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IN AND BEFORE THE OKLAHOMA STATE BOARD
OF MEDICAL LICENSURE AND SUPERVISION
STATE OF OKLAHOMA

FILED

MAY 14 1999

STATE OF OKLAHOMA, ex rel.,)
OKLAHOMA STATE BOARD OF)
MEDICAL LICENSURE AND)
SUPERVISION,)
)
Plaintiff,)
)
vs.)
)
JEFFREY H. SCHIMANDLE, M.D.,)
LICENSE NO. 19233)
)
)
Defendant.)

OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE & SUPERVISION

CASE NO. 99-01-2062

COMPLAINT

COMES NOW the plaintiff, the State of Oklahoma ex rel. the Oklahoma State Board of Medical Licensure and Supervision (the "Board"), by and through its attorney, Elizabeth A. Scott, Assistant Attorney General, and for its Complaint against the Defendant, Jeffrey H. Schimandle, M.D., alleges and states as follows:

1. The Board is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physicians and surgeons in the State of Oklahoma pursuant to 59 Okla. Stat. §§ 480 *et seq.*
2. Defendant, Jeffrey H. Schimandle, holds Oklahoma license no. 19233
3. On June 21, 1988, Defendant's license in the State of Maryland was suspended due to inappropriate handling of Demerol.
4. On August 22, 1988, Defendant entered into a three (3) month consent order whereby he was allowed to continue practicing medicine. During that period of time, Defendant had a positive urine drug screen for Demerol.
5. On November 16, 1988, Defendant's license in the State of Maryland was again suspended due to the positive drug screen.
6. On February 27, 1989, Defendant entered into a three (3) year consent order with the Maryland Medical Board whereby he agreed to random drug screens.

7. In 1992, Defendant moved to Georgia and on November 5, 1992, he entered into a consent order with the Georgia Medical Board wherein he was required to attend AA meetings, outpatient groups and to submit to random drug screens. Under this consent order, he was issued a one (1) year license.

8. On December 15, 1992, the Maryland Medical Board terminated Defendant's probation and his license was reinstated without restriction.

9. In or around November 1993, the Georgia Medical Board elected not to renew Defendant's one (1) year license due to the Defendant's violations of his consent order with the Georgia Medical Board.

10. Defendant subsequently obtained an unrestricted license in the State of Oklahoma.

11. On August 25, 1998, DIW, R.N., was working with Defendant at Hillcrest Health Center in Oklahoma City, Oklahoma. DIW observed Defendant fill a syringe with Demerol that he and another nurse had just removed from the med room at the hospital. DIW then observed Defendant take the syringe into which he had put the Demerol into his right front pocket, and then with his thumb, he brought out another syringe, leaving the syringe filled with Demerol in his right front pocket. He and the nurse then went to the patient's room with the syringe containing the unknown substance.

12. On November 9, 1998, DCW, R.N., was working with Defendant at Hillcrest Health Center when he requested Demerol 150mg for patient CTW. DCW, along with a witness, PPW, removed the Demerol from the Pysix and gave two (2) pre-filled syringes to Defendant, who drew the contents out of the two (2) syringes into a 3cc syringe. DCW discarded the empty syringes into the sharps container and followed Defendant to the patient's room. Prior to entering the patient's room, DCW noticed the plunger of another syringe in Defendant's right front pocket.

13. Upon entering the patient's room, Defendant placed his right hand, which was holding the Demerol filled syringe, into his right front pocket, then removed his hand. Defendant then reached back into his right front pocket and handed a syringe believed to contain Demerol to DCW to administer to the patient. Defendant then left the room. DCW did not administer the contents of the syringe given to her by Defendant to the patient. DCW waited approximately one (1) minute and then with PPW accompanying her, put the syringe which Defendant had given her to give to the patient in the locked drawer of a medicine cart.

14. DCW reported her actions to BTW, the duty nurse, who took the syringe from the locked medicine cart to the St. Anthony toxicology lab for analysis of the contents. BTW also submitted to the St. Anthony toxicology lab a control syringe containing the contents of two (2) tubes of Demerol 75mg.

15. On November 13, 1998, the St. Anthony toxicology lab reported that the control syringe contained the expected amount of Demerol but that the syringe given by the Defendant to DCW to be administered to the patient contained no Demerol.

16. On November 16, 1998, Hillcrest Health Center suspended Defendant due to repeated inappropriate and unprofessional handling and administration of controlled dangerous substances.

17. On November 20, 1998, St. Anthony Hospital suspended Defendant due to repeated medically questionable handling and administration of Demerol.

18. On November 20, 1998, after learning that St. Anthony Hospital had suspended him, Defendant voluntarily submitted to a drug test.

19. On November 24, 1998, the St. Anthony toxicology lab reported positive levels of Demerol and Dilantin for Defendant's November 20, 1998 drug test.

20. Defendant is in violation of the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act, 59 O.S. §509, paragraphs 5, 9 and 16 as follows:

5. Habitual intemperance or the habitual use of habit-forming drugs;
9. Dishonorable or immoral conduct which is likely to deceive, defraud, or harm the public;
16. The inability to practice medicine with reasonable skill and safety to patients by reason of age, illness, drunkenness, excessive use of drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition.

21. Defendant is also in violation of the unprofessional conduct provisions of the Rules and Regulations of the Oklahoma State Board of Medical Licensure and Supervision, as codified in Title 435, Chapter 10, Subchapter 7, Paragraph 4, Subparagraphs 3, 11, 15, 18, 39 and 40 of the Oklahoma Administrative Code as follows:

- (3) The habitual or excessive use of any drug which impairs the ability to practice medicine with reasonable skill and safety to the patient.

Conduct likely to deceive, defraud, or harm the public.

Gross or repeated negligence in the practice of medicine and surgery.

Practice or other behavior that demonstrates an incapacity or incompetence to practice medicine and surgery.

- (39) Violation of any provisions of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board.
- (40) The inability to practice medicine and surgery with reasonable skill and safety to patients by reason of age, illness, drunkenness, excessive use of drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition.

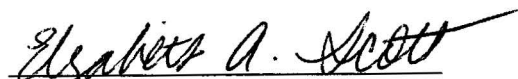
22. The Defendant is perpetuating significant harm to the public health, safety and welfare by committing the acts and/or omissions set forth in the above allegations.

23. These allegations raise serious concerns about Defendant's ability to practice as a physician and surgeon in the State of Oklahoma with reasonable skill and safety.

WHEREFORE, plaintiff requests that the Board conduct a hearing, and upon proof of the allegations contained herein, impose such disciplinary action as authorized by law, up to and including suspension or revocation, the assessment of costs and fees incurred in this action, and any other appropriate action with respect to Defendant's license to practice as a physician and surgeon in the State of Oklahoma.

Dated this 14~~th~~ day of May, 1999 at 9:45 a.m.

Respectfully submitted,



Elizabeth A. Scott (OBA #12470)

Assistant Attorney General

5104 N. Francis, Suite C

Oklahoma City, OK 73154

Attorney for State ex rel.

Oklahoma Board of Medical Licensure and
Supervision