remove the sutures. Licensee provided Patient 1 with his personal phone number and gave instructions to call or text if there were any post-operative issues. AR, p. 202, 205 and TV1, pp. 29 and 138-139.

Fourth Office Appointment – Suture Removal

11. On or about May 17, 2018, Patient 1 returned for a fourth office appointment to have the sutures from surgery removed with instructions to schedule a follow up appointment in one week. AR, p. 206.

12. On or about May 23, 2018, Patient 1 texted Licensee two photos of a possible infection on foot at the surgical site. Licensee prescribed antibiotics ("ABX") for Patient 1. The prescription was recorded in the medical records for Patient 1. AR, pp. 201, 207, 978, and 980-981.

Fifth Office Appointment – Post Operative Care

13. On or about May 25, 2018, Patient 1 returned for a fifth office appointment for post operative follow up on the excision of the ganglionic cyst. Patient 1 was released from Licensee's care and Licensee would Patient 1 back for follow up on *pro re nata* (PRN) basis. AR, p. 207.

Sixth Office Appointment – Second Surgery on Cyst

14. On or about February 7, 2019, Licensee surgically excised a ganglion cyst on Patient 1's foot. Instructions provided for follow up appointment in one week. AR, pp. 203, 208.

Licensee's Undocumented Medical Treatment of Patient 1

15. Licensee examined and provided medical treatment to Patient 1 on numerous occasions from May 2018 to October 2020 but did not enter said examinations and treatments into Patient 1's medical records – see citations below:

(a) On or about May 5, 2018, Patient 1 texted Licensee requesting a prescription for pain medication. Licensee did not check K-TRACS regarding Patient 1 but went ahead and wrote a prescription for pain medication for Patient 1. Licensee asked Patient 1 to stop at his residence to pick up the prescription. Licensee did not record this prescription in Patient 1's medical records. AR, pp. 2502-2504 and TV1, pp. 143-145, 148-149.

(b) On or about June 9, 2018, Patient 1 texted Licensee a photo of a possible infection on foot at the surgical site and texted still on antibiotics, but almost finished. Licensee directed Patient 1 to stay on antibiotics and that he would look at the foot in his office on the following Wednesday morning or Friday. Licensee testified that he probably looked at Patient 1's foot but there is no medical record of the exam. AR, pp. 1029-30 and TV1, pp. 155-156.

(c). On or about July 13, 2018, Patient 1 texted Licensee a photo and question regarding foot pain. Licensee testified that he did not recall whether he examined the foot or gave Patient 1 any medical advice. There is no medical record of the exam or treatment. AR, pp. 1127-1128 and TV2, pp. 202-203.

(d) On or about February 11, 2019, Patient 1 texted Licensee to thank him for the prescription for Norco. There is no medical record of this prescription. AR, pp. 1391 and TV2, pp. 212-213.

(e) On or about April 11, 2019, two months after the second cyst surgery, Patient 1 texted Licensee asking how long the tight, pulling feeling is expected to last on the incision scar on Patient 1's foot. Licensee testified that he speculated he discussed the foot scar with Patient 1 at work but there was no medical record of the discussion. Licensee testified that any care given Patient 1 was as indicated and appropriate. Licensee admitted that it was his mistake that there was no medical record and that "apparently and obvious now" he missed documenting medical care provided to Patient 1 that may have been on short requests, middle of the day requests, after hours requests, or via text. AR, p. 1467, TV1, pp. 60-61 and TV2, pp. 213-215.

(f) On or about December 17, 2019, Patient 1 sent a text to Licensee thanking Licensee for the Kenalog injection. There is no medical record of this injection. AR, p. 1724 and TV1, pp. 62-63.

(g) On or about August 27, 2020, Patient 1 texted Licensee "You are going to have to come up with a new plan for my foot" in response to a national shortage of dehydrated alcohol. Licensee testified that he thought options were discussed regarding treatment plans, but that if discussions were during office hours in between patients the information did not make it into Patient 1's

medical records. AR, p. 2091, TV1, pp. 65-67 and TV2, pp. 219-223.

(h) On or about October 19, 2020, Patient 1 testified (1) that this was the date Licensee administered the final Kenalog injection to Patient 1; and (2) CONFIDENTIAL

CONFIDENTIAL There is no medical record of this injection. TV1, pp. 66-67 and TV2, p. 224

Licensee's CONFIDENTIAL *Relationship with Patient 1*

CONFIDENTIAL

Licensee's Sexual Relationship with Patient 1

19. Beginning June 15 or 20, 2018 and ending October 19, 2020, Licensee had a two-year sexual relationship with Patient 1. Licensee and Patient 1 had sexual contact once in Licensee's Morton shop building, several times in Licensee's vehicle, and at least one or two times per week in numerous areas of Licensee's office from June 2018 through October 2020. TV1, pp. 47-48, 157 and TV2, pp. 195-199.

20. On or about October 19, 2020, Licensee's sexual relationship with Patient 1 ended when Licensee's spouse found out about Licensee's sexual relationship with Patient 1. AR, pp. 2412-2425, TV1, pp. 68-70, and TV2, pp. 224-229.

Licensee's Testimony in Response to Alleged Violations

21. Licensee testified he opened his practice in McPherson in 1998, sees 30-35 patients per day, has an active patient population of 7,000 and currently may be the only podiatrist in McPherson County, Kansas. TV1, pp. 107-108 and TV2, pp. 299-302.

22. In response to the question why he shouldn't lose his podiatry license, Licensee testified that (1) there was personal damage to everyone involved (including Patient 1 and family); (2) it has been a long painful journey trying to put lives back together, trying to confess, repent, reform; (3) he was appalled at who he was and he's not that way anymore; (4) he is the only provider in McPherson and people, patients, employees, and his family depend on him; (5) podiatry is his only career; (6) he has put everything into helping, serving, being available and treating people; and (7) taking away his license takes that life away from him and leaves his patient base with poor or no options – all based on the poor judgement and bad decisions of two people that should have known better. TV2, pp. 307-308.

23. In response to a question from the Presiding Officer regarding what he has learned from the current disciplinary proceeding, Licensee testified: (1) to be on guard and remove yourself from any potential problematic situation; (2) if think you can handle the situation you can't; (3) to be open and honest with your spouse about any potential situations and your spouse will become your ally and likely provide an immediate solution to the problem; (4) having a

relationship with God is crucial; and (5) to not overwork himself, things suffer when you are exhausted and you make bad decisions. TV2, pp. 323-326.

24. In response to a question from the Presiding Officer regarding how does the Board know this will never happen again, Licensee testified: (1) he will never forgive himself for this and he has his guilt; (2) his spouse will always be someone who checks up on him; (3) all of his best friends are part of this and are accountable to both him and his spouse. TV2, pp. 326-327.

II. Statement of Law

The Petition in this matter alleges three violations:

> Count I: From 2018 to 2020, Licensee had a sexual relationship with an individual that was his patient ("Patient 1") and throughout the time of the sexual relationship continued to provide medical treatment to Patient 1 in violation of K.S.A. 65-2006(a)(2) engaging in unprofessional or dishonorable conduct and K.S.A. 65-2837(b)(16) engaging sexual misconduct or other improper sexual contact that exploits the licensee-patient relationship with a patient.
>
> Count II: From 2018 to 2020, Licensee provided medical treatment to Patient 1 without keeping adequate medical records of such treatment in violation of K.S.A. 65-2006(a)(2) engaging in unprofessional or dishonorable conduct and K.S.A. 65-2837(b)(25) failure to keep written medical records that accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results and test results.
>
> Count III: On or about December 4, 2006, Licensee entered into a Consent Order with the Board. From 2002 to 2005, Licensee had a sexual relationship with his patient ("2006 Patient") CONFIDENTIAL Licensee was disciplined for sexual misconduct and failure to keep written medical records in violation of the same statutes listed above in Count I and Count II. Licensee's actions from 2018 to 2020 as listed in Counts I and II violate K.S.A. 65-2006(a)(6) as Licensee has willfully or repeatedly violated the podiatry act.

The Board's Guidelines for the Imposition of Disciplinary Sanctions ("Guidelines") re: sexual misconduct provides the following:

"These guidelines do not have the force and effect of law, and they do not create binding precedent. By publishing this information, the Board does not limit itself to any form of disciplinary order and it may consider its entire range of authority. The Board may depart from this policy as it determines appropriate and without giving notice. To be clear, the Board's sanctioning authority is defined and limited exclusively by the applicable statutes, regulations, and settled Kansas case law. The information contained herein is provided to give all stakeholders insight into the considerations that the Board commonly applies to its analysis pursuant to applicable law."

Guidelines Section 4 – Sexual Misconduct

Statute commonly applied: K.S.A. 65-2836(b)(16) (Sexual abuse, misconduct or exploitation related to practice).

CONFIDENTIAL

The professional boundary required between physicians and patients is based upon the fiduciary relationship in which the patient entrusts his or her welfare to the physician and reflects the physician's respect for the patient. [footnote 1]. That boundary, once crossed, severely impacts the patient's wellbeing on an individual basis, and causes distrust to other professional relationships in general.

Sexual misconduct is a harmful example of a boundary violation, occurring in multiple contexts and involving a wide range of behaviors. Sexual misconduct includes sexual relations with a patient, sexual impropriety towards a patient, sexual conduct towards patients, sexual harassment in the workplace, sexual conduct between supervisors and subordinates, the commission of sexual assault, and any sexual crimes.

Any sexual conduct towards current patients is considered misconduct even if otherwise consensual. Sexual conduct towards former patients is misconduct when the licensee exploits knowledge or information obtained from the previous physician-patient relationship. Sexual or romantic relationships between physicians and their patients may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's care, and may reflect a general lack of ability/willingness to maintain clinical objectivity.

Sexual misconduct between a physician and a patient is never diagnostic or therapeutic. Further, romantic or intimate relationships may impede the physician's ability to confront the patient about noncompliance with treatment or to bring up unpleasant medical information. Physicians must set aside their own needs or interests in the service of addressing the patient's needs. The physician-patient relationship depends upon the ability of patients to have absolute confidence and trust in the physician, and a patient has the right to believe that a physician is dedicated solely to the patient's best interests.

This category of misconduct is commonly deemed serious because in addition to the potential for patient harm, such misconduct erodes the public's trust and confidence in the health care profession and damages the credibility of the healing arts professions. Upon a finding of sexual misconduct, the Board will take appropriate measures to impose a sanction and/or monitoring requirements that address the severity of the misconduct and the potential risk to patients.

[Footnote 1] Glen O. Gabbard, M.D. and Carol Nadelson, M.D., Professional Boundaries in the Physician-Patient Relationship, Journal of the American Medical Association, May 10, 1995; Vol. 273, No. 18, pg. 1445.

The findings of fact listed above are largely undisputed on the issues that (1) Licensee failed to keep medical records that documented treatment Licensee provided to Patient 1; and (2) Licensee and Patient 1 engaged in a sexual relationship while Patient 1 was Licensee's patient CONFIDENTIAL.

The Presiding Officer acknowledges there may be differences and debate in determining the consequences of the conduct of Licensee. The Board has considered and determined similar issues in the past. The Presiding Officer believes the most complete analysis and decision in this matter will result not from the Presiding Officer, but from the full Board reviewing (1) the findings of fact; and (2) agency record and determining the conclusions of law and disciplinary sanctions.

III. Order

The Presiding Officer **STAYS** the effectiveness of this Final Order until such date as the full Board rules on the conclusions of law and disciplinary sanctions in this matter. K.S.A. 77-529.

The Presiding Officer requests **THE FULL BOARD REVIEW** the findings of fact and agency record and **DETERMINE** the conclusions of law and disciplinary sanctions in this matter.

IT IS THEREFORE, ORDERED.

KANSAS STATE BOARD OF HEALING ARTS

/s/ Warran Wiebe, #13572 for
Thomas Estep, M.D.
Presiding Officer

NOTICE OF 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, Licensee 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 Susan Gile, Executive Director, at 800 SW Jackson, Lower Level-Suite A, Topeka, KS 66612.

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing Final Order was served, by depositing the same in the United States mail, postage prepaid, and emailed on this 7th day of August 2024, addressed to:

Trent J. Timson, DPM
CONFIDENTIAL

Licensee

Kelli Stevens
Stevens Law, LLC
6750 Antioch Rd., Suite 215
Overland Park, KS 66204
kstevens@stevenslawllc.com
Attorney for Licensee

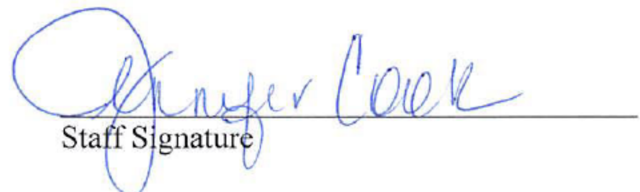
And copies were hand-delivered to:

Matthew Gaus, Deputy Litigation Counsel
Kansas State Board of Healing Arts
800 SW Jackson Lower Level, Ste A
Topeka, KS 66612
Matthew.gaus@ks.gov

And a copy was given to:

Thomas Estep, M.D.
KSBHA Presiding Officer
Kansas State Board of Healing Arts

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



Staff Signature