COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1913

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY JOHN M. BENNETT, LICENSE NO. 30690, 402 JACKSON STREET, BEREA, KENTUCKY 40403

AGREED ORDER

Come now the Kentucky Board of Medical Licensure (hereafter “the Board”), acting by and through its Inquiry Panel B, and John M. Bennett, M.D. (hereafter “the licensee”), and, based upon their mutual desire to fully and finally resolve this pending investigation without an evidentiary hearing, hereby ENTER INTO the following AGREED ORDER:

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Agreed Order:

1. At all relevant times, John M. Bennett, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.

2. The licensee’s medical specialty is Family Medicine.

3. In or around December 2017, several employees at the Berea Outpatient Clinic of the Lexington VA Medical Center (“Facility”) reported that the licensee was documenting the same repeat blood pressure, 128/78, for multiple patients. The Facility conducted an initial review and found that 83 percent of the licensee’s blood pressure rechecks from June 1 to November 29, 2017 were listed as 128/78; reading from other providers during the same period demonstrated a pattern consistent with reasonable blood pressure deviations. After contacting patients and learning that the licensee did not appropriately follow up on blood pressure readings, the Facility summarily suspended the licensee’s clinical privileges.
4. In 2018, the Department of Veterans Affairs Office of Inspector General ("OIG") conducted a healthcare inspection in response to the report that the licensee falsely documented patients’ blood pressure readings at the Facility. The OIG reviewed more than 5,000 of the licensee’s patient encounters and identified 1,370 encounters during which the patients had diagnoses that placed them at greater risk for adverse clinical outcomes (defined as death, a change in the course of treatment or diagnosis, or a significant change in the patient’s level of care) if/when their blood pressures were not well controlled. The OIG found that in 1,364 of the 1,370 encounters (99.5 percent), the licensee documented repeat blood pressures of 128/78.

5. The OIG found that in relation to sixty-four (64) previously-reviewed high-risk patients, the licensee rarely added or changed medications for hypertension in instances when it would have been appropriate; inconsistently ordered lab work to ensure that medications were not causing harm to organs; routinely scheduled nine-month follow-up appointments irrespective of the complexity of their conditions and sufficiency of blood pressure control; and documented secondary hypertension for multiple patients without evidence of a workup to justify the diagnosis.

6. During the OIG inspection, the licensee asserted that he ordered home blood pressure cuffs for patients to monitor their blood pressure; however, the OIG could find no evidence of this.

7. During the OIG inspection, the licensee acknowledged that he documented the same blood pressure readings as 128/78 in order to "turn off" the clinical reminder and he provided several rationales for this conduct; however, the OIG team did not
find his explanations plausible and concluded that his falsifications of blood pressure readings was most likely an effort to reduce workload as normal blood pressure readings would not require further intervention or documentation.

8. The Medical Executive Committee unanimously recommended that the licensee’s privileges be revoked.

9. On or about July 3, 2018, the Facility found that there was substantial evidence that the licensee so significantly failed to meet generally-accepted standards of clinical practice so as to raise reasonable concern for the safety of patients and, thus, revoked the licensee’s clinical privileges based on substandard care and professional misconduct. The Facility cited fifty (50) specifications ("findings") that the licensee had recorded inaccurate information in patient medical charts between December 11 and December 21, 2017, and the Director stated, in part,

   ... [T]he above offenses are egregious, directly related to your duties, intentional and frequently repeated. ... You have lost the confidence of your colleagues regarding your reliability, accuracy and integrity. Your reputation and character are no win questions. Physicians are in positions of trust and held to high standards, you have violated your patients’ and colleagues’ trust as well as failed to meet the standards entrusted to us as physicians. Your actions have placed Veterans in harm’s way and violate the established principals governing the practice of medicine. ...

10. The licensee did not appeal the Facility’s revocation of his clinical privileges.

11. On May 16, 2019, the Board’s Inquiry Panel B reviewed the investigation. The licensee was present and heard by the Panel before it chose to take action.

12. The Panel and the licensee agree to enter into this Agreed Order, in lieu of the issuance of a Complaint and Emergency Order of Suspension.
STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Agreed Order:

1. The licensee’s Kentucky license to practice medicine is subject to regulation and discipline by the Board.

2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by KRS 311.595(4), and KRS 311.595(10) and (21). Accordingly, there are legal grounds for the parties to enter into this Agreed Order.

3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending investigation without an evidentiary hearing by entering into an informal resolution such as this Agreed Order.

AGREED ORDER

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to fully and finally resolve this pending investigation without an evidentiary hearing, the parties hereby ENTER INTO the following AGREED ORDER:

1. The license to practice medicine in the Commonwealth of Kentucky held by John M. Bennett, M.D., is hereby placed on PROBATION FOR A PERIOD OF FIVE (5) YEARS, with that period to become effective immediately upon the filing of this Agreed Order.
2. During the effective period of this Agreed Order, the licensee’s license to practice medicine in the Commonwealth of Kentucky SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS:

a. Within twenty (20) days of the filing of this Agreed Order, the licensee SHALL make all necessary arrangements to enroll in the ProBE Program offered through the Center for Personalized Education for Professionals (CPEP), 720 South Colorado Boulevard, Suite 1100-N, Denver, Colorado 80246, Tel. (303) 577-3232, at the earliest time;

i. The licensee SHALL complete and “unconditionally pass” the ProBE Program at the time and date(s) scheduled, at his expense and as directed by CPEP’s staff;

ii. The licensee SHALL provide the Board’s staff with written verification that he has completed and “unconditionally passed” CPEP’s ProBE Program, promptly after completing the program;

iii. The licensee SHALL take all steps necessary, including signing any waiver and/or consent forms required to ensure that CPEP will provide a copy of any evaluations, reports or essays from the ProBE Program to the Board’s Legal Department promptly after their completion; and

b. Within twenty (20) days of the filing of this Agreed Order, the licensee SHALL make all necessary arrangements to enroll in the Medical Record Keeping Seminar at the Center for Personalized Education for Professionals (CPEP), 720 South Colorado Boulevard, Suite 1100-N, Colorado 80246 – 303/577-3232, at the earliest time;

i. The licensee SHALL complete the Medical Record Keeping Seminar at the time and date(s) scheduled, at his expense;

ii. The licensee SHALL also take all necessary steps to enroll in CPEP’s post-seminar program: “Personalized Implementation Program” (“PIP”).

iii. The licensee SHALL complete the PIP, at his expense, as directed by CPEP’s staff;

iv. The licensee SHALL provide the Board’s staff with written verification that he has successfully completed CPEP’s Medical Record Keeping Seminar, promptly after completing the Seminar, and that he has enrolled in PIP;
v. The licensee SHALL provide the Board’s staff with written verification that he has successfully completed PIP promptly after completing that program;

vi. The licensee SHALL take all steps necessary, including signing any waiver and/or consent forms required to ensure that CPEP will provide a copy of any evaluations from the Medical Record Keeping Seminar and PIP to the Board’s Legal Department promptly after their completion;

c. The licensee SHALL permit the Board’s agents to inspect, copy and/or obtain patient records, upon request, for review by the Board’s agents and/or consultants;

i. The licensee SHALL reimburse the Board fully for the costs of each consultant review performed pursuant to this Agreed Order. Once the Board receives the invoice from the consultant(s) for each review, it will provide the licensee with a redacted copy of that invoice, omitting the consultant’s identifying information. The licensee SHALL pay the costs noted on the invoice within thirty (30) days of the date on the Board’s written notice. The licensee’s failure to fully reimburse the Board within that time frame SHALL constitute a violation of this Agreed Order;

ii. The licensee understands and agrees that at least two (2) consultant reviews must be performed, on terms determined by the Panel or its staff, before the Panel will consider a request to terminate this Agreed Order before its expiration;

d. Pursuant to KRS 311.565(1)(y), the licensee SHALL submit payment of a FINE in the amount of five-thousand dollars ($5,000) to the Board within six (6) months from the date of entry of this Agreed Order; and

e. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee expressly understands and agrees that if he should violate any term or condition of this Agreed Order, the licensee’s practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Agreed Order, the Panel Chair is
authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board’s General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Agreed Order would render the licensee’s practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Agreed Order.

4. The licensee understands and agrees that any violation of the terms of this Agreed Order would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13), and may provide a legal basis for criminal prosecution.

SO AGREED on this 3rd day of June, 2019.

FOR THE LICENSEE:  

[Signature]

JOHN M. BENNETT, M.D.

JEFFREY A. DARLING, ESQ.

FOR THE BOARD:  

[Signature]

SANDRA R. SHUFFETT, M.D.
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