

BEFORE THE MINNESOTA
BOARD OF MEDICAL PRACTICE

**TRUE AND EXACT
COPY OF ORIGINAL**

In the Matter of the
Medical License of
Keith W. Sehnert, M.D.
Date of Birth: 5-25-26
License Number: 24,617

**AMENDED
STIPULATION
AND ORDER**

IT IS HEREBY STIPULATED AND AGREED, by and between Keith W. Sehnert, M.D. ("Respondent"), and the Minnesota Board of Medical Practice ("Board") as follows:

1. During all times herein, Respondent has been and now is subject to the jurisdiction of the Board from which he holds a license to practice medicine and surgery in the State of Minnesota.

FACTS

2. For the purpose of this amended stipulation, the Board may consider the following facts as true:

a. On January 11, 1997, the Board issued Respondent a Stipulation and Order ("Order") based on his concept that illness and pathophysiology revolved exclusively around candidiasis sensitivity syndrome and that a number of diagnoses were made without examination or lab work.

b. The January 11, 1997, Order required Respondent to successfully complete the Special Purposes Examination ("SPEX") and a records management course by January 11, 1998. On February 10, 1998, Respondent completed the records management course; however, he has not successfully completed the SPEX because of health conditions affiliated with the stress of learning the computer format of the testing procedure.

c. The January 11, 1997, Order also required Respondent to develop protocols for treating obese patients, weight-loss prescribing, and chemical-dependency assessment.

d. On February 12, 1997, Respondent submitted protocols for treating obese patients and weight-loss prescribing. The Complaint Review Committee ("Committee") requested specific changes be made to the protocols and that the protocols be resubmitted for approval. On October 17, 1997, Respondent submitted the chemical-dependency protocol. Respondent failed to resubmit the protocols for treating obese patients and weight-loss prescribing.

e. The January 11, 1997, Order required that Respondent obtain a supervising physician who submits quarterly reports to the Board. Although Respondent routinely informed the Board of his meetings with a supervising physician, who was approved by the Committee in May 1997, the Supervising Physician Agreement was not signed until February 26, 1998, and the supervising physician failed to submit a quarterly report as required by the Order until February 12, 1998.

f. In a letter dated March 12, 1998, Respondent informed the Board that he has not done any clinical work since December 1997 and does not plan to see patients in the future because he is officially retired.

g. On June 8, 1998, Respondent and his attorney appeared before the Committee to discuss Respondent's failure to comply with the terms and conditions of the January 11, 1997, Stipulation and Order. During this conference, Respondent agreed to retire from the active practice of medicine and not be involved in any patient care.

STATUTES

3. The Board views Respondent's practices as inappropriate in such a way as to require Board action under Minn. Stat. § 147.091, subd. 1(f) (1996) and Respondent agrees that the conduct described in the stipulation and order incorporated herein constitutes a reasonable basis in law and fact to justify the disciplinary action.

REMEDY

4. Upon this stipulation and all of the files, records, and proceedings herein, and without any further notice or hearing herein, Respondent does hereby consent that until further order of the Board, made after notice and hearing upon application by Respondent or upon the Board's own motion, the Board may make and enter an order amending the stipulation and order issued on January 11, 1997. The January 11, 1997, stipulation and order is incorporated by reference in its entirety and is attached as Exhibit A, with the exception of paragraph 4, which is rescinded and replaced with the following language:

a. Respondent is prohibited from engaging in patient care.

b. Respondent shall meet on a quarterly basis with a designated Board member. Such meetings shall take place at a time mutually convenient to Respondent and the designated Board member. It shall be Respondent's obligation to contact the designated Board member to arrange each of the quarterly meetings. The purpose of such meetings shall be to review Respondent's progress under the terms and conditions of this Amended Stipulation and Order.

c. This Amended Stipulation and Order shall remain in effect for a minimum of three years. After three years from the date of this Amended Order, Respondent may petition the Board to modify the terms and conditions of this paragraph 4, subparagraphs a-c. At the time of his petition, Respondent must appear before the Complaint Review Committee to discuss his petition and to provide proof that he is competent to resume patient care.

OTHER AGREEMENTS

5. If Respondent shall fail, neglect, or refuse to fully comply with each of the terms, provisions, and conditions herein, the Committee shall schedule a hearing before the Board. The Committee shall mail Respondent a notice of the violation alleged by the Committee and of the time and place of the hearing. Respondent shall submit a response to the allegations at least three days prior to the hearing. If Respondent does not submit a timely response to the Board, the allegations may be deemed admitted.

At the hearing before the Board, the Committee and Respondent may submit affidavits made on personal knowledge and argument based on the record in support of their positions. The evidentiary record before the Board shall be limited to such affidavits and this stipulation and order. Respondent waives a hearing before an administrative law judge and waives discovery, cross-examination of adverse witnesses, and other procedures governing administrative hearings or civil trials.

At the hearing, the Board will determine whether to impose additional disciplinary action, including additional conditions or limitations on Respondent's practice, or suspension or revocation of Respondent's license.

6. In the event the Board in its discretion does not approve this settlement, this amended stipulation is withdrawn and shall be of no evidentiary value and shall not be relied upon nor introduced in any disciplinary action by either party hereto except that Respondent agrees that should the Board reject the amended stipulation, Respondent will assert no claim that the Board was prejudiced by its review and discussion of the amended stipulation or any records relating hereto.

7. In the event Respondent should leave Minnesota to reside or practice outside the state, Respondent shall promptly notify the Board in writing of the new location as well as the dates of departure and return. Periods of residency or practice outside of Minnesota will not apply to the reduction of any period of Respondent's suspended, limited, or conditioned license in Minnesota unless Respondent demonstrates that practice in another state conforms completely with Respondent's Minnesota license to practice medicine.

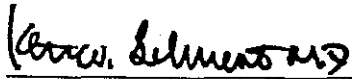
8. Respondent has been advised by Board representatives that he may choose to be represented by legal counsel in this matter and has chosen Donald F. Hunter.

9. Respondent waives any further hearings on this matter before the Board to which Respondent may be entitled by Minnesota or United States constitutions, statutes, or rules and agrees that the order to be entered pursuant to the amended stipulation shall be the final order herein.

10. Respondent hereby acknowledges that he has read and understands this amended stipulation and has voluntarily entered into the amended stipulation without threat or promise by the Board or any of its members, employees, or agents. This amended stipulation contains the entire agreement between the parties, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this amended stipulation.

Dated: 6/24, 1998

Dated: 7-11, 1998



KEITH W. SEHNERT, M.D.
Respondent



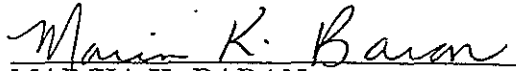
FOR THE COMMITTEE

Dated: 6/25, 1998

Dated: 6/23, 1998



DONALD F. HUNTER
Attorney for Respondent



MARCIA K. BARAN
Attorney for Committee

215 Opus Center
9900 Bren Road East
Minnetonka, MN 55343
(612) 933-9900

500 Capitol Office Building
525 Park Street
St. Paul, MN 55103
(612) 297-1138

* * *

ORDER

Upon consideration of this amended stipulation and all the files, records, and proceedings herein,

IT IS HEREBY ORDERED that the terms of this amended stipulation are adopted and implemented by the Board this 11th day of July, 1998.

MINNESOTA BOARD OF

MEDICAL PRACTICE

By: 

June 16, 1998

BEFORE THE MINNESOTA
BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Keith W. Schnert, M.D.

Date of Birth: 5-25-26
License Number: 24,617

STIPULATION
AND ORDER

IT IS HEREBY STIPULATED AND AGREED, by and between Keith W. Schnert, M.D. ("Respondent") and the Complaint Review Committee ("Committee") of the Minnesota Board of Medical Practice ("Board") as follows:

1. During all times herein, Respondent has been and now is subject to the jurisdiction of the Board from which he holds a license to practice medicine and surgery in the State of Minnesota.

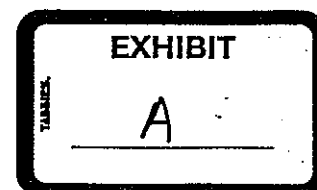
FACTS

2. For the purpose of this stipulation, the Board may consider the following facts as true:

a. A practice audit was conducted by Board consultants. Medical charts were randomly selected from Respondent's active clinical practice at Trinity Healthcare. General results of this audit indicate:

1) Almost without exception, Respondent's evaluations, diagnoses, investigative tests and treatments were the same for all twenty-seven patients. Respondent's concept of medical illness and pathophysiology revolves almost exclusively around candidiasis sensitivity syndrome as demonstrated by the following:

a) Respondent identified three interlocking "clusters" of problems common to his patients: (i) systemic candida infections; (ii) food allergies/intolerances; and (iii) hypothyroidism.



b) Regardless of the presenting complaint, Respondent administered a battery of questionnaires to his patients which consisted of one or more of the following:

(1) Cornell Medical Index Health Questionnaire, a general health questionnaire consisting of approximately 200 general health questions.

(2) Candida Questionnaire and Score Sheet, a three-part questionnaire pertaining to a patient's history and symptomatology, focusing on exposure to and use of yeast related substances, with questions relating primarily to non-specific symptoms (also an abbreviated version for children).

(3) Beck Depression Inventory, a brief psychological inventory consisting of statements relating to a patient's emotional state.

(4) Self-Test for Stress Levels, Respondent's version of the Holmes-Rahe stress test, consisting of 43 life events with applied point values (the higher the score, the greater the stress level).

(5) Allergy/Sensitivity Inventory, Respondent's own four-part questionnaire consisting of general health questions and questions specific to diet, chemicals/odors, and dust/dander.

c) Respondent consistently failed to document how questionnaires were scored and utilized in establishing treatment plans for his patients.

d) Although the patients had different complaints, Respondent's diagnostic impressions for all twenty-seven patients were remarkably consistent and included most frequently sinusitis (19 of the 27 patients), colitis (18 of the 27 patients), serous otitis media (11 of the 27 patients), and food allergies (11 of the 27 patients). Other common diagnostic impressions included glossitis, depression, dermatitis, hypothyroidism, rhinitis, and hypertension.

e) Although the patients had different complaints, Respondent treated the twenty-seven patients within a narrow range of options including dietary restrictions

(25 of the 27 patients), supplements including DDS (14 of the 27 patients) and thyroid medication (10 of the 27 patients), and prescribed antifungal therapy including Nystatin (23 of the 27 patients) and Nizoral (14 of the 27 patients).

2) The records do not indicate that Respondent considered alternative diagnoses, both physical and psychological, for the twenty-seven patients.

3) The records indicate that the majority of Respondent's diagnoses were made without the examinations and/or diagnostic tests generally considered necessary in the medical community to establish and confirm these diagnoses. Examples include the following:

a) Respondent admittedly diagnosed "yeast vaginitis" without performing a pelvic examination or laboratory testing.

b) Respondent admittedly diagnosed "prostatitis" without performing a rectal or proctoscopic examination.

c) Respondent admittedly diagnosed "colitis" based on history and abdominal tenderness and did not order and/or perform more invasive testing to either support this diagnosis or rule out other diagnoses.

d) Respondent admittedly diagnosed "sinusitis" without ordering radiographic studies to verify the presence or extent of the sinusitis.

e) Respondent diagnosed food allergies on the basis of an "IgG RAST" test. The IgG RAST test is not used by allergists in this medical community.

f) Respondent diagnosed "hypothyroidism" without any laboratory testing confirming that the patients were hypothyroid.

g) Although Respondent stated that he would refer "troublesome" patients who presented with complaints of vaginitis to nearby gynecologists for evaluation, none of the records reviewed included a documented gynecological referral or any other evidence that gynecological evaluation or testing had been recommended.

4) Even though some diagnostic tests were ordered, Respondent failed in certain cases to apply the test results to substantiate the diagnosis or treatment plan for patients. Examples include the following:

a) Some patients who had normal anti-candida antibody levels were treated in the same way as were patients who had abnormal levels.

b) Even where Respondent ordered diagnostic tests, Respondent treated patients with prescribed medications before the test results became available.

c) Respondent prescribed thyroid hormone for certain patients when there was no evidence by laboratory testing confirming that the patients were hypothyroid.

d) Respondent treated patients with prescribed medications even after the results of diagnostic tests were reported as normal.

5) Respondent treated patients with Nizoral (ketoconazole), an antifungal agent which has the potential for causing hepatotoxicity. The records do not document adequate monitoring. Respondent did not obtain baseline liver function tests and did not document ongoing liver function monitoring throughout the course of treatment.

6) The records do not indicate that Respondent obtained appropriate informed consent from patients documenting their understanding of the potential risks and side effects before antifungal agents and other medications were prescribed.

7) In some cases, Respondent continued to approve refills for prescribed medications after the prescribed course of treatment had been completed. Respondent states that he would suggest that the patient return to see him, although that is not documented in the patient records.

8) Respondent's use of anti-candida medications for the eradication of disease-related yeast colonization of the alimentary tract does not meet the community standard

of medical practice. Additionally, this practice has not withstood the test of comprehensive peer review.

9) The existence of candida hypersensitivity syndrome is not accepted by the majority of medical practitioners. In an August 1986 position statement, which has not been changed, the Executive Committee of the American Academy of Allergy, Asthma and Immunology concluded that the concept of candida hypersensitivity syndrome is unproven and, further, that the diagnosis, the special laboratory tests, and the special aspects of treatment should be considered experimental and reserved for use with informed consent in appropriate controlled trials that have been approved for scientific merit and safety by competent institutional review boards.

10) Respondent's role as either a primary physician or a consultant was unclear: he did not provide standard primary care, and he did not always provide consultative communications to the primary care physician.

b. The practice audit indicated the following:

1) With respect to the care provided to patient #1:

a) On October 8, 1987, Respondent prescribed Nystatin and a "protocol" (diet, vitamins, garlic, etc.) for patient #1 even though he did not see or examine her until December 3, 1987.

b) On December 3, 1987, Respondent first saw patient #1. The records do not indicate that Respondent took a complete history at this initial visit and his "clinical assessment" consisted of comments on the condition of patient #1's tongue. Respondent's treatment consisted of Nizoral therapy, blood tests and enemas.

c) Respondent diagnosed patient #1, in part, with sinusitis and food allergies. However, the records do not indicate that a complete physical examination was carried out or that confirmatory diagnostic tests such as sinus x-rays, IgE RAST or skin tests were carried out.

d) On February 25, 1988, Respondent next saw patient #1.

At that time, Respondent noted patient #1's history of depression which he indicated could possibly be attributed to various foods. Respondent's diagnostic impression ignored patient #1's well-documented history of virtually lifelong anxiety and depression, which included hospitalization, shock treatment and medication (Lithium, Xanax, Pamelor, Stelazine, Tofranil, Mellaril, Elavil, Sinequan, and Tranxene).

e) On December 28, 1987, Respondent prescribed Mycostatin vaginal suppositories for patient #1 based upon her son's telephone call in which he informed Respondent that "Mother has a flare-up of vaginitis" and without requiring an appointment with patient #1, performing a pelvic examination or obtaining appropriate microbiologic data.

f) In January 1988, Respondent prescribed Restoril for patient #1 despite knowing that patient #1 was taking Xanax. Restoril is contraindicated for patients taking Xanax.

g) Respondent did not assess patient #1's thyroid disease, renal insufficiency, and Lithium levels.

h) Respondent did not communicate with patient #1's other treating physicians and failed to clarify his role as either a primary physician or a consultant.

2) With respect to the care provided to patient #2:

a) On April 30, 1987, patient #2 presented to Respondent with complaints of persistent vaginitis, environmental sensitivity, increasing fatigue, memory loss, anxiety, and depression. Respondent noted that patient #2 appeared chronically ill and that she was hypomanic. Respondent diagnosed patient #2 with vaginitis, colitis, glossitis, sinusitis, eczema, and hammer toes without documenting a complete physical examination, without an examination of her genitalia, pelvis, or rectum and without ordering gastrointestinal or sinus x-rays or stool hemocult tests.

b) Although patient #2's November 1987 serum antibody studies for Candida were normal, Respondent continued to prescribe Nystatin, lactobacillus, and a thyroid extract for patient #2.

c) Respondent prescribed thyroid hormone to patient #2 without performing any thyroid function testing in his clinic, either before or during thyroid administration. The patient was referred for testing to Med Center on December 5, 1987.

d) Despite patient #2's presenting complaint of depression and Respondent's documentation that the patient appeared to be hypomanic, Respondent did not initiate any type of treatment plan for this problem.

e) Although patient #2's regular course of treatment was completed on March 14, 1988, Respondent continued to refill prescriptions for Nystatin and thyroid medication, between March 1988 and September 1989, without seeing or examining the patient.

3) With respect to the care provided to patient #3:

a) On August 28, 1989, patient #3 presented to Respondent with a history of complicated problems including congenital kyphoscoliosis, chronic asthma and bronchitis, and underlying heart disease. Patient #3 was on a variety of medications and used an oxygen inhaler. Respondent diagnosed patient #3 with chronic asthma/bronchitis, environmental sensitivity, kyphoscoliosis, osteoarthritis, hypertension, subclinical hypothyroidism and glossitis without documenting a complete physical examination and without ordering chest x-rays, or IgE RAST or skin tests.

b) Respondent prescribed thyroid medication for patient #3 even though the results of thyroid function tests (including a TSH level ordered by another physician) were normal. Respondent started patient #3 on thyroid replacement therapy without communicating with her primary physician or cardiologist, and despite any potential risks of initiating thyroid replacement in a patient with serious underlying heart disease.

c) When Respondent finally corresponded with patient #3's primary physician in a letter, some five months after beginning treatment, he claimed that the thyroid function tests (which reflected normal results) were "highly significant and in my experience indicate Hashimoto's thyroiditis. Because of that I prescribed Thyroid Armour It has been my experience that this helps boost immunity."

4) With respect to the care provided to patient #4:

a) On September 29, 1988, patient #4 presented to Respondent with complaints of repeated vaginitis, abdominal pain and cold feet. Respondent noted that patient #4 had been on antibiotics for acne, had taken birth control pills for several years and that she craved bakery goods. Respondent diagnosed patient #4 with sinusitis, colitis and acne without documenting a complete physical examination and without ordering gastrointestinal or sinus x-rays or stool hemocult tests. Respondent's diagnosis of colitis was based on a simple examination of the abdomen and no subsequent examination of the colon.

b) Respondent prescribed Nizoral for patient #4 without ordering a baseline liver panel. Respondent did not document regular monitoring of ongoing liver function throughout the course of treatment.

c) Respondent advised two of patient #4's three children (2 and 5 years old) to take cod liver oil and Nystatin based solely on their answers to a questionnaire and without having taken a medical history or having performed any physical examination. Additionally, Respondent failed to maintain medical records for the children for whom therapy was prescribed.

5) With respect to the care provided to patient #5:

a) On October 21, 1989, patient #5 presented to Respondent with a complaint of chronic post-nasal drainage for the past year. Patient #5 had been seen the previous month at the Mayo Clinic where he had undergone a general exam, x-rays, and extensive testing with all results being essentially normal. Respondent diagnosed patient #5

with sinusitis, colitis, and glossitis without documenting a complete physical examination and without ordering gastrointestinal or sinus x-rays, or stool hemocult tests.

b) Although Respondent ordered a baseline liver panel while treating patient #5 with Nizoral, the records do not indicate that he regularly monitored ongoing liver function throughout the course of treatment.

c) In January 1990, Respondent ordered thyroid function tests and started patient #5 on a trial of thyroid medication. Respondent continued to treat patient #5 with thyroid medication despite normal results of thyroid function tests.

d) Respondent failed to document specific symptoms or a treatment plan despite his "clinical assessment" that patient #5's mental state was abnormal.

e) Respondent failed to document any communication to or from patient #5's primary physician.

6) With respect to the care provided to patient #6:

a) On January 19, 1990, patient #6 presented to Respondent with complaints of recurrent sinusitis and bronchitis, multiple food allergies, increasing fatigue, bloating and belching, cold hands and feet, itchy scalp, and eczema on her elbows. Patient #6 had been treated for Candida related complex by two other physicians. Respondent diagnosed patient #6 with sinusitis, serous otitis media, glossitis, food allergies and colitis without documenting a complete physical examination and without ordering gastrointestinal or sinus x-rays, stool hemocult tests or IgE RAST or skin tests.

b) Respondent documented that patient #6's primary physician was treating her for rheumatoid arthritis but failed to document any communication regarding his treatment of patient #6 with this physician.

7) With respect to the care provided to patient #7:

a) On February 12, 1990, patient #7, a 12-year-old female with a history of emotional disturbances requiring temporary removal from the home, presented to Respondent with complaints of stomach aches, headaches, dizziness, severe

fatigue, and cold sensitivity. Respondent diagnosed patient #7 with sinusitis, colitis, and food allergies without documenting a complete physical examination and without ordering gastrointestinal or sinus x-rays, stool hemocult tests or IgE RAST or skin tests.

b) Respondent failed to document any communication to or from patient #7's primary physician or solicitation of psychiatric help for patient #7.

8) With respect to the care provided to patient #8:

a) On June 26, 1989, patient #8 presented to Respondent with complaints of multiple allergies, chronic bronchitis, sinusitis, vaginitis, chronic fatigue, cold hands and feet, and sores on the tongue and lips which had been relieved by Nystatin prescribed by another physician. Respondent diagnosed patient #8 with allergic rhinitis, sinusitis, glossitis, colitis and food allergies without documenting a complete physical examination and without ordering gastrointestinal or sinus x-rays, thyroid hormone levels or TSH levels, stool hemocult tests, or IgE RAST or skin tests.

b) Respondent prescribed Nizoral and Nystatin without any evidence to support a yeast infection. Additionally, although a baseline liver panel was ordered one month after patient #8 was started on Nizoral, the records do not indicate that Respondent regularly monitored ongoing liver function throughout the course of treatment.

c) Respondent prescribed a thyroid extract for patient #8 before the results of a thyroid antibodies test were obtained and despite the fact that laboratory evidence from a previous physician indicated patient #8 had normal thyroid function. Respondent continued treating patient #8 with thyroid medication even after thyroid antibodies test results were normal.

d) In a December 12, 1989 chart note, Respondent documented a telephone request for a prescription refill but failed to document what prescribed medication was being refilled.

9) With respect to the care provided to patient #9:

a) On August 18, 1988, patient #9 presented to Respondent with complaints of obesity, premenstrual syndrome, and yeast sensitivity. Respondent diagnosed patient #9 with obesity, sinusitis, serous otitis media, and colitis and depression without documenting a complete physical examination and without ordering gastrointestinal or sinus x-rays, or stool hemocult tests.

b) Respondent prescribed thyroid supplements for patient #9 without diagnostic evidence that the patient was hypothyroid. Respondent did not order thyroid function tests until three months after starting the patient on thyroid supplements. Although the overall results of thyroid function studies (including T3, T4 and T7 results) were normal, showing only slightly elevated anti-microsomal antibodies, Respondent continued to prescribe thyroid supplements for patient #9.

c) Although Respondent treated patient #9 with Nizoral and a baseline liver panel was ordered, the records do not indicate that Respondent regularly monitored ongoing liver function throughout the course of treatment.

d) Respondent provided patient #9 with an August 23, 1989 letter in which he wrote, "This letter has been prepared to state that I have prescribed a colon cleansing program as part of a treatment plan for [patient #9's] colitis and allergies."

e) Respondent advised patient #9's child (2 years old) to take "DDS" and "dot dose" (presumably Nystatin) based solely on the answers to a questionnaire and without having taken a medical history or having performed any physical examination. Respondent failed to maintain patient records for the child.

10) With respect to the care provided to patient #10:

a) On November 3, 1988, patient #10 presented to Respondent for a general health assessment. Respondent diagnosed patient #10 with food allergies, obesity, colitis, sinusitis, and family hyperlipidemia without documenting a complete physical examination and without ordering gastrointestinal or sinus x-rays, stool hemocult tests, or IgE RAST or skin tests.

b) On two occasions, Respondent administered to patient #10 a Candida Questionnaire which revealed "CROOK" scores of 115 and 91, respectively. By Respondent's own standard, a CROOK score of more than 180 indicates systemic candidiasis. Nystatin was ordered for therapy despite patient #10's CROOK scores.

c) During subsequent visits, Respondent prescribed DDS and added herbal tea to patient #10's treatment plan.

11) With respect to the care provided to patient #11:

a) On January 23, 1990, patient #11 presented to Respondent with complaints of chronic fatigue, post nasal drip, nasal congestion, and hoarseness. Respondent diagnosed patient #11, in part, with sinusitis, chronic rhinitis, food allergies and hypothyroidism-subclinical (possible) without documenting a complete physical examination and without ordering sinus x-rays, thyroid hormone levels or TSH levels, or IgE RAST or skin tests. Further diagnostic impressions included mixed stress reaction and depression.

b) Respondent placed patient #11 on an elimination and rotary diet, but failed to document a treatment plan which adequately addressed the patient's multiple diagnoses.

12) With respect to the care provided to patient #12:

a) On February 27, 1989, patient #12 presented to Respondent with complaints of fungus dermatitis of the groin and nails, fatigue, poor memory, bloating, and gas. Respondent diagnosed patient #12 with sinusitis, colitis, fungus dermatitis of the nails, and food allergies without documenting a complete physical examination and without ordering gastrointestinal or sinus x-rays, stool hemocult test or IgE RAST or skin tests.

b) Although Respondent noted, on February 27, 1989, "talk to Group Health," Respondent did not document any communication with Group Health regarding patient #12.

13) With respect to the care provided to patient #13:

a) On October 13, 1988, patient #13 presented to Respondent with a history of mastectomy three years prior, a ruptured uterus ten years prior and a thyroidectomy in 1968. Respondent also noted multiple food allergies. Respondent diagnosed patient #13 with sinusitis, glossitis, colitis, dermatitis/eczema, hypothyroidism and food allergies following an incomplete physical examination and without ordering gastrointestinal or sinus x-rays, stool hemocult tests or IgE RAST or skin tests.

b) Respondent did not communicate with patient #13's primary care physician despite knowing that patient #13 was scheduled to undergo a mastectomy in March 1989.

14) With respect to the care provided to patient #14:

a) On March 23, 1987, patient #14 presented to Respondent after reading a book concerning yeast syndrome. Patient #14 complained of a history of environmental sensitivities, behavioral changes, asthma and fatigue. On this initial visit, Respondent diagnosed patient #14 with colitis, prostatitis, dermatitis, serous otitis media, hypothyroidism, environmental sensitivities, asthma and multiple allergies without documenting a complete physical examination and without ordering thyroid hormone levels or TSH levels, stool hemocult tests, or IgE RAST or skin tests. Respondent's diagnosis of colitis was based solely on abdominal tenderness. Additionally, Respondent did not perform a rectal examination to verify his diagnosis of prostatitis.

b) In August 1987, patient #14 informed Respondent that he was experiencing some nocturia and urinary frequency. Respondent refilled patient #14's Nizoral but did not order a urinalysis.

c) Patient #14's course of treatment was completed in November 1987. Due to recurring symptoms, patient #14 returned to Respondent's care in June 1988, at which time Respondent prescribed Nizoral. At that time, patient #14 was also under the care of a neurologist for seizures of an unknown origin, and was being treated with Dilantin. Although patient #14 experienced seizures during 1988 and 1989 while under

Respondent's care, there is no evidence that Respondent attempted to communicate at any time with the patient's treating neurologist.

d) In July 1988, Respondent prescribed a thyroid hormone for patient #14 in response to the patient's telephone request, but did not order thyroid function tests until December 1989. Although the results of thyroid function tests were normal, Respondent continued to prescribe thyroid medication for patient #14. Additionally, despite the normal thyroid function tests, Respondent sent a letter to Blue Cross Blue Shield in which he stated, "[patient #14's] primary problem has been his thyroid problem, for which he is receiving thyroid supplement." Respondent also sent a letter to The Travelers Insurance Company, specifying patient #14's diagnoses, in part, as "Subclinical hypothyroidism."

e) In September 1989, patient #14 telephoned Respondent and informed him that he was taking a broad-spectrum antibiotic and would like to take an antifungal. Respondent prescribed Nystatin, based on patient #14's telephone request and prior history.

f) Despite the fact that Respondent diagnosed patient #14 with asthma, Respondent did not initiate any type of treatment plan for this problem.

15) With respect to the care provided to patient #15:

a) On July 27, 1989, patient #15 presented to Respondent with complaints of coughing for approximately one month, resulting in vomiting and weight loss. Patient #15 had been released from the hospital the previous day where he had undergone extensive diagnostic testing and antibiotic therapy.

b) Respondent diagnosed patient #15 with coughing of unknown origin, sinusitis, serous otitis media and allergic rhinitis without documenting a complete physical examination and prescribed Nystatin powder, Vitamin C, hot/cold, and nose drops. Respondent also recommended that patient #15 be restricted to indoor activity.

16) With respect to the care provided to patient #16:

a) On October 17, 1988, patient #16 presented to Respondent after changing his eating habits to conform to his wife's protocol diet, (his wife, patient #17, was also Respondent's patient) and, as a result, was feeling much better. In addition, patient #16 also started taking his wife's Nystatin Powder USP (prescribed for patient #17 by Respondent). Respondent diagnosed patient #16 with prostatitis, obesity, sinusitis, otitis media, and colitis without documenting a complete physical examination, without rectal or genitalia examination and without ordering gastrointestinal or sinus x-rays, or stool hemocult tests. Respondent based his diagnosis of colitis on abdominal tenderness. Respondent's diagnosis of sinusitis was based solely on tenderness over the maxillary sinuses.

b) Respondent treated patient #16 with Nizoral from October 17, 1988 through March 20, 1989, without ongoing monitoring of liver function.

c) Respondent approved a phone request for a refill of Nystatin Powder USP on January 31, 1990, almost a full year after patient #16 had been released from his care. No subsequent visits or other follow-up occurred following this prescription order.

17) With respect to the care provided to patient #17:

a) On March 17, 1988, patient #17 presented to Respondent with nonspecific complaints of forgetfulness, "feeling spacey," history of PMS, and multiple gynecological problems. Respondent's initial diagnosis included vaginitis and colitis. Respondent did not perform a pelvic, rectal or genitalia examination and did not order gastrointestinal x-rays or stool hemocult tests. Respondent also diagnosed patient #17 with sinusitis and hypothyroidism without ordering sinus x-rays or thyroid antibodies, hormone levels, or TSH levels.

b) Respondent performed no thyroid function tests; yet, he diagnosed patient #17 with hypothyroidism and prescribed thyroid medication for patient #17. Additionally, patient #17's chart included a complete thyroid profile completed approximately one year previously at a former clinic in which all results were normal.

18) With respect to the care provided to patient #18:

a) On August 31, 1989, patient #18 presented to Respondent with complaints of chronic fatigue, vaginitis (in the distant past), pelvic pain, bloating, belching, intestinal gas, itchy ears and mucous in her stools. Respondent diagnosed patient #18 with sinusitis, obesity, serous otitis media (left), and depression without documenting a complete physical examination and without ordering sinus x-rays or other tests to support the above diagnoses.

b) Despite the fact that Respondent diagnosed patient #18 with depression, Respondent failed to initiate any type of treatment plan for this problem.

19) With respect to the care provided to patient #19:

a) On January 22, 1990, patient #19, a five-year-old boy, presented to Respondent for a well child examination. Based on his assessment, Respondent diagnosed patient #19 with normal health and serous otitis media. Respondent's treatment plan for patient #19 consisted of DDS, grapefruit/cranberry juice, and a low sugar diet.

b) Respondent failed to document patient #19's immunization status.

20) With respect to the care provided to patient #20:

a) On April 20, 1989, prior to seeing patient #20, Respondent prescribed DDS, Nystatin douches, and Nystatin powder in response to patient #20's telephone complaint of vaginitis.

b) On April 27, 1989, patient #20 presented to Respondent with complaints of recurrent vaginitis, recurrent cystitis, fatigue, bloating, gas, and chronic itching of the eyes, feet, and scalp. Patient #20 had previously taken Nystatin under the direction of another physician. Respondent diagnosed patient #20 with serous otitis media, post-nasal drainage, colitis, glossitis and depression without documenting a complete physical examination and without ordering gastrointestinal x-rays or stool hemocult tests.

c) In September 1989, Respondent recommended that patient #20 "see a chiropractor regarding thyroid."

d) Although Respondent prescribed Nizoral for patient #20, the records do not indicate that liver function was monitored throughout the course of treatment.

e) Despite the fact that Respondent diagnosed patient #20 with depression, Respondent failed to initiate any type of treatment plan for this problem.

21) With respect to the care provided to patient #21:

a) The incomplete records do not include records of visits, examinations, or treatment plans for patient #21. The records do reveal that, on January 26, 1990, patient #21 completed Respondent's Allergy Sensitivity Inventory and, based on those results and the results of the IgG RAST food allergy test, thyroid tests and anti-candida antibodies test, patient #21 was placed on an elimination and rotary diet.

22) With respect to the care provided to patient #22:

a) On September 3, 1987, patient #22 presented to Respondent with complaints of sinusitis, environmental chemical sensitivity, and increasing fatigue; since 1985. Respondent diagnosed patient #22 with Tietze syndrome (inflammation of chondrocostal junctions), serous otitis media, colitis, and sinusitis without documenting a complete physical examination and without ordering gastrointestinal or sinus x-rays, stool hemocult tests, or IgE RAST or skin tests.

b) Respondent prescribed thyroid medication for patient #22 without ordering thyroid function tests to establish a diagnosis of hypothyroidism. The records do not contain any clinical or diagnostic evidence that the patient was hypothyroid.

c) Although Respondent treated patient #22 with Nizoral and a baseline liver panel was ordered, the records do not indicate that Respondent regularly monitored ongoing liver function throughout the course of treatment.

23) With respect to the care provided to patient #23:

a) On January 19, 1989, patient #23 presented to Respondent with a history of multiple health problems over the last 20 years, including runny stools and abdominal pain (diagnosed as Crohn's disease in March 1985) skin lesions (diagnosed as eczema), chronic fungus dermatitis of the feet and toenails, bad breath, and coated tongue. Respondent diagnosed patient #23 with Crohn's disease, hypertension, food allergies and fungus dermatitis of the toenails without documenting a complete physical examination and without ordering gastrointestinal x-rays, stool hemocult tests or IgE RAST or skin tests.

b) Respondent noted that patient #23 was on numerous medications for his hypertension, Crohn's disease, and fungal dermatitis. Over the course of his treatment of patient #23, Respondent prescribed Nystatin, Nizoral, DDS, Flax Energy Food and Aloe Vera, and reduced patient #23's Hydrochlorothiazide and Catapres, all without communicating with patient #23's primary physician.

c) Respondent did not order a baseline liver panel when originally prescribing Nizoral for patient #23, and the records do not indicate that ongoing liver function was regularly monitored throughout the course of treatment.

24) With respect to the care provided to patient #24:

a) On January 22, 1990, patient #24 presented to Respondent suspecting a Candida-related immune problem because of previous antibiotic treatment for bronchitis. Patient #24 also complained that he caught "every flu and cold that comes around." Respondent diagnosed patient #24 with hypertension, chronic bronchitis, sinusitis, rhinitis, serous otitis media, food allergies, duodenal ulcer, depression and obesity without documenting a complete physical examination and without ordering gastrointestinal, chest or sinus x-rays, or IgE RAST or skin tests.

b) Respondent prescribed Nystatin and Nizoral for patient #24 and placed him on an elimination and rotary diet, but failed to document a treatment plan which addressed the patient's multiple diagnoses.

c) Although Respondent treated patient #24 with Nizoral and a baseline liver panel was ordered, the records do not indicate that Respondent regularly monitored liver function throughout the course of treatment.

25) With respect to the care provided to patient #25:

a) On January 26, 1990, patient #25 presented to Respondent with complaints of dizziness. Respondent diagnosed patient #26 with dizziness/vertigo, serous otitis media and sinusitis without documenting a complete physical examination and without ordering sinus x-rays.

b) During patient #25's initial visit, Respondent noted that CRC (Candida-related-complex) and food allergies should be considered.

26) With respect to the care provided to patient #26:

a) On August 25, 1988, patient #26 presented to Respondent complaining of feeling "drained", having difficulty concentrating, repeated bouts of sinusitis and post nasal drip, recurrent constipation and diarrhea, depression, and cold feet. On his initial visit, patient #26 was treated with Nystatin and Nizoral for presumed candidiasis hypersensitivity syndrome.

b) Respondent prescribed thyroid supplements without documenting any clinical examination or laboratory studies indicating that patient #26 was hypothyroid.

c) Respondent wrote a letter to patient #26's father in which he described candida-related complex as a "complex neuroimmune disorder. We know it causes a triangle of symptoms: (i) emotional psychological; (ii) allergic immunological; and (iii) hormonal endocrinological . . . it will be years before all the connections are made and proven by research."

d) Respondent documented his awareness that patient #26 was being seen at the Menninger Clinic regarding his psychological/intellectual difficulties; yet

Respondent failed to address these issues with the patient or to communicate with other treating physicians involved in this aspect of the patient's care.

27) With respect to the care provided to patient #27:

a) On December 8, 1988, patient #27 presented to Respondent with complaints of prostatitis, sinusitis, athlete's foot and recurring sensitivity to odors. Respondent diagnosed patient #27 with sinusitis, colitis, and prostatitis without documenting a complete physical examination and without ordering gastrointestinal or sinus x-rays or stool hemoccult tests. Respondent's diagnosis of colitis was based on abdominal tenderness and history. Respondent did not perform a rectal examination to verify his diagnosis of prostatitis.

b) In January 1989, Respondent prescribed Nizoral for patient #27 without ordering a baseline liver panel and the records do not indicate that ongoing liver function was monitored throughout the course of treatment.

c) The incomplete records include chart notes for only the patient's first three visits, although it appears that patient #27 saw Respondent on at least five occasions between December 1988 and October 1989.

c. In September 1995, the Board received a complaint which alleged violations in Respondent's care and treatment of patient #28. A review of the patient's records and Respondent's written response to the complaint indicate:

1) On June 15, 1995, patient #28 presented to Respondent with a lengthy history of candida-related problems for which she had been taking Nystatin, prescribed by other physicians, as well as vitamins, herbs, etc. Respondent noted that patient #28 was having ongoing problems with depression, sinusitis, vaginitis, brainfog/confusion, and food allergies. Respondent diagnosed patient #28 with systemic candidiasis (severe), sinusitis, probable food allergies (Type II-delayed), possible hypothyroidism, serous otitis media, and depression without documenting a complete physical examination and without ordering sinus x-rays, IgE RAST or skin tests.

2) Respondent prescribed the anti-fungal agents Diflucan and Nystatin for patient #28, prior to receiving the results of confirmatory diagnostic tests.

3) Respondent provided patient #28 with a written "Candida-Related Complex Protocol" which outlined the general course of treatment, including a restrictive (yeast free, sugar free) diet, prescribed medications, and recommended dietary supplements.

4) Patient #28 was informed that she should contact Wellness Resources, Inc. (located next door to Respondent's office), to obtain the dietary supplements Hepagen, DDS, Pantethine, and Aminotate.

a) Respondent served as one of two original members of the Board of Directors of Wellness Resources, Inc; originally incorporated in September 1985 under the name Stress Energy Diagnostics, Inc.

b) When patient #28 expressed concerns regarding the high cost of the supplements and asked about obtaining the supplements through a less expensive source, Respondent informed patient #28 that the recommended supplements were prepared in a "special way" by Wellness Resources, Inc.

5) On July 12, 1995, patient #28 called Respondent and complained of dizziness, weakness, fatigue, and weight loss (120 lbs. to 113 lbs.) during the past month.

a) Respondent informed patient #28 that she was experiencing a yeast "die-off" reaction and that she should reduce her anti-fungal medications and consult with the nutritionist at Wellness Resources, Inc.

b) The nutritionist at Wellness Resources, Inc., recommended that patient #28 increase her caloric intake to stabilize the weight loss she experienced while following the dietary restrictions recommended by Respondent.

6) On August 20, 1995, Respondent received an "angry phone call" from patient #28, during which Respondent "became very angry" when patient #28 complained that Respondent's course of treatment was inappropriate.

7) In an August 28, 1995, letter to patient #28, Respondent acknowledged her complaint, stating that her "reaction was most unusual and has not occurred in the several thousand patients I have treated with systemic candidiasis." Respondent recommended that patient #28 "continue treatment with the antifungals Diflucan and Nystatin, but without the restricted diet."

STATUTES

3. The Committee views Respondent's practices as inappropriate in such a way as to require Board action under Minn. Stat. § 147.091, subd. 1(g), (k), (o), (p) and (s) (1994) and Respondent agrees that the conduct cited above constitutes a reasonable basis in law and fact to justify the remedy set forth below.

REMEDY

4. Upon this stipulation and all of the files, records, and proceedings herein, and without any further notice or hearing herein, Respondent does hereby consent that until further order of the Board, made after notice and hearing upon application by Respondent or upon the Board's own motion, the Board may make and enter an order conditioning and restricting Respondent's license to practice medicine and surgery in the State of Minnesota as follows:

a. Within one year of the date of this order, Respondent shall successfully complete the Special Purposes Examination and a records management course approved by the Board. Successful completion shall be determined by the Board.

b. Respondent shall close his family practice by March 15, 1997. Respondent shall notify his patients that his practice will be closing and make arrangements to transfer patient care. Respondent shall not accept any new patients as of the date of this order.

c. Effective March 15, 1997, Respondent shall limit his practice to acting as Medical Director of the New Life Weight Management Group. Respondent shall not diagnose or treat patients for conditions other than obesity. Respondent shall prescribe only FDA-approved medications for weight loss.

d. Respondent shall develop and submit for Board approval, practice protocols that address the following:

- (1) treating obese patients;
- (2) weight loss prescribing; and
- (3) assessing patients for chemical dependency

If a protocol needs to be revised in the future, Respondent shall submit the revised protocol to the Board for approval before changing his practice.

e. Respondent must obtain advance approval from the Board if he wishes to practice in any other capacity or practice setting. To obtain such approval, Respondent must make a written request to the Board. Before acting on Respondent's request, the Board may require Respondent to attend the Colorado Personalized Education for Physicians program or similar program.

f. Respondent shall obtain a supervising physician approved in advance by the Board, who shall provide quarterly reports to the Board regarding Respondent's prescribing and overall work performance.

g. Respondent shall meet quarterly with a designated Board member. Such meetings shall take place at a time mutually convenient to Respondent and the designated Board member. It shall be Respondent's responsibility to contact the designated Board member to arrange each of the quarterly meetings. The purpose of such meetings shall be to review Respondent's progress with the terms of this Stipulation and Order.

h. Respondent shall pay to the Board a civil penalty of \$10,000.

i. Respondent shall comply fully and completely with the statutes and rules of the Board.

5. Within ten days of the date of this order, Respondent shall provide the Board with a list of all hospitals and skilled nursing facilities at which Respondent currently has medical privileges and a list of all states in which Respondent is licensed or has applied for licensure. The information shall be sent to Robert A. Leach, Minnesota Board of Medical Practice,

University Park Plaza, 2829 University Avenue SE, Suite 400, Minneapolis, Minnesota 55414-3246.

6. If Respondent shall fail, neglect, or refuse to fully comply with each of the terms, provisions, and conditions herein, the Committee shall schedule a hearing before the Board. The Committee shall mail Respondent a notice of the violation alleged by the Committee and of the time and place of the hearing. Respondent shall submit a response to the allegations at least three days prior to the hearing. If Respondent does not submit a timely response to the Board, the allegations may be deemed admitted.

At the hearing before the Board, the Committee and Respondent may submit affidavits made on personal knowledge and argument based on the record in support of their positions. The evidentiary record before the Board shall be limited to such affidavits and this stipulation and order. Respondent waives a hearing before an administrative law judge and waives discovery, cross-examination of adverse witnesses, and other procedures governing administrative hearings or civil trials.

At the hearing, the Board will determine whether to impose additional disciplinary action, including additional conditions or limitations on Respondent's practice, or suspension or revocation of Respondent's license.

7. In the event the Board in its discretion does not approve this settlement, this stipulation is withdrawn and shall be of no evidentiary value and shall not be relied upon nor introduced in any disciplinary action by either party hereto except that Respondent agrees that should the Board reject this stipulation and if this case proceeds to hearing, Respondent will assert no claim that the Board was prejudiced by its review and discussion of this stipulation or of any records relating hereto.


8. In the event Respondent should leave Minnesota to reside or practice outside the state, Respondent shall promptly notify the Board in writing of the new location as well as the dates of departure and return. Periods of residency or practice outside of Minnesota will not apply to the reduction of any period of Respondent's suspended, limited, or conditioned license in Minnesota unless Respondent demonstrates that practice in another state conforms completely with Respondent's Minnesota license to practice medicine.

9. Respondent has been advised by Board representatives that he may choose to be represented by legal counsel in this matter and chosen Donald F. Hunter.

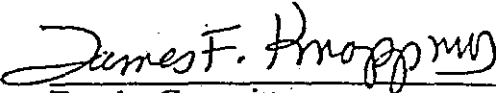
10. Respondent waives any further hearings on this matter before the Board to which Respondent may be entitled by Minnesota or United States constitutions, statutes, or rules and agrees that the order to be entered pursuant to the stipulation shall be the final order herein.

11. Respondent hereby acknowledges that he has read and understands this stipulation and has voluntarily entered into the stipulation without threat or promise by the Board or any of its members, employees, or agents. This stipulation contains the entire agreement between the parties, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this stipulation.

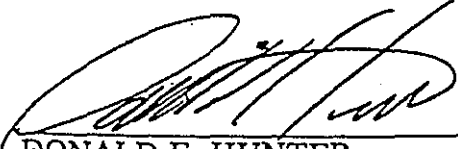
Dated: 12/26, 1996



KEITH W. SEHNERT, M.D.
Respondent



For the Committee



DONALD F. HUNTER
Attorney for Respondent



DAVID E. FLOWERS
Attorney for Committee

215 Opus Center
9900 Bren Road East
Minnetonka, Minnesota 55343
Telephone: (612) 933-9900

500 Capitol Office Building
525 Park Street
St. Paul, Minnesota 55103
Telephone: (612) 297-1050

ORDER

Upon consideration of this stipulation and all the files, records, and proceedings herein,
IT IS HEREBY ORDERED that the terms of this stipulation are adopted and
implemented by the Board this 1th day of January, 1997.

MINNESOTA BOARD OF
MEDICAL PRACTICE

By: Robert J. O'Keefe

AFFIDAVIT OF SERVICE BY MAIL

Re: In the Matter of the Medical License of Keith W. Sehnert, M.D.
License No. 24,617

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

TAMMIE L. REEVES, being first duly sworn, deposes and says:

That at the City of St. Paul, County of Ramsey and State of Minnesota, on July 13, 1998, she served the attached AMENDED STIPULATION AND ORDER by depositing in the United States mail at said city and state, a true and correct copy thereof, properly enveloped, with first-class postage prepaid, and addressed to:

DONALD F HUNTER
ATTORNEY AT LAW
215 OPUS CTR
9900 BREN RD E
MINNETONKA MN 55343

Tammie L. Reeves

TAMMIE L. REEVES

Subscribed and sworn to before me
this 13th day of July, 1998.

Christine A. Arnold
Notary Public

