



STATE OF WISCONSIN

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MEDICAL EXAMINING BOARD MEETING
Room 121A, 1400 E. Washington Avenue, Madison
DRL Contact: Tom Ryan (608) 261-2378
May 16, 2012

The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting items may be removed from the agenda. Please consult the meeting minutes for a summary of the actions and deliberations of the Board.

8:00 A.M.

OPEN SESSION

- 1. Call to Order – Roll Call**
- 2. Declaration of Quorum**
- 3. Introduction of New Board Member(s)**
- 4. Recognition of Board Member(s)**
- 5. Adoption of the Agenda (insert) (1-6)**
- 6. Approval of Minutes of April 18, 2012 (insert) (7-16)**
- 7. Approval of Minutes of May 1, 2012 Teleconference (insert) (17-18)**
- 8. Case Presentations**

Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s) in the Matter of:

- a. Linda D. Meehan, DO - 11 MED 372 **(637-642)**
 - Attorney Susan Gu
 - Case Advisor – LaMarr Franklin
- b. Guy R. Powell, MD – 10 MED 187 **(643-648)**
 - Attorney Arthur Thexton
 - Case Advisor – Sridhar Vasudevan
- c. Jesse O. Vegafria, MD – 11 MED 041 **(649-664)**
 - Attorney Arthur Thexton
 - Case Advisor – LaMarr Franklin
- d. Marc L. Smith, DO – 08 MED 364 **(665-676)**
 - Attorney Pamela Stach
 - Case Advisors – Jack Lockhart and James Conterato

- e. Bradley T. Bodner, PA – 09 MED 198 **(677-688)**
 - Attorney Pamela Stach
 - Case Advisor – Raymond Mager
- f. Dale Sinnett, MD – 11 MED 163 **(689-694)**
 - Attorney Pamela Stach
 - Case Advisor – James Conterato
- g. Michael G. O’Mara, MD – 10 MED 165 **(695-700)**
 - Attorney Kim Kluck
 - Case Advisor – LaMarr Franklin

9. Executive Director Matters

10. Items Received After Mailing of Agenda

- a. Presentation of Proposed Stipulations and Final Decisions and Orders
- b. Presentation of Proposed Decisions
- c. Presentation of Interim Orders
- d. Petitions for Re-hearing
- e. Petitions for Summary Suspension
- f. Petitions for Extension of Time
- g. Petitions for Assessments
- h. Petitions to Vacate Orders
- i. Requests for Disciplinary Proceeding Presentations
- j. Motions
- k. Appearances from Requests Received or Renewed
- l. Speaking Engagement, Travel and Public Relation Requests
- m. Application Issues
- n. Examination Issues
- o. Continuing Education Issues
- p. Practice Questions

11. Items for Board Discussion

- a. FSMB Matters
 - 1. Report from FSMB Annual Meeting – Sheldon Wasserman, LaMarr Franklin and Kenneth Simons
- b. Maintenance of Licensure **(insert) (19-24)**
- c. Chapter MED 8 Update
- d. Chapter MED 10 Update
 - 1. Review Currency of MED 10.02(2)(s) Pertaining to Prescribing Amphetamines **(insert) (25-30)**
 - 2. MED 10 Project Plan Timeline **(insert) (31-36)**
- e. Legislative Report
 - 1. Criminal Background Check Law **(insert) (37-38)**
 - a. MEB/DSPS Access to the National Crime Information Center (NCIC) **(insert) (39-40)**
- f. Informed Consent and Review of WI Supreme Court Decision **(insert) (41-52)**
- g. Medical Board Newsletter
- h. Board Outreach

- 12. Screening Panel Report**
- 13. Informational Item(s)**
- 14. Public Comment(s)**
- 15. Other Business**

CLOSED SESSION

CONVENE TO CLOSED SESSION to deliberate on cases following hearing (Wis. Stat. § 19.85 (1) (a)); consider closing disciplinary investigation(s) with administrative warning(s) (Wis. Stat. § 19.85 (1) (b), and Wis. Stat. § 440.205); consider individual histories or disciplinary data (Wis. Stat. § 19.85 (1) (f)); and to confer with legal counsel (Wis. Stat. § 19.85 (1) (g)).

CS-1 Full Board Oral Examination – 9:30 a.m. – Thomas J. Byrne, MD (insert) (53-574)

CS-2 Full Board Oral Examination – 9:45 a.m. – Saman K. Jayasinghe, MD (insert) (575-636)

CS-3 Deliberation of Stipulation(s), Final Decision(s) and Order(s) in the Matter of:

- a. Linda D. Meehan, DO - 11 MED 372 **(insert) (637-642)**
 - o Attorney Susan Gu
- b. Guy R. Powell, MD – 10 MED 187 **(insert) (643-648)**
 - o Attorney Arthur Thexton
- c. Jesse O. Vegafria, MD – 11 MED 041 **(insert) (649-664)**
 - o Attorney Arthur Thexton
- d. Marc L. Smith, DO – 08 MED 364 **(insert) (665-676)**
 - o Attorney Pamela Stach
- e. Bradley T. Bodner, PA – 09 MED 198 **(insert) (677-688)**
 - o Attorney Pamela Stach
- f. Dale Sinnett, MD – 11 MED 163 **(insert) (689-694)**
 - o Attorney Pamela Stach
- g. Michael G. O’Mara, MD – 10 MED 165 **(insert) (695-700)**
 - o Attorney Kim Kluck

CS-4 Deliberation of Proposed Administrative Warning(s)

- a. 11 MED 267 (D.W., MD) **(insert) (701-704)**
 - o Attorney Arthur Thexton
 - o Case Advisor – Raymond Mager
- b. 11 MED 183 (C.J.M., MD) **(insert) (705-706)**
 - o Attorney Kim Kluck
 - o Case Advisor – Raymond Mager

c. 11 MED 070 (M.G., MD) **(insert) (707-712)**

- Attorney Pamela Stach
- Case Advisor – Gene Musser

CS-5 Consideration of Complaint(s)

a. 11 MED 101 (M.T.P., MD) **(insert) (713-716)**

CS-6 Monitoring (insert) (717-718)

- a. Dale Bertram, MD – Request for Modifications **(insert) (719-738)**
- b. David Buchanan, MD – Request for Extension of Time to Complete CE **(insert) (739-750)**
- c. **APPEARANCE – JENE VANDENHOUT, RCP, AND ATTORNEY KAREN JULIAN – 10:15 A.M.**
 - Jene VanDenHout, RCP – Request for Modifications and Stay of Suspension **(insert) (751-770)**

CS-7 Case Closings (insert) (771-772)

CS-8 Consulting with Legal Counsel

Deliberation of Items Received in the Bureau after Preparation of Agenda

- a. Proposed Stipulations
- b. Proposed Decisions and Orders
- c. Proposed Interim Orders
- d. Objections and Responses to Objections
- e. Complaints
- f. Petitions for Summary Suspension
- g. Remedial Education Cases
- h. Petitions for Extension of Time
- i. Petitions for Assessments
- j. Petitions to Vacate Orders
- k. Motions
- l. Administrative Warnings
- m. Matters Relating to Costs
- n. Appearances from Requests Received or Renewed
- o. Examination Issues
- p. Continuing Education Issues
- q. Application Issues
- r. Monitoring Cases
- s. Professional Assistance Procedure Cases

Division of Enforcement – Meeting with Individual Board Members

Division of Enforcement – Case Status Reports and Case Closings

Ratifying Licenses and Certificates

RECONVENE INTO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

Voting on Items Considered or Deliberated on in Closed Session if Voting is Appropriate

Other Business

ADJOURNMENT

12:45 PM

CLOSED SESSION

Examination of 2 Candidates for Licensure – Drs. Musser, Simons, Vasudevan and Wasserman

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**MEDICAL EXAMINING BOARD
MINUTES
APRIL 18, 2012**

PRESENT: Carolyn Bronston; LaMarr Franklin; Jude Genereaux; Sujatha Kailas, MD; Raymond Mager, DO; Suresh Misra, MD; Gene Musser, MD; Sandra Osborn, MD; Kenneth Simons, MD; Timothy Swan, MD; Sridhar Vasudevan, MD; Sheldon Wasserman, MD (arrived at 8:30 a.m.)

EXCUSED: Rodney Erickson, MD

STAFF: Tom Ryan, Executive Director; Sandy Nowack, Legal Counsel; Karen Rude-Evans, Bureau Assistant; other DSPS staff

GUESTS: Mark Grapentine, Wisconsin Medical Society; Eric Jensen, WI Society of Anesthesiologists; Jeremy Levin, RWHC; Judy Warmuth, WHA; Tim Stumm, WHN; Scott Becher, Becher Group; David Wahlberg, WI State Journal

CALL TO ORDER

Dr. Gene Musser, Vice Chair, called the meeting to order at 8:00 a.m. A quorum of eleven (11) members was confirmed.

ADOPTION OF AGENDA

Amendments:

- Under PRESENTATION OF PROPOSED STIPULATIONS..., add:
 - h. Penny Cornelius, PA – 11 MED 123
 - Attorney Kim Kluck
 - Case Advisor – Christopher Magiera
 - i. Donald J. Baccus, MD – 10 MED 254
 - Attorney Arthur Thexton
 - Case Advisor – Sandra Osborn
- Under PRESENTATION OF PROPOSED SUMMARY SUSPENSIONS, add:

APPEARANCES – 8:15 A.M. – DOE Attorney Kim Kluck, Attorney Mark Budzinski and Terrance Moe, MD

 - a. Terrance Moe, MD – 08MED 323, 10 MED 430, 10 MED 431 (**Red Folder**)
 - Attorney Kim Kluck
 - Case Advisor – Sheldon Wasserman

APPEARANCES – 8:30 A.M. – DOE Attorney Arthur Thexton and James D. Hanna, MD

- b. James D. Hanna, MD – 12 MED 136 (**Red Folder**)
 - Attorney Arthur Thexton
 - Case Advisor – Raymond Mager

- Add in open session, APPEARANCE IN CONSIDERATION OF PETITION FOR REMOVAL OF INTERIM ORDER FROM THE NPDB – VICTORIA MONDLOCH:
- Item 9h – under PRACTICE QUESTIONS/FAQ’s, add:
 1. PGY-1 Resident Prescribing
- Item 14 – OTHER BUSINESS, add:
 - a. Letter from Dr. Wasserman to DHHS Secretary Kathleen Sebelius Regarding Licensing Fees
- Item CS-3, DELIBERATION OF STIPULATIONS..., add:
 - h. Penny Cornelius, PA – 11 MED 123
 - Attorney Kim Kluck
 - j. Donald J. Baccus, MD – 10 MED 254
 - Attorney Arthur Thexton
- Item CS-3(1) – DELIBERATION OF PROPOSED SUMMARY SUSPENSIONS, add:
 - a. Terrance Moe, MD – 08MED 323, 10 MED 430, 10 MED 431
 - Attorney Kim Kluck
 - b. James D. Hanna, MD – 12 MED 136
 - Attorney Arthur Thexton
- Item CS-4(1) – CONSIDERTION OF COMPLAINTS, add:
 - a. 11 MED 123 (P.L.A., MD)
 - b. 12 MED 002 (R.L.P., MD)
 - c. 12 MED 136 (J.D.H., MD)
- Item K (closed session) – MOTIONS, add: Deliberation of Petition for Removal of Interim Order from the National Practitioners Data Bank in the Matter of Victoria J. Mondloch, MD
- Case Status Report – insert at the end of the agenda in closed session

MOTION: Kenneth Simons moved, seconded by Carolyn Bronston, to adopt the agenda as amended. Motion carried unanimously.

APPROVAL OF MINUTES OF MARCH 21, 2012

MOTION: Kenneth Simons moved, seconded by LaMarr Franklin, to approve the minutes of March 21, 2012 as written. Motion carried unanimously.

PRESENTATION OF PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS

DOE Attorneys presented Proposed Stipulations, Final Decisions and Orders in the following disciplinary proceedings:

David D. Kim, MD	09 MED 122
William G. Sybesma, MD	09 MED 249
Karen L. Butler, MD	11 MED 117
Michael West, MD	10 MED 147

Syed G. Mohiuddin, MD	10 MED 425
Susan A. Watson, MD	11 MED 096
Michael T. Plante	11 MED 328
Penny Cornelius, PA	11 MED 123
Karen Butler, MD	11 MED 117
Donald J. Baccus, MD	10 MED 254

These items will be deliberated in closed session.

PRESENTATION OF PROPOSED SUMMARY SUSPENSIONS

DOE Attorney Kim Kluck and respondent's Attorney Mark Budzinski appeared before the Board regarding the proposed Summary Suspension of the license of **Terrance Moe, MD**, in **cases 08 MED 323, 10 MED 430 and 10 MED 431**. This matter will be deliberated in closed session.

DOE Attorney Arthur Thexton appeared before the Board regarding the proposed Summary Suspension of the license of **James D. Hanna, MD**, in **case 12 MED 136**. This matter will be deliberated in closed session. Legal Counsel Sandy Nowack was excused during the presentation. Colleen Baird stepped in as legal counsel for this matter.

APPEARANCE IN CONSIDERATION OF PETITION FOR REMOVAL OF INTERIM ORDER FROM THE NPDB

Attorney Mary Lee Ratzel appeared on behalf of **Victoria J. Mondloch, MD (09 MED 258, 10 MED 363)**, to petition for removal of an Interim Order from the National Practitioners Data Bank. This matter will be deliberated in closed session. Sheldon Wasserman was excused during the presentation. Gene Musser chaired the meeting in Dr. Wasserman's absence.

EXECUTIVE DIRECTOR MATTERS

Medical Board Annual Report

The Board reviewed the Annual Report and made changes.

MOTION: Sujatha Kailas moved, seconded by LaMarr Franklin, to approve the Annual Report with the changes as discussed and to authorize Sheldon Wasserman to review the redrafted Annual Report and approve it for publication to the DSPS website. Motion carried unanimously.

ITEMS FOR BOARD DISCUSSION

Prescription Drug Monitoring Program (PDMP) Report

Tom Ryan updated the Board on the progress of the PDMP.

Maintenance of Licensure and FSMB Matters

The FSMB Annual Meeting is next week, April 26-28, 2011, in Fort Worth, Texas. Sheldon Wasserman will attend as the Board's delegate. LaMarr Franklin received a FSMB public

member scholarship for this meeting and Kenneth Simons will attend the MOL workshop. Attendees will give a report to the Board at the May meeting

Review of Wis. Admin. Code Med 8

Gene Musser reported there was a teleconference to further discuss Med 8. The workgroup continues to work on this rule.

Wis Admin. Code Chapter MED 10 Update

Sandy Nowack reported to the Board on the current status of MED 10. Sheldon Wasserman raised a concern with social media networks and inappropriate postings by medical personnel and students.

Medical Examining Board Newsletter

Topics for the next Newsletter should be submitted by the end of May. Sandra Osborn will draft an article regarding retired physicians and licensure.

Upcoming Outreach Opportunities

Gene Musser has been invited to give a presentation at the Wisconsin Hospital Association's annual Wisconsin Rural Health Conference at the Osthoff Resort in Elkhart Lake on June 28, 2012.

MOTION: Kenneth Simons moved, seconded by Sujatha Kailas, to authorize Gene Musser to give a presentation to the Wisconsin Hospital Association's Rural Health Conference on June 28, 2012. Motion carried unanimously.

Sandra Osborn gave a presentation to the Patient, Doctor and Society class at the U.W. School of Medicine on March 27, 2012.

Practice Questions/FAQ's

- PGY-1 Resident Prescribing
The Board reviewed the document drafted by legal counsel regarding the legal status of PGY-1 resident prescribing in Wisconsin.

LEGISLATIVE REPORT

Sandy Nowack and Gene Musser reviewed the legislation signed into law with the Board. The rule-making process needs to be initiated.

MOTION: Carolyn Bronston moved, seconded by Gene Musser, to ask the Department of Safety and Professional Services to begin the rules process as relates to Wisconsin Act 159. Motion carried unanimously.

MOTION: Gene Musser moved, seconded by Jude Genereaux, to ask the Department of Safety and Professional Service to begin the rules process as relates to Wisconsin Act 160. Motion failed.

No Board determined that no further action was needed regarding Act 160 at this time.

Sandy Nowack reviewed Wisconsin Act 161 with the Board. No Board action was taken at this time. Ms. Nowack will report back to the Board at the next meeting.

The Board reviewed 2011 Wisconsin Act (AB 259) to amend 119.04(1) and to create 118.293 of the statutes relating to concussions and other head injuries in youth athletic activities. No Board action was taken.

MOTION: Sridhar Vasudevan moved, seconded by Sandra Osborn, to ask the Department of Safety and Professional Services to begin the rules process as relates to Wisconsin Act 32 and respiratory care practitioners. Motion carried unanimously.

SCREENING PANEL REPORT

Jude Genereaux reported sixty five (65) cases were screened. Twenty two (22) cases were opened and four (4) ten-day letters were sent.

Sheldon Wasserman and Jeanette Lytle discussed a pilot study to send complaints regarding medical specialties to the corresponding Board member specialist. The Board member would review the information and make a recommendation to the screening panel. The Board members and Ms. Lytle expressed concerns regarding possible delays in case reviews. Dr. Wasserman would like to proceed with the pilot project.

INFORMATIONAL ITEMS

The informational items were noted.

PUBLIC COMMENTS

None.

OTHER BUSINESS

The Board reviewed and edited the letter from Sheldon Wasserman to DHHS Secretary Kathleen Sebelius.

RECESS TO CLOSED SESSION

MOTION: Kenneth Simons moved, seconded by Sandra Osborn, to convene to closed session to deliberate on cases following hearing (Wis. Stat. § 19.85 (1) (a)); consider closing disciplinary investigation(s) with administrative warning(s) (Wis. Stat. § 19.85 (1) (b), and Wis. Stat. § 440.205); consider individual histories or disciplinary data (Wis. Stat. § 19.85 (1) (f)); and to confer with legal counsel (Wis. Stat. § 19.85 (1) (g)). Roll call: Carolyn

Bronston-yes; LaMarr Franklin-yes; Jude Genereaux-yes; Sujatha Kailas-yes; Raymond Mager-yes; Suresh Misra-yes; Gene Musser-yes; Sandra Osborn-yes; Kenneth Simons-yes; Timothy Swan-yes; Sridhar Vasudevan-yes; Sheldon Wasserman-yes. Motion carried unanimously.

Open session recessed at 11:11 a.m.

RECONVENE IN OPEN SESSION

MOTION: Kenneth Simons moved, seconded by LaMarr Franklin, to reconvene in open session. Motion carried unanimously.

Open session reconvened at 1:32 p.m.

ITEMS VOTED ON DURING CLOSED SESSION

FULL BOARD ORAL EXAMINATION

MOTION: Sridhar Vasudevan moved, seconded by Sandra Osborn, to deny the application for licensure to **Abedulnaasser Mohammedlamien, MD**, as he has not satisfied the Board that he meets the requirements for licensure. Motion carried. Sujatha Kailas opposed.

ORAL INTERVIEW FOR VISITING PROFESSOR LICENSE

MOTION: Suresh Misra moved, seconded by Sujatha Kailas, to grant a visiting professor license to **Aeyal Raz, MD**, when all requirements are met. Motion carried. Kenneth Simons and Sridhar Vasudevan opposed.

PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS

MOTION: Raymond Mager moved, seconded by LaMarr Franklin, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **David D. Kim, MD (09 MED 122)**. Motion carried. Gene Musser and Kenneth Simons abstained.

MOTION: Gene Musser moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **William G. Sybesma, MD (09 MED 249)**. Motion carried. Sujatha Kailas was excused during deliberation and abstained from voting.

MOTION: Jude Genereaux moved, seconded by Raymond Mager, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **Karen L. Butler, MD (11 MED 117)**. Motion carried. Kenneth Simons opposed and LaMarr Franklin abstained.

- MOTION:** Suresh Misra moved, seconded by Carolyn Bronston, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **Michael West, MD (10 MED 147)**. Motion carried unanimously.
- MOTION:** Suresh Misra moved, seconded by Sujatha Kailas, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **Syed G. Mohiuddin, MD (10 MED 425)**. Motion carried unanimously.
- MOTION:** Sujatha Kailas moved, seconded by Carolyn Bronston, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **Susan A. Watson, MD (11 MED 096)**. Motion carried. Kenneth Simons abstained.
- MOTION:** Suresh Misra moved, seconded by LaMarr Franklin, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **Michael T. Plante, MD (11 MED 328)**. Motion carried unanimously.
- MOTION:** Sujatha Kailas moved, seconded by Raymond Mager, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **Penny Cornelius, PA (11 MED 123)**. Motion carried. Sridhar Vasudevan opposed.
- MOTION:** Kenneth Simons moved, seconded by LaMarr Franklin, to reject the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **Donald J. Baccus, MD (10 MED 254)**. Motion carried. Raymond Mager and Gene Musser abstained.

PROPOSED PETITIONS FOR SUMMARY SUSPENSION

- MOTION:** Sridhar Vasudevan moved, seconded by Jude Genereaux, to adopt the Petition for Summary Suspension in the disciplinary proceedings against **Terrance Moe, MD (08 MED 323, 10 MED 430, 10 MED 431)**. Motion carried unanimously.
- MOTION:** Gene Musser moved, seconded by Sujatha Kailas to adopt the Petition for Summary Suspension in the disciplinary proceedings against **James D. Hanna, MD (12 MED 136)**. Motion carried. Raymond Mager and Sandra Osborn were excused during deliberation and abstained from voting. Legal Counsel Sandy Nowack was excused during deliberation and Attorney Colleen Baird stepped in as Legal Counsel.

PROPOSED ADMINISTRATIVE WARNING(S)

MOTION: Carolyn Bronston moved, seconded by Suresh Misra, to issue the Administrative Warning in case **11 MED 247** against respondent **J.L.K., DO**. Motion carried unanimously.

CONSIDERATION OF COMPLAINT(S)

MOTION: Sujatha Kailas moved, seconded by Suresh Misra, to find probable cause to issue a complaint in the matter of **11 MED 123**. Motion carried unanimously.

MOTION: Carolyn Bronston moved, seconded by Raymond Mager, to find probable cause to issue a complaint in the matter of **12 MED 002**. Motion carried unanimously.

MOTION: Gene Musser moved, seconded by Sujatha Kailas, to find probable cause to issue a complaint in the matter of **12 MED 136**. Motion carried. Raymond Mager and Sandra Osborn were excused during deliberation and abstained from voting.

MONITORING

MOTION: Sujatha Kailas moved, seconded by Gene Musser, to grant the request from **Joel Jacobson, MD**, for termination of the therapy requirement and to deny the request for a reduction in drug screens. Motion carried. Timothy Swan opposed.

PETITION FOR REMOVAL OF INTERIM ORDER FROM THE NPDB

MOTION: Kenneth Simons moved, seconded by Suresh Misra, to reject the Petition for removal on the Interim Order from the National Practitioners Data Bank in the disciplinary proceedings against **Victoria J. Mondloch, MD (09 MED 258, 10 MED 363)**. Motion carried. Sheldon Wasserman was excused during deliberation and abstained from voting. Gene Musser was Acting Chair for this matter.

CASE CLOSINGS

MOTION: Carolyn Bronston moved, seconded by LaMarr Franklin, to close case **11 MED 261** for no violation. Motion carried unanimously.

MOTION: Raymond Mager moved, seconded by Suresh Misra, to close case **11 MED 256** for no violation. Motion carried unanimously.

MOTION: Carolyn Bronston, moved, seconded Suresh Misra, to close case **10 MED 188** for no violation. Motion carried unanimously.

RATIFY ALL LICENSES AND CERTIFICATES

MOTION: Gene Musser moved, seconded by Suresh Misra, to ratify all licenses and certificates as issued. Motion carried unanimously.

OTHER BUSINESS

The Board reviewed the re-drafted letter from Sheldon Wasserman to DHHS Secretary Kathleen Sebelius.

MOTION: Timothy Swan moved, seconded by LaMarr Franklin, to approve the re-drafted letter to DHHS Secretary Kathleen Sebelius. Motion carried unanimously.

MOTION: Suresh Misra moved, seconded by LaMarr Franklin, to approve Sridhar Vasudevan to work with Sandy Nowack and Arthur Thexton to develop proposed guidelines for opioid prescribing and to bring the proposal to a future Board meeting for review. Motion carried unanimously.

ADJOURNMENT

MOTION: Gene Musser moved, seconded by Sandra Osborn to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 1:44 p.m.

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**MEDICAL EXAMINING BOARD
TELECONFERENCE MINUTES
MAY 1, 2012**

PRESENT: Carolyn Bronston; LaMarr Franklin; Jude Genereaux; Sujatha Kailas, MD; Suresh Misra, MD; Gene Musser, MD; Sandra Osborn, MD; Kenneth Simons, MD; Timothy Swan, MD; Sheldon Wasserman, MD (joined at 8:17 a.m.)

EXCUSED: Rodney Erickson, MD; Raymond Mager, DO; Sridhar Vasudevan, MD

STAFF: Tom Ryan, Executive Director; Sandy Nowack, Legal Counsel; Karen Rude-Evans, Bureau Assistant; Shawn Leatherwood; Chad Zadrazil

GUESTS: none

CALL TO ORDER

Dr. Gene Musser, Vice Chair, called the teleconference to order at 8:16 a.m. A quorum of nine (9) members was confirmed. Sheldon Wasserman joined the teleconference at 8:17 a.m. and took over as Chair.

ADOPTION OF AGENDA

Amendments:

- Stipulation and Interim Order in the Disciplinary Proceedings Against Terrance Moe, MD – 08 MED 323, 10 MED 430 and 10 MED 431

The agenda was approved by consensus.

**PRESENTATION OF PETITION FOR DESIGNATION OF HEARING OFFICIAL AND
CONSIDERATION OF STIPULATION AND INTERIM ORDER IN THE MATTER OF
TERRANCE MOE, MD
08 MED 323, 10 MED 43 AND 10 MED 431**

DOE Attorney Kim Kluck gave a presentation to the Board in the disciplinary proceedings against **Terrance Moe, MD**.

RECESS TO CLOSED SESSION

MOTION: Sandra Osborn moved, seconded by Sujatha Kailas, to convene to closed session to consider individual histories or disciplinary data (Wis. Stat. § 19.85 (1) (f)); and to confer with legal counsel (Wis. Stat. § 19.85 (1) (g)). Roll call: Carolyn Bronston-yes; LaMarr Franklin-yes; Jude Genereaux-yes; Sujatha Kailas-yes; Suresh Misra-yes; Gene Musser-yes; Sandra Osborn-yes; Kenneth Simons-yes; Timothy Swan-yes; Sheldon Wasserman-yes. Motion carried unanimously.

Open session recessed at 8:24 a.m.

RECONVENE IN OPEN SESSION

MOTION: Sujatha Kailas moved, seconded by Sandra Osborn, to reconvene in open session. Motion carried unanimously.

Open session reconvened at 8:34 a.m.

ITEMS VOTED ON DURING CLOSED SESSION

MOTION: Kenneth Simons moved, seconded by Gene Musser, to designate Chad Zadrazil as the hearing official in the disciplinary proceedings against **Terrance Moe, MD (08 MED 323, 10 MED 430 and 10 MED 431)** and to authorize the Division Administrator for Board Services to appoint another hearing official in the event Mr. Zadrazil is unable to fulfill this assignment. Motion carried unanimously.

MOTION: Kenneth Simons moved, seconded by Gene Musser, to adopt the Findings of Fact, Conclusions of Law, Stipulation and Interim Agreement Order in the disciplinary proceedings against **Terrance Moe, MD (08 MED 323, 10 MED 430 and 10 MED 431)**. Motion carried unanimously.

MOTION: Sandra Osborn moved, seconded by Sujatha Kailas, to delegate the signature of documents to Department staff. Motion carried unanimously.

ADJOURNMENT

MOTION: Sujatha Kailas moved, seconded by Kenneth Simons to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 8:36 a.m.

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: May 16, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Maintenance of Licensure Report	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Report from Dr. Simons and Dr. Wasserman following MOL meeting on 4/26 at FSMB annual meeting.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date

Maintenance of Licensure (MOL) Pilot Plan Summary

State Readiness Inventory

Summary

The State Readiness Inventory pilot entails the creation of an electronic survey designed to facilitate discussion of the best approach to participation in MOL pilots and implementation of MOL and to address any issues the medical boards may identify regarding either. It will help inform the medical boards about their ability and readiness to participate in current, and future, pilots as the MOL initiative progresses and will help inform the pilot selection process. Development of the survey will begin in February 2012 and will be distributed to pilot participating boards in April 2012. The survey is expected to take 60 minutes to complete; no additional resources will be required by participants.

Pilot Purpose

The pilot will identify issues state medical boards need to consider and possibly resolve to ensure the successful participation in MOL pilots and implementation of MOL. A survey will be prepared and presented to the participating board. Results of the survey will facilitate further refinement of other pilots and will help inform the state boards about 1) their ability and readiness to participate in the pilots and 2) the pilot selection process. The output of the survey will also be used as a means to discuss the approach to the implementation to MOL and to address any issues that were identified by the board.

The development of the survey will be led by staff from the Trilateral Collaborative (ABMS, FSMB and NBME) but will incorporate input and feedback from a variety of stakeholders, including: state medical boards, physicians, partner organizations, the MOL Implementation Group, and trilateral governance and staff. It is anticipated that any medical board planning to participate in a MOL pilot or implement MOL will complete the pilot. And, it is felt that the pilot will be modified over time as the implementation of MOL proceeds.

Pilot Objectives

- To develop and test an electronic survey for use as a consistent tool for medical boards and supporting organizations to assess the readiness and challenges they may face when participating in MOL pilots or implementing MOL
- To incorporate specific medical board insights and information on:
 - Motivation for participating in MOL and the pilot process
 - Selection of and preparation for upcoming pilot activities
 - The desired approach the board wants to take in executing the pilot, such as:
 - Whether the pilot will be conducted separately or incorporated into the existing renewal process
 - Selection of participants
 - Resources available and/or required for the pilot
 - Timing of the pilot
 - Costs and available funding
 - Communication and reporting

- o Additional support needed by the medical board during the pilot process

Pilot Participants

The survey will be circulated to key stakeholders, including state medical boards, physicians, partner organizations, the MOL Implementation Group, and trilateral governance and staff. It is anticipated that this survey will be completed by all pilot participating boards and would be distributed to:

- o Board Members (1 – many)
- o Executive Director (1)
- o Licensing Staff (1 – many)
- o Finance and Accounting Staff (1 – many)
- o Medical Director (1 – many)
- o Board Attorneys (1 – many)

The survey will be refined throughout the process of implementing MOL for pilot participating boards as well as for boards that implement MOL after the pilot work is complete.

Pilot Milestones

Milestones	Start Date	End Date	Potential State Medical Board Role/Responsibility
Development of MOL Readiness Survey, communication, instructions	Feb-12	Feb-12	
Review and approve MOL Readiness Survey	Mar-12	Mar-12	1. Vet survey.
Distribute MOL Readiness Survey	Apr-12	Apr-12	
Compile survey results	May-12	Jun-12	
Distribute and discuss survey results with MOL pilot board	Jul-12	Jul-12	1. Review results & provide feedback. 2. Engage in discussions about potential impact to SMB policy.
Adjust MOL Readiness Survey, communication, instructions	Aug-12	Aug-12	1. Provide suggestions for improvement.

Pilot Resource Requirements

Trilateral staff will manage the design, development, feedback, distribution and reporting of the survey. The identified stakeholder groups will provide input on the survey content. It is anticipated that the survey may take up to 60 minutes to complete by each medical board staff and board member; distribution of the survey will be determined by the participating executive director and/or board chair.

Maintenance of Licensure (MOL) Pilot Plan Summary **State Board License Renewal Process Integration**

Summary

The State Board License Renewal Process Integration pilot focuses on identifying the means by which MOL integrates with the various licensure renewal processes, policies and procedures. It will assess the license renewal cycle and board structure, and will provide the tools necessary to demonstrate compliance with MOL. Mechanisms will include analysis of existing board processes and structures, audits (via surveys, focus groups, etc.) and reports. While the organization and implementation of this pilot will be administered by the organizations participating in pilots, expertise on existing medical board licensure renewal processes will be critical to the success of the pilot.

Pilot Purpose

The pilot will be used to demonstrate how the proposed MOL system can be integrated into existing license renewal policies and procedures. Further, the pilot will be used to identify any impact on state board policies and procedures, practices, statutes and rules. Pilot participants will develop a plan and approach to either work around or resolve identified impediments, barriers or issues inhibiting the implementation of MOL.

Pilot Objectives and Measures

- To evaluate how the state board structure and infrastructure is impacted by the MOL system
 - Impact on key functions (i.e., departments and staff)
 - Impact on licensure and license renewal process steps (including periodicity)
 - Ease of MOL integration from the board staff and physicians' perspective
- To assess which state board policies and procedures are impacted by the MOL system
 - Physician participation in MOL requirements versus board CME requirements will be measured, along with impact on legislation, rules and regulation
- To determine the impact on the MOL system caused by varied license renewal processes and periodicities
 - Identification of key renewal process steps impacted by the MOL process
 - Ease of MOL implementation by point of entry into the renewal cycle
 - Degree of completeness of the three MOL components within that license renewal cycle
- To outline the means by which physicians demonstrate compliance with MOL
 - A record of the specific activities a physician engages in and an assessment of whether physician activities meet the needs of: 1) Board-required CME activities, 2) MOL-required activities and 3) MOC/OCC-required activities
 - An analysis of how acceptable proposed MOL reporting methods and content are to physicians, state boards and the activity providers

Pilot Participants

Based upon the purpose and objectives of the pilot and variability between board structure and requirements, a concerted effort will be made to maintain a consistent method and approach using:

- Focus groups (in person, webinar or teleconference) of physicians, state boards and activity providers
- Surveys (electronic and in person) of physicians, state boards and activity providers
- Analysis and mapping of board structure and license renewal processes
- Satisfaction of reporting techniques used in the pilot
- Key informant interviews
- Site visits for observation and data gathering

The sample size will be determined primarily by the pilot design but will need to be large enough to allow for meaningful results and will include (in excess of 25 licensees for each): 1) self-assessments, 2) assessment of knowledge and skills, 3) assessment of performance in practice, 4) board-required CME activities and 5) MOC/OCC-required CME activities. Two points of entry into the license renewal cycle will be considered (i.e., earlier and later).

Pilot Milestones

Milestones	Start Date	End Date	Potential State Medical Board Role/Responsibility
Identification of state board participants	Jan-12	Feb-12	
Analysis of board structure	Mar-12	Apr-12	1. Review compiled information.
Map board structure and license renewal process	Mar-12	Apr-12	1. Review compiled information.
Outline physician activities to satisfy board CME and MOL requirements	Mar-12	Apr-12	1. Review compiled information.
Create, review and approve report structure and mechanisms	Mar-12	Apr-12	1. Identify available reporting structures & mechanisms. 2. Approve report structure & mechanisms. 3. Engage in discussions about potential impact to SMB policy/procedures. 4. Implement report structure & mechanisms.
Gather business requirements for data transmission & storage	May-12	Nov-12	1. Identify business requirements for data transmission/storage.
Establish in-process auditing function	May-12	Nov-12	
Identify physicians participating in the pilot	May-12	May-13	1. Identify physicians (limited, indirect or no communication with physicians). 2. Recruit physicians (direct communication with physicians). 3. Input on incentives for physician participation.
Define/establish physician and practice characteristics	May-12	May-13	1. Review analyzed & compiled data.
Outline physician activities to satisfy board MOC/OCC requirements	May-12	May-13	1. Review compiled information. 2. Engage in discussions about potential impact to SMB policy.
Conduct surveys and focus groups	Nov-12	Nov-13	1. Provide sample for local focus groups. 2. Provide input on focus group design and content.
Report findings	Jun-13	Feb-14	1. Review final report. 2. Engage in discussions about potential impact to SMB policy/procedures.

Pilot Resource Requirements

Trilateral staff and consultants will manage the pilot activities and draw upon partner organizations and the identified stakeholder groups to provide input on content and approach. The expertise of the participating medical boards will be essential as this pilot is focused on the integration of the MOL system with the license renewal process.

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Dr. Kailas,

As you may recall, I became aware that the Wisconsin Medical Examining Board is revisiting the recommendations in regards to prescription stimulant therapy [Med 10.02(2)(s)]. As a board certified sleep physician I take great interest in this topic.

My background is as a board certified general Internist in Wisconsin from 1996-2006, and 2007-2011. I completed a sleep medicine fellowship at the University of Houston Health Science Center in Houston, TX during a sabbatical year 2006-2007 (and immediately obtained sleep medicine board certification). Since late 2011, I have exclusively practiced sleep medicine in Wisconsin. My practice is clinical, and there are many academic sleep specialists in Wisconsin and across the nation who are academicians pursuing clinical and basic research. In an attempt to keep this relatively brief, I will be liberally quoting or summarizing from their work. This is not a formal clinical review and any mistakes or misattributions are solely my own.

I have 2 general concerns. The first involves the current and specific indications for schedule II stimulant medications which misses a number of sleep and neurologic disorders. The second involves the Examining Board's treatment of these agents and the specificity in listing their indications.

There are a number of conditions which result in primary excessive daytime somnolence (EDS) which are not covered by the Medical Examining Board's guidelines. Schedule II stimulant therapy has been the mainstay of pharmacologic treatment for many if not most of these disorders, which are not limited to narcolepsy.

Patients diagnosed with narcolepsy currently are diagnosed as either narcolepsy with cataplexy or narcolepsy without cataplexy; this difference is not merely semantic but reflects neurologic differences in orexin/hypocretin levels. Patients with narcolepsy without cataplexy have excessive daytime somnolence which is treated in the same fashion as those with cataplexy.

There is consideration in the American Academy of Sleep Medicine (AASM) that the diagnosis of narcolepsy without cataplexy may be folded into the diagnosis of idiopathic hypersomnia, which is recognized, described and treated in sleep medicine with schedule II stimulants, but is not currently recognized by the WMEB. A patient treated for years for narcolepsy without cataplexy would then find herself unable to obtain stimulant therapy because of a definitional change in her diagnosis.

Note that idiopathic (primary) hypersomnia is distinct from undiagnosed hypersomnia and was described in the early 1970s (Roth et al. Arch Gen Psych 1972; 26:456). Idiopathic hypersomnia differs from narcolepsy in part by the absence of sleep onset REM periods (SOREMs) on multiple sleep latency testing (MSLT), which is a means of assessing the propensity to sleep. EDS in this syndrome is disabling and usually lifelong. Stimulant therapy has been the primary pharmacologic therapy for this disorder. See the Mayo Clinic Sleep Medicine and Stanford Hospitals and Clinics Sleep

Medicine websites which specifically state this as well. This is not controversial in sleep medicine.

Other pathologies of the CNS may result in clinically severe daytime sleepiness including paramedian hypothalamic strokes, as well as some traumatic brain injuries including blast injuries, tumors, cysts, multiple sclerosis plaques, and other structural brain lesions. Patients with myotonic dystrophy and Parkinson's disease frequently have EDS which can occasionally be severe with narcolepsy-like features including fall asleep at the wheel episodes causing driving accidents. If other sleep disorders are excluded, some of these patients are treated with stimulant drugs (Poryazova et al. *European Neurology* 2010;63:129).

Some patients with viral infections with neurologic manifestations such as atypical viral pneumonia, influenza (von Economo encephalitis), mononucleosis, and Guillain-Barre syndrome may have persistent hypersomnia after their recovery from the acute illness. There are also several recurrent hypersomnias, such as Kleine-Levin syndrome which usually occurs in adolescent boys and a similar syndrome in women, especially in the perimenstrual period and another in middle aged adults . Again, treatment may require stimulant drugs. (Young & Silber. *Chest* 2006;130:913)

Modafinil (and armodafinil) are schedule IV agents which can be effective for patients with EDS but are not a panacea. They are typically very expensive even if covered by insurance. Many insurers list the schedule ii agents as preferred. Not all patients with narcolepsy or other hypersomnias respond favorably to modafinil. As an aside, although effective for ADHD in studies of 6-17 year olds, modafinil was not approved for pediatric cases by the FDA due to side effects. Modafinil side effects include Stevens' Johnson syndrome, toxic epidermal necrolysis, and angioedema.

There are also a group of patients with residual somnolence despite documented use of CPAP at appropriate pressures and times. Animal models suggest that this may be related to hypoxemia induced damage of brain areas involved in controlling wake although this remains to be completely understood. Modafinil (and armodafinil) have FDA approval. In some patients, class II stimulants are used as off-label alternatives. (Hirshkowitz M, et al., *Respiratory Medicine*, 2007; 101(3): 616. Black JE, Hirshkowitz M Czeisler CA, et al., *New England Journal of Medicine*, 2005; 353(5): 476–486.)

In the current and 5th edition of the *Principles and Practice of Sleep Medicine*, edited by M. Kryger, T. Roth, and W. Dement, management guidelines for sleep specialists advise considering the prescription of off-label use of schedule II of stimulants for shift work sleep disorder, albeit judiciously and as part of an overall management strategy (p 792 in chapter 71, Shift Work, Shift-Work Disorder, and Jet Lag)

The AASM advises that amphetamine preparations are effective for otherwise intractable excessive somnolence and should not be withheld from appropriate patients. They are used for patients with documentation of more severe sleepiness, exclusion of other treatable causes of EDS, and when other medications are proven ineffective.

My second concern is that schedule II stimulants are limited to a specific list of 8 indications by the Wisconsin MEB. Although I am not an enthusiast when it comes to prescribing these agents, it troubles me to see a specific list of 'approved' diagnoses. Any current list becomes outmoded in time.

Patient care, medical science, pharmacology, and clinical practice are constantly evolving. The target is moving. We find everything from newly recognized medical problems, to newly recognized side effects and/or benefits for both old and new medications. Sleep medicine is one of the newest and youngest medical fields.

I do not think these agents should be casually or commonly prescribed in general practice, but they continue to be vital for some patients who have not been recognized by this current list. Any specific list faces this same problem. Creating a list based on FDA approval does not solve this problem. Many drugs are now used primarily off-label. For example, I believe tricyclic antidepressants are now mostly used for neuropathic pain.

My simplistic understanding is that off-label use is essentially an attempt to balance the competing goals of protecting patients from unsafe or ineffective therapies and the ability of physicians to use their professional judgement in treating patients. Off-label prescription per se is not illegal, unethical, or uncommon but the physician must be convinced that the lack of FDA approval is outweighed by the potential benefit to the patient and of course this should be discussed with the patient.

Per the FDA, "Good medical practice and the best interests of the patient require that physicians use legally available drugs, biologics and devices according to their best knowledge and judgment. If physicians use a product for an indication not in the approved labeling, they have the responsibility to be well informed about the product, to base its use on firm scientific rationale and on sound medical evidence, and to maintain records of the product's use and effects."

Yours,

Allen Foster, M.D.
Director, Center for Sleep Disorders
Agnesian HealthCare
Fond du Lac, WI

Wis. Admin Code § MED 10.02(2)(s) defines unprofessional conduct to include:

Prescribing, ordering, dispensing, administering, supplying, selling, or giving any amphetamine or sympathomimetic amine drug designated as a schedule II controlled substance to or for any person except for any of the following:

1. Use as an adjunct to opioid analgesic compounds for treatment of cancer-related pain,
2. Treatment of narcolepsy,
3. Treatment of hyperkinesis,
4. Treatment of drug induced brain dysfunction,
5. Treatment of epilepsy,
6. Differential diagnostic psychiatric evaluation of depression,
7. Treatment of depression shown to be refractory to other therapeutic modalities,
8. Clinical investigation of the effects of such drugs or compounds in which case an investigative protocol therefore shall have been submitted to and reviewed and approved by the board before such investigation has been begun.

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**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Sandy Nowack Legal Counsel		2) Date When Request Submitted: May 3, 2012 Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: May 16, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? MED10 Project Plan Timeline	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: As part of the Board's MED10 update, the project plan establishes working deadlines and the process to be used in completing the rules draft.			
11) Authorization <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 40%;"> </div> <div style="width: 20%; text-align: center;"> 5/3/12 Date </div> <div style="width: 30%; text-align: right;"> </div> </div> <hr/> Signature of person making this request			
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda) Date			
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			



State of Wisconsin

DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

CORRESPONDENCE / MEMORANDUM

DATE: May 5, 2012

TO: Gene Musser, M.D.
Chair, MED 10 Work Group

Sheldon Wasserman, M.D.
Chair, Wisconsin Medical Examining Board

FROM: Sandy Nowack
Legal Counsel

RE: MED10 Project Plan

This memo accompanies the projected project plan for MED10 completion. This project plan contemplates the final legislative report to be filed with the Governor's Office in March, 2013.

(The term "topic areas" refers to general groups of misconduct that are logically related and therefore will probably be discussed and drafted together).

Month	Tasks	Who is Responsible	Status
July 2010	Scope Statement published	<ul style="list-style-type: none"> Shawna 	<ul style="list-style-type: none"> Done
	Research Other States	<ul style="list-style-type: none"> Workgroup 	<ul style="list-style-type: none"> Done
	Target outstanding issues and topics	<ul style="list-style-type: none"> Workgroup/Sandy 	<ul style="list-style-type: none"> In progress
05.11.12	Receive WMS/Stakeholder response to conceptual draft	<ul style="list-style-type: none"> Stakeholders/Sandy 	<ul style="list-style-type: none"> In progress
06.04.12	Work Group Meeting/ Review of Stakeholder input by topic area	<ul style="list-style-type: none"> Work Group/Sandy 	<ul style="list-style-type: none"> Target Date
June-July	Drafting by topic area	<ul style="list-style-type: none"> Sandy/Shawn 	<ul style="list-style-type: none"> Pending
07.10.12	Draft to Work Group	<ul style="list-style-type: none"> Sandy/Shawn 	<ul style="list-style-type: none"> Target Date
07.17.12	Work Group Meeting: Review draft by topic area and review of input from Stakeholders	<ul style="list-style-type: none"> Workgroup/Sandy Stakeholders 	<ul style="list-style-type: none"> Target Date
July-Aug.	Drafting Topic Area	<ul style="list-style-type: none"> Workgroup/Sandy 	<ul style="list-style-type: none"> Pending
08.07.12	Draft to Work Group	<ul style="list-style-type: none"> Workgroup/Sandy 	<ul style="list-style-type: none"> Target Date
08.14.12	Work Group Meeting: Review Draft Work & continue to review stakeholder input by topic area	<ul style="list-style-type: none"> Workgroup/Sandy 	<ul style="list-style-type: none"> Target Date
Aug.-Sept.	Complete drafting work	<ul style="list-style-type: none"> Sandy/Shawn 	<ul style="list-style-type: none"> Pending
09.10.12	Proposed Rule and Rule Analysis in submitted to Work Group	<ul style="list-style-type: none"> Sandy/Shawn 	<ul style="list-style-type: none"> Target Date
09.18.12	Work Group Meeting: Revise/approve Proposed Rule for submission to MEB	<ul style="list-style-type: none"> Sandy 	<ul style="list-style-type: none"> Target Date
10.03.12	Agenda Deadline for placing Proposed Rule on MEB BRD Oct. Agenda	<ul style="list-style-type: none"> Sandy/Shawn 	<ul style="list-style-type: none"> Target Date
10.17.12	Full Board discussion of Proposed Rule at Oct. Meeting	<ul style="list-style-type: none"> MED BRD/ Sandy 	<ul style="list-style-type: none"> Target Date

10.24.12	Revisions to Proposed Rule as approved by the MED BRD forwarded to the Work Group (motion to delegate member of the Work Group to approval Final Draft of rule for submission to Clearinghouse)	<ul style="list-style-type: none"> Sandy 	<ul style="list-style-type: none"> Target Date
10.29.12	Work Group approval of Proposed Rule including MEBB BRD revisions (Delegate to approve)	<ul style="list-style-type: none"> Workgroup/Sandy 	<ul style="list-style-type: none"> Target Date
Nov 2012	<i>Proposed Rule, Fiscal Estimate, & Economic Impact Analysis</i> submitted for Clearinghouse Review (20 days)	<ul style="list-style-type: none"> Shawn 	<ul style="list-style-type: none"> Pending
12.01.12	Clearinghouse Report of Proposed Rule returned to Staff	<ul style="list-style-type: none"> Shawn 	<ul style="list-style-type: none"> Target Date
12.03.12	<i>Stakeholder Roundtable</i>	<ul style="list-style-type: none"> Sandy 	<ul style="list-style-type: none"> Pending per approval by Division Administrator
12.07.12	<i>Notice of Public Hearing</i> regarding the Proposed Rule Posted (Public Comment Period begins and will end on 02/01/2013)	<ul style="list-style-type: none"> Shawn 	<ul style="list-style-type: none"> Target Date
12.12.2012	MED BRD Review of <i>Clearinghouse Report</i> of Proposed Rule on MED BRD Dec. Agenda	<ul style="list-style-type: none"> Sandy/Shawn 	<ul style="list-style-type: none"> Tentative if necessary
01.16.2013	<i>Public Hearing</i> held on MED BRD Jan. Meeting	<ul style="list-style-type: none"> Tom/Sandy 	<ul style="list-style-type: none"> Target Date
02.01.2013	Public Comment Period Ends	<ul style="list-style-type: none"> Shawn 	<ul style="list-style-type: none"> Target Date

02.20.2013	<i>Clearinghouse Report and Public Comments</i> regarding the Proposed Rule submitted to the Board for Review at the FEB Meeting/	<ul style="list-style-type: none"> • Sandy/Shawn 	<ul style="list-style-type: none"> • Target Date
03.01.2013	<i>Final rule draft</i> of the proposed rule incorporating all revisions & <i>Legislative Report</i> generated	<ul style="list-style-type: none"> • Sandy/Shawn 	<ul style="list-style-type: none"> • Target Date
03.20.2013	Board grants approval for submission of Final Draft Rule & Legislative Report to the Legislature after gubernatorial review/approval	<ul style="list-style-type: none"> • Shawn 	<ul style="list-style-type: none"> • Target Date
03.28.2013	Rules Coordinator submits the Final Rule Draft to the Governor's Office for approval (The Governor's Office has an indefinite amount of time to review and grant approval of the Final Rule Draft)	<ul style="list-style-type: none"> • Shawn 	<ul style="list-style-type: none"> • Target Date
TBD	Final Draft of Rule submitted to legislature (Subject to approval granted by the Governor)	<ul style="list-style-type: none"> • Shawn 	<ul style="list-style-type: none"> • Target Date

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**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Gene Musser		2) Date When Request Submitted: _____	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: May 16, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Criminal Background Check Law	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required: _____	
10) Describe the issue and action that should be addressed: Board Discussion			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date

Date of enactment: **April 6, 2012**

2011 Senate Bill 464 Date of publication*: **April 19, 2012**

* Section 991.11, WISCONSIN STATUTES 2009-10 : Effective date of acts. "Every act and every portion of an act enacted by the legislature over the governor's partial veto which does not expressly prescribe the time when it takes effect shall take effect on the day after its date of publication as designated" by the secretary of state [the date of publication may not be more than 10 working days after the date of enactment].

2011 WISCONSIN ACT 255

AN ACT to amend 440.03 (13) (b) (intro.); and to create 440.15 of the statutes; relating to: prohibiting fingerprinting in connection with professional credentials issued by the Department of Safety and Professional Services or an examining board or affiliated credentialing board, except as provided in the statutes, and requiring the exercise of rule-making authority.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 440.03 (13) (b) (intro.) of the statutes is amended to read:

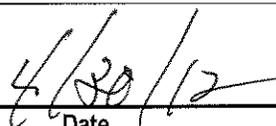
440.03 (13) (b) (intro.) The department may investigate whether an applicant for or holder of any of the following credentials has been charged with or convicted of a crime only pursuant to rules promulgated by the department under this paragraph, including rules that establish the criteria that the department will use to determine whether an investigation under this paragraph is necessary, except as provided in par. (c):

SECTION 2. 440.15 of the statutes is created to read:

440.15 No fingerprinting. Except as provided under s. 440.03 (13) (c), the department or a credentialing board may not require that an applicant for a credential or a credential holder be fingerprinted or submit fingerprints in connection with the department's or the credentialing board's credentialing.

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Sandy Nowack Legal Counsel		2) Date When Request Submitted: April 30, 2012 <small>Items will be considered late if submitted after 4:30 p.m. and less than:</small> <ul style="list-style-type: none"> - 10 work days before the meeting for Medical Board - 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: May 16, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? National Crime Information Center (NCIC) QUERIES NOT AVAILABLE FOR REVIEW OF MEB APPLICANTS	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: The Board requested I explore requirements for MEB/DSPS access to NCIC queries of applicants for licensure by the Medical Examining Board. Under federal law, the only method available for non-law enforcement entities to query NCIC is through fingerprinting. Current state law bars regulatory agencies from requiring fingerprinting without explicit legislative authority to do so. Therefore, it is legally impossible for the MEB or DSPS to access NCIC's data for application review.			
11) Authorization			
			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

Nowack, Sandra L - DSPS

From: Sime, Kevin A. [SimeKA@DOJ.STATE.WI.US]
Sent: Monday, April 30, 2012 3:38 PM
To: Nowack, Sandra L - DSPS
Cc: Neverman, Walter M - DOJ; Fortunato, Dennis J - DOJ
Subject: NCIC question

Hello Sandra,

Walt had sent your question below over to me. You are correct. The FBI requires civil applicants to submit fingerprints for background check clearance. They will only process fingerprint searches when statutory authority under federal laws or state statutes approved by the FBI under section 92-544. Name searches of the CJIS / FBI are for law enforcement personnel only to conduct criminal investigations or justice employment searches. Law enforcement personnel are required to pass security training to access these systems. Searches based on name only are problematic. There are over 60 million arrested persons in the FBI systems. Searching databases that large without unique identifiers could return many hits that would require further investigation. DSPS does have an FBI approved statute to license many of your licensees under Chapter 440.

Thank you,

Kevin Sime
Justice Records Supervisor

Hi Walt:

The Med Board has asked me to look into the legal requirements for accessing NCIC for new applicants. Sharon suggested you were the best person to confirm: my understanding is that NCIC will provide information as required by state law (meaning statute) and that for non-law enforcement purposes, NCIC will provide access only via fingerprinting and not via name query.

Is that accurate? If you are not the person who can answer that, do you have another suggestion.

Thanks. Hope all is well with you.
Sandy.

Sandra L. Nowack
Legal Counsel
Division of Board Services
Department of Safety and Professional Services
1400 E. Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935
Telephone: (608) 266-8098
Fax: (608) 266-2264
Email: Sandra.Nowack@Wisconsin.gov

Thank you,

Kevin A Sime
Justice Records Supervisor
Crime Information Bureau
Wisconsin Department of Justice

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Sandy Nowack Legal Counsel		2) Date When Request Submitted: May 4, 2012 <small>Items will be considered late if submitted after 4:30 p.m. and less than:</small> <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 														
3) Name of Board, Committee, Council, Sections: Medical Examining Board																
4) Meeting Date: May 16, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Review of Wisconsin Supreme Court Decision, Jandre v. Wis. Injured Patients and Families Compensation Fund														
7) Place item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:														
10) Describe the issue and action that should be addressed: Board will have an opportunity to discuss and ask questions concerning the recent decision of the Wisconsin Supreme Court concerning a physician's duty to inform patients of all viable alternative modes of treatment, as required by Wis Stat. 448.30, Wis. Admin. Code Chapter 18, Alternate Modes of Treatment, and Wis. Admin. Code sec MED 10.02(2)(u)																
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; vertical-align: top;">11)</td> <td style="width: 60%; text-align: center; vertical-align: top;"> Authorization  </td> <td style="width: 30%; text-align: center; vertical-align: top;">  </td> </tr> <tr> <td colspan="2" style="border-top: 1px solid black; border-bottom: 1px solid black;"> Signature of person making this request </td> <td style="border-top: 1px solid black; border-bottom: 1px solid black;"> Date </td> </tr> <tr> <td colspan="2" style="border-top: 1px solid black; border-bottom: 1px solid black;"> Supervisor (if required) </td> <td style="border-top: 1px solid black; border-bottom: 1px solid black;"> Date </td> </tr> <tr> <td colspan="3" style="border-top: 1px solid black; border-bottom: 1px solid black;"> Bureau Director signature (indicates approval to add post agenda deadline item to agenda) </td> <td style="border-top: 1px solid black; border-bottom: 1px solid black;"> Date </td> </tr> </table>				11)	Authorization 		Signature of person making this request		Date	Supervisor (if required)		Date	Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date
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Supervisor (if required)		Date														
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date													
Directions for including supporting documents: <ol style="list-style-type: none"> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting. 																



State of Wisconsin

DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

CORRESPONDENCE / MEMORANDUM

DATE: May 4, 2012

TO: Medical Examining Board

FROM: Sandy Nowack
Legal Counsel

RE: INFORMED CONSENT
Jandre v. Wis. Injured Patients and Families Comp. Fund,
2012 WI 38 (Wis. 2012)

The following is a discussion of the Wisconsin Supreme Court's recent decision in *Jandre v. Wis. Injured Patients and Families Comp. Fund*, 2012 WI 38 (Wis. 2012) along with an explanation of the Court's guidance for evaluating allegations that a physician violated the duty to inform patients of alternate viable modes of treatment or diagnosis. A summary of the case by an employee of the State Bar of Wisconsin is reprinted with permission of the State Bar of Wisconsin, and is attached. The primary purpose of this memo is to review relevant considerations Board members will make in assessing complaints concerning informed consent.

The Facts. In *Jandre*, the Court upheld a jury's determination that a physician had been negligent in her duty to provide a patient with viable reasonable alternative diagnostic procedures. The medical facts as set out in the *Jandre* decision, at ¶¶ 39-55, are as follows:

On June 13, 2003, the coffee Jandre was drinking began coming out of his nose and he began drooling and slurring his speech. The left side of his face drooped. He experienced about 20 minutes of dizziness and weakness in his legs.

Jandre's co-workers took him to the emergency room, and the ER nurse noted these symptoms in Jandre's chart.

Jandre was evaluated at the emergency room by Dr. B., who read Jandre's chart, took Jandre's medical, social and family history, and performed a physical examination. Dr. B. testified that her differential diagnosis included "Bell's Palsy, stroke, TIA, all of those stroke syndromes including ischemic as well as hemorrhagic, tumors, syndromes like—things like Guillain-Barré, MS [multiple sclerosis], and multiple other things like that." She noted that it included "some of the more obscure disease processes."

There are two types of strokes: hemorrhagic and ischemic. Either type can cause death or permanent injury.

Hemorrhagic strokes involve bleeding in the brain tissue. After arriving at her differential diagnosis, Dr. B. ordered a CT scan,

which could rule out a hemorrhagic stroke and brain tumors. The results were normal. A CT scan will not detect an ischemic stroke.

Ischemic strokes are commonly caused by a blockage in the carotid artery in the neck that cuts off the brain's blood supply. "Ischemic stroke event" is used here to refer to both a full-blown ischemic stroke and the less serious conditions called a "temporary ischemic attack" (TIA) and a "reversible ischemic neurological deficit" (RIND). TIA and RIND are two types of "mini-strokes," which are warning signs of a full-blown stroke, but usually do not cause long-term damage.

To determine whether Jandre had suffered an ischemic stroke event, Dr. B listened to Jandre's carotid arteries with a stethoscope in an effort to detect the "whooshing sound" characteristic of turbulent blood flow caused by a blocked artery, known as a "bruit." Dr. B. admitted at trial that listening to the carotid arteries for a bruit is a "very, very poor screening test for determining what shape the arteries are in." Her testimony established that a bruit will not be heard if an artery is severely blocked and it will also not be heard if the artery is clear.

Dr. B. had the option of ordering a carotid ultrasound to assess the state of Jandre's carotid arteries, but she chose not to. A carotid ultrasound is a non-invasive diagnostic technique that was available at the hospital and is more reliable than listening with a stethoscope for bruits.

Also pertinent here is testimony that Jandre's symptoms were atypical of Bell's palsy...

On the basis of the symptoms and the tests performed, Dr. B. ruled out an ischemic stroke event and came to a final diagnosis of a mild form of Bell's palsy. Notably, Bell's palsy is a "diagnosis of exclusion"...

Dr. B. did not tell Jandre any of the following: (1) that he had an atypical presentation of Bell's palsy; (2) that his symptoms were also consistent with an ischemic stroke event; (3) that her method of eliminating an ischemic stroke event from the differential diagnosis was "very poor"; (4) that she could have ordered a carotid ultrasound to definitively rule out the possibility of an ischemic stroke event; and (5) that an event such as a TIA or a RIND is often a harbinger of a full-blown ischemic stroke...

On the evening of June 24, 2003, Jandre suffered a full-blown stroke, which impaired his physical and cognitive abilities. A carotid ultrasound performed at the hospital revealed that his right internal carotid artery was 95 percent blocked. Two expert witnesses at trial testified that they would have ordered a carotid ultrasound for Jandre on June 13, 2003; that Jandre had experienced a TIA or RIND on that day; that a carotid ultrasound would have revealed the blockage in Jandre's carotid artery; and that surgery could have been performed, reducing the likelihood that Jandre would suffer a stroke."

The Decision: The case concerned whether a physician's duty to obtain informed consent requires physicians to inform patients about non-invasive and accurate diagnostic tools that would rule out dangerous conditions, even if the physician is determined to be "not negligent" in providing another diagnosis, unrelated to the diagnostic tool at issue.

A majority of the Supreme Court said yes, and explained that the scope of the duty to inform is based on information a reasonable person would want to know concerning the patient's *symptoms* and not the ultimate diagnosis. From a legal perspective, the duty exists even when the physician was not ultimately negligent in diagnosis or treatment.

The Court rejected a proposal to adopt a bright line rule that would have said that "once a physician makes a non-negligent final diagnosis, there is no duty to inform the patient about diagnostic tests for conditions unrelated to the condition that was included in the final diagnosis." Following long-standing precedence, the Court reiterated that a physician's duty to inform requires a case-by-case analysis using a reasonable patient standard and not the proposed "bright line rule".

The majority emphasized that its decision does not change existing law and wrote:

This opinion does not expand the duty of informed consent in Wisconsin. It simply applies well-established, objective, negligence-based principles to a particular fact situation. Patients are not entitled to more information or tests after this opinion than they were before. Physicians are at no greater risk of liability after this opinion than they were before and therefore should feel no additional pressure to practice defensively.

Jandre, 2012 WI 39, ¶ 176.

Relevant statute and rules (unchanged by the decision):

Wisconsin Stat. § 448.30, Information on alternate modes of treatment, states:

Any physician who treats a patient shall inform the patient about the availability of alternate, viable medical modes of treatment and about the benefits and risks of these treatments. The physician's duty to inform the patient under this section does not require disclosure of:

- (1) Information beyond what a reasonably well-qualified physician in a similar medical classification would know.
- (2) Detailed technical information that in all probability a patient would not understand.
- (3) Risks apparent or known to the patient.
- (4) Extremely remote possibilities that might falsely or detrimentally alarm the patient.
- (5) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.
- (6) Information in cases where the patient is incapable of consenting.

Wis. Admin. Code § MED10.02(2)(u) defines professional misconduct to include:

Failure to inform a patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments, including the benefits and risks associated with the use of extended wear contact lenses.

Wis. Admin. Code Chapter 18, Alternate Modes of Treatment, sets out required communication of alternate modes of treatment and exceptions to required communication of alternate modes of treatment as follows:

Med 18.02 (3) “Viable” as used in s. 448.30, Stats., to modify the term, “medical modes of treatment” means modes of treatment generally considered by the medical profession to be within the scope of current, acceptable standards of care.

Med 18.03 Communication of alternate modes of treatment. (1) It is the obligation of a physician to communicate alternate viable modes of treatment to a patient. The communication shall include the nature of the recommended treatment, alternate viable treatments, and risks or complications of the proposed treatment, sufficient to allow the patient to make a prudent decision. In the communication with a patient, a physician shall take into consideration:

- (a) A patient’s ability to understand the information;
- (b) The emotional state of a patient; and,
- (c) The physical state of a patient.

(2) Nothing in sub. (1) shall be construed as preventing or limiting a physician in recommending a mode of treatment which is in his or her judgment the best treatment for a patient.

Med 18.04 Exceptions to communication of alternate modes of treatment. (1) A physician is not required to explain each procedural or prescriptive alternative inherent to a particular mode of treatment.

(2) In an emergency, a physician is not required to communicate alternate modes of treatment to a patient if failure to provide immediate treatment would be more harmful to a patient than immediate treatment.

(3) A physician is not required to communicate any mode of treatment which is not viable or which is experimental.

(4) A physician may not be held responsible for failure to inform a patient of a possible complication or benefit not generally known to reasonably well-qualified physicians in a similar medical classification.

(5) A physician may simplify or omit communication of viable modes of treatment if the communication would unduly confuse or frighten a patient or if a patient refuses to receive the communication.

Med 18.05 Recordkeeping. A physician shall indicate on a patient’s medical record he or she has communicated to the patient alternate viable modes of treatment.

CONSIDERATIONS IN EVALUATING ALLEGATIONS THAT A PHYSICIAN VIOLATED THE DUTY TO INFORM PATIENTS OF VIABLE ALTERNATE MODES OF TREATMENT AND DIAGNOSIS

Jandre did not change Wisconsin law.

“Wisconsin law requires that a physician disclose information **necessary for a reasonable person to make an intelligent decision with respect to the choices of treatment or diagnosis.**”
Jandre, 2012 WI 39, ¶8.

Physicians must document, within the patient healthcare record, discussions about viable alternate modes of treatment or diagnosis.

The reasonable person standard requires consideration of facts and circumstances in each case, and asks you to balance a patient’s right of self-determination in making reasoned health care decisions and a physician’s need to practice medicine “without fearing unfair and unpredictable liability”. *Jandre* at ¶13.

Factors considered in *Jandre*, which may be applicable in cases before the Board:

- the diagnostic procedure offered was not as accurate as another available diagnostic procedure;
- the more accurate diagnostic procedure was available and non-invasive;
- the patient’s symptoms were atypical to the diagnosis the physician made without use of the more accurate diagnostic procedure;
- the erroneous diagnosis was one of exclusion and the physician had not adequately ruled out other life-threatening explanations for the symptoms;
- the risk to the patient due to the physician’s failure to offer a diagnostic procedure was life-threatening;
- the physician was aware of the possible alternate diagnosis but did not do enough to rule it out;
- standards in the profession required the physician to offer the alternate non-invasive diagnostic procedure

A physician must inform the patient:

- of information a reasonable person in the patient’s position would reasonably regard as significant when deciding to accept or reject a diagnostic procedure;
- whether a diagnostic procedure is ordinarily performed in the circumstances confronting the patient;
- whether the alternate procedures are reasonably available;
- what the outlook is for success or failure of each alternate procedure;
- the benefits and risk inherent in each alternate procedure;
- options which are known to reasonable physicians within the physician’s own classification
- of alternate available diagnostic procedures if a person in the patient’s position would reasonably want the information, even if the disclosure is not customary in the medical profession. It is the patient’s perspective that is highly relevant.

A physician need NOT inform the patient of:

- experimental or unrealistic modes of treatment or diagnosis;
- complications or benefits not generally known to reasonably qualified physicians;
- in emergencies, options that would unreasonably delay diagnosis or treatment and place the patient at unacceptable risk of harm;
- diagnostic or treatment options the relevance of which rely on facts not known to the physician and which a reasonable physician is not expected to know;
- options known only to specialists outside of the physician's own medical classification (emergency physicians are not expected to offer options known only to specialists);
- detailed technical information that in all probability a patient would not understand;
- risks apparent or known to the patient;
- extremely remote possibilities that might falsely or detrimentally alarm the patient;
- information in emergencies where failure to provide treatment would be more harmful to the patient than treatment;
- information in cases where the patient is incapable of consenting.

This is an objective standard, based on a reasonable person in the patient's circumstances.

Supreme court sides with patient in physician informed consent case

By Joe Forward, Legal Writer, State Bar of Wisconsin

April 19, 2012 – Can a jury decide that a medical doctor was *not* negligent in diagnosing a patient's condition, but also conclude the doctor breached a duty to inform the patient about diagnostic tests that relate only to medical conditions the physician ruled out? Recently, a Wisconsin Supreme Court majority said yes.

In *Jandre v. Physicians Insurance Company of Wisconsin*, 2012 WI 39 (April 17, 2012), a 4-3 majority affirmed an appeals court ruling in favor of a plaintiff-patient, Thomas Jandre, who suffered a massive stroke 11 days after an emergency room visit for stroke-like symptoms.

The emergency room doctor, Dr. Therese Bullis, diagnosed Jandre with Bell's palsy, a non-life threatening condition that does not carry an increased risk of stroke.

A jury found that Bullis wasn't negligent in reaching the final diagnosis of Bell's palsy, even though the diagnosis was ultimately wrong. That is, the jury found that Bullis used reasonable, care, skill, and judgment in her method of diagnosing Jandre's condition.

But the same jury awarded Jandre almost \$2 million because Bullis did not inform him about a diagnostic test that would have signaled the imminence of more severe problems.

Specifically, Bullis did a physical exam to rule out "ischemic stroke" – a condition caused by blockage in the carotid artery of the neck – but did not perform a carotid ultrasound.

More importantly for the case, Bullis did not inform Jandre that the carotid ultrasound, a noninvasive procedure, was available to rule out the possibility of ischemic stroke.

Bullis used a CT scan to rule out "hemorrhagic stroke," which can occur when there is bleeding in the brain. But CT scans can't detect ischemic stroke.

The ultrasound would have revealed that Jandre had a 95 percent blockage in a carotid artery in his neck, meaning the massive stroke Jandre later suffered might have been prevented.

Bullis, her medical malpractice insurer and the Wisconsin Injured Patients and Families Compensation Fund appealed the judgment on the verdict.

Appeals court affirmed

The defendant-appellant argued that, as a matter of law, Wisconsin's informed consent law, Wis. Stat. section 448.30, doesn't hold doctors liable for failing to inform patients about alternative "diagnostic" testing where the doctor isn't negligent in reaching a final diagnosis.

In other words, the defendant-appellants argued that doctors must only inform patients about available procedures related to treating the final, non-negligently diagnosed condition.

However, a state appeals court relied on prior case law to determine that doctors must inform patients about alternative tests during the “diagnostic” testing stage, if a reasonable person in the patient’s shoes would want to know the information in choosing a course of action.

Thus, the court of appeals upheld the jury’s verdict in *Jandre v. Physicians Insurance Co. of Wisconsin*, 2010 WI APP 136 (Sept. 28, 2010). The jury had found that a reasonable patient in Jandre’s shoes would have wanted to know about the carotid ultrasound.

“We are not holding that Dr. Bullis had to provide information about *any possible condition* or that she had to provide information about conditions Jandre might suffer *at some point in the future*,” wrote District I appeals court Judge Kitty Brennan.

“Rather, we conclude that Dr. Bullis was required to inform Jandre about a test to rule out a condition she thought he was possibly suffering from, and which she did not rule out.”

On appeal to the Wisconsin Supreme Court in *Jandre*, a majority (4-3) affirmed the appeals court decision. But the justices disagreed on the future scope of informed consent law.

Chief Justice Shirley Abrahamson wrote a 75-page lead opinion (joined by Justices Ann Walsh Bradley and Patrick Crooks) in favor of Jandre. Justice Patience Roggensack wrote a dissenting opinion (joined by Justices Annette Ziegler and Michael Gableman).

Justice David Prosser affirmed the appeals court decision, breaking a 3-3 split, noting that a reversal would require the court to “change the law,” and such action was “not warranted by the facts of the case.” But Justice Prosser, in a concurring opinion, voiced concern.

“These concerns are that the law of informed consent is being expanded beyond its original scope and purpose, with profound consequences for the practice of medicine,” wrote Justice Prosser, who refused to join the lead opinion other than affirming the appeals court.

Informed consent statute

Wis. Stat. section 448.30 requires any physician who treats a patient to “inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments.” However, there are six limitations.

A physician’s duty to inform does not require disclosure of:

- Information beyond what a reasonably well-qualified physician in a similar medical classification would know;
- Detailed technical information that in all probability a patient would not understand;
- Risks apparent or known to the patient;
- Extremely remote possibilities that might falsely or detrimentally alarm the patient;
- Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment;
- Information in cases where the patient is incapable of consenting.



On appeal to the Wisconsin Supreme Court, Physician's Insurance Company of Wisconsin (PIC) asked the court to adopt a bright-line rule that physicians don't have a duty to inform patients of alternative tests for conditions that are unrelated to the final diagnosis.

PIC argued that the court of appeals decision "imposes a dramatically increased burden on Wisconsin health care providers which appears to be more onerous than the informed-consent duty imposed in any other jurisdiction in the country."

PIC also argued that prior case law contravenes that plain language of the statute, because the statute does not say doctors must inform patients on viable modes of "diagnosis." It only requires them to inform patients on viable and alternative modes of "treatment."

Differing opinions

In a lead opinion, Chief Justice Shirley Abrahamson (joined by Justices Bradley and Crooks), refused to adopt the bright-line rule requested by PIC, concluding that precedent (*stare decisis*) on the "reasonable patient standard" governed the case.

Under the reasonable patient standard, doctors must disclose "information necessary for a reasonable person to make an intelligent decision with respect to the choices of treatment or diagnosis," the chief justice explained.

Justice Prosser suggested that there may be situations in which the "reasonable patient standard" is not appropriate, and policymakers should revisit the issue.

"Inasmuch as the court has determined that 'treatment' includes diagnosis, it becomes imperative for policy makers to fashion reasonable limits to that term and to the duty imposed by statute upon Wisconsin's physicians," he wrote.

In her dissenting opinion, Justice Roggensack (joined by Justices Gableman and Ziegler) concluded that Wisconsin's informed consent law did not apply at all.

"I conclude that Wis. Stat. § 448.30 is not implicated in this malpractice action because there was no failure to inform the patient about the risks and benefits of the treatment and procedures that the physician employed," she wrote.

The lead opinion "would have imposed strict liability for missed diagnoses by expanding a patient's right of informed consent under § 448.30," wrote Justice Roggensack, noting that Justice Prosser did not concur with the lead opinion's reasoning.

Attorneys

- D. James Weis, Linda Meagher, and James Fergal of Habush & Rottier S.C., Waukesha, represented plaintiff-respondents Thomas and Barbara Jandre.
- Michael Van Sicklen and Krista Sterken of Foley & Lardner LLP, Madison, represented Physicians Insurance Company of Wisconsin.

- Guy DuBeau of Axley Brynelson LLP, Madison, filed an amicus curiae brief on behalf of the Wisconsin Medical Society Inc., the Wisconsin Hospital Association, and the Wisconsin Chapter of the American College of Emergency Physicians, Inc.
- Lynn Laufenberg of Laufenberg, Stombaugh & Jassak S.C., Milwaukee, and William Gleisner III, Hartland, filed an amicus brief on behalf of the Wisconsin Association for Justice.
- William Bauer and Karen Gallagher of Coyne, Schultz, Becker & Bauer S.C., Madison, filed an amicus brief on behalf of Dean Health System Inc., Marshfield Clinic and Gunderson Lutheran Health System Inc.

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