

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

FILED

FEB 20 2026

KS State Board of Healing Arts

In the Matter of)

Docket No.: 26-HA00019

Jacqueline M. Youtsos, M.D.)

Kansas License No. 04-38483)

ORDER AFFIRMING EMERGENCY SUSPENSION

NOW ON this 20TH day of February 2026, the Presiding Officer, upon due notice and having given Licensee, Jacqueline M. Youtsos, M.D., the opportunity to be heard in this matter, finds that substantial and competent evidence supports the December 19, 2025, Emergency Order of Suspension. Licensee's SUSPENSION from the practice of medicine and surgery in Kansas continues until such time as her situation no longer poses an immediate danger to the public health and safety or as otherwise ordered. The FINDINGS OF FACT AND CONCLUSIONS OF LAW are as follows:

1. On January 13, 2025, Tom Estep, M.D., the duly appointed Presiding Officer in this matter, held the hearing on the December 19, 2025, Emergency Order of Suspension via the Zoom format. The hearing continued with intermittent recesses and was concluded on January 29, 2026.

2. The dates of the hearing were agreed to by the parties and preferred over other dates offered to hear the matter earlier. In addition, the hearing was extended at the request of the Licensee to hear additional witnesses that Licensee chose to have testify after Licensee.

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3. C. Sabastian Thomas Orosco, Deputy Litigation Counsel, appeared virtually on behalf of the Disciplinary Panel #40 (Petitioner).

4. Jacqueline M. Youtsos, M.D. (Licensee) appeared virtually. Counsel for Licensee, Kelli J. Stevens and Monica A. Doffing of Stevens Law, LLC also appeared virtually on behalf of Licensee.

5. It cannot be overstated: the care at issue in this case involved a tragic Medical/Surgical accident on June 25, 2024, which resulted in the death of Licensee's patient, the death of whom was totally avoidable. Further, this death occurred within a facility that Licensee owns, manages, supervises, and in which she is responsible for the care of patients. Hearing transcript, Vol. I, 70:12-20; Vol. 2, 53:19-54:4. This fact is the overarching fact that remains at the heart of this case.

6. Based on the evidence and arguments presented at the hearing, on the applicable law, and the record before him, the Presiding Officer further FINDS AND ORDERS the following:

- a) Licensee and her clinic staff have insufficient knowledge, training, equipment or protocols in place to address adverse outcomes like that which occurred on June 25, 2024.
- b) K.A.R. 100-25-3(a)(2) requires at least one person to have training in advanced resuscitative techniques and to be in the immediate presence of patients at all times until the patient is discharged from anesthesia care.

Licensee's protocols and the lack of training records do not comply with the requirements of K.A.R. 100-25-3(a)(2) jeopardizing patient care. Little weight can be afforded Licensee's expert in this regard. Although Licensee's expert testified that training in advanced resuscitative techniques is inherent in medical school education, hearing transcript, Vol. 1, 29:2-18, his testimony sounded more akin to assumption. Licensee concluded medical school in 2009 and residency training in 2012, more than ten years before the care at issue in the present matter. Licensee Exhibit K. Further, to the extent Licensee did receive any training in advanced resuscitative techniques during her medical education, it has not been updated or regularly reviewed. No such advanced care techniques were utilized during the care at issue. No advanced care techniques were initiated until after the arrival of Emergency Medical Services (EMS). Petitioner Exhibit 14. It defies reason that if she had the required advanced resuscitative training from medical school that she wouldn't have applied those skills when it was required of her.

- c) Pursuant to K.A.R. 100-25-3(c), resuscitation and emergency equipment must be present in offices performing surgery and special procedures. Based on the evidence presented, Licensee's clinic office does not have all the required equipment. Specifically, there is no positive-pressure ventilation device, emergency airway equipment, or back-up energy source. Neither Licensee's protocols nor her emergency preparedness plans show she has contemplated

sufficient space to accommodate all necessary equipment, all of which are required under K.A.R. 100-25-3(c). Hearing transcript, Vol. II, 13:10-14:24. Further, Licensee's required plan and protocols omit reference to equipment maintenance, and how staff are appropriately trained to utilize the same.

- d) Since the patient death at issue, Licensee has implemented new protocols. Licensee Exhibits A-D. Although a step in the right direction, they do not go far enough. Licensee's expert testified that Licensee and her clinic practice meet the standard of care. However, Licensee's expert's testimony is afforded little weight in that regard. A standard of care cannot exist that is lower than that required by law, in this case, pursuant to K.A.R. 100-25-3.
- e) Licensee's expert was unaware of any training logs for Licensee's clinic, and no such training documentation was presented at the hearing to confirm to what degree Licensee and her staff have been trained on the new protocols. Hearing transcript, Vol. 1, 69:20-70:11. Therefore, while Licensee's expert may have the opinion that Licensee's protocols are appropriate, despite the protocols lack of compliance with K.A.R. 100-25-3, Licensee's expert's opinion cannot be given the weight required to establish a standard.
- f) From the testimony of Licensee and her own explanation of her protocols, Licensee shows little, if any, understanding of her obligations under K.A.R. 100-25-3(e)(2) to notify the Board in writing within 15 calendar days following the death of a patient during any office-based surgery or special procedure or

when the transport of a patient to a hospital emergency department occurs. See, Petitioner's Exhibit 12. Although Licensee now has a protocol that states that post-event actions include a report of the event as required by law, Licensee's Exhibit C, the Presiding Officer finds that Licensee's protocol lacks specificity and a clear delineation of responsibility regarding her reporting responsibilities to the Board. Licensee was given ample opportunity on cross-examination to identify an understanding of her regulatory duties. Instead, she deflected blame on the Board arguing that they failed to contact her.

- g) Mention must also be made about Licensee's ongoing failures in supervision. Licensee's protocol provides that she will continue to supervise her staff during surgical procedures. Licensee equivocates on how that supervision continues while she has been suspended. Only M.D.s and D.O.s may conduct surgery. K.S.A. 65-2803 (license required to practice a profession regulated by the Board); K.S.A. 65-2869 (defines the performance of "any surgical operation of whatever nature" as the practice of medicine and surgery). Yet, her clinic remains open for business and operating under her name.
- h) Licensee's attitude toward record-keeping as being something that her office is too small to require (Vol. II, 48:14-49:14) or only for her own information, (Vol. I, 138:1-23) or something to be "cleaned-up" after the fact shows her lack of regard for the rightful importance of record-keeping in health care. Vol. 1, 155:7-25; Vol. II, 55:4-56:15. Little credibility is given to Licensee's assurances

that she is equipped to communicate expectations, supervise staff, and prevent harm in the future in light of her own testimony about record-keeping.

7. Individually and collectively, these findings result in a continued danger to the public necessitating Licensee's continued suspension. This is the least restrictive action the Board can take at this time and still assure the public's interests are protected.
8. This case shall proceed to a full hearing on the alleged violations of the Kansas Healing Arts Act contained in Petitioner's November 20, 2025, Petition without further delay.
9. The parties are asked to prepare a proposed case management order and submit it to the presiding officer within 14 days of the entry of this order.

WHEREFORE, because of the immediate danger posed by Licensee were she to resume practice as a physician, Licensee's SUSPENSION REMAINS IN EFFECT until further order or action.

IT IS SO ORDERED.

FOR THE KANSAS STATE BOARD OF HEALING ARTS

*1 Jerenda Mitchell #11690
Attorney for the Presiding Officer*

Tom Estep, M.D.
Presiding Officer

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CERTIFICATE OF SERVICE

I certify that a true and correct copy of the foregoing **Order Affirming Emergency Suspension** was served this 20th day of February 2026, by depositing the same in the United States Mail, first-class postage prepaid, and via email addressed to:

Jacqueline M. Youtsos, M.D.

CONFIDENTIAL

Licensee

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and a copy was hand-delivered to the office of:

C. Sebastian Thomas Orosco, Associate Litigation Counsel
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Kansas State Board of Healing Arts
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And the original was filed with the office of the Executive Director.

L. Hunter-Roach

Staff Signature

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