BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
	)	
JOHN R. TOTH, M.D.	)	Docket No. 05-HA-79
Kansas License No. 04-18310	)	
	)	
	)	

EMERGENCY ORDER

NOW ON THIS Eleventh Day of June 2005, comes before the Board a motion for an *ex parte* emergency order. Kelli J. Benintendi, Associate Counsel, appears for the Board. There are no other appearances.

Board members Nance Welsh, M.D., Ms. Sue Ice, Vinton Arnett, D.C., and Ronald Whitmer, D.O. participated in the investigative and prosecutorial Board functions, and therefore are recused.

Having the agency record before it, the Board 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 Board may issue an order without notice and hearing, and may temporarily limit or suspend a license if the Board finds an imminent harm to the public health and safety.

2. The petition and motion for an emergency order in the present case alleges that Respondent John R. Toth, M.D., a licensee of the Board, demonstrated professional incompetency by practicing below the standard of care to a degree constituting gross negligence when treating two separate patients. The motion is accompanied by six affidavits from physicians who had knowledge regarding at least a portion of Respondent's care of those two patients.

3. The Board may take disciplinary action against a licensee upon a finding of professional incompetency. Professional incompetency is defined by K.S.A. 65-2837(a)(1) as at least one instance of practice below the standard of care to a degree constituting gross negligence.

4. To prove gross negligence, it must be shown that Respondent had a duty and breached that duty, and that he did so with wantonness or with reckless disregard for the consequences. The Board members may rely upon their own expertise as health care providers in order to evaluate the evidence.

5. Respondent has treated Patient #1 for approximately 11 years. He diagnosed the patient with Lyme disease. Respondent treated Patient #1 in his office using Bismacine. The drug was administered intravenously. Patient #1 was admitted to the hospital on April 19, 2005 with a diagnosis of acute renal failure. This patient was discharged on April 24, 2005, and remains on outpatient kidney dialysis. The cause of renal failure was the consequence of the Bismuth treatment.

6. There is evidenced that the diagnosis for Lyme disease was not supported for Patient #1. The evidence presently before the Board does not necessarily establish that Respondent failed to practice within the standard of care in reaching the diagnosis. The evidence does support the finding that Respondent's treatment for the Lyme disease was below the standard of care.

7. Patient #2 received Bismacine treatments for Lyme disease on April 14, 2005. This patient presented to Respondent's office on April 18 for a second administration of

Bismacine. Patient #2 went into cardiac arrest in the office as a result of the Bismacine. The patient was hospitalized with acute renal and respiratory failure and was unresponsive.

8. Bismacine is a solution of Bismuth citrate. The petition describes Bismuth as a toxic metallic element. Board counsel described the drug as not having FDA approval for IV use. The Board finds that the intravenous administration of a toxic metal substance such as Bismuth that is not indicated for the disease and that is without adequate support in the scientific literature, is a reckless disregard for the known dangers of the drug. The recklessness of this conduct is highlighted by the fact that two of Respondent's patients experienced life-threatening and debilitating outcomes at about the same time.

9. The hospital that received Patient #1 and Patient #2 summarily suspended Respondent's privileges. The Board finds that the public is in imminent danger by Respondent's continued practice of medicine and surgery. This imminent danger arises out Respondent's repeated instances of the failure to adhere to the applicable standard of care, accompanied by Respondent's reckless disregard for the toxicity of treatment. Further, the Board finds that there is no evidence that Respondent has hospital privileges to admit patients needing hospitalization as a result of these or other treatments. The Board determines that the license of Respondent should be immediately suspended until the conclusion of further proceedings.

IT IS, THEREFORE ORDERED, that the license of John R. Toth, M.D. is hereby immediately suspended.

IT IS FURTHER ORDERED that Board member Roger D. Warren, M.D. is appointed to preside in further proceedings, and at the conclusion of those proceedings to issue an Initial Order.

PLEASE TAKE NOTICE that a hearing on this matter is set for June 20, 2005 at 12:30 p.m. at the Board office, 235 S. Topeka Blvd., Topeka, KS. The issue to be determined is whether the emergency order of suspension should remain in place, modified or terminated. A party who does not appear or participate may be held in default and administrative orders issued. No further notice of hearing will be given.

PLEASE TAKE FURTHER NOTICE that this is an emergency order. An emergency order is effective when issued. Service of an emergency order constitutes notice of agency action for purposes of the Kansas act for judicial review of agency action. As provided by that act, a person whose license is affected by an emergency order may seek review in the district court. A copy of a petition for review must be served upon the Executive Director, State Board of Healing Arts, 235 S. Topeka Blvd., Topeka, KS 66603.

Dated this 13 Day of June 2005.

KANSAS STATE BOARD OF HEALING ARTS

_/s/_____
Mark W. Stafford, General Counsel, for
Lawrence T. Buening, Jr.
Executive Director

Certificate of Service

I certify that a true copy of the foregoing Emergency Order was served this 13th day of June 2005 by United States mail, first-class postage prepaid, and addressed to:

John R. Toth, M.D.
2115 S.W. 10th Street
Topeka, KS 66604

And by hand-delivery to the office of:
Kelli J. Benintendi
Associate Counsel
235 S. Topeka Blvd.
Topeka, Kansas

__Mark W. Stafford_____