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



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| **STATE OF OKLAHOMA EX REL. THE OKLAHOMA BOARD OF MEDICAL LICENSURE AND SUPERVISION,** | ) | |
| **Plaintiff,** | ) | |
| **v.** | ) | **Case No. 08-07-3548** |
| **ROBERT L KALE, M.D., LICENSE NO. 24797** | ) | |
| **Defendant.** | ) | |

# FINAL ORDER OF REVOCATION

This cause came on for hearing before the Oklahoma State Board of Medical Licensure and Supervision (the "Board") on March 26, 2009, at the office of the Board, 5104 N. Francis, Suite C, Oklahoma City, Oklahoma, pursuant to notice given as required by law and the rules of the Board.

Elizabeth A. Scott, Assistant Attorney General, appeared for the plaintiff and defendant appeared through counsel, Sam Sexton, III.

The Board *en banc* after hearing arguments of counsel, reviewing the exhibits admitted and the sworn testimony of witnesses, and being fully advised in the premises, found that there is clear and convincing evidence to support the following Findings of Fact, Conclusions of Law and Orders:

## *Findings of Fact*

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.* The Board has jurisdiction over this matter, and notice has been given in all respects in accordance with law and the rules of the Board.

2. Defendant, Robert L. Kale , M.D, holds Oklahoma medical license no. 24797 and practices in Roland, Oklahoma.

## SEXUAL MISCONDUCT-PATIENT TNW

3. Beginning in or around December 2007 and continuing through at least August 7, 2008, Patient TNW was a patient of Defendant. Beginning with Patient TNW's first visit with Defendant, Patient TNW claimed that he engaged in physical conduct with Patient TNW which was sexual in nature. During this visit, Patient TNW claimed that Defendant pinched and twisted her nipples and told her he was just teasing her. During later visits, Plaintiff claimed that Defendant made numerous sexually inappropriate remarks to her. Defendant engaged in this sexually explicit and demeaning behavior at the same time he was maintaining a doctor-patient relationship and prescribing controlled dangerous substances and other dangerous drugs to this patient.

4. On or about August 7, 2008, Patient went to Defendant's office for an appointment scheduled for 5:00 p.m. During this appointment, Defendant gave Patient TNW three (3) prescriptions: 360 Actiq lozenges 800 mcg, a Schedule II controlled dangerous substance, 60 Opana, a Schedule II controlled dangerous substance, and 60 Trazadone. During this same visit, Patient TNW advised Defendant that she was having a hard time affording her appointments with Defendant. Defendant then asked Patient TNW if she would have sex with him in exchange for her appointment with him. Patient TNW told Defendant she would not have sex with him, but Defendant persisted in asking Patient TNW to have sex with him, in that he told her it would be a "legitimate business transaction" for her to trade "sex" for an "appointment". Defendant engaged in this sexually explicit and demeaning behavior at the same time he was maintaining a doctor-patient relationship and prescribing controlled dangerous substances and other medications to this patient.

## PRESCRIBING VIOLATIONS

5. From April 29, 2008 until May 13, 2008, Defendant wrote or authorized six (6) prescriptions for controlled dangerous drugs to Patient TRW for alleged wrist, arm and back pain. These prescriptions include six (6) prescriptions for Morphine, Oxycodone and Opana Oxymorphine, Schedule II controlled dangerous drugs, for a total of 1,590 dosage units, for an average of **113.57 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, specifically that he did not examine the patient's back, lower or upper extremities and did not perform any neurological examination, that he did not order appropriate tests, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart reflects that on the patient's first visit to Defendant, Defendant increased the patient's opioid exposure by **1000%** from the limited amount of Lortab the patient was taking when he first came to Defendant.

6. From May 9, 2006 until January 22, 2008, Defendant wrote or authorized forty-one (41) prescriptions for controlled dangerous drugs to Patient EWW for alleged depression,

joint paint and rheumatoid arthritis. These prescriptions include twenty-three (23) prescriptions for Methadone, Oxycontin, Oxycodone and Duragesic Patch, Schedule II controlled dangerous drugs, for a total of 8,510 dosage units, four (4) prescriptions for Hydrocodone 10 mg., a Schedule III controlled dangerous drug, for 1,440 dosage units, and fourteen (14) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 1,460 dosage units, for a total of **11,410 total dosage units** at an average of **58.21 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, specifically that he did not examine the patient's neck, shoulder or joints that he did not obtain a psychiatric evaluation for the patient's depression, that he did not order appropriate tests, that he did not perform any drug screens, that he did not obtain an EKG while prescribing Methadone, that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. The patient complained of depression, but Defendant treated the patient with a mood depressant. On the patient's first visit, Defendant increased her opioid exposure by **250%** from the limited amount of Lortab she was taking.

7. From April 9, 2007 until July 8, 2008, Defendant wrote or authorized forty (40) prescriptions for controlled dangerous drugs to Patient DGW for alleged back pain, depression, insomnia, stump pain and optic nerve injury. These prescriptions include twenty-eight (28) prescriptions for Methadone and Morphine, Schedule II controlled dangerous drugs, for a total of 27,660 dosage units, and twelve (12) prescriptions for Fioricet, a Schedule III controlled dangerous drug, for 2,160 dosage units, for a total of **29,820 total dosage units** for an average of **80.16 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not obtain an EKG while prescribing Methadone, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart on this patient reflects that on the initial visit, the patient advised Defendant that he was taking 300 mg. of morphine per day. The patient provided no documentation of the medication he was allegedly taking. However, Defendant immediately increased the patient's opioids to 320 mg. Methadone per day, 600 mg. MSContin per day and 360 mg. Oxycodone per day. Throughout the patient's treatment, even though the patient reported that he was doing well and his functions were improving, Defendant continued to increase the patient's opioids. Additionally, Defendant's physical examinations of the patient did not address the patient's back and stump pain.

8. From September 15, 2006 until July 23, 2008, Defendant wrote or authorized forty-seven (47) prescriptions for controlled dangerous drugs to Patient SKW for alleged headaches and depression. These prescriptions include thirty (30) prescriptions for Morphine, Oxycodone and Methadone, Schedule II controlled dangerous drug, for 18,750 dosage units, fifteen (15) prescriptions for Fiorinal/Codeine and Fioricet/Codeine, Schedule III controlled dangerous drugs, for 2,340 dosage units, and two (2) prescriptions for Promethazine, a Schedule V controlled dangerous drug, for 200 dosage units, for a total of **21, 290 total dosage units** for

an average of **56.03 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, that he failed to obtain a full history of the patient, that he did not order appropriate tests including any neurology evaluation, that he did not obtain an EKG while prescribing Methadone, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. At one point, the patient noted that he was doing well, yet Defendant nevertheless increased the patient's opioids.

9. From November 8, 2006 until July 8, 2008, Defendant wrote or authorized thirty-seven (37) prescriptions for controlled dangerous drugs to Patient CGW for alleged joint pain, back, leg and knee pain, insomnia and depression. These prescriptions include twenty-seven (27) prescriptions for Morphine, Oxycodone and Methadone, Schedule II controlled dangerous drugs, for 17,900 dosage units, thirty-two (32) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 3337 dosage units, and sixty (60) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 4710 dosage units, for a total of **19,700 total dosage units** for an average of **52.96 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, specifically that he never performed a physical examination of her back, knee or leg, that he did not obtain an EKG while prescribing Methadone, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. On the patient's first visit to Defendant, he increased her opioid exposure over 250%. During the patient's treatment, she advised Defendant that she was obtaining pain relief and her functioning was increasing, yet Defendant continued to increase her opioid use.

10. From July 9, 2007 until July 14, 2008, Defendant wrote or authorized seventy-six (76) prescriptions for controlled dangerous drugs to Patient NGW for alleged back pain, leg pain, insomnia, depression and headaches. These prescriptions include twenty-eight (28) prescriptions for Oxycodone, Methadone and Opana, Schedule II controlled dangerous drugs, for 11,385 dosage units, thirteen (13) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 4,680 dosage units, and thirty-five (35) prescriptions for Soma, Triazolam and Diazepam, Schedule IV controlled dangerous drugs, for 3,240 dosage units, for a total of **19,305 total dosage units** for an average of **52.04 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not obtain an EKG while prescribing Methadone, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. During the patient's treatment, she advised Defendant that she was obtaining pain relief and her functioning was increasing, yet Defendant continued to increase her opioid use. Although the patient complained of back and leg pain, Defendant did not address these complaints in his physical examinations.

11. From July 26, 2007 until July 23, 2008, Defendant wrote or authorized forty-three (43) prescriptions for controlled dangerous drugs to Patient JCW for alleged anxiety and chronic pain syndrome. These prescriptions include twenty-eight (28) prescriptions for Oxycodone and Methadone, Schedule II controlled dangerous drugs, for 15,260 dosage units, one (1) prescription for Testosterone, a Schedule III controlled dangerous drug, for 10 dosage units, and forty-three (43) prescription for Diazepam, a Schedule IV controlled dangerous drug, for a total of **18,630 total dosage units** for an average of **51.32 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not obtain an EKG while prescribing Methadone, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

12. From July 16, 2007 until July 14, 2008, Defendant wrote or authorized thirty-seven (37) prescriptions for controlled dangerous drugs to Patient PFW for alleged back pain, depression, insomnia, joint pain in his hand, and post-traumatic stress disorder. These prescriptions include twenty-eight (28) prescriptions for Oxycodone, Methadone and Dilaudid, Schedule II controlled dangerous drugs, for a total **18,840 total dosage units**, for an average of **51.76 dosage units per day of controlled dangerous drugs**. Defendant's chart reflects that the patient had a history of substance abuse and admitted recreational drug use during his monthly visits to Defendant. Defendant's chart on this patient reveals that he failed to perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not order any drug screens after the patient's initial admission of use of an illegal drug, that he did not obtain an EKG while prescribing Methadone, that he did not order any psychological evaluations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. On numerous visits, Defendant noted that the patient was "doing well" but then he significantly added or increased the patient's dosages of Methadone, Dilaudid and Oxycodone without any legitimate medical reason.

13. From February 28, 2008 until July 23, 2008, Defendant wrote or authorized twenty-nine (29) prescriptions for controlled dangerous drugs to Patient TAW for alleged knee and elbow pain, insomnia and depression. These prescriptions included twenty-one (21) prescriptions for Oxycodone and Methadone, Schedule II controlled dangerous drugs, for 5700 dosage units, and eight (8) prescriptions for Hydrocodone and Testosterone Cream, Schedule III controlled dangerous drugs, for 2,160 dosage units, for a total of **7,860 total dosage units**, for an average of **47.07 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not obtain an EKG while prescribing Methadone, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. On at least one (1)

visit, Defendant noted that that the patient had no complaints, but then he significantly increased the patient's dosages of Oxycodone and Methadone.

14. Defendant's treatment of the following other patients was similar to those set forth in paragraphs 5 through 13 as follows:

a. Patient JLW: average of **43.61 dosage units per day** of controlled dangerous drugs.
b. Patient BNW: average of **40.36 dosage units per day** of controlled dangerous drugs.
c. Patient AMW: average of **39.80 dosage units per day** of controlled dangerous drugs.
d. Patient MWW: average of **37.11 dosage units per day** of controlled dangerous drugs.
e. Patient ALW: average of **35.96 dosage units per day** of controlled dangerous drugs.
f. Patient LHW: average of **33.24 dosage units per day** of controlled dangerous drugs.
g. Patient SHW: average of **30.54 dosage units per day** of controlled dangerous drugs.
h. Patient KWW: average of **27.02 dosage units per day** of controlled dangerous drugs.
i. Patient GTW: average of **26.90 dosage units per day** of controlled dangerous drugs.

15. With respect to each of these patients, as well as the patients set forth in paragraphs 5 through 13 above, Defendant's physical examination documentation consists of a computer generated summary which is virtually identical to the physical examination description from the previous visit and the physical examination description from other patients. In numerous instances, patients noted no problems or complaints, yet Defendant significantly increased the patients' opioid dosages to extremely high and dangerous levels. Defendant rarely performed drug tests on his patients, including those who admitted to him that they abused drugs. Defendant likewise never obtained an EKG on patients for whom he prescribed Methadone. On only one of these instances in paragraph 14 did Defendant timely obtain any records from previous physicians and on only one instance did he obtain a consultation from another physician.

16. Based on the allegations stated above, Defendant is guilty of unprofessional conduct as follows:

A. Engaged in dishonorable or immoral conduct which is likely to deceive, defraud or harm the public in violation of 59 O.S. § 509 (8) and OAC 435:10-7-4 (11).

B. Engaged in physical conduct with a patient which is sexual in nature, or in any verbal behavior which is seductive or sexually demeaning to a patient in violation of 59 O.S. §509 (17).

C. Failed to maintain an office record for each patient which accurately reflects the evaluation, treatment, and medical necessity of treatment of the patient in violation of 59 O.S. §509 (18) and OAC 435:10-7-4(41).

D. Prescribed or administered a drug or treatment without sufficient examination and the establishment of a valid physician patient relationship in violation of 59 O.S. §509 (12).

E. Prescribed, dispensed or administered a controlled substance or narcotic drugs in excess of the amount considered good medical practice, or prescribed, dispensed or administered controlled substances or narcotic drugs without medical need in accordance with published standards in violation of 59 O.S. 509(16).

F. Engaged in the indiscriminate or excessive prescribing, dispensing or administering of controlled or narcotic drugs in violation of OAC 435:10-7-4(1).

G. Prescribed, dispensed or administered controlled substances or narcotic drugs in excess of the amount considered good medical practice or prescribed, dispensed or administered controlled substances or narcotic drugs without medical need in accordance with published standard in violation of OAC 435:10-7-4(2) and (6).

## *Conclusions of Law*

1. The Board has jurisdiction and authority over the Defendant and subject matter herein pursuant to the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act (the "Act") and its applicable regulations. The Board is authorized to enforce the Act as necessary to protect the public health, safety and welfare.

2. Defendant is guilty of unprofessional conduct in that he:

A. Engaged in dishonorable or immoral conduct which is likely to deceive, defraud or harm the public in violation of 59 O.S. § 509 (8) and OAC 435:10-7-4 (11).

B. Engaged in physical conduct with a patient which is sexual in nature, or in any verbal behavior which is seductive or sexually demeaning to a patient in violation of 59 O.S. §509 (17).

C. Failed to maintain an office record for each patient which accurately reflects the evaluation, treatment, and medical necessity of treatment of the patient in violation of 59 O.S. §509 (18) and OAC 435:10-7-4(41).

D. Prescribed or administered a drug or treatment without sufficient examination and the establishment of a valid physician patient relationship in violation of 59 O.S. §509 (12).

E. Prescribed, dispensed or administered a controlled substance or narcotic drugs in excess of the amount considered good medical practice, or prescribed, dispensed or administered controlled substances or narcotic drugs without medical need in accordance with published standards in violation of 59 O.S. 509(16).

F. Engaged in the indiscriminate or excessive prescribing, dispensing or administering of controlled or narcotic drugs in violation of OAC 435:10-7-4(1).

G. Prescribed, dispensed or administered controlled substances or narcotic drugs in excess of the amount considered good medical practice or prescribed, dispensed or administered controlled substances or narcotic drugs without medical need in accordance with published standard in violation of OAC 435:10-7-4(2) and (6).

3. The Board further found that the Defendant's license should be **REVOKED** based upon any or all of the violations of the unprofessional conduct provisions of 59 O.S. §509 (8), (12), (16), (17) and (18) and OAC 435:10-7-4 (1), (2), (6), (11) and (41).

***Order***

IT IS THEREFORE ORDERED by the Oklahoma State Board of Medical Licensure and Supervision as follows:

1. The license of Defendant, Robert L. Kale, M.D., Oklahoma medical license no. 24797, is hereby **REVOKED** as of the date of this hearing, March 26, 2009.

2. Promptly upon receipt of an invoice, Defendant shall pay all costs of this action authorized by law, including without limitation, legal fees and costs, investigation costs, staff time, salary and travel expenses, witness fees and attorney's fees.

Dated this 31st day of March, 2009.

Gerald C. Zumwalt, M.D., Secretary
Oklahoma State Board of Medical
Licensure and Supervision

**CERTIFICATE OF SERVICE**

I certify that on the 31 day of March, 2009, I mailed, via first class mail, postage prepaid, a true and correct copy of this Order to Sam Sexton, III, McCutchen, Sexton, Strunks Law Firm, P.O. Box 1971, Fort Smith, AR 72902-1971 and to Robert Kale, 107290 South 4806 Road, Muldrow, OK 74948.

Janet Swindle