



STATE OF WISCONSIN

Department of Safety and Professional Services
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Governor Scott Walker Secretary Dave Ross

MEDICAL EXAMINING BOARD
Room 121A, 1400 E. Washington Avenue, Madison
Contact Tom Ryan (608) 261-2378
September 18, 2013

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 record of the actions of the Board.

AGENDA

8:00 A.M.

OPEN SESSION – CALL TO ORDER – ROLL CALL

- A. Adoption of Agenda (1-6)**
- B. Adoption of Minutes**
 - 1) August 14, 2013 **(7-12)**
 - 2) August 23, 2013 **(13-14)**
 - 3) August 30, 2013 **(15-16)**
- C. 8:05 A.M. APPEARANCE – Attorney Arthur Thexton – DLSC Presentation of Petition for Summary Suspension in Case Number 12 MED 263, Jerry N. Yee, DO (17-40)**
- D. 8:15 A.M. APPEARANCE – Attorney Arthur Thexton - DLSC: Presentation of Petition for Summary Suspension in Case Number 13 MED 229, Kent Gregory Brockmann, MD (41-108)**
- E. Legislative and Administrative Rule Matters – Discussion and Consideration**
 - 1) MED 1.02 Relating to Diploma Copy Requirements **(109-114)**
 - 2) MED 8 - Review of CR 12-005 for Approval and Submission to the Legislature **(115-126)**
 - 3) MED 10 Update – Review of CR 13-008 **(127-128)**
 - 4) Wis. Admin. Code POD 1.02 and POD 7 Relating to Podiatric X-Ray Assistants – Review and Comment for Recommendation to Podiatry Affiliated Credentialing Board **(129-134)**
 - 5) Position Statements Related to Physicians – Board Review **(135-140)**

- F. Prescription Drug Monitoring Program Powerpoint Presentation – Chad Zadrazil**
- G. Fall Newsletter – Discussion (141-142)**
- H. Speaking Engagements**
 - 1) 2013 Wisconsin Radiological Society – Recent Changes to MED 10 and Licensing Updates **(143-144)**
 - 2) Speaking request – Kenneth Simons - MCW-Marquette Alumni Meeting – February 25, 2014 – Board Consideration
- I. FSMB Matters – Discussion and Consideration**
 - 1) FSMB Member Visit **(145-148)**
 - 2) FSMB Nominations/Endorsement **(149-164)**
- J. Informational Items – Discussion and Consideration**
 - 1) Maintenance of Licensure **(165-168)**
 - 2) State Medical Boards – Problem of Unnecessary Care and Treatment **(169-178)**
- K. Screening Panel Report**
- L. Items Added After Preparation of Agenda:**
 - 1. Introductions, Announcements and Recognition
 - 2. Executive Director Matters
 - 3. Education and Examination Matters
 - 4. Credentialing Matters
 - 5. Practice Matters
 - 6. Disciplinary Matters
 - 7. Legislation/Administrative Rule Matters
 - 8. Informational Items
 - 9. Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
 - 10. Presentation of Proposed Decision(s)
 - 11. Presentation of Interim Order(s)
 - 12. Petitions for Re-Hearing
 - 13. Petitions for Summary Suspension
 - 14. Petitions for Assessments
 - 15. Petitions to Vacate Orders
 - 16. Petitions for Designation of Hearing Examiner
 - 17. Requests for Disciplinary Proceeding Presentations
 - 18. Motions
 - 19. Petitions
 - 20. Appearances from Requests Received or Renewed
 - 21. Speaking Engagement, Travel, and Public Relation Requests

M. Public Comments

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

N. Monitoring Matters

- 1) **John Hale, MD – Requesting Interruption in Drug Screens (179-198)**
- 2) **Terrance Moe, MD – Requesting Full Licensure (199-224)**

O. Summary Suspension(s)

- 1) **Deliberation of Petition for Summary Suspension in Case Number 12 MED 263, Jerry N. Yee, DO (17-40)**
- 2) **Deliberation of Petition for Summary Suspension in Case Number 13 MED 229, Kent Gregory Brockmann, MD (41-108)**

P. Consideration of Petition for Designation of Hearing Official

1. **Consideration of Petition for Designation of Hearing Official in Case Number 12 MED 263, Jerry N. Yee, DO (229-232)**
2. **Consideration of Petition for Designation of Hearing Official in Case Number 13 MED 229, Kent Gregory Brockmann, MD (225-228)**

Q. Presentation and Deliberation of Items from the Division of Legal Services and Compliance Attorney Sandra Nowack

- 1) **Proposed Stipulations, Final Decisions and Orders**
 - a. **13 MED 005 – Devinder K. Sidhu, MD (233-244)**
 - b. **13 MED 130 – Judith L. Chantelois, MD (245-254)**
 - c. **13 MED 180 – LuAnn Moraski, DO (255-266)**

R. Presentation and Deliberation of Items from the Division of Legal Services and Compliance Attorney Kim Kluck

- 1) **Proposed Stipulations, Final Decisions and Orders**
 - a. **13 MED 046 – Kenneth Raskin, MD (267-274)**
- 2) **Complaint for Determination of Probable Cause**
 - a. **11 MED 232 – Cha Lee, MD (275-280)**

S. Presentation and Deliberation of Items from the Division of Legal Services and Compliance Attorney Arthur Thexton

- 1) **Administrative Warning**
 - a. **11 MED 400 (V.S.C.) (281-282)**
- 2) **Proposed Stipulations, Final Decisions and Orders**
 - a. **13 MED 048 – Fredrick E. Ekberg, MD (283-288)**
 - b. **12 MED 263 – Jerry N. Yee, DO (289-294)**

- 3) **Complaint for Determination of Probable Cause**
 - a. **13 MED 229 – Kent G. Brockmann, MD (295-298)**
 - b. **12 MED 263 – Jerry N. Yee, DO (299-308)**

- T. Presentation and Deliberation of Proposed Decisions and Final Orders**
 - 1) **12 MED 231 – Ronald Plemmons, MD (309-316)**

- U. Presentation and Deliberation of Order Fixing Costs**
 - 1) **12 MED 339 – Leonard Green (317-322)**

- V. DLSC Matters**
 - 1) Case Status Report **(323-330)**

- W. Reconsideration of Board Decision Regarding Full Board Oral Requirement for Dashell J. Slabbert, MD – Discussion and Consideration (331-448)**

- X. Seeking Equivalency for 12 Months of ACGME Approved Post-Graduate Training Based on Education and Training – Discussion and Consideration**
 - 1) Oussama Darwish, MD **(449-474)**

- Y. Consulting with Legal Counsel**

- Z. Deliberation of Items Added After Preparation of the Agenda**
 - 1. Disciplinary Matters
 - 2. Education and Examination Matters
 - 3. Credentialing Matters
 - 4. Proposed Stipulations, Final Decisions and Orders
 - 5. Proposed Decisions
 - 6. Proposed Interim Orders
 - 7. Complaints
 - 8. Petitions for Summary Suspension
 - 9. Remedial Education Cases
 - 10. Petitions for Extension of Time
 - 11. Petitions for Assessments and Evaluations
 - 12. Petitions to Vacate Orders
 - 13. Motions
 - 14. Administrative Warnings
 - 15. Matters Relating to Costs
 - 16. Appearances from Requests Received or Renewed
 - 17. Monitoring Matters
 - 18. Professional Assistance Procedure (PAP) Matters
 - 19. Case Status Report
 - 20. Case Closings
 - 21. FSMB Matters

- AA. Ratifying Examination Results, Licenses, and Certificates**

RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

BB. Vote on Items Considered or Deliberated Upon in Closed Session, if Voting is Appropriate

CC. Open Session Items Noticed Above not Completed in the Initial Open Session

ADJOURNMENT

**CONVENE TO DISCIPLINARY GUIDELINES COMMITTEE MEETING
IMMEDIATELY FOLLOWING FULL BOARD MEETING
12:00 P.M.**

ATTENDEES: Kenneth Simons, MD; Greg Collins; Timothy Swan, MD

**ORAL EXAMINATION OF CANDIDATES FOR LICENSURE
ROOM 121A, B, C, AND 199B
12:30 P.M.**

CLOSED SESSION – Reviewing applications and conducting oral examinations of twelve (12) candidates for licensure – Drs. Vasudevan, Westlake, Yale and Misra **(475-476)**

NEXT MEDICAL EXAMINING BOARD MEETING: October 16, 2013

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**MEDICAL EXAMINING BOARD
MEETING MINUTES
AUGUST 14, 2013**

PRESENT: James Barr; Kenneth Simons, MD; Greg Collins; Timothy Westlake, MD; Timothy Swan, MD; Mary Jo Capodice, DO; Rodney Erickson, MD; Russell Yale, MD; Sridhar Vasudevan, MD; and Gene Musser, MD

Jude Genereaux entered at 8:17 a.m.

EXCUSED: Suresh Misra, MD; Carolyn Ogland Vukich;

STAFF: Tom Ryan, Executive Director; Joshua Archiquette, Bureau Assistant; and other Department Staff

CALL TO ORDER

Dr. Kenneth Simons, Chair, called the meeting to order at 8:00 a.m. A quorum of 10 (ten) members was present.

ADOPTION OF AGENDA

- **Move Item** Q.1.a. M.F.O. 12 MED 157 to W.14.a.M.F.O. 12 MED 157
- **Remove Item** E.3. Draft of Proposed Rules Regarding Med 1.02

MOTION: Sridhar Vasudevan moved, seconded by Greg Collins, to adopt the agenda as amended. Motion carried unanimously.

APPROVAL OF MINUTES OF JULY 17, 2013

- Note that Sridhar Vasudevan voted no in the matter under Administrative/Legislative Matters regarding MED 8.07(2) and change “Motion carried unanimously” to “Motion carried”

MOTION: Sridhar Vasudevan moved, seconded by, Greg Collins, to approve the minutes of July 17, 2013 as amended. Motion carried.

Gene Musser abstained from voting in the above matter

ADMINISTRATIVE/LEGISLATIVE RULE MATTERS

MOTION: Sridhar Vasudevan moved, seconded by Russell Yale, to adopt MED 10, relating to Unprofessional Conduct. Motion carried.

Timothy Swan voted no in the above motion

DELEGATION TO TRAVEL AND SPEAK

MOTION: Sridhar Vasudevan moved, seconded by James Barr, to designate Mary Jo Capodice, DO, as the Board’s representative to attend the Wisconsin Association of Osteopathic Physicians and Surgeons meeting in Appleton Wisconsin, on Saturday/Sunday October 26-27, 2013. Motion carried unanimously.

MOTION: Timothy Swan moved, seconded by Gene Musser, to designate Sridhar Vasudevan, MD; as the Board's representative to attend the Community Opioid Education Day at Merriter Hospital in Madison Wisconsin on Friday, November 1, 2013. Motion carried.

Jude Genereaux abstained from voting in the above matter

MODEL POLICY FOR THE USE OF OPIOID ANALGESICS IN THE TREATMENT OF CHRONIC PAIN

MOTION: Sridhar Vasudevan moved, seconded by Jude Genereaux, to remove the position statement regarding Pain Management and replace it with a link to the FSMB's Pain Policy. Motion carried unanimously.

FSMB MATTERS

MOTION: James Barr moved, seconded by Gene Musser, to designate Sridhar Vasudevan, MD as the Board's representative to take the SPEX exam. Motion carried unanimously.

SCREENING PANEL REPORT

Greg Collins reported that 14 (fourteen) cases were reviewed. 7 (seven) cases were opened for investigation. 0 (zero) ten-day letters were sent.

CLOSED SESSION

MOTION: James Barr moved, seconded by Jude Genereaux, to convene to closed session pursuant to Wisconsin State statutes 19.85(1)(a)(b)(f) and (g) for the purpose of conducting appearances, reviewing monitoring requests, requests for licensure, deliberate on stipulations, administrative warnings, proposed decisions and orders, consulting with Legal Counsel and Division of Legal Services and Compliance case status reports. Dr. Kenneth Simons read the language of the motion. The vote of each member was ascertained by voice vote. Timothy Swan, MD – yes; Timothy Westlake, MD – yes; James Barr - yes; Greg Collins - yes; Kenneth Simons, MD - yes; Gene Musser, MD – yes; Mary Jo Capodice, DO - yes; Jude Genereaux - yes; Rodney Erickson, MD - yes; Sridhar Vasudevan, MD – yes; and Russell Yale, MD – yes. Motion carried unanimously.

The Board convened into Closed Session 9:43 a.m.

FULL BOARD ORAL EXAM OF CANDIDATES FOR LICENSURE

MOTION: Sridhar Vasudevan moved, seconded by Mary Jo Capodice, to approve Dr. Navtejpal S. Kahlon's application for Medical licensure once all requirements are met. Motion failed.

Gene Musser and Rodney Erickson voted no in the above matter.

MOTION: Sridhar Vasudevan moved, seconded by Rodney Erickson, to reconsider the motion to approve the above matter. Motion carried unanimously.

MOTION: Sridhar Vasudevan moved, seconded by Mary Jo Capodice, to approve Dr. Navtejpal S. Kahlon's application for Medical licensure once all requirements are met. Motion carried.

Greg Collins voted no in the above matter

MOTION: Timothy Westlake moved, seconded by Gene Musser, to deny Dr. Nipa H. Sinh's application for Medical licensure. Reason for Denial: unable to practice with reasonable skill and safety based upon her lack of adequate clinical experience for the last three years. Motion carried.

Sridhar Vasudevan voted no in the above matter

BOARD REVIEW OF FULL BOARD ORAL EXAMINATION REQUIREMENT FOR DASHHELL J. SLABBERT M.D.

MOTION: Timothy Swan moved, seconded by Russell Yale, to find that there was no error with regard to the finding of adverse formal action during the course of Dr. Dashell J. Slabbert's post graduate training and the applicant is required to participate in a Full Board Oral Examination. The Board finds that there was an error in the Examination finding that the applicant had not practiced medicine and surgery for a period of three years prior to the application. Motion carried unanimously.

DELIBERATION OF PROPOSED STIPULATIONS AND FINAL DECISIONS AND ORDERS

MOTION: Gene Musser moved, seconded by Timothy Swan, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the matter of disciplinary proceedings against Derek Heldzinger, M.D. (12 MED 345) Motion carried unanimously.

MOTION: Timothy Westlake moved, seconded by Jude Genereaux, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the matter of disciplinary proceedings against Stephen Haughey, M.D. (12 MED 388) Motion carried unanimously.

MOTION: James Barr moved, seconded by Timothy Westlake, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the matter of disciplinary proceedings against Noemi A. Prieto, M.D. (12 MED 188) Motion carried unanimously.

MOTION: Sridhar Vasudavan moved, seconded by Greg Collins, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the matter of disciplinary proceedings against Angelo Charles Alexander, M.D. (12 MED 265) Motion carried unanimously.

MOTION: Timothy Swan moved, seconded by Gene Musser, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the matter of disciplinary proceedings against George F. Knight M.D. (13 MED 015) Motion carried unanimously.

MOTION: Russell Yale moved, seconded by Rodney Erickson, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the matter of disciplinary proceedings against Thomas D. Spera M.D. (13 MED 323) Motion carried unanimously.

CASE CLOSINGS

MOTION: Rodney Erickson moved, seconded by Gene Musser, to close case 12 MED 222 (J.Y.) for Insufficient Evidence (IE). Motion carried unanimously.

MOTION: Capodice moved, seconded by Russell Yale, to close case 12 MED 373 (J.N.) for No Violation (NV). Motion carried unanimously.

MOTION: Greg Collins moved, seconded by Jude Genereaux, to close case 12 MED 411 (R.K.) for Insufficient Evidence (IE). Motion carried.

Dr. Kenneth Simons has recused himself from deliberation and voting in the above matter.

Dr. Kenneth Simons left the room at 12:30 p.m.

Dr. Kenneth Simons returned to the room at 12:35 p.m.

MOTION: Timothy Swan moved, seconded by Jude Genereaux, to close case 12 MED 424 (P.F.) for No Violation (NV). Motion carried unanimously.

MOTION: Jude Genereaux moved, seconded by Timothy Swan, to close case 13 MED 001 (J.B.) for No Violation (NV). Motion carried unanimously.

MOTION: Timothy Westlake moved, seconded by Russell Yale, to close case 13 MED 080 (W.H.) for Prosecutorial Discretion (P2). Motion carried unanimously.

MOTION: Timothy Westlake moved, seconded by Timothy Swan, to close case 13 MED 085 (M.D.) for Prosecutorial Discretion (P2). Motion carried unanimously.

MOTION: Rodney Erickson moved, seconded by Greg Collins, to close case 13 MED 141 (T.J. & N.P.) for No Violation (NV). Motion carried unanimously.

MOTION: Sridhar Vasudevan moved, seconded by Greg Collins, to close case 13 MED 182 (T.M.) for No Violation (NV). Motion carried unanimously.

MOTION: Rodney Erickson moved, seconded by Timothy Swan, to close case 13 MED 213 (J.P.) for Prosecutorial Discretion (P5). Motion carried unanimously.

ADMINISTRATIVE WARNINGS

MOTION: Gene Musser moved, seconded by Greg Collins, to issue an Administrative Warning in the matter of DLSC case number 12 MED 157 (M.F.O.). Motion carried.

Dr. Kenneth Simons has recused himself from deliberation and voting in the above matter.

Dr. Kenneth Simons left the room at 12:15 p.m.

Dr. Kenneth Simons returned to the room at 12:21 p.m.

RATIFY ALL LICENSES AND CERTIFICATES

MOTION: Jude Genereaux moved, seconded by James Barr, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

RECONVENE TO OPEN SESSION

MOTION: Sridhar Vasudevan moved, seconded by Greg Collins, to reconvene into open session. Motion carried unanimously.

The Board reconvened into Open Session at 12:49 a.m.

VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION, IF VOTING IS APPROPRIATE

MOTION: Timothy Swan moved, seconded by Rodney Erickson, to affirm all motions made in closed session. Motion carried unanimously.

ADJOURNMENT

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

The meeting adjourned at 12:50 a.m.

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**MEDICAL EXAMINING BOARD
TELECONFERENCE MEETING MINUTES
AUGUST 23, 2013**

PRESENT: James Barr; Greg Collins; Timothy Swan, MD; Mary Jo Capodice, DO; Gene Musser, MD; Jude Genereaux; and Kenneth Simons, MD;

Timothy Westlake Joined the Meeting at 8:07 a.m.

EXCUSED: Suresh Misra, MD; Carolyn Ogland Vukich, MD; Rodney Erickson, MD; Russell Yale, MD; Sridhar Vasudevan, MD

STAFF: Tom Ryan, Executive Director; Nicholas Tank, Bureau Assistant; and other Department Staff

CALL TO ORDER

Dr. Kenneth Simons, Chair, called the meeting to order at 8:00 a.m. A quorum of seven (7) members was present.

ADOPTION OF AGENDA

MOTION: Gene Musser moved, seconded by Greg Collins, to adopt the agenda as published. Motion carried unanimously.

CE AUDIT PLANNING

MOTION: Timothy Swan moved, seconded by Gene Musser, that the June motion for CME requirements in this renewal period is rescinded. Further, the audit for the license period ending 10/31/13 will include any CME acquired during calendar years 2012 and 2013. Motion carried unanimously.

ADJOURNMENT

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

The meeting adjourned at 8:16 a.m.

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**MEDICAL EXAMINING BOARD
TELECONFERENCE
MEETING MINUTES
AUGUST 30, 2013**

PRESENT: Greg Collins; Timothy Swan, MD; Mary Jo Capodice, DO; Jude Genereaux; Kenneth Simons, MD; Sridhar Vasudevan, MD; Suresh Misra, MD

James Barr entered at 9:09 a.m.

EXCUSED: Russell Yale, MD; Timothy Westlake, MD; Carolyn Ogland, MD; Gene Musser, MD; Rodney Erickson, MD

STAFF: Jeff Weigand, Policy Director; Tom Engels, Division Administrator; Joshua Archiquette, Bureau Assistant; and other Department Staff

CALL TO ORDER

Kenneth Simons, Chair, called the meeting to order at 9:08 a.m. A quorum of seven (7) members was confirmed.

ADOPTION OF AGENDA

MOTION: Greg Collins moved, seconded by Sridhar Vasudevan, to adopt the agenda as published. Motion carried unanimously.

STATUS OF CLEARINGHOUSE RULE 12-005

MOTION: Greg Collins moved, seconded by Sridhar Vasudevan to recall Clearinghouse Rule 12-005 relating to Physician Assistants which was inadvertently submitted to the Legislature prematurely by DSPS Staff. Motion carried unanimously.

ADJOURNMENT

MOTION: Timothy Swan moved, seconded by Jude Genereaux, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 9:16 a.m.

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Mitali Chatterjee, Paralegal on behalf of Attorney Arthur Thexton Division of Legal Services and Compliance		2) Date When Request Submitted: September 10, 2013 <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: Wisconsin Medical Examining Board			
4) Meeting Date: September 18, 2013	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Presentation of Petition for Summary Suspension in Case Number 12MED263 Jerry N. Yee, D.O.	
7) Place Item in: <input type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input checked="" type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? <input checked="" type="checkbox"/> Yes (Fill out Board Appearance Request) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required: Dr. Sridhar Vasudevan	
10) Describe the issue and action that should be addressed: The Board must decide whether to grant the Petition for Summary Suspension. Respondent has the right to appear during open session presentation to be heard [Wis. Stat. § 448.02(4)]. The Board must decide whether there is probable cause to believe that: <ol style="list-style-type: none"> 1. Jerry N. Yee, D.O., has violated the Board's statutes and rules; 2. It is necessary to suspend Jerry N. Yee's license immediately to protect the public health safety or welfare. 			
11)	Authorization		
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive 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 Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting. 			

BOARD APPEARANCE REQUEST FORM

Appearance Information

Board Name: WI Medical Examining Board

Board Meeting Date: 9-18-13

Person Submitting Agenda Request: Mitali Chatterjee, Paralegal

Person(s) requesting an appearance: Attorney Arthur Thexton -DLSC

(NOTE: Contact information is not required for Department staff.)

Reason for Appearance: Presentation for Summary Suspension in Case No. 12MED263 Yee

AppearanceContact Information

(NOTE: If the appearing party is represented by an attorney skip the "AppearanceContact Information" section and complete the "Attorney Contact Information" section.)

Mailing address:

Email address:

Telephone #:

Attorney Contact Information

Attorney Name: Werner E. Scherr, Esq.

Attorney's mailing address: Scherr & Scherr, LLP, 230 W. Wells Street, Suite 610, Milwaukee, Wisconsin 53203-1845

Attorney's e-mail address:

Attorney's telephone #: 414-224-0900

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY :
PROCEEDINGS AGAINST :
: DLSC Case No. 12 MED 263
JERRY N. YEE, D.O., :
RESPONDENT. :

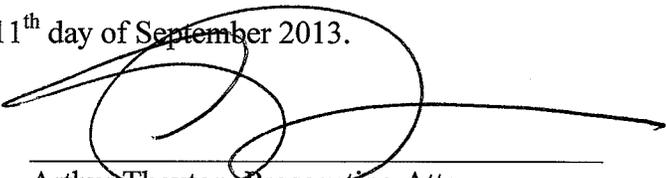
NOTICE OF PRESENTATION OF PETITION FOR SUMMARY SUSPENSION

To: Jerry Ning Yee, D.O.
11803 W. North Ave.
Wauwatosa, WI 53226-2077

PLEASE TAKE NOTICE that the Petitioner, Wisconsin Department of Safety and Professional Services, Division of Legal Services and Compliance, will present the attached Petition for Summary Suspension to the Wisconsin Medical Examining Board at the following date, time and place:

Date: Wednesday, September 18, 2013
Time: 8:05 a.m., or as soon thereafter as counsel may be heard
Place: Room 121A
1400 E. Washington Avenue (enter at 55 N. Dickinson St.)
Madison, Wisconsin

Dated at Madison, Wisconsin this 11th day of September 2013.



Arthur Thexton, Prosecuting Attorney
Division of Legal Services and Compliance
WI State Bar No. 1016702
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 8935
Madison, WI 53708-8935
Phone: 608-266-9814
Arthur.Thexton@Wisconsin.gov

cc: Werner E. Scherr, Esq.
Scherr & Scherr LLP
230 W Wells St Ste 610
Milwaukee WI 53203-1845

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE SUMMARY :
SUSPENSION OF THE LICENSE OF :
: DLSC Case No. 12 MED 263
JERRY N. YEE, D.O., :

PETITION FOR SUMMARY SUSPENSION
[Wis. Stat. § 448.02(4) and Wis. Admin. Code ch. SPS 6]

Arthur Thexton, being duly sworn on oath, upon information and belief, deposes and states, as follows:

1. I am an attorney employed by the Wisconsin Department of Safety and Professional Services, Division of Legal Services and Compliance, and in the course of my job duties have been assigned to the investigation and prosecution of case no. 12 MED 263 against Respondent Jerry Ning Yee, D.O., for the Wisconsin Medical Examining Board.

2. My business address is 1400 East Washington Avenue, Madison, Wisconsin 53703, and my business mailing address is P.O. Box 8935, Madison, Wisconsin 53708.

3. Respondent Jerry Ning Yee, D.O., (dob July 10, 1932), is licensed in the State of Wisconsin to practice medicine and surgery, having license number 18823-21, first issued on July 10, 1974, with registration current through February 28, 2014. Respondent was formerly licensed in California, Michigan, and West Virginia. Respondent is a general practitioner and is not certified by any AOA or ABMS specialty board.

4. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is 11803 W. North Ave., Wauwatosa, WI 53226-2077.

5. Respondent was previously disciplined by the Board in case 83 MED 94 (January 24, 1990) when his license was suspended for one year, and that suspension was stayed on condition that he attend a recordkeeping course, take a home study course in pharmacology, and complete a 12 week preceptorship. The outcome arose from a complaint about Respondent's prescribing of controlled substances.

6. Respondent was again disciplined by the Board in case 05 MED 320 (March 18, 2009). In that case, Respondent was reprimanded, and required to attend a course in appropriate prescribing of controlled substances, as a condition of his being able to prescribe opioids for more than 30 days in any 12 month period, for any patient. He was further required to obtain a Professional Mentor. Respondent was restored to an unlimited license on May 20, 2009.

7. On March 21, 2007, Respondent had an initial office visit with a 31-year-old woman whose chief complaint was opioid addiction. The patient also stated she had prior addiction to alcohol, gambling, and tobacco. The patient was noted to have a blood pressure of 180/102, pulse of 84. She was measured at 5'2", weight 173½ pounds. The patient reported difficulties with constipation, fatigue, depression, sleep, concentration anxiety, and mood swings. She reported not currently drinking alcohol, but drinking 5 cups of coffee per day, and smoking 20 cigarettes a day for the past 4 years. Respondent recorded her current medications as buprenorphine (Suboxone®), escitalopram (Lexapro®), Adderall®, and celecoxib (Celebrex®). There is no indication as to who may have prescribed these medications. Respondent diagnosed the patient with drug dependency, fatigue, and depression, prescribed buprenorphine 8 mg TID, and modafinil 200 mg BID, and asked the patient to return in 2 weeks.

8. The patient returned to Respondent's care on March 28, 2007; her blood pressure was found to be 162/100. Respondent charted that "we have to watch her recent 2 high blood pressures." The patient reported having few cravings, and was prescribed a 30 day supply of buprenorphine 8 mg TID, escitalopram 20 mg QD, and modafinil 200 mg, BID.

9. The patient returned to Respondent's care on May 9, 2007, or her blood pressure was found to be 128/82. The patient continued in care on an approximately monthly basis through April 29, 2011. During this period, her blood pressure fluctuated between high and normal, but patient was not started on any medication until February 2010.

10. During this period, Respondent prescribed bupropion (Wellbutrin®), vitamin B12 injections, promethazine (Phenergan®) with codeine syrup, Adderall®, Adderall XR®, clonazepam (Klonopin®), diazepam (Valium®), zolpidem (Ambien®), alprazolam (Xanax®), and aripiprazole (Abilify®). The patient's dosage of buprenorphine was tapered, and discontinued in December, 2009.

11. On November 30, 2010, the patient admitted relapsing to the use of heroin, and was restarted on buprenorphine 8 mg BID.

12. On December 29, 2010, Respondent conducted the first drug screen of this patient. The patient's oral fluid sample was positive for cocaine, heroin, and morphine. The patient returned to care on January 26, 2011, the entire narrative portion of the chart for that visit is: "discussed results of drug screen with patient today, done 12/29/10." An oral fluid sample was again taken, which was positive for cocaine, heroin, and morphine, and negative for prescribed alprazolam.

13. The patient returned to Respondent's care on February 25, 2011. The entire narrative portion of Respondent's chart for that visit is: "discussed results of 1/26/11 of oral fluid analysis. Patient admits "falling off the wagon."" No new sample was taken at that visit.

14. The patient returned to Respondent's care on April 1, 2011. The entire narrative portion of Respondent's chart note for that visit is: "patient states she has quit the opiates except for the Suboxone." A sample of the patient's urine was collected, and found to be positive for amphetamines and buprenorphine, but negative for benzodiazepines, including her prescribed alprazolam.

15. The patient returned to Respondent's care on April 29, 2011. The entire narrative portion of Respondent's chart for that visit is: "discussed UDT results. Discuss DUR review. Patient states she has "cleaned up her act" of opiates. Immediate release Adderall was discontinued, extended release Adderall was substituted." Respondent also continued to prescribe alprazolam 2 mg TID. A sample of the patient's urine was collected, and found to be negative for benzodiazepines, including her prescribed alprazolam.

16. Respondent's next contact with the patient was on September 2, 2011, his chart note for that visit is, in its entirety: "phone call from patient that in Florida she had undergone 2 months of rehabilitation from all opiates and has been clean for an additional month. She is deciding whether or not to move to Florida permanently to get away from all her drug "friends" here in Milwaukee. She requested to meds. Rx: 1) Xanax to milligrams #21, take one TID for one week only, no refills; 2) Wellbutrin 300 mg #30, take one per day, no refills."

17. On October 5, 2011, a copy of the patient's chart was sent to a health care provider in Florida.

18. The patient returned to Respondent's care on November 22, 2011. Respondent prescribed zolpidem, aripiprazole, lisinopril, bupropion, alprazolam, and Adderall® for the patient. The chart note reads, in its entirety: "Patient was an in-house patient in rehab facility in Florida for 90 days for opiate addiction. Since being discharged, patient is back in the real world. Her anxiety, depression, ↑BP, ADD, bipolar, is [sic] still present. She requests her meds for those conditions." Her blood pressure was 129/83.

19. On January 20, 2012, the patient returned to Respondent's care, and received additional prescriptions for the same medications as were prescribed on November 22, 2011. The chart note reads, in its entirety: "Patient to recheck her blood pressure at a drug store and report me [sic] the results. No other complaints. She states her refills of 11/22/11 helped her off of opiates and helped her other medical conditions." Her blood pressure at this visit was 157/111, pulse 105.

20. On March 23, 2012, the patient returned to Respondent's care and received prescriptions for Adderall®, zolpidem, and alprazolam. The chart note reads, in its entirety: "heart – RRR without murmur. Lungs – clear to A-P." Her blood pressure at this visit was 115/83, pulse 121.

21. On May 29, 2012, the patient returned to Respondent's care, and received an additional prescription for Adderall®. Her blood pressure on this date was 158/111, pulse 97. The chart note reads, in its entirety: "told patient to resume her listen approval, because it was elevated. heart – RRR without murmur. Lungs – clear to A-P." The patient did not subsequently return to care.

22. Respondent's care and treatment of the patient fell below the standard of care in the following respects:

- a. Respondent's initial history and physical was inadequate in that it failed to include an adequate substance abuse history, list past treatment providers including their

treatment modalities and outcomes, and a bodily fluid test for controlled substances.

- b. Respondent failed to contact past providers to either discuss the patient with them, or obtain their records.
- c. A patient beginning buprenorphine therapy must be seen as far more frequently at first; 2 or 3 times a week for the first week, then weekly, when biweekly, before monthly follow-up is appropriate. Drug testing is the standard of care at nearly every visit, particularly at the beginning of therapy.
- d. The patient was not required to attend, or even referred for, counseling or other therapeutic interventions such as 12-step meetings, even after she admitted relapsing.
- e. The patient was diagnosed with vitamin B12 deficiency without any laboratory confirmation, and administered the injection therapy when her symptoms could have been caused by other conditions such as anemia or a thyroid condition.
- f. While prescribing buprenorphine, Respondent also prescribed an opioid preparation for cough on two occasions.
- g. Respondent diagnosed the patient with attention deficit disorder without adequate support for the diagnosis, and prescribed a schedule II stimulant for this condition. Respondent, on occasion, prescribed both amphetamines and modafinil concurrently. Respondent also prescribed immediate release amphetamine products, instead of extended release products.
- h. Respondent prescribed several benzodiazepines *seriatim*, at non-minimal dosage levels. Respondent later prescribed zolpidem concurrently with benzodiazepines.
- i. The patient exhibited repeated high blood pressure, which was not addressed for almost 3 years.
- j. Respondent's diagnosis of the patient as "possibly bipolar" is without any substantiated basis in the chart, and his prescribing of aripiprazole was not indicated.
- k. At no time did Respondent keep a medication sheet for any medication which he prescribed, other than buprenorphine. At no time did Respondent have a written medication agreement with the patient, which restricted the patient to a single prescriber had a single pharmacy, and imposed other standard conditions to prevent diversion.
- l. Respondent prescribed abusable and addictive medications to the patient after she had completed an inpatient rehabilitation program in Florida, and was presumably in aftercare, without making any contact with the program, and without any confirmation of her condition.

- m. Respondent failed to take any meaningful action upon receiving drug test results which were inconsistent with the therapy he had prescribed, and which clearly indicated that the patient was taking unprescribed medications, and not taking prescribed medications.

23. Respondent's practices as set forth above created the following unreasonable risks to the patient:

- a. The failure to understand the extent of the patient's addictive disease, resulting in inadequate or inappropriate treatment, and the possibility of administering buprenorphine while the patient still had opiates in her body, resulting in unnecessary withdrawal symptoms.
- b. The failure to understand the extent of the patient's addictive disease, resulting in inadequate or inappropriate treatment, or duplication of past ineffective treatment, or concurrent prescribing resulting in overdose or diversion..
- c. The failure to detect withdrawal or other adverse effects, the failure to provide support resulting in relapse, or the failure to detect diversion.
- d. The failure of the patient to develop the personal tools necessary to avoid relapse, thus increasing the chances of relapse.
- e. Treatment of this patient with a condition which she did not have, and failure to treat the patient for a condition which she did have, and which is easily treatable. Injection therapy also carries the risk of infection.
- f. Treatment with an ineffective medication, potentially causing the patient to take more than prescribed, and experiencing an adverse effect, while failing to appropriately treat coughing with effective non-opioid medication such as dextromethorphan.
- g. Diagnosis of ADD requires ruling out other causes, including overconsumption of caffeine such as the patient reported here. Treatment with a highly abusable stimulant carries the risk of causing addiction to stimulants, particularly when immediate release products are used instead of extended release products. Amphetamines and modafinil have similar effects, and their concurrent use could cause additive effects, and is unnecessary.
- h. Benzodiazepines are also abusable and addictive, particularly in a patient prone to addiction such as this patient. Zolpidem, when used concurrently with benzodiazepines, can make the patient more drowsy than intended or otherwise potentiate the effects of both medications.
- i. The patient was placed in a higher risk for stroke, and a diagnosis of alcohol abuse or dependence was not considered. If the patient had been abusing alcohol, while taking benzodiazepines, she was at higher risk for overdose and death.

- j. Treatment of the patient for a condition which the patient does not have, with medication, delays the diagnosis of a condition which may be masked by the medication, and increases the risk of unintended interactions of medications.
 - k. Failing to keep a medication sheet for all controlled substances increases the risk of overprescribing through provision of early refills. Failing to have a written medication agreement increases the risk of diversion, or overtreatment by multiple prescribers.
 - l. Prescribing controlled substances to a patient who has just been released from a rehabilitation program runs the risk of interfering with the recovery of the patient, and increasing the risk of relapse.
 - m. Prescribing controlled substances to a patient who is not taking prescribed medication, or who is taking unprescribed controlled substances, increases the risk that the patient will overdose and die from a combination of unprescribed and prescribed medications, and/or is diverting controlled substances by either selling or trading prescribed medications for unprescribed controlled substances.
24. A competent physician, practicing within the standard of care, would have minimized these risks by taking the following steps:
- a. Taking an adequate and complete history, and conducting an appropriate physical exam including a test for controlled substances in the patient's body.
 - b. Contacting prior physicians or other providers, and either obtaining records, or discussing the patient's course of treatment with that provider.
 - c. Requiring the patient to return to care frequently during the first 2 weeks, and then less frequently only as the patient's condition warranted.
 - d. Referring the patients to qualified therapists, obtaining or progress reports from those therapists, referring the patient to appropriate 12-step programs, and discussing the patient's progress in such modalities, at each office visit.
 - e. Conducting appropriate studies to determine the true etiology of the patient's condition, and prescribing only that treatment which was supported by those studies.
 - f. Prescribing only nonnarcotic preparations for treatment of common conditions such as cough.
 - g. Confirming a condition such as ADD only with science-based or validated tests, or with prior treating physicians who had conducted such tests, and after ruling out other causes of the patient's symptoms, and then treating only with less abusable preparations after weighing the risks and benefits of treatment. A reasonable physician would never prescribe both amphetamines and modafinil concurrently.

- h. Investigating thoroughly the etiology of the patient's conditions which may indicate benzodiazepine therapy, and then considering non-benzodiazepine and non-drug alternatives; using the lowest doses possible, and increasing them only if absolutely necessary, based on patient experience; and using alternative sleep hygiene methods instead of zolpidem.
- i. Treating the patient with medication within the first 6 months of assuming care, discussing with the patient causes of high blood pressure, including situational and substance related causes, and conducting a standard blood test for alcohol markers.
- j. If the patient was truly suspected of being bipolar, any reasonable physician would have referred her to a psychiatrist for diagnosis and appropriate treatment, instead of prescribing aripiprazole.
- k. The standard of care is that every prescriber of chronic controlled substance therapy should keep a medication sheet, either on paper or electronically, and check it before every visit to ensure that the patient is not getting early refills. The standard of care is that every reasonable prescriber of chronic controlled substance therapy should have a written medication agreement with the patient which outlines the expectations the prescriber has for the patient, and states what the patient can expect from the prescriber. These agreements have been the standard of care for many years, for all patients with substance abuse histories, such as this one.
- l. The standard of care is that no reasonable physician would have provided these prescriptions without first checking to determine whether the patient was in an aftercare program, and then checking with the medical director of the program before prescribing any controlled substance.
- m. The standard of care is that no reasonable physician would continue to prescribe controlled substances to a patient who tested positive for cocaine, until the patient had been comprehensively evaluated by an addictionologist. The standard of care is that no reasonable physician would continue to prescribe to a patient who consistently tested negative for a prescribed medication. The standard of care is that no reasonable physician would have failed to chart the patient's explanations for these aberrant results, and a plan to ensure future compliance, including by referral to more intensive treatment programs, more frequent visits with the prescriber, pill counts, and drug testing.

23. Respondent Jerry N. Yee, D.O., by engaging in conduct which tends to constitute a danger to the health, welfare, or safety of patient or public, as set out in the paragraphs above, has committed unprofessional conduct, as defined by Wis. Admin. Code § MED 10.02(2)(h) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

24. A proposed formal Complaint to be filed with the Division of Hearings and Appeals, alleging that Respondent has committed unprofessional conduct is submitted

concurrently with this petition, and will be filed within 10 days of any order of summary suspension.

25. There is probable cause to believe that it is necessary to suspend Respondent's license immediately to protect the public health, safety or welfare, based upon the following recent conduct by the Respondent:

- a. Records of the Wisconsin prescription drug monitoring program show that Respondent has prescribed buprenorphine to 177 patients since approximately September 2012. Of that number, at least 6 have received both scheduled stimulants and benzodiazepines concurrently with buprenorphine, including as recently as August 23, 2013. At least 11 have received scheduled stimulants concurrently with buprenorphine, and at least 38 have received benzodiazepines concurrently with buprenorphine.
- b. Respondent also engaged in the following prescribing for a 61-year-old male patient:

	#	days	written
hydrocodone-acetaminophen 10-325	90	90	9/10/2012
oxycodone HCL 30 mg tablet	180	30	1/2/2013
oxycodone HCL 30 mg tablet	180	30	2/4/2013
hydrocodone-acetaminophen 10-325	90	90	3/4/2013
hydrocodone-acetaminophen 10-325	90	90	3/4/2013
oxycodone HCL 30 mg tablet	180	30	3/4/2013
oxycodone HCL 30 mg tablet	180	30	4/2/2013
oxycodone HCL 30 mg tablet	180	30	5/1/2013
oxycodone HCL 30 mg tablet	180	30	6/3/2013
oxycodone HCL 30 mg tablet	180	30	7/1/2013

- c. And the following prescribing for a 57-year-old male patient:

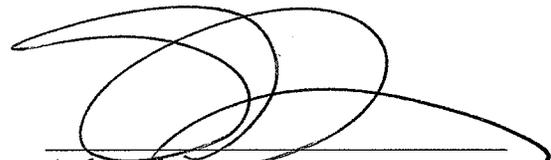
	#	days	written
oxycodone HCL 10 mg tablet	120	30	1/2/2013
alprazolam 2 mg tablet	90	30	1/29/2013
oxycodone HCL 10 mg tablet	120	30	1/29/2013
alprazolam 2 mg tablet	90	30	2/27/2013
oxycodone HCL 10 mg tablet	120	30	2/27/2013
alprazolam 2 mg tablet	90	30	3/27/2013
oxycodone HCL 10 mg tablet	120	30	3/27/2013
alprazolam 2 mg tablet	90	30	4/26/2013
oxycodone HCL 10 mg tablet	120	30	4/26/2013
alprazolam 2 mg tablet	90	30	5/24/2013
oxycodone HCL 10 mg tablet	97	24	5/24/2013
oxycodone HCL 10 mg tablet	120	24	6/14/2013
alprazolam 2 mg tablet	90	30	6/28/2013

oxycodone HCL 10 mg tablet	120	30	7/12/2013
oxycodone HCL 10 mg tablet	120	30	9/4/2013
alprazolam 2 mg tablet	90	30	9/4/2013

- d. The prescribing of significant dosages of short acting opioids, over extended periods of time, without transitioning the patient to extended release products is a significant violation of published standards for prescribing these products.

WHEREFORE, the Division of Legal Services and Compliance hereby requests that the Wisconsin Medical Examining Board:

1. Find that sufficient notice has been given to Respondent Jerry N. Yee, D.O., under Wis. Admin. Code § SPS 6.05.
2. Find probable cause to believe that Respondent Jerry N. Yee, D.O., has committed unprofessional conduct, and has engaged in or is likely to engage in conduct such that the public health, safety or welfare imperatively requires emergency suspension of Respondent's license and registration to practice surgery and medicine.
3. Issue an order summarily suspending the license and registration of Respondent Jerry N. Yee, D.O., to practice surgery and medicine in the State of Wisconsin and order that such suspension continue until the effective date of a final decision and order issued in the disciplinary proceeding against Respondent, unless otherwise ordered by the Board; and for such other relief as may be fair, just, and appropriate under the circumstances.



Arthur Thexton

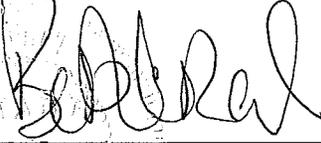
STATE OF WISCONSIN)
) ss
COUNTY OF DANE)

Arthur Thexton, being first duly on affirmation, deposes and says that he is a prosecuting attorney for the State of Wisconsin, Department of Safety and Professional Services, Division of Legal Services and Compliance, and that he has read the foregoing petition and knows the contents thereof and that the same is true to his own knowledge, except as to those matters therein stated on information and belief, and as to such matters, he believes them to be true.



Arthur Thexton

Subscribed to and affirmed before me
this September 11, 2013.



Notary Public, State of Wisconsin
My Commission 3-27-2010

Arthur Thexton, Prosecuting Attorney
Division of Legal Services and Compliance
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- d. The patient was not required to attend, or even referred for, counseling or other therapeutic interventions such as 12-step meetings, even after she admitted relapsing. This increases the chance of failure of the patient to develop the personal tools necessary to avoid relapse, thus increasing the chances of relapse. It is the standard of care to refer patients to qualified therapists, including obtaining or progress reports from those therapists; referring the patient to appropriate 12-step programs; and discussing the patient's progress in such modalities at each office visit.
- e. The patient was diagnosed with vitamin B12 deficiency without any laboratory confirmation, and administered the injection therapy when her symptoms could have been caused by other conditions such as anemia or a thyroid condition. This could result in the treatment of this patient for a condition which she did not have, and could result in failure to treat the patient for a condition which she did have, and which is easily treatable. Injection therapy also carries the risk of infection. It is the standard of care to conduct appropriate studies to determine the true etiology of the patient's condition, and prescribing only that treatment which was supported by those studies.
- f. While prescribing buprenorphine, Respondent also prescribed an opioid preparation for cough on two occasions. Treatment with an opioid medication increases the chances of causing the patient to take more than prescribed, and experiencing an adverse effect, while failing to appropriately treat coughing with effective non-opioid medication such as dextromethorphan. A reasonable physician would prescribe only nonnarcotic preparations for treatment of common conditions such as cough, to a patient taking buprenorphine.
- g. Respondent diagnosed the patient with attention deficit disorder without adequate support for the diagnosis, and prescribed a schedule II stimulant for this condition. Respondent, on occasion, prescribed both amphetamines and modafinil concurrently. Respondent also prescribed immediate release amphetamine products, instead of extended release products. Diagnosis of ADD requires ruling out other causes, including overconsumption of caffeine such as the patient reported here. Treatment with a highly abusable stimulant carries the risk of causing addiction to stimulants, particularly when immediate release products are used instead of extended release products. Amphetamines and modafinil have similar effects, and their concurrent use could cause additive effects, and is unnecessary. A reasonable physician would confirm a condition such as ADD only with science-based or validated tests, or with prior treating physicians who had conducted such tests, and after ruling out other causes of the patient's symptoms. A reasonable physician would treat a patient taking buprenorphine only with less abusable preparations, and after weighing the risks and benefits of such treatment. A reasonable physician would never prescribe both amphetamines and modafinil concurrently.
- h. Respondent prescribed several benzodiazepines seriatim, at non-minimal dosage levels. Respondent later prescribed zolpidem concurrently with benzodiazepines. Benzodiazepines are also abusable and addictive, particularly in a patient prone to addiction such as this patient. Zolpidem, when used concurrently with benzodiazepines, can make the patient more drowsy than intended or otherwise potentiate the effects of both medications. A reasonable physician would investigate thoroughly the etiology of the patient's conditions which may indicate benzodiazepine therapy, and then consider non-benzodiazepine and non-drug alternatives; use the lowest doses possible, and

increase them only if absolutely necessary, based on patient experience; and use alternative sleep hygiene methods instead of zolpidem.

- i. The patient exhibited repeated high blood pressure, which was not addressed for almost 3 years. The patient was placed in a higher risk for stroke, and a diagnosis of alcohol abuse or dependence was not considered. If the patient had been abusing alcohol, while taking benzodiazepines, she was at higher risk for overdose and death. A reasonable physician would have treated the patient with medication for high blood pressure within the first 6 months of assuming care, would have discussed causes of high blood pressure with the patient, including situational and substance related causes, and would have conducted a standard blood test for alcohol markers.
- j. Respondent's diagnosis of the patient as "possibly bipolar" is without any substantiated basis in the chart, and his prescribing of aripiprazole was not indicated. Treatment of the patient for a condition which the patient does not have, with medication, delays the diagnosis of a condition which may be masked by the medication, and increases the risk of unintended interactions of medications. If the patient was truly suspected of being bipolar, any reasonable physician would have referred her to a psychiatrist for diagnosis and appropriate treatment, instead of prescribing aripiprazole.
- k. At no time did Respondent keep a medication sheet for any medication which he prescribed, other than buprenorphine. At no time did Respondent have a written medication agreement with the patient, which restricted the patient to a single prescriber had a single pharmacy, and imposed other standard conditions to prevent diversion. Failing to keep a medication sheet for all controlled substances increases the risk of overprescribing through provision of early refills. Failing to have a written medication agreement increases the risk of diversion, or overtreatment by multiple prescribers. The standard of care is that every prescriber of chronic controlled substance therapy should keep a medication sheet, either on paper or electronically, and check it before every visit to ensure that the patient is not getting early refills. The standard of care is that every reasonable prescriber of chronic controlled substance therapy should have a written medication agreement with the patient which outlines the expectations the prescriber has for the patient, and states what the patient can expect from the prescriber. These agreements have been the standard of care for many years, for all patients with substance abuse histories, such as this one.
- l. Respondent prescribed abusable and addictive medications to the patient after she had completed an inpatient rehabilitation program in Florida, and was presumably in aftercare, without making any contact with the program, and without any confirmation of her condition. Prescribing controlled substances to a patient who has just been released from a rehabilitation program risks interfering with the recovery of the patient, and increases the risk of relapse. The standard of care is that no reasonable physician would have provided these prescriptions without first checking to determine whether the patient was in an aftercare program, and then checking with the medical director of the program before prescribing any controlled substance.
- m. Respondent failed to take any meaningful action upon receiving drug test results which were inconsistent with the therapy he had prescribed, and which clearly indicated that the patient was taking unprescribed medications, and not taking prescribed medications. Prescribing controlled substances to a patient who is not taking prescribed medication, or who is taking unprescribed controlled substances, increases the risk that the patient will

overdose and die from a combination of unprescribed and prescribed medications, and/or is diverting controlled substances by either selling or trading prescribed medications for unprescribed controlled substances. The standard of care is that no reasonable physician would continue to prescribe controlled substances to a patient to tested positive for cocaine, until the patient had been comprehensively evaluated by an addictionologist. The standard of care is that no reasonable physician would continue to prescribe to a patient to consistently tested negative for a prescribed medication. The standard of care is that no reasonable physician would have failed to chart the patient's explanations for these aberrant results, and a plan to ensure future compliance, including by referral to more intensive treatment programs, more frequent visits with the prescriber, pill counts, and drug testing.

3. I have personally examined the records of the Wisconsin prescription drug monitoring program, which revealed that respondent prescribed the following medications, to the following patients, on the following days:

	#	Days	Written	Rx #	New/ refill	
amphetamine salts 30 mg tab	45	15	3/11/2013	316984	N	Pt A
alprazolam 0.5 mg tablet	30	15	3/11/2013	316985	N	Pt A
Suboxone 8 mg-2 mg SL film	15	8	3/11/2013	4481216	N	Pt A
Suboxone 8 mg-2 mg SL film	15	8	3/11/2013	4481216	R	Pt A
amphetamine salts 30 mg tab	90	30	3/29/2013	2235061	N	Pt A
Suboxone 8 mg-2 mg tablet SL	4	2	3/29/2013	4481633	N	Pt A
buprenorphine-naloxone 8-2 mg tab	30	15	3/29/2013	4481633	R	Pt A
Suboxone 8 mg-2 mg tablet SL	6	3	3/29/2013	4481633	R	Pt A
Suboxone 8 mg-2 mg tablet SL	5	2	3/29/2013	4481633	R	Pt A
Suboxone 8 mg-2 mg tablet SL	8	4	3/29/2013	4481633	R	Pt A
Suboxone 8 mg-2 mg tablet SL	4	2	3/29/2013	4481633	R	Pt A
Suboxone 8 mg-2 mg tablet SL	3	2	3/29/2013	4481633	R	Pt A
alprazolam 0.5 mg tablet	60	30	3/29/2013	4481634	N	Pt A
amphetamine salts 30 mg tab	90	30	4/29/2013	332545	N	Pt A
alprazolam 0.5 mg tablet	60	30	4/29/2013	332546	N	Pt A
Suboxone 8 mg-2 mg SL film	5	2	4/29/2013	4482192	N	Pt A
Suboxone 8 mg-2 mg SL film	3	2	4/29/2013	4482192	R	Pt A
Suboxone 8 mg-2 mg SL film	52	26	4/29/2013	4482192	R	Pt A
Suboxone 8 mg-2 mg SL film	60	30	5/29/2013	4482803	N	Pt A
amphetamine salts 30 mg tab	90	30	6/28/2013	2880344	N	Pt A
alprazolam 0.5 mg tablet	60	30	6/28/2013	2880345	N	Pt A
Suboxone 8 mg-2 mg SL film	60	30	6/28/2013	4483437	N	Pt A
amphetamine salts 30 mg tab	90	30	7/24/2013	2889887	N	Pt A
alprazolam 0.5 mg tablet	60	30	7/24/2013	2889890	N	Pt A
Suboxone 8 mg-2 mg SL film	60	30	7/24/2013	4483853	N	Pt A
amphetamine salts 30 mg tab	90	30	8/23/2013	2901910	N	Pt A
alprazolam 0.5 mg tablet	60	30	8/23/2013	2901913	N	Pt A
Suboxone 8 mg-2 mg SL film	52	29	8/23/2013	4484427	N	Pt A
clonazepam 1 mg tablet	30	30	12/11/2012	1391462	N	Pt B
dextroamp-amphet ER 20 mg cap	90	30	1/9/2013	2211531	N	Pt B
Suboxone 8 mg-2 mg SL film	38	30	1/9/2013	4420354	N	Pt B
Suboxone 8 mg-2 mg SL film	30	30	2/6/2013	1397563	N	Pt B

clonazepam 1 mg tablet	30	30	2/6/2013	1397566	N	Pt B
dextroamp-amphet ER 20 mg cap	90	30	2/6/2013	1397570	N	Pt B
diphenoxylate-atropine tablet	20	6	2/14/2013	2613030	N	Pt B
clonazepam 1 mg tablet	30	30	3/8/2013	1401730	N	Pt B
Suboxone 8 mg-2 mg SL film	30	30	3/8/2013	1401731	N	Pt B
dextroamp-amphet ER 20 mg cap	15	5	3/8/2013	1401732	N	Pt B
diphenoxylate-atropine tablet	20	6	3/22/2013	2629809	N	Pt B
clonazepam 1 mg tablet	30	30	4/5/2013	1405511	N	Pt B
butalbital-ASA-caffeine cap	45	15	4/5/2013	1405512	N	Pt B
Suboxone 8 mg-2 mg SL film	30	30	4/5/2013	1405513	N	Pt B
diphenoxylate-atropine tablet	20	6	4/12/2013	1407849	N	Pt B
butalbital-ASA-caffeine cap	270	90	4/12/2013	408015099	N	Pt B
butalbital-ASA-caffeine cap	20	6	4/22/2013	1407855	N	Pt B
clonazepam 1 mg tablet	30	30	5/3/2013	1409281	N	Pt B
Suboxone 8 mg-2 mg SL film	30	30	5/3/2013	1409283	N	Pt B
dextroamp-amphet ER 20 mg cap	45	15	5/3/2013	1409298	N	Pt B
Suboxone 8 mg-2 mg SL film	30	30	5/3/2013	1421033	N	Pt B
dextroamp-amphet ER 20 mg cap	45	15	5/15/2013	1410975	N	Pt B
dextroamp-amphet ER 20 mg cap	90	30	5/31/2013	1413121	N	Pt B
Suboxone 8 mg-2 mg SL film	30	30	5/31/2013	1413123	N	Pt B
dextroamp-amphet ER 20 mg cap	60	30	6/28/2013	1417227	N	Pt B
Suboxone 8 mg-2 mg SL film	30	30	6/28/2013	1417229	N	Pt B
dextroamp-amphet ER 10 mg cap	120	30	7/26/2013	1421036	N	Pt B
dextroamp-amphet ER 20 mg cap	60	30	8/26/2013	1425270	N	Pt B
Suboxone 8 mg-2 mg SL film	60	30	5/30/2013	1398086	N	Pt C
lorazepam 2 mg tablet	90	30	5/30/2013	1398087	N	Pt C
lorazepam 2 mg tablet	90	30	5/30/2013	1398087	R	Pt C
dextroamp-amphet ER 20 mg cap	30	30	5/30/2013	1398088	N	Pt C
Suboxone 8 mg-2 mg SL film	30	15	12/28/2012	1786780	N	Pt D
diazepam 2 mg tablet	60	30	12/28/2012	1786781	N	Pt D
lorazepam 1 mg tablet	60	30	1/11/2013	1790266	N	Pt D
Suboxone 8 mg-2 mg SL film	50	30	1/11/2013	1790270	N	Pt D
lorazepam 1 mg tablet	60	30	2/8/2013	1203096	N	Pt D
Suboxone 8 mg-2 mg SL film	60	30	2/8/2013	1203295	N	Pt D
Suboxone 8 mg-2 mg SL film	60	30	3/8/2013	1803703	N	Pt D
lorazepam 1 mg tablet	60	30	3/8/2013	1803704	N	Pt D
Adderall XR 10 mg capsule	60	30	4/5/2013	1608069	N	Pt D
Suboxone 8 mg-2 mg SL film	60	30	4/5/2013	4623175	N	Pt D
lorazepam 1 mg tablet	60	30	4/5/2013	4623176	N	Pt D
Suboxone 8 mg-2 mg SL film	60	30	5/2/2013	4623322	N	Pt D
Adderall XR 10 mg capsule	60	30	5/3/2013	2612282	N	Pt D
Adderall XR 10 mg capsule	60	30	5/31/2013	2612396	N	Pt D
Suboxone 8 mg-2 mg SL film	31	17	5/31/2013	4623462	N	Pt D
lorazepam 1 mg tablet	60	30	5/31/2013	4623463	N	Pt D
Adderall XR 10 mg capsule	60	30	6/28/2013	2612512	N	Pt D
lorazepam 1 mg tablet	60	30	6/28/2013	4623604	N	Pt D
Adderall XR 10 mg capsule	60	30	7/26/2013	2612643	N	Pt D
Suboxone 8 mg-2 mg SL film	54	30	7/26/2013	4623749	N	Pt D
lorazepam 1 mg tablet	60	30	7/26/2013	4623750	N	Pt D

amphetamine salts 20 mg tablet	60	30	1/9/2013	641799	N	Pt E
Suboxone 8 mg-2 mg SL film	30	15	1/9/2013	1593461	N	Pt E
Suboxone 8 mg-2 mg SL film	5	5	2/4/2013	1596205	N	Pt E
Suboxone 8 mg-2 mg SL film	30	15	2/8/2013	651357	N	Pt E
amphetamine salts 20 mg tablet	30	15	2/8/2013	652121	N	Pt E
amphetamine salts 20 mg tablet	60	30	2/22/2013	655777	N	Pt E
alprazolam 1 mg tablet	20	10	3/6/2013	659538	N	Pt E
alprazolam 1 mg tablet	90	30	3/12/2013	661244	N	Pt E
amphetamine salts 20 mg tablet	60	30	3/12/2013	665313	N	Pt E
amphetamine salts 20 mg tablet	60	30	4/10/2013	585009	N	Pt E
alprazolam 1 mg tablet	90	30	4/10/2013	2948296	N	Pt E
Suboxone 8 mg-2 mg SL film	16	15	12/12/2012	748814	N	Pt F
Suboxone 8 mg-2 mg SL film	20	10	12/12/2012	748814	R	Pt F
Suboxone 8 mg-2 mg SL film	12	10	12/12/2012	748814	R	Pt F
Suboxone 8 mg-2 mg SL film	10	10	12/12/2012	748814	R	Pt F
Suboxone 8 mg-2 mg SL film	10	10	12/12/2012	748814	R	Pt F
Suboxone 8 mg-2 mg SL film	2	1	12/12/2012	748814	R	Pt F
amphetamine salts 30 mg tab	60	30	1/9/2013	2716092	N	Pt F
alprazolam 2 mg tablet	60	30	1/9/2013	4725601	N	Pt F
Suboxone 8 mg-2 mg SL film	20	12	1/30/2013	752760	N	Pt F
Suboxone 8 mg-2 mg SL film	10	10	1/30/2013	752760	R	Pt F
Suboxone 8 mg-2 mg SL film	12	10	1/30/2013	752760	R	Pt F
amphetamine salts 30 mg tab	90	30	1/30/2013	2222852	N	Pt F
Suboxone 8 mg-2 mg SL film	6	2	2/27/2013	755384	N	Pt F
Suboxone 8 mg-2 mg SL film	20	7	2/27/2013	755384	R	Pt F
Suboxone 8 mg-2 mg SL film	12	7	2/27/2013	755384	R	Pt F
Suboxone 8 mg-2 mg SL film	10	7	2/27/2013	755384	R	Pt F
alprazolam 2 mg tablet	60	30	2/27/2013	4467425	N	Pt F
amphetamine salts 30 mg tab	90	30	2/27/2013	3093887	N	Pt F

4. The records of the Wisconsin prescription drug monitoring program also demonstrate that Respondent engaged in the following prescribing for a 61-year-old male patient:

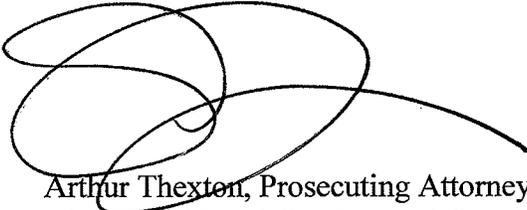
	#	days	written
hydrocodone-acetaminophen 10-325	90	90	9/10/2012
oxycodone HCL 30 mg tablet	180	30	1/2/2013
oxycodone HCL 30 mg tablet	180	30	2/4/2013
hydrocodone-acetaminophen 10-325	90	90	3/4/2013
hydrocodone-acetaminophen 10-325	90	90	3/4/2013
oxycodone HCL 30 mg tablet	180	30	3/4/2013
oxycodone HCL 30 mg tablet	180	30	4/2/2013
oxycodone HCL 30 mg tablet	180	30	5/1/2013
oxycodone HCL 30 mg tablet	180	30	6/3/2013
oxycodone HCL 30 mg tablet	180	30	7/1/2013

And the following prescribing for a 57-year-old male patient:

	#	days	written
oxycodone HCL 10 mg tablet	120	30	1/2/2013
alprazolam 2 mg tablet	90	30	1/29/2013

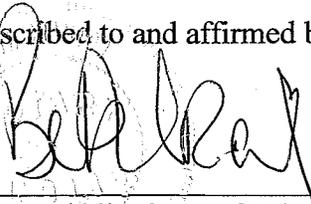
oxycodone HCL 10 mg tablet	120	30	1/29/2013
alprazolam 2 mg tablet	90	30	2/27/2013
oxycodone HCL 10 mg tablet	120	30	2/27/2013
alprazolam 2 mg tablet	90	30	3/27/2013
oxycodone HCL 10 mg tablet	120	30	3/27/2013
alprazolam 2 mg tablet	90	30	4/26/2013
oxycodone HCL 10 mg tablet	120	30	4/26/2013
alprazolam 2 mg tablet	90	30	5/24/2013
oxycodone HCL 10 mg tablet	97	24	5/24/2013
oxycodone HCL 10 mg tablet	120	24	6/14/2013
alprazolam 2 mg tablet	90	30	6/28/2013
oxycodone HCL 10 mg tablet	120	30	7/12/2013
oxycodone HCL 10 mg tablet	120	30	9/4/2013
alprazolam 2 mg tablet	90	30	9/4/2013

The prescribing of significant dosages of short acting opioids, over extended periods of time, without transitioning the patient to extended release products is a significant violation of published standards for prescribing these products.



Arthur Thexton, Prosecuting Attorney
 Division of Legal Services and Compliance
 WI State Bar No. 1016702
 Department of Safety and Professional Services
 Division of Legal Services and Compliance
 P.O. Box 8935
 Madison, WI 53708-8935
 Phone: 608-266-9814
Arthur.Thexton@Wisconsin.gov

Subscribed to and affirmed before me this September 11, 2013.



Notary Public, State of Wisconsin
 My Commission 3-27-16

General Information

Name: **William Russell Pinkonsly**
Address: *W715 Klondike Rd., Berlin, WI 54923*
Phone: *920-290-4074*
Email: *wrpinkonsly@hotmail.com*

Business: *Community Health Network*
Address: *N2934 Hwy 22, Wautoma, WI 54982*
Phone: *920-787-4613*
Email: *william.pinkonsly@chnwi.org*

Citizenship: *US Citizen*
Birth Place: *Chicago, IL*
Birth Date: *01/29/1960*

Education

Residency:	<i>Mercy/Mayo Family Practice Residency Des Moines, IA</i>	<i>JUL 2001 - JUN 2003</i>	
	<i>Racine Family Practice Residency 1320 Wisconsin Avenue Racine, WI 53402</i>	<i>JUL 2000 - JUL 2001</i>	
Medical School:	<i>University of Osteopathic Medicine and Health Sciences Des Moines, IA</i>	<i>JUL 1995 - MAY 2000</i>	<i>D.O.</i>
Undergraduate:	<i>Loyola University of Chicago Chicago, IL</i>	<i>AUG 1988 - JUN 1994 (Magna Cum Laude)</i>	<i>B.S. Psychology</i>
	<i>College of Lake County Grayslake, IL</i>	<i>JUN 1982 - JUN 1988</i>	<i>A.S. Nursing</i>

Examinations

NBOME Part 1: *Pass June 1998*
NBOME Part 2: *Pass March 2000*
NBOME Part 3: *Pass June 2001*

Medical Licensure

Current US Medical Licensure: *WI 48295-021* Expires: *02/28/2014*

US Medical Licensure Route: *NBOME/Complex*
Medical License Suspended: *No*
Medical License Revoked: *No*
Current Malpractice Case Pending: *No*
Board Certification: *Yes in Family Practice*
DEA: *BP75130669/XP7513066 Expires: 03/31/2016*
Veteran: *Yes*
Certificates: *ACLS, BCLS, PALS*

Memberships

ASAM
WI-ASAM
Wisconsin Medical society
AAFP

Employment

AUG 2009 - Present
Community Health Network, Berlin, WI
Family practice and emergency medicine, specialized in AODA

JUL 2007 – AUG 2009
Locum Medical Group, Cleveland, OH

Mercy Medical Center, Janesville, WI
Emergency Medicine

St. Joseph's Health Care, Hillsboro, WI
Emergency Medicine

AUG 2005 – JUL 2007
Riverside Medical Center, Waupaca, WI
Emergency Medicine

JUN 2004 – AUG 2005
Emergency Practice Associates, Ottomwa, IA
Emergency Medicine

AUG 2003 – JUN 2004
Monroe County Hospital, Albia, IA
Family Practice

MAY 1997 – MAY 2000
Mercy Hospital and Medical Center, Des Moines, IA
Critical Care Nurse
Manage the care of critically ill trauma, neurological, medical, and surgical patients
AUG 1996 - MAY 1997

University of Osteopathic Medicine, Des Moines, IA
Teaching Assistant
Taught Osteopathic Manipulative Treatment

MAY 1995 – JAN 1998
Des Moines General Hospital, Des Moines, IA
Critical Care Nurse
Care of critically ill patients, both medical and surgical

AUG 1988 – MAY 1995
Loyola University Medical Center, Maywood, IL
Critical Care Nurse
In charge of 8 – 10 nurses, 2 nursing assistants, and unit secretary; coordinating staffing, nursing assignments, and patient care

Volunteer Experience

MAR 1997 – MAR 1998
Undergraduate American Academy of Osteopathy, Des Moines, IA
UOMHS Regional representative
Coordinated the activities of five chapters of UAAO

MAR 1997 – MAR 1998
Undergraduate American Academy of Osteopathy, Des Moines, IA
UOMHS President of Des Moines Chapter
Oversaw all club activities and finances

MAR 1996 – MAR 1998
University of Osteopathic Medicine
Health Fair
Performed cholesterol/blood sugar screening and Osteopathic Manipulative Medicine

MAR 1996 – MAR 1997
Undergraduate American Academy of Osteopathy, Des Moines, IA
National representative
Coordinated the activities of our school's chapters of UAAO with the national office; acting as a liaison

Hobbies/Interests

Family, Photography, camping, bicycling, addiction science, and learning to play the guitar.

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

AGENDA REQUEST FORM

Name and Title of Person Submitting the Request: [Redacted] Cramton on behalf of Attorney Arthur Thexton Division of Legal Services and Compliance	Date When Request Submitted: September 9, 2013 <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 meeting for all other boards
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Name of Board, Committee, Council:

Medical Examining Board

Board Meeting Date: September 18, 2013	Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	How should the item be titled on the agenda page? Presentation of Petition for Summary Suspension in case number 13 MED 229, Kent Gregory Brockmann, M.D., M.D.
---	--	---

Place Item in: <input type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input checked="" type="checkbox"/> Both	Is an appearance before the Board being scheduled? If yes, by whom? <input checked="" type="checkbox"/> Yes by Samuel Arthur (name) THEXTON <input type="checkbox"/> No	Name of Case Advisor(s), if required: Greg Collins
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Describe the issue and action the Board should address:

The members must decide whether to grant the Petition for Summary Suspension. Respondent has the right to appear during open session presentation and be heard [Wis. Stat. § 448.02(4)].

The MEB must decide whether there is probable cause to believe that:

1. Respondent has violated the Board's statutes and rules.
2. It is necessary to suspend Respondent's license immediately to protect the public health safety or welfare.

Authorization:

	9-9-13 Date
--	----------------

	9/9/13 Date
--	----------------

Bureau Director signature (indicates approval to add late items 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's Executive Director.
3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

BOARD APPEARANCE REQUEST FORM

Board Name: Medical Examining Board

Board Meeting Date: September 18, 2013

Person Submitting Agenda Request: Beth Cramton

Person requesting an appearance: Attorney Arthur Thexton

Mailing address: P.O. Box 8935, Madison, WI 53708-8935

Email address: arthur.thexton@wisconsin.gov

Telephone #: (608) 266-9814

Reason for Appearance: Consideration of Petition for Summary Suspension in case number
13 MED 229, Kent G. Brockmann, M.D.

Is the person represented by an attorney? If so, who?

Attorney's mailing address:

Attorney's e-mail address:

Phone Attorney:

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY :
PROCEEDINGS AGAINST :
: DLSC Case No. 13 MED 229
KENT G. BROCKMANN, M.D., :
RESPONDENT. :

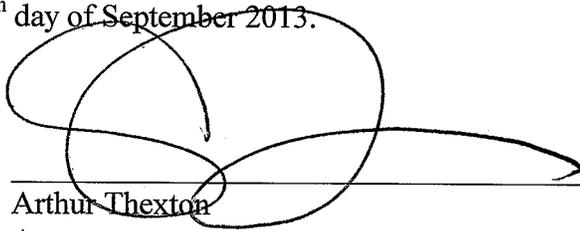
NOTICE OF PRESENTATION OF PETITION FOR SUMMARY SUSPENSION

To: Kent G. Brockmann, M.D.
8673 Eagle Point Blvd
Lake Elmo, MN 55042

PLEASE TAKE NOTICE that the Petitioner, Wisconsin Department of Safety and Professional Services, Division of Legal Services and Compliance, will present the attached Petition for Summary Suspension to the Wisconsin Medical Examining Board at the following date, time and place:

Date: September 18, 2013
Time: 8:15 a.m. or soon thereafter
Place: Room 121A
1400 E. Washington Avenue
Madison, Wisconsin

Dated at Madison, Wisconsin this 9th day of September 2013.



Arthur Thexton
Attorney
Wisconsin State Bar Number 1016702
Department of Safety & Professional Services
Division of Legal Services and Compliance
P.O. Box 8935
Madison, WI 53708
Tel. (608) 266-9814
Fax (608) 266-2264

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY :
PROCEEDINGS AGAINST :
 : DLSC Case No. 13 MED 229
KENT G. BROCKMANN, M.D. :
RESPONDENT. :

PETITION FOR SUMMARY SUSPENSION
[Wis. Stat. § 448.02(4) and Wis. Admin. Code ch. SPS 6]

Arthur Thexton, being duly on affirmation, upon information and belief, deposes and states, as follows:

1. I am a prosecuting attorney employed by the Wisconsin Department of Safety and Professional Services, Division of Legal Services and Compliance, and in the course of my job duties have been assigned to the investigation and prosecution of case number 13 MED 229 concerning Respondent Kent G. Brockmann, M.D., for the Wisconsin Medical Examining Board.

2. My business address is 1400 East Washington Avenue, Madison, Wisconsin 53703, and my business mailing address is Post Office Box 8935, Madison, Wisconsin 53708.

3. Respondent Kent Gregory Brockmann, M.D., (dob July 1, 1957), is licensed in the state of Wisconsin to practice medicine and surgery, having license number 48376-20, first issued on July 12, 2005, with registration current through October 31, 2013. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is 8673 Eagle Point Boulevard, Lake Elmo, Minnesota 55042. He is also licensed in Minnesota, and is certified in psychiatry by the American Board of Psychiatry and Neurology.

4. At the time of the events set out below, Respondent was engaged in the active practice of psychiatry in Wisconsin and Minnesota.

5. Beginning in 2006, Respondent provided psychiatric care and treatment to a female patient born in 1974, and who was married and the mother of 4 children. The patient was diagnosed with Graves' Disease, and had a number of mental health conditions. Respondent saw the patient at his offices in Lake Elmo, Minnesota, and Balsam Lake, Wisconsin.

6. On an exact date unknown, but while engaged in providing psychiatric therapy, care, and treatment for the patient at his Balsam Lake office, Respondent invited the patient to sit on his lap. The patient did so, and Respondent engaged in kissing the patient on her face and lips.

7. On an exact date unknown, but in 2010 or 2011, Respondent telephoned the patient, and suggested that they meet at a park in St. Croix County Wisconsin. On that occasion, Respondent engaged in kissing the patient, caressing and kissing her breasts, and basing his finger inside her vagina. Respondent then requested that the patient hold his scrotum in her hand; Respondent then masturbated to ejaculation, while the patient held his scrotum.

8. On another occasion in early July, 2012, the exact date of which is unknown, but is within 2 years of Respondent providing psychiatric care and treatment, Respondent telephoned the patient and invited her to meet him at a park near the patient's home in Chisago County Minnesota. On that occasion, Respondent sat with the patient in her vehicle, and engaged in kissing her, unbuttoning her shirt, and caressing her breasts.

9. Respondent Kent G. Brockmann, M.D., by engaging in inappropriate sexual contact, exposure, gratification, or other sexual behavior with or in the presence of a person who had been a patient within the previous 2 years, as set forth in paragraphs 6-8, above, has committed unprofessional conduct, as defined by Wis. Admin. Code § MED 10.02(2)(zd) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

10. Respondent Kent G. Brockmann, M.D., by intentionally having sexual contact, with a patient, as set forth in paragraph 6, above, has committed unprofessional conduct, as defined by Wis. Admin. Code § MED 10.02(2)(z) and Wis. Stat. § 940.22(2), and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

11. A formal complaint to be filed with the Division of Hearings and Appeals, alleging that Respondent has committed unprofessional conduct is submitted concurrently with this petition, and, if approved, will be filed within 10 days of any order summarily suspending the license of Respondent.

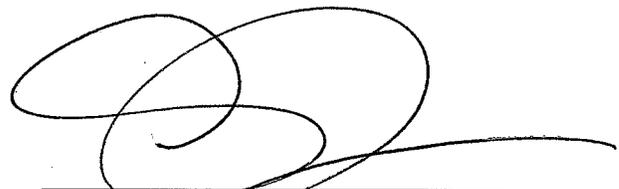
12. There is probable cause to believe that it is necessary to suspend Respondent's license immediately to protect the public health, safety or welfare, based upon conduct by the Respondent described above, and upon the following:

- a. During all of the time described above, Respondent was also functioning as a religious pastor advisor to the patient, and was involved with her in leading a small congregation which met at the home of the patient, or some other private homes.
- b. In addition to being involved in this congregation, Respondent and the patient traveled to Illinois to religious gatherings, where persons present prayed for the patient. Respondent was interviewed by an investigator for the Chisago County Sheriff's Department on August 8, 2013, where he stated that these prayer sessions saved the patient's life.
- c. At this same interview, Respondent admitted having sexual contact with the patient, and further stated the following:
 - "I go above and beyond for my patients"
 - "I am a hell of a good doctor"
 - "I've seen tons of patients that seen tons of other doctors and they want to see me because I really try and help patients"

- "you guys probably think I am fricking nuts, okay, but truth is I was magna cum laude in chemistry before I went to medical school, I mean it's hard to do better than that in chemistry. I went to chemistry, I was in the top 10% of my class, my biology, chemistry and physics and yet... I probably know more about psychotropic medication than 99% of the psychiatrists in the country and yet we have patients and we can do all the therapy in the world and we can do all of the medications in the world and they still are so sick they want to kill themselves. And what do you do for those patients? Well I know what most psychiatrists do. They (inaudible) the State of Minnesota wants them to do is wash their hands of it and let them kill themselves basically. So what do I do? I try to find other answers. Maybe there's answers in the alternative medicine and stuff. And this guy [*name omitted*] we prayed for people (inaudible) things need to happen."
 - "I am going to tell you... if the State of Minnesota and Chisago County destroy my medical career, you are going to lose one of the best doctors out there and that's gonna be a huge tragedy."
- d. At this interview, Respondent told the investigator that his prayers had saved a 4-month-old infant who was thought to have a fatal congenital lung condition, and that on another occasion he had prayed for a seriously injured beta fish being kept in an aquarium by the son of the patient, and that the fish then lived for an extended period.
- e. At this interview, Respondent also stated that he prayed with some of his patients, while seeing them in his office as a psychiatrist.

WHEREFORE, the Division of Legal Services and Compliance hereby requests that the Wisconsin Medical Examining Board:

1. Find that notice has been given to Respondent Kent G. Brockmann, M.D., under Wis. Admin. Code § SPS 6.05.
2. Find probable cause to believe that Respondent Kent G. Brockmann, M.D., has engaged in or is likely to engage in conduct such that the public health, safety or welfare imperatively requires emergency suspension of Respondent's license and registration to practice medicine and surgery.
3. Issue an order summarily suspending the license and registration of Respondent Kent G. Brockmann, M.D., to practice medicine and surgery in the state of Wisconsin and order that such suspension continue until the effective date of a final decision and order issued in the disciplinary proceeding against Respondent, unless otherwise ordered by the Board.



Arthur Thexton

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF :
DISCIPLINARY PROCEEDINGS AGAINST :
 : DLSC Case No. 12 MED 103
KENT G. BROCKMANN, M.D., :
RESPONDENT. :

AFFIDAVIT OF ARTHUR THEXTON

STATE OF WISCONSIN)
) SS
COUNTY OF DANE)

Arthur Thexton, being first on affirmation, upon information and belief, deposes and states, as follows:

1. I am an attorney for the Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division), in this action and make this affidavit on personal knowledge.

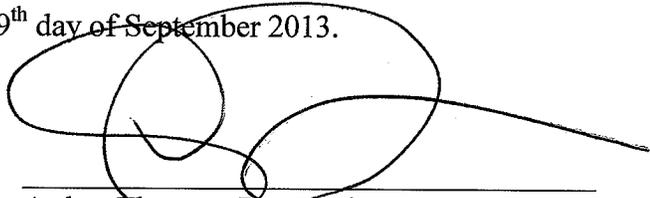
2. I make this affidavit in support of the Petition for Summary Suspension.

3. I have received the attached transcript of an interview with Respondent, dated August 8, 2013, and Supplementary Report summarizing the interview conducted of the patient and her husband, dated August 13, 2013, directly from the Chisago County Sheriff's Department, in the ordinary course of business.

4. I have every reason to believe that the transcript accurately reflects the statements of Respondent made to the questions asked, and that the interview and transcription were made in the ordinary course of business of the Chisago County Sheriff's Department. The statement of Respondent is reliable because it was made against his penal interest.

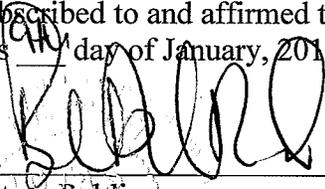
5. I have every reason to believe that the supplementary report accurately summarizes the interview of the patient and her husband, because it was made by a sworn law-enforcement officer in the course of her regular duties, and because I have read the transcript of the interview.

Dated in Madison, Wisconsin, this 9th day of September 2013.

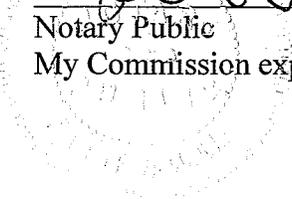


Arthur Thexton, Prosecuting Attorney
Department of Safety and Professional Services
Division of Legal Services and Compliance

Subscribed to and affirmed to before me
this 9th day of January, 2013.



Notary Public
My Commission expires March 27, 2016.



Incident Report Number

13-025963

Incident Location:

Kable AVE/344th ST;LT, North Branch, MN, 55056

Incident Date:

07/23/2013

KB Yeah.

ML Okay.

KB And I'll take a lie detector test (inaudible) I don't care and I didn't know why (inaudible) in the world (inaudible) district attorney. Um,

ML Have you had any contact with [REDACTED] in recent months? I think you said it's been quite a while.

KB Last time I talked to [REDACTED] was...four or five months ago. I talked to her on the phone because I called several people to tell them that BJ who had never been a patient of mine had died unexpectedly.

ML Okay.

KB And I thought she would like to know.

ML Okay. Was she part of the fellowship?

KB She was.

ML Oh, it was a female? BJ was a fe

KB Yeah, she was an eighty year old woman.

ML Okay.

KB Or I don't know

ML She was

KB I may be off by a year or two.

ML Older...older woman. Okay.

JT Okay.

KB And so I thought she would want to know about that.

ML Okay. Has anybody contacted you in regards to any of this prior to us?

KB Well I told you that I heard from Becky that she may have talked to the police department.

Reporting Officer(s):

Lalonde, Michelle L.

ID Number

112

ID Number

Pages: **50**

40 Of 46

Incident Report Number

13-025963

Incident Location:

Kable AVE/344th ST;LT, North Branch, MN, 55056

Incident Date:

07/23/2013

ML Okay.

KB So I figured it the police department wants to talk to me, well it must be related to this.

ML Okay.

KB Because I've never been sued, never had a criminal charge, never had anything so I figure it was either this or remote possibility you were investigating something else with some patient or something I knew and maybe a (inaudible) couldn't figure out what else it would be.

ML Okay.

KB So

ML Ya know right now just this ya know I wouldn't have any contact with [REDACTED]. I don't see

KB I (inaudible)

ML (inaudible) yeah, so um and then the fellowship um I don't know if [REDACTED] has anything to do with the fellowship anymore but I

KB She hasn't had (inaudible) over a month. I don't know what she's doing.

ML Okay. So um ya know I appreciate you coming in and being honest with us.

KB Yeah, well that's probably the stupidest thing I ever did but

ML Well, sometimes ya know not talking about it ya know you're a doctor, not talking about it can make it worse too.

KB I don't know, I mean when I yeah you're right, I mean you want to know what really bothers me about this I mean yeah, it's okay, it's unfortunate some of these (inaudible) yes, I'm sure there's some things I should do different. Yes, I would never do it again, yes, okay, I, yeah I made some mistakes.

ML Mm, hmm.

KB I'm gonna tell you...in the state of Minnesota and Chicago County destroys my medical career, you're gonna lose one of the best doctors out there and that's gonna be a huge tragedy (inaudible) I've been thinking about this (inaudible) part of me would like to get out.

ML Mm, hmm.

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KB Oh yeah.

ML So

KB Yeah.

ML Those lines were crossed between you and [REDACTED].

KB Okay.

ML Ya know I have to do my job (inaudible)

KB I'm not mad at you.

ML Yeah.

JT Mm, hmm.

ML Ya know I'm just sayin this is I have to look into it obviously.

KB I, I know.

ML And let the county attorney's review it cause they make the charging decisions ya know

KB (Inaudible)

JT And [REDACTED] was in a pretty vulnerable state during the time that you were treating her too.

KB Actually (inaudible) I don't think she was in a vulnerable (inaudible) I think she was at the lowest she's ever been.

JT Okay. Well you said several times she was suicidal so

KB I'm not denying it. (Inaudible) that that was true.

JT Okay.

KB I just (inaudible) I think she was well aware of what she was doing.

ML Yeah, I guess I think there was an emotional attachment between both [REDACTED] to you and you to [REDACTED] so

KB Well I believe that's true.

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ML Um, if you have questions, I'll give you my card.

KB Okay.

ML If Polk County calls and I just I wanted to let you know Polk County ya know in case you get a phone call and you're going I already talked to an investigator ya know um they may, they may not call you, I don't know.

KB Okay.

ML Okay?

KB And you (inaudible).

ML Well it, it's a possibility, each, each place that any, anything occurred at is a different jurisdiction so if something happened down in Lake Elmo, Lake Elmo would (inaudible)

KB (Inaudible) happened in the State of Minnesota (inaudible) you want to be technical, I don't remember any of this inappropriate touching occurring in the state of Minnesota.

ML Well you touched her on your walk in the park in Minnesota. You looked at her breasts in Minnesota.

KB No.

ML Okay.

KB It was all in Wisconsin.

ML That time you met around your birthday?

KB I didn't touch her on that (inaudible) birthday.

ML Well [REDACTED] saying that you had touched her breasts at that at that time.

KB Okay.

ML There might be so many instances you guys can't keep them all straight too.

KB I don't think anything happened in Minnesota.

ML Okay.

KB I mean we're gonna be technical about this, I don't think so.

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NARRATIVE

CCSO ICR #13-25963

TRANSCRIBED STATEMENT WITH KENT BROCKMANN

ALSO PRESENT: JOLENE THORSEN, CHISAGO COUNTY HUMAN SERVICES

ML Investigator LaLonde, badge number 112. ICR is 13-25963. I'm be meeting with a Kent Brockmann in regards to a crim sex. Today's date is August 8th, 2013 at approximately 1500 hours.

ML And Kent, just for the record, what is your full name and date of birth?

KB Kent K-e-n-t Brockmann B-r-o-c-k-m-a-n-n, July 1st 1957.

ML Do you have a middle name?

KB Gregory. (Inaudible)

ML Okay. And a good phone number to contact you at?

KB Ah 715-246-7916.

ML What was the last four?

KB 7916.

ML 7916? And a good address for you Kent?

KB 1128 Circle Pine Drive

ML What city is that in?

KB New Richmond, Wisconsin.

ML Okay. Um and just ya know I explained to you um ya know we just received a complaint um and your name has come up to during the investigation um you're not under arrest. If I ask you questions you don't feel comfortable with, you can leave at any time, okay?

KB Okay.

ML You can ask for a lawyer at any time, whatever, okay?

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KB Okay.

ML So just so you ya know you

KB Okay.

ML you don't have to stay here if you don't want to.

KB All right.

ML Okay. Um, so can I get a little bit of background on, on you? I don't quite know who you are and that's I'd like to get to know somebody before I sit down and talk.

KB Well I'm a physician, I've have a private practice in um (inaudible) Minnesota.

ML Okay.

KB I'm the medical director in Polk County and Washburn County. Um, I'm extremely busy ah

ML We appreciate you being able to come in and make time.

KB well it is remarkable actually (inaudible) decided to take this Thursday off.

ML Oh, okay.

KB Months ago.

ML Oh.

KB So

ML So you're the medical director in Polk County and, and Washburn County?

KB That's correct.

ML That and they're both Wisconsin, right?

KB That's correct.

ML And then you have a private practice in

KB Lake Elmo.

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ML Lake Elmo?

KB Minnesota.

ML Okay. Um, and what kind of what do you practice then?

KB I'm a psychiatrist.

ML Psychiatrist.

KB And I, I don't know, been practice in Minnesota I don't know eight years or something like that.

ML Eight years in Minnesota?

KB (Inaudible) how many years.

JT Okay, how about Wisconsin?

KB Um, probably six years.

JT Okay.

KB I mean I could look up those exact (inaudible)

ML That nope it doesn't have to be specific. Um, what kind of I guess do you see just all sorts of type of clients or do you have a specific

KB I, (inaudible) patients from six to sixty.

ML Okay.

KB I don't do very many geriatric patients, I get some because people ask ya know where could (inaudible) take children under six because somebody asked me, usually I'm already seeing a relative or a friend.

ML Okay.

KB I do that. But generally that's a group I prefer to treat.

ML Okay.

KB I don't really like treating people under six cause (inaudible) questions whether it's appropriate to medicate kids under six and only in rare occasions do I and ah I don't feel my specialty is geriatrics.

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ML Okay.

KB That's pretty much how I get those numbers.

JT Okay.

ML And then being the medical director for Polk County and Washburn County, what does that entail um?

KB Well I see a lot of patients in both those counties. Um, I ah supervise psychologists in Polk County, um, I supervise social workers in Polk County. I used to supervise drug and alcohol treatment but I've been trying to cut back on my practice.

ML Okay.

KB I gave that to Dr. Brown (inaudible) some expertise in that area. She is doing that now. Um, actually the only and actually Polk County came to me first and asked if I'd work for them and I started working for them. Then they asked me take on all these supervisor positions and Washburn County came and asked if I'd work for them.

ML Okay.

KB And so most everything I do except my private practice people came to me asked me if I'd do it for 'em.

ML Okay. So Polk County and Wa so do you do um ah I guess I'm not sure exactly what a medical director does. Do you see patients then that are

KB I see lots of patients

ML come in at from the county or like people (inaudible) the county in (inaudible)

KB Well I see patients that are private insurance, I see patients that are on Medicare and Medicaid. Some patients are brought in from the jail that I see. Um,

JT So they're brought into your office at Polk County, right?

KB Yeah. I mean everybody I see in Polk County I see in my office in Polk County. Everybody I see in Washburn County I see in my office in Washburn County.

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JT Okay.

ML Is that in Balsam Lake, the Polk County then?

KB Yes, it is.

ML Okay. And then Washburn County, I guess

KB Washburn County is Spooner.

ML Spooner. So you're driving all over the place?

KB Well that's true but they both came to me and asked me if I'd work for them and they agreed to pay me my normal rate for time while I drove back and forth

JT Hmm.

ML Hmm.

KB to work so I get paid time while working so

ML That's (inaudible)

KB I and really I wasn't I didn't go looking for this business but they've been good to me, the counties have treated me well and so that's why I didn't know what I'd think of Polk County. Started out working there one day a week, then I worked there two days a week.

ML Okay.

KB And I liked it I guess when Washburn County came, I decided to do that so I work three days a week in the counties ah about two and a half cause I don't work every week in Washburn County.

ML Okay. And then you get

KB And then I have two days a week in my private practice.

ML Okay, I was gonna say when do you fit in your private practice?

KB Well I'd closed my private practice (inaudible) patients on rare occasions, I have people that I turn down all the time to see me. I have people beg me to get in the office on a rare occasion I'll do it cause I see a family member or something but really I'm trying to cut back my practice.

ML Okay.

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KB Really, honestly I feel overworked.

ML Overworked?

KB And that's my honest opinion.

ML Yep. Overworked, underpaid, that's that I always think.

KB Well I don't claim (inaudible)

ML (Laughs)

KB I'm paid reasonably well.

ML Yeah. Okay.

KB I mean that's the truth.

ML Okay. So Polk County and Washburn County you supervise and, and you see people from the jail ya know inmates and, and stuff like that different and private (inaudible)

KB No I well I don't see that many inmates. The percent of inmates that I see in Polk County and Washburn County is less than five percent of the patients I see.

ML Okay.

KB And a percentage of the patients I see are committed is less than five percent of the patients.

ML Okay.

KB But ninety percent of the patients I see are regular patients with a high percentage being fairly poor patients who probably at best have some form of Medicare for or Medicaid for insurance.

ML Mm, hmm.

KB And um basically (inaudible) patients and it's in my private practice most of the patients I see are middle class and upper middle class patients so I get I like the mix

ML (Inaudible) variety

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KB Some days I work with poor patients, sometimes I work with middle class and upper middle class patients, I kind of do both.

ML Mm, hmm. We just ya know um we the information that we had received is that there might've been some boundaries crossed between you and one of your patients.

KB Okay.

ML Do you have any idea of which patient I might be talking about?

KB Well I probably have an idea since I'm good friends with her brother in law and her sister in law and I heard something that well

ML Okay.

KB [REDACTED] had some complaint against

ML Okay. How do you how do you know [REDACTED]?

KB Well [REDACTED] was a patient of mine for...I don't know, four or five years.

ML Okay.

KB She um...she was a patient I mean I don't know, I mean if you know who I am, you'd know I do this all the time but I go above and beyond for my patients.

ML Okay.

KB And she was a patient who was at our private practice who I, I, I many times I was seeing twice a week. She frequently was suicidal.

ML Mm, hmm.

KB I mean you probably have records of I remember one time I'm pretty sure this is Chisago County but it was somewhere up here um where my wife was on the telephone talking to police officer, I was on the telephone talking to [REDACTED] and finally I got enough out of her so the police could find her weaving down the street where she was and take her into the hospital.

ML Okay. When

KB I don't know, I, I remember one time she frequently would threaten to kill herself.

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ML Hmm.

JT Mm, hmm.

KB One time she was at her sister's and she threatened to kill herself and somehow they she said she was gonna drive off and drive her car into a lake and kill herself because (inaudible) keep her on the telephone long enough to pull my car behind her and then walk into the house with her sister

ML (Inaudible)

KB I can confirm this.

ML Mm, hmm.

KB She told her sister she was just gonna go out and I don't know relax and pray in her car or something. Her sister had no idea she was gonna go kill herself.

ML When did you start treating [REDACTED] Do you remember approximately what year maybe?

KB Yeah, I haven't looked at her chart. (Inaudible) she hasn't been my patient for three years so I don't

ML Okay

KB I'm guessing eight years ago, seven years ago

ML Okay.

KB I mean to be honest if you want me to give you anything, we would have to

ML Well, I, I don't need exact

KB I'd have to pull the chart.

ML I don't need exact dates or

KB But I saw her for three or four years

ML Okay.

KB And I started seeing her I would estimate seven years ago.

ML Okay.

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KB And ah she would call our office sometimes four or five times a week and often times I couldn't even talk to her. My wife is our off my office manager we and she would frequently spend an hour or more a day talking to [REDACTED] trying to (inaudible).

ML Okay.

KB (Inaudible) I only do this for [REDACTED], well that's not true.

ML Okay.

KB I mean um, Brady's a patient of mine who lives in Hudson, Wisconsin. I mean less than two weeks ago, maybe it was three weeks ago, I'm pretty busy, I have a lot of patients (inaudible)

ML Mm, hmm.

KB He was threatening to jump off a bridge at 94 and a police officer literally pulled him down and I spent a Saturday well an hour or so with his family and him and we seemed to have gotten him turned around. I mean I do go above and beyond for my patients. I mean maybe that's bad, I don't know. I mean ya know

ML What's, what's your relationship like with, with [REDACTED] since you treated her for so long?

KB Ya know, I talk to her two or three times a week. I probably and I'm not kidding ah and if she's (inaudible) I've probably saved her life five or six times. She's told me that before.

ML Mm, hmm.

KB But...sitting here time after time after time I guess in some words we probably became almost like friends.

ML Okay.

KB I mean that's the truth.

ML You guys talked about I mean she'd call you and, and talk to you about life and

KB She did.

ML other things?

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KB She did.

ML Okay.

KB (Inaudible) keeping her alive but we probably talked about too much too often because she scared me to death. She had four kids. I think she was one of the most suicidal patients I've ever seen. She's had multiple diagnoses. Depression, schizophrenia...and, an and at one level she's a very nice young lady but she can go so far off the deep end, it scared me.

ML Mm, hmm.

KB And...ya know I mean I have a patient Maury right now I see, he's an eighty year old male, I spend every week with him and the guy got involved in homosexuality. He'd been married I don't know fifty years or so. I spent time with him every weekend, finally he and his wife are starting to turn around their marriage, it might be fate. I mean I really go above and beyond to try to help my patients.

ML So you

KB And maybe I try too hard.

ML you became pretty good friends with [REDACTED] then and?

KB That's true.

ML Okay.

KB I mean it's true.

ML So you treated her for three to fo three to four years you (inaudible)

KB I think

ML approximately.

KB four or five but

ML Okay.

KB I could get details.

ML Okay.

JT And she hasn't been your patient for three years?

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KB No, she hasn't been a patient since 2011.

JT Okay.

KB I haven't talked to [REDACTED] in like five months.

ML Okay.

KB At all.

ML Okay.

KB Last time I talked to [REDACTED] was when a mutual friend of ours...BJ who is an eighty year old woman died and we were unexpectedly we called all the people (inaudible) and said BJ died.

ML Okay.

KB That's the last time I talked to [REDACTED].

ML Okay, so

KB Actually in 2011...I thought...things were getting to the point where (inaudible) the boundaries and I asked her to go see someone else.

ML Okay.

KB That's why I don't see her anymore. Because I thought things were getting

ML How would you say those boundaries were being ya know pushed a little bit?

KB Well we became like friends, we did, I mean we...and ya know and I worried a lot about...ordinarily I worry about her being suicidal, I worried about what went on in her home which I thought was one of the big reasons she was so frequently suicidal. I mean she was in a woman's shelter for a while, I thought her hu her husband was very emotionally abusive um

ML Did you visit her?

KB (Inaudible) I visited her house with her husband and her.

ML Okay.

KB I mean her husband...she said on one occasion was physically abusive, she told a mutual friend that he'd raped her and I know that frequently conflicts lead to her being suicidal and so yeah, I worried a lot about what was going

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on in that household and I can show I mean I've seen reports who psychologist after psychologist telling her to leave her husband

ML And you

KB and actually for years and years and years I would tell her I can't tell you what you should do about that, you've gotta decide for yourself but finally after years of this, I said I think you should leave him.

ML Mm, hmm.

KB And so she also tried to she's see psychologist she had a track record of seeing psychologists and, and she'd see them for six months or (inaudible) start telling her to leave her husband and (inaudible) believe the psychologist and I've seen records out of Fairview Hospital describing the kind abusive interaction the psychologist saw between the two of them in the hospital where she was hospitalized.

ML And I mean [REDACTED] would be somewhat pretty vulnerable, is that correct? Just because of her mental health?

KB Well I kind of agree with that. I don't (chuckle) totally agree with that but

ML Okay. Okay. So you would

KB She's a very intelligent woman, I can tell you that. She's not stupid, I mean she's

ML But

KB she (inaudible) an IQ test she had done by a psychologist I don't know (inaudible) genius level or whatever

ML But medically, for her like for depression and all that stuff and her suicidal

KB She's she is very to me she's very emotionally (inaudible) I would certainly agree with that.

ML Okay. When you said at one point you, you told her that she needed to see somebody else cause you were afraid those boun boundaries would've been crossed, what, what were you guys feeling at that time or you thought they were gonna be, be crossed?

KB I (inaudible) feelings towards each other so that's why I ask her to see

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someone else.

ML Okay. Had there been in, inappropriate contact between you and [REDACTED]?

KB I, at one time, she kissed me.

ML Okay.

KB And I decided we needed to do something about this.

ML Okay.

KB So

ML Would that have been a like a peck when she was seeing you or at a practice in

KB (Inaudible) in my office.

ML In your office?

KB Yep.

ML Okay.

KB So

JT What office was she at when that happened?

KB Um, she actually was in the Washburn office.

ML Washburn office?

JT Okay.

KB (Inaudible) that was the Balsam Lake office. I mean she would get extremely upset about things

ML She confided in you a lot?

KB I would agree that she did.

ML And so you were there emotionally for her to comfort her?

KB That's probably true.

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ML And that's maybe where you were starting to feel like things were getting too close or?

KB Yeah. I mean I'm not disagreeing with that.

ML Okay. But you you're saying only on one occasion that there might've been some boundaries crossed between you and [REDACTED]

KB I don't know, we were getting closer than we probably should've so I guess I don't know.

ML I mean cause there must've been some ya know obviously me and Jolene have talked to [REDACTED]

KB Yeah.

ML and she said ya know you guys were definitely ya know she confided in you, she ya know you were her person to, to go to.

KB She did?

ML And ya know she said you would comfort her and

KB Yep.

ML and you would kiss and stuff like that. I mean is that inaccurate?

KB We kissed on a couple occasions, yes.

ML Okay. Did it go further than kissing?

KB One time she pulled up her shirt but I said that was enough.

ML Okay. Ah she exposed her breasts to you?

KB Yeah. She did.

ML Okay. Did she ever touch you ya know anywhere?

KB She touched my chest.

ML Okay. Um, she [REDACTED] stated that ya know during some sessions ya know I and I don't know how you are for comforting or whatever she said you'd rub her hands and, and maybe rub her face and kiss her face is

KB (Inaudible) started out isn't quite (inaudible) now I think you're making

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this up.

ML Well, I, I ya know tell me how

KB Sometimes she got extremely psychotic.

ML Okay.

JT Was this a time

KB (Inaudible) what?

JT Was this a time that she was at in one of your offices that she

KB Yep.

JT Okay.

KB She's in the Lake Elmo office.

JT Okay.

KB She got extremely psychotic and we couldn't get a hold of her husband and so...she couldn't drive her car so...so I got in her car and drove her home, Barb was right behind me and she starts kissing my hand

ML Okay.

KB multiple times. Um...and so...yeah, I don't know how to talk about this and maybe I should talk to an attorney but the trouble is, I'm trying to be honest. The trouble is...she initiated a few things I finally decided we have to get put an end to this.

ML If you

KB I spent years trying to save this woman's life. I spent years trying to help this woman. And finally I had to distance myself. There's not a thing I'm telling you that my wife doesn't know. I probably (inaudible) too much already, I mean do I worry about talking about this, yeah, I worry about (inaudible) my career.

ML Mm, hmm.

JT Mm, hmm.

KB I'm a hell of a good doctor. I mean we create a society where everybody's so frickin politically correct that doctor's pretty much suck now a days cause

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they don't do anything except (inaudible) people and people complain but they come in and they get their fifteen minute medicine checks and

ML Out the door they go.

KB (Inaudible) and I'm ti I've seen tons of patients that seen tons of other doctors and they want to see me because I really try and help patients.

ML (Inaudible) care for her. I mean ya know care about her.

KB (Inaudible) care for all my patients but yes, I did really care for her. But what it bothers me about this is it comes out like (inaudible) just really cared about [REDACTED] That's bull shit.

ML You care about all of your patients.

KB When I started being a doctor years ago, I (inaudible) I wanted every patient (inaudible) so this thing spun out of control (inaudible) yeah it and it did

ML With, with you and [REDACTED]

KB Yep.

ML Would you meet um each other in different areas not at any practice?

KB We did on a few occasions.

ML What would happen during those occasions?

KB Usually just walk.

ML Walk?

KB Talk.

ML Okay. Were there occasions where you can think of where boundaries were crossed and things shouldn'ta happened?

KB Well we did kiss on a couple occasions.

ML Yeah. Did you ever touch her breasts?

KB I did when she exposed her breasts, yeah.

ML Okay. How about um did she ever touch you um on your penis, um on your

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scrotum, anything like that?

KB She did touch my penis once.

ML Okay. And I, I'm glad you're being honest because I mean that...ya know we've talked to [REDACTED] and [REDACTED] definitely cares about you and ya know um ya know she almost said ya know she didn't she didn't have a father grow father figure growing up and she was confiding in you on stuff and

KB (Inaudible)

ML (Inaudible) but then like you said, boundaries were starting to get pushed. Do you think were you falling in love with her?

KB I think we developed emotional feelings attachments towards each other.

ML Okay.

KB I don't know.

ML You guys belong to a church group or a religious group?

KB We went to church fellowship.

ML Okay. Together or?

KB A long time...

ML Okay, so you were seeing her as a doctor and her

KB Well that was part of the reason I said we needed to separate this relationship. I couldn't she couldn't be my patient anymore.

ML Okay.

KB Actually she asked me (inaudible) I didn't ask her to be

ML For the fellowship?

KB Yeah.

ML Okay.

JT So she asked you about the fellowship?

KB She asked to be part of the (inaudible) fellowship.

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JT Okay.

KB I (inaudible) I mean she had been she probably been on every medication known to (inaudible)

JT Okay.

KB pretty close, I mean she, I mean I, I remember one time going through her chart and right now it's twenty five medications trying to (inaudible) anywhere else you have a chart...and she was getting and she still was determined she was gonna kill herself.

JT Mm, hmm.

KB I (inaudible) three more medicine three more months to live, I mean I really I didn't think she was gonna live three more months.

ML You thought she was just that suicidal that she'd eventually

KB Yep. She (inaudible) suicidal and I thought she'd kill herself.

ML Mm, hmm.

KB I would have very few suicides (inaudible) only one suicide with another patient I knew fairly well which was a male patient and I try my damndest (inaudible) killing himself. (Inaudible) I don't know.

ML Did you get to invol too attached or too feel like you need to save him or ya know

KB (Inaudible) maybe. I mean maybe I do.

ML Mm, hmm.

KB Just...cause I really do try to help people.

ML Mm, hmm.

JT So with these fellowships, can you tell us a little bit more about

KB Yeah, I can tell you (inaudible) with that.

JT Okay.

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KB (Inaudible) I don't know, I'm sure she's been to at least a dozen therapists, she's I'm sure she'd been at least a half a dozen therapists at least before anything (inaudible), okay?

JT Okay.

KB And then um...I so I said well I knew this man and sometimes they pray for people that really helped them, and I did, his name was Tom Deckard (sp?) and he, he had and I, I really felt she was going to kill herself and ah so I told or you need to talk to your husband and talk to your family but I think (inaudible) pray for you and see if it helps. Ya know we tr you tried every therapy just about, tried every medication just about, I think she's even had electroshock therapy.

ML Mm, hmm.

KB And so...she agreed to go meet this man Tom Deckard who did pray for her and she said it helped. She said it helped tremendously.

ML From what we understood is she made it sound like it saved her life.

KB She told me it saved her life. She said it saved her life.

ML Mm, hmm.

KB She told me afterward that she didn't really have three months to live, she decided Tom Deckard didn't help (inaudible) she's gonna kill herself maybe even when she was (inaudible) Tom Deckard. I told her she needed to discuss it with her husband (inaudible) discuss it with everyone cause I was trying to save her life without doing anything wrong. (Exhale)

ML When you say doing anything wrong, is that (inaudible)

KB Well I was concerned about boundary violations, yeah, I know it (inaudible) I mean boundary violations, okay? It wasn't like I went into this thing not trying to just it wasn't like I was trying to (inaudible) it wasn't like I was trying to do anything, I was trying to save her life.

ML Mm, hmm.

JT So as far as the boundary issues, you were worried about introducing her to this fellowship?

KB After she went down there and he prayed for her and she said he saved her life, those aren't my words. I believed it did, I believe it really changed her and whatever reason (inaudible) like I don't know (inaudible) it's in this little town (inaudible) in Illinois and a couple other people from (inaudible)

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talk and pray for. He doesn't have a lot of money if not any (inaudible) I don't know why

ML Did you guys start like a group at her house then or at (inaudible)

KB Well we did eventually. (Inaudible) tell you (inaudible)

ML Okay.

KB So there had been a fellowship in my house which I had for some time which [REDACTED] wasn't a part of or anything. And after she'd gone down there and this guy had prayed for her and saved her life, she went down there again. She (inaudible) her sister's down there cause she thought it made a big difference in her life.

ML Mm, hmm.

JT Were you with her when she went down there again?

KB I (inaudible) with her the first time.

JT Okay.

KB Cause there were several people in the car with me. We (inaudible) six or more people go (inaudible)

ML Okay.

KB And we (inaudible) travel (inaudible) usually with one of her sisters and I don't know whoever else, other friends or whatever.

JT Okay.

KB But I was with her the first time she went down and I don't remember everybody was in the car (inaudible) I don't know, I know Barb my wife was there, [REDACTED] was there and there's two (inaudible) people there and she stayed in a separate place and everything else and I really I didn't know how this could save her life.

JT Mm, hmm.

KB And it worked but he (inaudible) oh, well why would anybody do that? I guess the reason somebody'd do it (inaudible) these stupid ass doctor who actually tries to do everything I can to help patients. And this case, I don't know, it may cost me my career. But I really try to help people. I don't know, I don't know though what will happen with all this.

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ML She said ya know and that when she went down there that she felt like it did help her out and I think she stated (inaudible) felt like she that he saved her life.

KB It really did. So she went back I think the second time or third time or something, maybe the second time she and her sister were in the car but I can't remember but at she'd gone she went down there many times after that I know on her own.

ML Okay.

KB And my, my memory isn't perfect about all this, I'm trying to be honest.

ML Mm, hmm.

KB (Exhale) Yeah, it, it must've been the second time she went down with her sister (inaudible) cause I remember now the conversation about this fellowship (inaudible) and she said would you please do a fellowship in our house. So I hmm'd and hawed (inaudible) to be honest was concerned about a number a number of things. I probably should've just said no (inaudible) not good at saying no but she said well we the only thing that [REDACTED] what we do is we do it in our house with [REDACTED] there.

ML And [REDACTED] her husband, is that correct?

KB That's correct. And that and Jessica said ah we live so far away and the only way we could do it in (inaudible) so I decided okay, we'll have the fellowship at your house.

ML Okay.

KB (Inaudible) on her house cause she asked me to have it her house. I was about all these things (inaudible) you can't be my patient anymore cause I thought things were spinning out of control. (Inaudible) obviously I was right.

ML Were you were you at that point kind of like it was more of a friendship than a doctor/patient relationship?

KB I don't think so but I think (exhale) I don't know, these things merged slowly, I, I can't tell you exactly (inaudible) my friends.

ML I mean you've known each other for so many years that

KB I could tell you more an eighty year old man (inaudible) homosexual (inaudible) I've got no interest in any way mostly other than I've seen him as

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a patient so long he's kind of a friend.

ML Mm, hmm.

KB I could tell you when you get involved with patients like I do over years and years and years, to pretend that they never become friends is just a frickin lie (inaudible) or else you're one uncaring doc, maybe that's how I should be, I don't know.

ML Can't just be ya know disconnected

KB It's hard to talk to people about all this stuff (inaudible) how they want to kill themselves and the, the problems they have (inaudible) try to encourage (inaudible) hard to do that for years and years and years and not build any kind of a friendship, it's hard to do.

ML Mm, hmm.

KB At least it's hard for me to do.

ML Yep. No, I

KB I mean that's

ML I'm not gonna disagree with you.

KB And I'm not I'm not trying

ML So boundaries were overstepped.

KB Well I think it's true.

ML Okay, did you guys ever have intercourse?

KB No.

ML No?

KB Never.

ML So what would you say the farthest is that you guys ever went?

KB I touched her breasts and we touched each other.

ML When you say touched each other, I know it's hard to talk about, I mean did you touch her on her vagina and she touched you on your penis or something

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else?

KB She lifted up her underpants and I touched her vagina.

ML Okay. Um, that

KB That was pretty much the de you want the details (inaudible)

ML Ya know, I, I know, I know it's hard, hard to talk about and that's ya know um ya know ah

KB I don't even know why I'm talking about it, my attorney (inaudible) he'll probably tell me I'm fuckin out of my mind.

ML Are you requesting that you want an attorney?

KB What else can I tell ya? I've already told you the worst. But this state or this county isn't gonna hang me and destroy my career? I've already done it.

ML Well you we just I mean I we just want to know the truth. Ya know [REDACTED]

KB I'm telling you the truth.

ML [REDACTED] said (inaudible)

KB I mean how else how much worse (inaudible) but we did we never did

ML [REDACTED] said on one occasion that ah you guys masturbated together or there was some masturbation over in a park in St. Croix Falls.

KB I don't remember that at all. I don't believe that.

ML Okay.

KB Even when I told you on one occasion, I touched her vagina and she touched my penis after she exposed her breasts, I don't remember ever masturbating with her at all.

ML Do you remem

KB I mean I (exhale) I, I (inaudible) I believe (inaudible) but I'd have to say (inaudible) that's a delusion.

ML Okay.

KB Cause (inaudible) that never happened, ever.

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ML Do you remember where it was where you touched her vagina? Which where you were at when that happened and when she touched your penis?

KB I believe it was the parking lot near Wal-Mart, I think at Wal-Mart in St. Croix Falls.

ML Okay. But you

KB That's all I remember.

ML you never had intercourse

KB We never had intercourse?

ML You never had sex?

KB We never had sex.

ML Any type of oral sex?

KB Never had oral sex.

ML Never had oral sex. So it was pretty much touching?

KB It was touching.

ML Okay.

KB She (inaudible) touching (inaudible) but (inaudible)

JT And did most of those touching occur in your office while you were treating her?

ML Or in like different locations and vehicles?

KB Probably half and half. Cause a couple times we well there was only one touching time that I remember (inaudible) kissing her a couple times in vehicle

JT Okay.

KB I remember one touching (inaudible).

ML Did you or did she call you or did you call her last year around your birthday? You must have a birthday somewhere in the end of June beginning of July?

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KB Yeah, my birthday in the beginning of July.

ML Okay, did you guys meet at a park kind of by her house?

KB Yeah, that's true.

ML Do you remember what happened on that occasion?

KB Yeah, we walked.

ML You walked?

KB We walked for about...a hundred feet and that was it.

ML Was there any kissing? Touching involved there?

KB I don't remember any maybe we kissed, I don't now, but no touching.

ML Okay. She expose her breasts to you? (Inaudible)

KB I only remember that one time.

ML Okay.

KB I don't remember any...thing else.

ML Okay, but ya know you've been honest that you're saying there, there was no it was no intercourse, there was no

KB (Inaudible) I mean, I don't know is there any way we could take a lie detector test? I mean I don't know how much (inaudible) that I did, there was never intercourse, there was never

ML Okay.

JT Okay.

ML And you said your wife knows pretty much what had occurred between you and [REDACTED]

KB My wife knows everything I told you.

ML Okay.

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KB I mean you want to bring her here and ask her? I'm not saying she all together happy about it, on the other hand, I think my wife actually understands it.

ML Okay.

KB My wife probably talked to [REDACTED] more than I did. (Inaudible) she talked to my wife like four hours a week.

ML You, you, you said your wife's name is [REDACTED].

KB No, my wife is Barb.

ML Or Barb.

JT Did [REDACTED] have your personal cell phone number? How would or how would she get a hold of you when you weren't at work?

KB She did, yeah.

JT Okay. Do you typically give your patients your personal cell phone number?

KB I give em a lot of patients my personal cell phone number through the years, especially ones I thought were suicidal. I don't give it to a lot of patients, (inaudible) my patient's cause she doesn't like if anybody calls and it's like eight or ten o'clock at night.

JT Mm, hmm.

ML Mm, hmm.

KB Maybe I should've never gave it to any patients. The only reason I gave [REDACTED] my personal cell phone number was probably (inaudible) on a few occasions cause she'd call me like eight o'clock at night say I'm gonna go kill myself.

JT Mm, hmm.

KB And I can tell you that's how for example you can see a report I'm sure I think it was this county but if it wasn't, it'd be around here. But (inaudible) and took her to Fairview Hospital. Um,

ML You would see [REDACTED] when she would be in different hospital settings, I is that correct?

KB I've seen her in two or three times in the hospital, yes.

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ML Okay. Like may maybe was she, she's been in multiple

KB She probably got (inaudible) I don't know for sure.

ML Okay.

KB I'm certain the number is higher than ten, I wouldn't be surprised

JT So when you

KB (Inaudible) I don't know of a patient ever at any hospital (inaudible) that didn't get committed by the state, I'm amazed it never happened

ML Mm, hmm.

KB She managed to get hospitalized, and hospital and hospital and not get committed, I don't know how she did it.

JT So when she was hospitalized several times and you would go and see her, were you treating her at those facilities or just visiting her?

KB Just visiting and asked how she was doing and stuff.

JT Okay. Is that typical for you to visit your other patients in a hospital?

KB I visit several of my patients in a hospital. Actually I don't have any (inaudible) none (inaudible) for at least five years there was any hospitalizations of [REDACTED]. I'd like to think that because I'm a frickin damn good doctor.

JT Mm, hmm.

ML Mm, hmm.

KB I would like I know this all sounds like oh god, he (inaudible) stuff and yeah it went a little too far because I know it did but...I don't care if you're an eighty year old man or sixteen year old kid or whatever, I really, really do try to keep these people alive and help them.

ML Mm, hmm.

KB And I...yeah, I've been trying to cut back on my practice, that's one of the first things I told (inaudible)

ML Mm, hmm.

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KB Maybe I tried too hard. Maybe I do too much, I don't know.

ML Was there any

KB But I'm disgusted to be honest with ya, I'm a psychiatrist. Average doctor in this country...most psychiatrists walking around they ask you two or three questions, they don't really care what's going on, they just change your (inaudible) if you're not, if you're doing well (inaudible) cover their butts so that if they get sued, they have their butt covered and most people hate it.

ML Mm, hmm.

KB Even ask my wife, we get patient after patient after patient saying I can't believe he actually listens to me.

ML Good quality is that ya know you're willing to listen and

KB I mean (inaudible) I don't know.

ML Are there any other

KB I really try to be (inaudible) or any rampages or anything (inaudible) any boundary (inaudible) is it true, have I ever gone out of my way to spend time with a patient, I just told ya Brady three weeks ago I (inaudible) at him

ML Mm, hmm.

JT Mm, hmm.

KB And (inaudible) I was gonna go down there with Jessica her sister actually was a patient of mine very briefly way, way back

ML Je, Jessica is Bonnie's , correct?

KB Correct.

JT Okay.

KB Jessica came in to see me...and the main goal she wanted to do is her other psychiatrist wouldn't take her off her medication, she thought she was doing fine and I didn't see why she couldn't come off her medication, I, I tried take her off medication, saw her two or three times and that was it. I don't know, it was a year or two or whatever.

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ML Mm, hmm.

KB Well I suggested [REDACTED] see...go down and see Tom Deckard but Jessica then (inaudible) told me she's going with her sister down there, she (inaudible) the other sister come down there. I didn't encourage her to bring Jessica or anything else.

ML Okay.

KB She just brought Jessica because she thought this guy'd helped her. I don't know, maybe she thought Jessica (inaudible) help Jessica (inaudible) but...ya know but Jessica got involved in the fellowship and one time confronted her father about the abuse that occurred in their childhood.

ML Mm, hmm.

KB I mean according to Jessica, there was severe I don't know what you want to call it, I guess ah...ah...cultic abuse

ML Okay.

KB Jessica said that her parents and other members of their household would have hold knives and kill animals and

ML They grew up in a pretty abusive

KB (Inaudible) sort of weird whatever events occurred in the household, they were children. So that's what Jessica confronted her father on that with her husband and her husband and father (inaudible) I agreed to step in while she confronted her father.

ML Was that on a friend level or was I mean or was it just (inaudible)

KB No, it was years after she was a patient.

ML Oh.

KB (Inaudible) not a friend level, it was after [REDACTED] asked me (inaudible) a fellowship at her house.

ML Okay.

KB And she then (inaudible) she and Jessica and that (inaudible)

JT And whose Becky?

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KB And Derek was a male, Becky is another sister that (inaudible) Becky Molohan(sp?) husband Matt and Derek (inaudible) who was a guy I knew who had a very sick child and...and I don't know, sometimes people would invite other people too but those are probably the most common contenders for this fellowship.

ML To the fellowship?

KB I after (inaudible) had gone on I don't know a year or so, Jessica asked me if I would go with her

ML When they confronted her

KB and that was years after she had been my patient and I agreed to go with her.

ML Mm, hmm.

KB Derek (inaudible)...I mean you ya know you guys probably think I'm frickin nuts, okay, but truth is I was Magna Cum Laude in chemistry before I went to medical school, I mean it's hard to do better than that in chemistry.

ML Okay.

KB I went to chemistry, I was in the top ten percent of my class my biology, chemistry and physics and yet...I probably know more about psychotropic medication that ninety-nine percent of the psychiatrists in the country and yet we have patients and we can do all the therapy in the world and we can do all the medications in the world and they still are so sick they want to kill themselves.

ML Mm, hmm.

KB And what do you do for those patients? Well I know what most psychiatrists do. They (inaudible) the state of Minnesota wants them to do is wash their hands of it and let them kill themselves basically. So what do I do? I try to find other answers. Maybe there's answers in alternative medicine and stuff.

ML Mm, hmm.

KB And this guy Tom Deckard we prayed for people (inaudible) things need to happen.

ML So the fellowship became part of healing for [REDACTED] and

KB Well it did but actually most the time we didn't pray for healing whatever

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in fellowship but on occasion I would.

ML Mm, hmm.

JT How often did or how long did the fellowships last at ~~Barb's~~ home?

KB Two or three hours.

JT Okay. What was the time period? Was it over a year that you guys met there?

KB I don't remember exact dates because the fellowship would move around I mean

JT Okay.

KB It started at her house cause she asked to have at her house her husband (inaudible) I guess a year and a half.

JT Okay.

KB And then it moved to her brother in law's house at Molohan's. They met there a year. (Inaudible) I didn't (inaudible) so I went back I says ya know what this (inaudible) always be at my house, I'm just gonna do my house and

ML In New Richmond?

KB In New Richmond and if people don't want to drive that far, fine, whatever, cause I felt like I could control (inaudible) crucified (inaudible) the boundaries that are in my own house.

ML Would Barb be at these?

KB Barb was at them all the time. Barb knows that

ML What, what is your wife wife's middle name?

KB Barbara (inaudible)

ML How do you spell that?

KB M-e-l-l-i-n-g (inaudible)

ML M-e-l-l

KB i-n-g-e-r.

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ML And same last name as you?

KB Correct.

ML Okay. Cause you said you've confided in her in (inaudible)

KB Yeah (inaudible) I have but

ML Okay, is there a phone number we could reach her at if we needed to talk to her?

KB Um,

ML (Inaudible) cell phone

KB You can reach her right now. 651-895-4945.

ML 895-49

KB 45. I assume she has her cell phone on right now.

ML Does she know that you were coming in today to meet with us?

KB Yeah.

ML Okay. And, and you said there's no other patients that you've ever crossed boundary lines with

KB That's true.

ML other than [REDACTED]?

KB Well okay never hit never

ML Contact.

KB had physical contact, never but I already told you I went over to Brady (inaudible) house with his parents and talked to the kid for a while and prayed for him

ML Mm, hmm.

KB I already told you that I was gonna tell you about Derek Jagowski (sp?) I mean (inaudible)

ML But no, no physical contact? No

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KB Well, no physical contact. If you really know who I am, if you're really interested in the truth (inaudible) out of here.

ML Okay.

KB Put it in

ML You can tell us, I'm all I'm we're all ears.

KB Okay, Derek Jagowski...very tough hard core I don't know about thirty year old male...frankly a marijuana dealer most of his life, ran with Mexican mafia gangs and stuff, I mean tough ass guy.

ML Mm, hmm.

KB And um he called me one night cause he got involved in fellowship and he called me one night and he said you know a guy (inaudible) help me and I didn't believe that actually but I may be the only guy that could help him that night. His son (inaudible) on a ventilator at Fairview Riverside Hospital from about the first week he was born.

ML Okay.

KB He was about four months old at this time. I (inaudible) at the hospital Derek to see his son. I can't explain I don't understand it and I think most people that pray for healing they may as well just I don't know comb their hair or throw a feather in the wind or something, it doesn't mean jack.

JT Mm, hmm.

KB I don't know why some people can pray and it seems to make a difference, especially Tom Deckard. I don't know why I (inaudible) sometimes and it makes a difference. Cause I already told you I know lots about hard core signs (inaudible) in physics and chemistry and (inaudible) but Derek called me that night and he said and he, he is he had a surgeon at Fairview Riversides children was considering one of the top pediatric cardio thoracic surgeons in America to have open up his son's chest that day. His lung was deteriorating, he had no connection between his bronch and his trachea. The kid was going was supposed to die that night. The surgeon said your son won't live through the night. Derek called me on Saturday night at about ten o'clock at night, in fact he asked me he once said do you know a person who can help (inaudible) what the hell do I (inaudible) and then he told me his son was dying and I said I'm on my way. My wife and I drove to Fairview Riverside Hospital, we went up to the ICU, he was in the pediatric ICU, I don't know how to explain this but sometimes I pray and I feel energy, I told Derek I would pray for his son. His grandparents were in the room in the ICU when I arrived, I said well I don't know how to explain this Derek but I can't do this when your

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grandparents are here and I said I know they're (inaudible) but there's too much doubt (inaudible) so his grandparents went home (inaudible) that was the last time that they were gonna see him. I prayed with Derek's son that night, I prayed one specific prayer that he would live through the night, he did live through the night. I came back the next day cause I figured if I if he lived through the night, I could (inaudible) figure out what the heck I should pray for and I specifically prayed that he would grow a bronch. (Inaudible) sound like the wildest damn thing in the world. I mean I knew (inaudible) that sounds like frickin maybe you think I'm psychotic but you want to know something, I did pray for (inaudible). Monday that surgeon came back and said well I got the timing right but the baby won't live through the night. I said to Derek and his wife, I'm not gonna pray for healing cause I believe god already has healed your son, I'm just gonna pray that we don't have (inaudible). The surgeon's partner came back on Tuesday. They have big screen now when they scope you, they can put it on a (inaudible) and show you a screen of what they are seeing, okay?

ML Mm, hmm.

JT Mm, hmm.

KB His wife (inaudible) the baby scream multiple times, she said it was after that Tuesday after I prayed for him that Saturday and Sunday that it I (inaudible) his trachea was always coagulating blood and stuff it was all gone. And then the surgeon said looks like a bronch to me. Six months later Derek asked the surgeon...(exhale) six months later Derek asked the surgeon what's your explanation for why my son lived? And the surgeon says I have no explanation. Maybe it was that guy that prayed for your son. Now, I don't know (inaudible) do I think I can heal anything actually, no I don't actually. I don't think I can heal (inaudible) but I do believe for some reason god sometimes uses me as a tool like surgeon uses a scalpel. There's a few times I prayed for pe I never asked quite frankly when this thing whole started, a friend of mine came to me one time and said will you pray for my (inaudible) and I thought that's crazy, he wants me to pray for his (inaudible) and I thought in my head well the bible says do you have faith (inaudible) believe in your heart move this mountain (inaudible) I prayed this in my head (inaudible) pray to (inaudible) that I can heal a tooth but maybe just maybe he'll give me an (inaudible) faith in me enough to heal him too. That guy's name is (inaudible) I prayed for his tooth. (Inaudible) he's never been a patient of mine, he's just a good friend of mine but I don't know, five or six years from the very beginning we were involved in (inaudible) I didn't really start this fellowship, it was started by Todd Bernick (sp?) He's the assembly of god minister.

ML Mmm.

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KB But he moved and asked me to learn it after he moved, that's how I even got involved. I didn't even ask about it, I didn't encourage (inaudible) in fact I even asked well you asked me to do it. Tom Deckard was there actually when he asked me to do it and he asked Tom Deckard (inaudible) this is crazy but I agreed to do it cause I no one else was gonna do it. I'm thinking how the hell am I gonna do this and run my medical practice? (Inaudible) I do pray for (inaudible) and another person or two asked me if I'd pray for them and they got better.

ML So the prayer has been helping people as well?

KB It seems to help people. Ask [REDACTED], this sounds crazy to you but this is a true story, ask her, call her up and (inaudible)

ML She told us about the healing that she received from (inaudible)

KB Ask her about the fish.

ML Oh.

KB Her son I don't know about this tall he was (inaudible) had beta fish, I don't know if you know what beta fish are

ML The little fighting fish?

KB Yep.

ML Yep.

KB When I was a kid, I used to keep fish I used to keep beta fish even, I had fish for a long time but I, I cause I kept fish when I was a little kid sometimes their guts protrude out their (inaudible) well when that happened I never seen a fish live more than twelve more hours, I mean that's like they're done for.

ML Mm, hmm.

JT Mm, hmm.

KB [REDACTED] asked me if I would pray for that little (inaudible) fighting fish. The kid was crying, he was all upset about it. (inaudible) this sounds crazy so I (inaudible) pray for it. I said lord I know this sounds nuts but I this kid is so upset is there any way you can heal a Siamese fighting fish? I prayed for that fish, I don't know how long that fish lived but that fish lived for a month or two after that, I know that, and there was no way in heck that fish should've lived another twelve hours.

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ML Mm, hmm.

KB How do you explain all this stuff I'm telling you? I come across anything (inaudible) and then it's true, I can line up witnesses to tell you it's true.

ML Would you have a lot of your patients that you'd seen for in your practice been join would a lot of them join this fellowship then or?

KB No, pretty small percent.

ML Pretty small percentage?

KB I do pray for some of my patients in my office.

ML When they're in therapy with you?

KB Lot of patients I mean they know (inaudible) you come into my office and they (inaudible) something or if it's like the first thing you read is Dr. Brockmann's a Christian psychiatrist (inaudible) use Christian principles to help.

ML Okay.

KB I've never hid it (inaudible) at least half and probably most of (inaudible) were actually asking if I will pray for them.

ML Okay.

KB I pray for...I don't know, I see like two thousand patients, I'm blanking on her name now

ML Well (inaudible)

KB But I can see her right now.

JT Mm, hmm.

KB I pray for this fifteen year old patient I have she and her mother were in my office. Her mother asked me if I would pray for her daughter. Her daughter used to get suicidal a lot, she's been in eating disorder programs and she's been hospitalization, she's been in day treatment at Prairie Care. I mean most of the people I pray for are hard core patients that are lucky if it we keep them alive for five more years (inaudible).

JT Mm, hmm.

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KB I agreed to pray for the patient and it was the mother's idea. But I prayed for her...her mother said I it was amazing when you prayed for her. It was like she was engulfed in something. I mean I don't know, I don't see stuff. I never see anything. [REDACTED] claims to see angels and demons, I don't know if she told you any of that.

ML Mm, hmm.

KB But I've had (inaudible) feel stuff

ML (Inaudible)

KB (Inaudible) but it really helped. I've been in [REDACTED]'s house where we had the fellowship and she'll say there's an alien in the room. She said she can see it and I'll sit there and say yeah, okay, it's behind me and I'll reach at them with my hand like right there (inaudible) right there and she'll say that's where she sees. I don't know, I don't know how to explain it, I feel it, I don't see nothing.

ML Mm, hmm.

KB Never have, I don't know if I ever will. But I feel these things.

ML So you got your practice and then do you guys call it a religion or prayer group or I guess?

KB Well I tell ya (inaudible) what we believe. On one hand, I'm a born again Christian, I believe Jesus really lived and died, died for my sins and that (inaudible) be saved and go to heaven. I mean that's fairly conventional Christianity.

ML Mm, hmm.

KB And I also believe in keeping the covenant or what Jesus did or what the jews did today or what actually the twelve disciples did in Jesus' lifetime. I keep (inaudible) those Jewish holidays and I keep and, and we worship god and Jesus on Friday nights and Saturday, that's the most (inaudible) worship from Friday sundown to Saturday sundown.

ML Okay.

KB Why do we make that well because the bible says (inaudible) to keep it holy and most people consider Sunday the first day of the week and Saturday the seventh day.

ML Okay.

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JT Mm, hmm.

KB That's why we have our fellowship on Saturday. So back when this prayer stuff...I we kind of combine Christianity and Jesus (inaudible) that's what Jesus did, Jesus said (inaudible) my custom. Do you know the last supper, most people don't know the last supper occurred right before Jesus died on the cross.

ML Mm, hmm.

KB You know what that day is actually, what it was (inaudible) says in the bible, it was Passover.

ML Okay.

KB Jesus kept Passover at the last supper. So Jesus was a Jew his whole life so we (inaudible) on the Christianity stuff. And trying to explain this to somebody (inaudible) so it's understandable.

ML Okay.

KB A lot of people say that miracles ended with (inaudible) first century when the disciples died. And the (inaudible) talks about miracles. (Inaudible) mostly true, I mean I think that there are few miracles through the years but not very many. But what did they do different than most Christians have done since the first century? They the disciples combined Judaism with Christianity, they were Jews, they were (inaudible) in Jewish. Even (inaudible) you don't have to keep (inaudible) to be saved when you become a Christian (inaudible) believe you do. You can (inaudible) Jerusalem to celebrate when the Jewish holidays (inaudible) to be safe, they're still keeping the Jewish laws (inaudible).

ML Okay.

KB Okay, so we combined those two things cause that's why we worship on Friday nights to Saturday.

ML Okay.

KB So why wouldn't we worship in a big temple or at church? (inaudible) I mean there's probably two hundred people in the world that I (inaudible) two hundred people in the world (inaudible) cause I don't know (inaudible)

ML Okay.

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KB Where does (inaudible) go? I don't know, I think it will but who knows.

JT Are you still meeting on Friday nights

KB Nope.

JT for fellowship at your house?

KB Nope. Oh at my house we are on Saturdays.

JT Oh on Saturdays.

ML Okay.

KB And ah (inaudible)

ML Okay.

JT Would that

KB As of right now they're not patients.

ML Would that be a boundary I, I don't know licensing stuff like that, would that be a boundary or a (inaudible)

KB I don't know but that was part of my concern about boundaries which is why I said to [REDACTED] I can't be our doctor anymore.

ML Okay.

KB It wasn't because I didn't think I could be a good doctor for her.

ML You just thought that things were growing you both were growing attached emotionally

KB Well and also there also there was this fellowship, I mean I thought it was pushing boundaries a lot of levels.

ML Mm, hmm.

KB I was trying I was desperately trying to do what was right. Did I do something wrong, yeah. I just (inaudible) a few times when I touched her breasts and we had some inappropriate touching one time. We got emotionally attached in some (inaudible) we shouldn't have.

ML But [REDACTED] the only patient that that has occurred with?

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KB Yeah.

ML Okay.

KB And I'll take a lie detector test (inaudible) I don't care and I didn't know why (inaudible) in the world (inaudible) district attorney. Um,

ML Have you had any contact with [REDACTED] in recent months? I think you said it's been quite a while.

KB Last time I talked to [REDACTED] was...four or five months ago. I talked to her on the phone because I called several people to tell them that BJ who had never been a patient of mine had died unexpectedly.

ML Okay.

KB And I thought she would like to know.

ML Okay. Was she part of the fellowship?

KB She was.

ML Oh, it was a female? BJ was a fe

KB Yeah, she was an eighty year old woman.

ML Okay.

KB Or I don't know

ML She was

KB I may be off by a year or two.

ML Older...older woman. Okay.

JT Okay.

KB And so I thought she would want to know about that.

ML Okay. Has anybody contacted you in regards to any of this prior to us?

KB Well I told you that I heard from Becky that she may have talked to the police department.

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ML Okay.

KB So I figured it the police department wants to talk to me, well it must be related to this.

ML Okay.

KB Because I've never been sued, never had a criminal charge, never had anything so I figure it was either this or remote possibility you were investigating something else with some patient or something I knew and maybe a (inaudible) couldn't figure out what else it would be.

ML Okay.

KB So

ML Ya know right now just this ya know I wouldn't have any contact with [REDACTED]. I don't see

KB I (inaudible)

ML (inaudible) yeah, so um and then the fellowship um I don't know if [REDACTED] has anything to do with the fellowship anymore but I

KB She hasn't had (inaudible) over a month. I don't know what she's doing.

ML Okay. So um ya know I appreciate you coming in and being honest with us.

KB Yeah, well that's probably the stupidest thing I ever did but

ML Well, sometimes ya know not talking about it ya know you're a doctor, not talking about it can make it worse too.

KB I don't know, I mean when I yeah you're right, I mean you want to know what really bothers me about this I mean yeah, it's okay, it's unfortunate some of these (inaudible) yes, I'm sure there's some things I should do different. Yes, I would never do it again, yes, okay, I, yeah I made some mistakes.

ML Mm, hmm.

KB I'm gonna tell you...in the state of Minnesota and Chicago County destroys my medical career, you're gonna lose one of the best doctors out there and that's gonna be a huge tragedy (inaudible) I've been thinking about this (inaudible) part of me would like to get out.

ML Mm, hmm.

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KB Part of me is so sick of killing myself trying to take care of people, trying to actually be (inaudible) doctor's close to me and there so few of us anymore.

ML If

KB but another part of me thought that it's like you ask me to come in about this shit, I saw patient after patient (inaudible)

ML Mm, hmm.

KB I thought god I've helped those patients so much, what's gonna happen to these patients if I'm gone. I don't know.

ML And that your medical stuff is that's I mean that's up to the medical board. I don't know anything about that, that ya know that part.

KB All right ,well I don't know.

ML Ya know, all I can tell you

KB (Inaudible) I don't know, maybe I'll go to jail for this. I don't know.

ML I, I can tell you that um Polk County Wisconsin just because your practice is in Polk County ya know um they, they have an active investigation too um

KB Oh, they do.

ML And they were gonna try to be here today but she was not able to not able to be here so um there is an investigator

KB (Inaudible) I'm not sure why, I've never done anything in Polk County.

ML Well she was seen at your practice in Polk County.

KB Yeah, I suppose.

ML Mm, hmm. So

KB Actually she came over there because she was actively suicidal that day and there was no way I could see her at my office in Minnesota

ML Mm, hmm.

KB And so I said okay, well (inaudible) my scheduled patients, why don't you walk in the office and I'll see you here in Polk County.

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ML Yeah. Well and I, I'm just telling you so if you get a phone call from the Polk County Investigator, not to be not to be surprised, um, ya know.

KB Yeah, well I know, I mean I (inaudible)

ML What I'll do is ah we'll do our reports up and the we'll let the county attorney review it um touching obviously in the State of Minnesota um or fondling, touching fondling um would be a 4th degree crim sex but I can't cl I can't (inaudible) that's what

KB Well yeah, but that a misdemeanor, a felony or what?

ML In the State of Minnesota, it would be a felony.

KB Okay.

ML I couldn't tell you what the State of Wisconsin would be. But that's up to the what I do is I interview, I do my reports and the county attorney's reviews it, okay?

KB Yep.

ML That that's what will happen. Wisconsin I can't tell ya what happens over in Wisconsin.

KB (Inaudible) probably screwed myself with being honest. I don't know, maybe (inaudible)

ML Do you have any more questions for me? We might be in contact with your wife ya know um

KB Well I don't know. I don't I'm incredible (inaudible) my wife, I see people do horrible things over time

ML Mm, hmm.

KB And they walk all the time, they do nothing but somebody tried to do things right, I really do really (inaudible) I see it time after time after time.

ML Well

KB That's probably what'll happen.

ML You know there's boundaries between doctors and their patients and what shouldn't be crossed.

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KB Oh yeah.

ML So

KB Yeah.

ML Those lines were crossed between you and [REDACTED].

KB Okay.

ML Ya know I have to do my job (inaudible)

KB I'm not mad at you.

ML Yeah.

JT Mm, hmm.

ML Ya know I'm just sayin this is I have to look into it obviously.

KB I, I know.

ML And let the county attorney's review it cause they make the charging decisions ya know

KB (Inaudible)

JT And [REDACTED] was in a pretty vulnerable state during the time that you were treating her too.

KB Actually (inaudible) I don't think she was in a vulnerable (inaudible) I think she was at the lowest she's ever been.

JT Okay. Well you said several times she was suicidal so

KB I'm not denying it. (Inaudible) that that was true.

JT Okay.

KB I just (inaudible) I think she was well aware of what she was doing.

ML Yeah, I guess I think there was an emotional attachment between both [REDACTED] to you and you to [REDACTED] so

KB Well I believe that's true.

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ML Um, if you have questions, I'll give you my card.

KB Okay.

ML If Polk County calls and I just I wanted to let you know Polk County ya know in case you get a phone call and you're going I already talked to an investigator ya know um they may, they may not call you, I don't know.

KB Okay.

ML Okay?

KB And you (inaudible).

ML Well it, it's a possibility, each, each place that any, anything occurred at is a different jurisdiction so if something happened down in Lake Elmo, Lake Elmo would (inaudible)

KB (Inaudible) happened in the State of Minnesota (inaudible) you want to be technical, I don't remember any of this inappropriate touching occurring in the state of Minnesota.

ML Well you touched her on your walk in the park in Minnesota. You looked at her breasts in Minnesota.

KB No.

ML Okay.

KB It was all in Wisconsin.

ML That time you met around your birthday?

KB I didn't touch her on that (inaudible) birthday.

ML Well [REDACTED] saying that you had touched her breasts at that at that time.

KB Okay.

ML There might be so many instances you guys can't keep them all straight too.

KB I don't think anything happened in Minnesota.

ML Okay.

KB I mean we're gonna be technical about this, I don't think so.

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ML Okay.

KB It all occurred in Wisconsin.

ML Well, I'll ya know like I said I'll let the county attorney they can review it and stuff like that. Okay?

KB Okay.

ML All right, we appreciate you coming in Ken.

KB All right.

ML And here is my card if you have any questions or if anybody else has
END OF STATEMENT

ML/JT/hlv
08132013

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Supplementary Report

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New Incident: Sex Offense - Disabled	Original CFS Code - 1: 1199	New CFS Code - 1: 3621
		New CFS Code - 2:

NARRATIVE

13.25963

On 072313, I, Investigator LaLonde-#112, Chisago County Sheriff's Office, had been contacted by Deputy LeVasseur-#119, Chisago County Sheriff's Office, in regards to a criminal sexual conduct complaint that he had taken a report on in regards to a female party, identified as [REDACTED], advising that she had been sexually assaulted by her psychiatrist, who was identified as KENT BROCKMANN. Deputy LeVasseur did state that he had spoken to [REDACTED] over the phone and had taken a taped statement from her. Deputy LeVasseur did state at that time that [REDACTED] had informed him that there had been multiple occasions where her psychiatrist, Kent Brockmann, had inappropriately touched her, multiple times, including kissing her face, rubbing her arms, caressing her face, caressing her lap, having her sit on his lap, and also, on one occasion, where he had had her hold on to his scrotum while he masturbated. Deputy LeVasseur informed me that these incidents had occurred both in Minnesota and also Wisconsin, possibly in Polk County.

I then reviewed Deputy LeVasseur's report and informed him that myself and Jolene Thorsen, Chisago County Adult Protection, would take over the investigation and would interview [REDACTED] in regards to the allegations that had occurred.

On 073013, myself and Jolene Thorsen met with [REDACTED] at the North Branch health and human services building and did conduct an interview with her. Upon arrival at the facility, [REDACTED] was escorted into a conference room at which time myself and Jolene Thorsen explained to her that we would like to talk to her in regards to the information that she had provided Deputy LeVasseur. She indicated that that would be fine and had been, actually, in contact with Jolene Thorsen earlier that afternoon wishing to speak to us in regards to what was going on. It should also be noted that we had received information that [REDACTED] and her husband, [REDACTED] had been receiving harassing phone calls from a church group that they used to belong to and that they were somewhat threatening in nature and were upset with [REDACTED] for reporting to law enforcement what Kent Brockmann had done.

When [REDACTED] arrived at the health and human services building, she was brought into the conference room. I did inform [REDACTED] that I needed to record our conversation and she stated that that would be fine and that she was more than willing to give a taped statement. It should be noted that [REDACTED], when she arrived, appeared to be extremely nervous and somewhat quiet and somewhat withdrawn. Upon talking to [REDACTED], I asked her how everything had been going and she indicated that everything was going good at

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home, but was very quiet. I asked her how her summer had been going and she indicated that she had gone up to see her parents this summer, up by Perham, and that that had not gone so well. She indicated that with everything going on she did indicate that her husband was being very supportive of her. At this time, she indicated that the reason she had contacted Deputy LeVasseur was to inform him that her psychiatrist had inappropriate contact with her. [REDACTED] then indicated that she started seeing Dr. Kent Brockmann back in around 2006-2007 and that she had been diagnosed with Graves Disease. She indicated that at that time she was very demonic and had been seeing and hearing voices and was not sure what was real and what was not real. She indicated that she had been in and out of psychiatric hospitals and that she had begun seeing Kent Brockmann because she was recommended to see a psychiatrist when she was released from the psychiatric hospital. She then indicated that on one occasion she took a bottle of Ativan and had attempted suicide and that she had informed Dr. Brockmann that it was just a matter of time before she would end up committing suicide and that she was in a very dark place at that time. She indicated that she had had a number of suicide attempts and had been seeing Dr. Brockmann for therapy during this time. She then indicated that eventually Dr. Brockmann had talked to her about a church group that he belonged to or a fellowship that he belonged to and had talked to her about someone who he thought could possibly help her. She indicated that her and Dr. Brockmann and several others went down to Illinois to see this guy that Dr. Brockmann stated could help her. She indicated that during the ceremony this guy had called out to her and had her come up to the front and placed his hand over her forehead. She then indicated that she felt like he had casted out all the demons from her and had felt them coming out of her forehead and could see the demons leaving her body. She indicated that after this had occurred she had talked to the gentleman again before they left for the weekend and that he indicated to her that the demons could possibly come back and that seven new ones could enter her body, which were worst than the first demons that she had. She then indicated that she had felt like she had been saved and that this guy had actually helped her as crazy as she advised it sounded. She then indicated that her and Dr. Brockmann started a fellowship at her home located on Lanesboro Court. She indicated that that's when things all kind of started. She stated that this church group had started at her house approximately two and one-half years ago and that the church group was called "Cradle of Hope" and that Dr. Brockmann was the only one that was able to do the fellowship and was the only other person trained in Minnesota other than somebody down in Redwing, MN. During the statement, she did inform us that she had been seeing Dr. Brockmann as her psychiatrist and was also having Dr. Brockmann do the fellowship at her residence. She then indicated that the church group involved her family and her friends and also some of Dr. Brockmann's friends.

[REDACTED] then indicated that she had met a female party, who she identified as CHRISTINE HANSON (sp?), and she had met her in Dr. Brockmann's office as well. She indicated that this Christine Hanson also went to Illinois

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as well to get some help. During the statement, she indicated that they did the group every Friday night and that it would last for a couple of hours. She indicated during the group that they would listen to a message, pray, and that it was based on a Christian and Jewish based-type religion. She then stated that they would do juice and bread and would call it Kaddish. She indicated that the church group was an obedience through Christ and through the process of fighting off spiritual warfare and to help her cast out bad thoughts. She indicated that this fellowship was helping her and that she was not sure how she was feeling, but that she has been struggling like she had been, like she was crazy, so she would read scriptures, which would help her.

██████████ then indicated that as time went on people got more comfortable around each other and that dysfunctions began. She stated that a male party joined the group, by the name of MATT MULLIHAN (sp?), and that things eventually got worse. She indicated that her sister was going through a very bad divorce and had been physically abused by her husband and so her sister had started coming to this group as well. She indicated that her sister and Matt Mullihan had met at this group and approximately a week later, after meeting, had gotten married. ██████████ indicated that while this was occurring, Matt Mullihan was also looking at Christine Hanson in a way that she believed was inappropriate and stated that Christine, at that time, was very young and was probably 17 or 18 years of age at the time. ██████████ indicated that Matt Mullihan had told her, along with other people in the group, that he had gotten a 17-year old girl pregnant and had a child with her and that it had been one of their babysitters down in the southern states. She indicated as the sessions were going on and people got more comfortable and the dysfunctions were occurring they would listen to a discord CD. She then indicated that the group eventually moved out of her residence and moved into Matt Mullihan's house. She indicated that on one occasion she had observed Matt Mullihan kick their seven-year old daughter and that she could actually see or hear the breath come out of the child's lungs. She indicated that she had told Kent Brockmann about this, along with Christine Hanson, who was present and had observed this, and also talked to her sister and stated that this was not right and it needed to be reported to child protection. She indicated that she went to talk to Kent about it and that Kent had called a meeting about it and that the meeting was all about judging Matt and what he had done wrong, but that it began coming back judging her and what they had done wrong and that they should not be judging Matt for what he had done. She indicated after this incident had occurred she quit going to some of the meetings due to the fact she disagreed with how Matt Mullihan had treated this child. She also indicated that on one occasion, when this had occurred, she had talked to Kent about it and that Kent told her not to contact child protection, that she had told Kent believing that he was a mandated reporter and would have to report the information himself. She indicated that sister was "Becky", now known as BECKY MULLIHAN.

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During the statement, [REDACTED] was able to talk about many things that had occurred, but would sometimes get off track. She indicated that she was very sorry and that she had had electric shock therapy and that it was hard for her to go back and talk about things. She then went on to indicate that things between her and Dr. Kent Brockmann started getting more intense. She indicated that she trusted Dr. Brockmann and that he had always been there for her. She indicated that he was somewhat of a father figure for her, but did state that he was still her doctor and was still doing the church fellowship stuff with her. She then indicated that at some point Christine Hanson's husband reported Dr. Brockmann to an unknown source and at that time Dr. Brockmann had gone to Christine Hanson and to [REDACTED], along with some other clients, and stated that he could no longer be their doctor and that they needed to seek professional medical help through somebody else, but still provided services to her sister, Becky, and Christine, and [REDACTED].

[REDACTED] indicated that when she first met Dr. Brockmann that their relationship was very professional. She indicated that throughout time, when the sessions would go on, that he began being overly comforting to her. She indicated that he would rub her hands and arms and then she indicated that he began hugging her. She indicated that he would have her sit on his lap and would hug her and rub her face and would start kissing her face, all over her face, her chin, and her forehead, but would not kiss her lips. She indicated that she was seeing Dr. Brockmann weekly at this time and would be seeing him at his office in Balsam Lake, WI. She then indicated that she realized that things were becoming inappropriate and that Dr. Brockmann was kissing her face and her forehead. She indicated one time she then kissed him back on his lips and he kissed her. She then indicated that her and her husband had been going through a very difficult time and that her husband had used to be very verbally abusive towards her and that she had gone to a women's shelter. She stated that when she went to the women's shelter things became more physical between her and Dr. Brockmann while she was in the women's shelter. She indicated that Dr. Brockmann would call her approximately three times a day and that they would meet alone and that Dr. Brockmann would come and visit her. She indicated that he had contacted her and wanted to meet her and had indicated that her and her husband had had an extremely fight. She indicated that she was very upset and distraught and that Dr. Brockmann had contacted her and wanted to meet up with him. She indicated that they met in their vehicle at a park located in Wisconsin, just off of Interstate 35 by St. Croix Falls. She indicated that they met in her van, or in her vehicle, she was not [REDACTED], but indicated that he began to overly comfort her. [REDACTED] stated that she felt like she owed him and that he had saved her life and he had always been there for her so she felt as if she owed him more. She stated that Dr. Brockmann then had asked to see her breasts at which time she indicated that she had let him see her breasts and had also let him touch her breasts on the bare skin under her clothing. She then indicated things got out of hand and he wanted her to hold on to him while he masturbated. She stated that she had held on to his scrotum while Dr. Brockmann masturbated.

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She indicated that during this time she was terrified, but did state that she felt like she owed him and that if she didn't do it that he would get upset with her. She indicated that Dr. Brockmann masturbated to the point of ejaculation and that he had ejaculated and that he had wiped himself up with some type of napkins or something within the vehicle. She did indicate that during this time, when he had masturbated, he had also touched her vagina and she did indicate that he had put his fingertip inside of her vagina. She indicated that this incident occurred over in St. Croix Falls at the park off of Interstate 35. She indicated that when she felt scared or terrified that Dr. Brockmann would tell her that he put his license on the line for her, that he had saved her life, and that she needed to feel thankfulness for what he had done for her and that she also indicated that he was her support system and that she felt like she owed him and needed to please him. She indicated that this time, that had occurred over in St. Croix Falls, that she had had that argument with her husband and that she was very upset about what had happened between her and her husband and things had gotten out of hand and more physical.

When asked about the incident that had occurred, [REDACTED] indicated that Dr. Kent Brockmann had touched her on her bare breasts on that occasion. She indicated that she had held on to his scrotum and that he had unzipped his pants, but that his pants were still on. She indicated that she was afraid at that time that they were going to have intercourse, but stated that they did not have intercourse, but that she might as well have had intercourse with him since she had committed a sin by having the inappropriate contact with Dr. Brockmann. She, again, reiterated that he did masturbate until ejaculation and had cleaned himself up with some napkins. After that had occurred, she indicated that he left and she left from the area. She, once again, indicated that she was terrified during this time and, once again, stated that she felt like she owed him. She also indicated that this is the occasion where he did put his fingertip inside of her vagina.

[REDACTED] then stated that after this incident had occurred she had contacted her husband and told her husband about what had happened. She stated that she was having a hard time processing it and stated that she needed to tell her husband what had happened and that she believed that he was going to be mad at her because she had committed the unforgiveable sin. She indicated that she felt like God was going to punish her and at any time could strike lightning down upon her. She indicated that once she did talk to her husband her husband did not become very upset. She indicated that her and her husband had talked about what had occurred and that they actually started communicating together and, at that time, she realized that God still loved her for committing the unforgiveable sin.

[REDACTED] stated that her, Dr. Brockmann, Dr. Brockmann's wife, and her husband had a meeting down in Illinois in regard to the inappropriate incidents that were going on. She indicated that after this meeting she had

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Chisago County Sheriff

Continuation

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made a promise to herself that things would never happen again and that she was going to try to stay away from Dr. Kent Brockmann. She then stated that he would call her and would ask to meet up with her. She indicated that he had contacted her again on one occasion and stated that he wanted to talk. She indicated when he would call her that he would make her feel guilty and that she would eventually meet up with him. She stated on one occasion they met at the Kost Dam and that all he wanted to do was see her breasts. She indicated that she then had exposed her breasts to Dr. Brockmann and that he had, once again, touched them on her bare skin.

██████████ the indicated that round the 3rd of July, 2012, she had once again received a phone call from Dr. Brockmann. She indicated that Dr. Brockmann was upset with her due to the fact that she had not called him on his birthday and had not wished him a happy birthday. She indicated that she believed his birthday was on the first of July. She then indicated that Dr. Brockmann, again, wanted to meet up with her and that they met at the Sunrise Landing just off of county road 14 in Chisago County. She stated that when they met at the landing they hugged each other and that they went for a short walk. She indicated that Dr. Brockmann was upset with her and that he was upset due to the fact that she had not called him on his birthday. She then indicated that it started to rain and they eventually went to sit inside the vehicle. She then stated that Dr. Brockmann, again, asked to see her boobs at which time she stated that he saw her breasts and then felt her boob. She then stated that Dr. Brockmann then left. She indicated that it was hard for her not to say no because she felt like she owed Dr. Brockmann for all the help that he had given her in the past and indicated that he had saved her life and had done so much for her. She then indicated that she was starting to feel more uncomfortable with Dr. Brockmann and did not want to see him. She then stated that in December of 2012 she had gone into inpatient treatment in Cambridge and that Dr. Brockmann had come and visited her there as well. She indicated that Dr. Brockmann, once she was released from the inpatient treatment in Cambridge, would call her and would want to meet up with her and talk to her. She then indicated another time he had called her at her residence and wanted to meet. She indicated that she was home alone with the kids and did not want Dr. Brockmann to come to her residence. She stated on one occasion that she had received a call from Dr. Brockmann and was in her vehicle on her way to get the kids. She indicated that Dr. Brockmann stated that he was in the area and wanted to see her. She indicated that she did not want to see him and then stated that eventually Dr. Brockmann pulled up behind her while she was driving down the road and somewhat kind of pulled her over. She indicated that Dr. Brockmann, again, wanted her to sit on his lap and show him her breasts, but she indicated that she could not and that she needed to pick up her children. She indicated that she indeed needed to pick up her children that were being taken care of at a different location. She indicated that she had cut off all contact with Dr. Brockmann, but had seen him down in Illinois at a function for the church. She also indicated that she had been down in New Ulm at a treatment facility approximately two-to-three months ago

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and that he had called her and had asked her why she was seeking counseling outside of him and that she was sinning for not going to the church group. She indicated after these incidents had occurred in New Ulm her and her husband had talked about things and were trying to split off all ties from Dr. Brockmann. I did ask [REDACTED] if she knew of any other victims that Dr. Kent Brockmann had had an inappropriate relationship with, including Christine Hanson, and she indicated that she did not believe Christine Hanson had inappropriate relations with Dr. Brockmann and indicated that Dr. Brockmann was actually mean to her and that her and Dr. Brockmann would fight over how their relationship was with Christine and that's why Dr. Brockmann was so mean to Christine and did not care how she felt.

[REDACTED], once again, reiterated that she and Dr. Brockmann did not have intercourse, but stated that they had inappropriately touched each other on multiple occasions over multiple years. See the full taped statement from [REDACTED] in regards to this information.

It should be noted that after talking to [REDACTED] she did give us permission to talk to her husband, [REDACTED] for further follow-up.

PENDING INVESTIGATION

ML/slb 081313

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Shawn Leatherwood		2) Date When Request Submitted: September 6, 2013 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 ▪ 08 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: September 18, 2013	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? MED 1.02 Discussion and Consideration	
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: N/A	
10) Describe the issue and action that should be addressed: Discuss Med 1.02 and authorize a member of the Board to approve the proposed rule draft of MED 1.02 relating to diploma copy requirements for submission to the Clearinghouse.			
11) Shawn Leatherwood Signature of person making this request		Authorization September 6, 2013 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.			

State of Wisconsin
DEPARTMENT OF REGULATION AND LICENSING
Scope Statement
Rules of the Medical Examining Board

November, 2008

Subject.

Application requirements for a license to practice medicine.

POLICY ISSUES.

Objective of the Rule.

To eliminate the requirement that applicants for a license to practice medicine and surgery submit a verified photographic copy of the diploma conferring the degree of doctor of medicine or doctor of osteopathy granted to the applicant verifying graduation from a medical or osteopathic school approved by the board.

Existing Policies Relevant to the Rule, New Policies Proposed and Analysis of Policy Alternatives.

Currently, physician applicants are required to submit as part of the application to practice medicine and surgery in Wisconsin verified documentary evidence of graduation from a medical or osteopathic school approved by the board and a verified photographic copy of the diploma from the school. Diplomas are more susceptible to fraud than verification directly from the school and are viewed by the Division of Credential Processing as unnecessary so long as verified documentary evidence from the school is required.

Statutory authority.

Sections 15.08 (5) (b), 227.11 (2) and 448.40 (1), Stats.

Existing or proposed federal legislation.

None.

Entities affected by the rule.

Physician applicants, medical and osteopathic schools approved by the board, and the Wisconsin Department of Regulation and Licensing.

Estimate the amount of state employee time and any other resources that will be necessary to develop the rule.

80 hours.

Med 1.02 (Copy of diploma requirement) Scope Statement 11-17-08

receives information regarding graduation directly from medical and osteopathic schools of medicine.

Section 1. amends Med 1.02 (2) by deleting the language pertaining to a copy of the applicant's diploma.

Summary of, and comparison with, existing or proposed federal regulation:

None.

Comparison with rules in adjacent states:

Illinois:

Illinois requires an official transcript and diploma or an official transcript and certification of graduation from the medical school. 68 Ill. Adm. Code 1285.70.

Iowa:

Iowa requires a copy of the applicant's medical degree and a certification from the medical school. 653 IAC 9.4 (147,148).

Michigan:

Michigan requires that an applicant establish that he or she is a graduate of medical school. Mich. Admin. Code R 338.2317.

Minnesota:

Minnesota requires an original or certified copy of the diploma from the medical or osteopathic school. Minn. R. 5600.0200 Subp. 2.

Summary of factual data and analytical methodologies:

The Medical Examining Board ensures the accuracy, integrity, objectivity and consistency of data were used in preparing the proposed rule and related analysis.

Analysis and supporting documents used to determine effect on small business or in preparation of economic impact analysis:

These proposed rules do not have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. The Department's Regulatory Review Coordinator may be contacted by email at Greg.Gasper@wisconsin.gov, or by calling (608) 266-8608.

Fiscal Estimate and Economic Impact Analysis:

The Fiscal Estimate and Economic Impact Analysis are attached.

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

IN THE MATTER OF RULE-MAKING : PROPOSED ORDER OF THE
PROCEEDINGS BEFORE THE : MEDICAL EXAMINING BOARD
MEDICAL EXAMINING BOARD : ADOPTING RULES
: (CLEARINGHOUSE RULE)

PROPOSED ORDER

An order of the Medical Examining board to amend Med 1.02, relating to copy of diploma requirement.

Analysis prepared by the Department of Safety and Professional Services.

ANALYSIS

Statutes interpreted:

s. 448.05 (2), Stats.

Statutory authority:

ss. 15.08 (5), 227.11, 448.05 (2), and 448.40, Stats.

Explanation of agency authority:

The Medical Examining Board, (Board), pursuant to ss. 15.08 (5) and 227.11, Stats., has the general power to promulgate rules for guidance within the profession and to interpret the statutes it enforces. Section 448.40, Stats., grants the Medical Examining Board blanket authority to promulgate rules that carry out the purposes of the Medical Practices Act. The Board seeks to interpret a statute that it administers specifically, s. 448.05 (2), Stats., which deals with applicants being required to possess a diploma. Therefore, the Board is both generally and specifically empowered to promulgate the proposed rule.

Related statute or rule:

Wis. Admin. Code s. Med 1.02 (2)

Plain language analysis:

The proposed rule seeks to amend Wis. Admin Code Med 1.02 by eliminating the requirement that applicants provide a verified photographic copy of their diploma when applying for licensure. The requirement is duplicative and unnecessary since the board

Effect on small business:

These proposed rules do not have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. The Department's Regulatory Review Coordinator may be contacted by email at Greg.Gasper@wisconsin.gov, or by calling (608) 266-8608.

Agency contact person:

Shawn Leatherwood, Department of Safety and Professional Services, Division of Board Services, 1400 East Washington Avenue, Room 151, P.O. Box 8935, Madison, Wisconsin 53708; telephone 608-261-4438; email at Shancethea.leatherwood@wisconsin.gov.

Place where comments are to be submitted and deadline for submission:

Comments may be submitted to Shawn Leatherwood, Department of Safety and Professional Services, Division of Board Services, 1400 East Washington Avenue, Room 151, P.O. Box 8935, Madison, WI 53708-8935, or by email to Shancethea.Leatherwood@wisconsin.gov. Comments must be received on or before _____ to be included in the record of rule-making proceedings.

TEXT OF RULE

SECTION 1. Med 1.02 is amended to read:

Med 1.02 (2) Verified documentary evidence of graduation from a medical or osteopathic school approved by the board ~~and a verified photographic copy of the diploma conferring the degree of doctor of medicine or doctor of osteopathy granted to the applicant by such school.~~ The board recognizes as approved those medical or osteopathic schools recognized and approved at the time of the applicant's graduation therefrom by the council on medical education and hospitals of the American medical association, or the American osteopathic association, or the liaison committee on medical education, or successors. If an applicant is not a graduate of a medical school approved by the board, but is a graduate of a medical school recognized and listed as such by the world health organization of the united nations, such applicant shall submit verified documentary evidence of graduation from such school ~~and a verified photographic copy of the diploma conferring the degree of doctor of medicine or equivalent degree as determined by the board granted to the applicant by such school~~ and also verified documentary evidence of having passed the examinations conducted by the educational council for foreign medical graduates or successors, and shall also present for the board's inspection the originals thereof, and if such medical school requires either social service or internship or both of its graduates, and if the applicant has not completed either such required social service or internship or both, such applicant shall also submit verified

documentary evidence of having completed a 12 month supervised clinical training program under the direction of a medical school approved by the board.

SECTION 2. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin administrative register, pursuant to s. 227.22 (2) (intro.), Stats.

(END OF TEXT OF RULE)

Dated _____

Agency _____

Member of the Board
Medical Examining Board

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Shawn Leatherwood		2) Date When Request Submitted: September 6, 2013 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 ▪ 08 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
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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: MED 8 Update	
10) Describe the issue and action that should be addressed: The Board will review CR 12-005 MED 8 and authorize the Chair or other member of the Board to approve the Legislative Report and Draft for Clearinghouse Rule 12-005 for submission to the Legislature.			
11) Authorization			
Shancethea Leatherwood			
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: <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
MEDICAL EXAMINING BOARD

IN THE MATTER OF RULE-MAKING : REPORT TO THE LEGISLATURE
PROCEEDINGS BEFORE THE : ON CLEARINGHOUSE RULE 12-005
MEDICAL EXAMINING BOARD : (S. 227.19 (3), Stats.)
:

I. THE PROPOSED RULE:

The proposed rule, including the analysis and text, is attached.

II. REFERENCES TO APPLICABLE FORMS:

The proposed rule does not require new forms.

III. FISCAL ESTIMATE AND EIA:

The Fiscal Estimate and EIA are attached.

IV. DETAILED STATEMENT EXPLAINING THE BASIS AND PURPOSE OF THE PROPOSED RULE, INCLUDING HOW THE PROPOSED RULE ADVANCES RELEVANT STATUTORY GOALS OR PURPOSES:

The purpose of the proposed rule is to increase the physician to physician assistant ratio in Wis. Admin. Code s. Med 8.10 (1). The current rule allows a physician to concurrently supervise no more than 2 physician assistants at a time unless a written plan is submitted to the Board for its approval. The proposed rule increases the maximum number of physician assistants a physician may concurrently supervise from 2 to 4. The Board was prompted by the Council on Physician Assistants to initiate the proposed rule in recognition of a national trend of physician workforce shortages. By increasing the number of physician assistants to physician ratio, the proposed rule proactively addresses an impending physician workforce shortage; increases the efficiency of health care delivery; and insures public safety goals such as protecting the public.

V. NOTICE OF PUBLIC HEARING:

The Medical Examining Board held a public hearing on February 15, 2012. Written comments were accepted until February 15, 2012. The following people either testified at the hearing, submitted written comments or both:

Mark Grapentine, Senior Vice President-Government Relations Wisconsin Medical Society
Madison, WI,

Lou Falligant, PA-C UW Health Cottage Grove, Stoughton, WI,

David Wilson, President, Wisconsin Academy of Physician Assistants, Madison, WI,

Anne Hletko, La Crosse, WI, Wisconsin Academy of Physician Assistants, Madison, WI

Judith F. Warmuth Madison, Vice President Workforce, Wisconsin Hospital Association, Madison, WI

Clark Collins, Wisconsin Academy of Physician Assistants, Sun Prairie, WI,

Michael D. Richards, La Crosse, WI Executive Director of External Affairs representing Gundersen Lutheran

Lisa Simpson, PA-C UW Health Deforest-Windsor, Windsor, WI

SUMMARY OF PUBLIC HEARING COMMENTS:

Mr. Grapentine of Madison, WI Senior Vice President- Government Relations representing the Wisconsin Medical Society submitted written comments and testified in support of the rule with suggestions for modifications. He proposed striking the language "is minimally competent to practice medicine and surgery" found in s. Med 8.05 (2) (e) and replacing it with "has met requirements for licensure." He also suggested eliminating any ambiguity between s. Med 8.08 (1) (d) and Med 8.08(3) (e) by deleting the words "during each review." Mr. Grapentine argued this change would clarify that physicians and physician assistant's signatures are not required more than annually and reviews done more frequently would not require sign-off.

Mr. Lou Falligant of Stoughton, WI Executive Vice President representing the Wisconsin Academy of Physician Assistants submitted written comments and testified in support of the rule with suggestions for modifications. He warned the Board to avoid adding significant layers of complexity to Med 8. He argued that Med 8 should be streamlined. He suggested that s. Med 8.08 should be deleted in its entirety due to the language being obsolete now that PAs have been granted prescribing authority.

The Wisconsin Academy of Physician Assistants also retained the law firm of Axley Brynelson, LLP, to review the proposed rule. The firm's recommendations were included in the written statement provided by Mr. Falligant. Axley Brynelson suggested the following changes: (1) amend the language in s. Med 8.01 (2) to express that the discretion of physician-led teams to determine whether more direct or intensive supervision is needed or should be practiced in accordance with the appropriate rules; (2) clarify the intent of s. Med 8.05 (2) (e) as to whether there are other factual circumstances that would require a personal appearance other than those stated in s. Med 8.05 (2) (b), (3) revise s. Med 8.08 in its entirety; and (4) define the terms "written guidelines" and "periodic review".

Mr. David Wilson of Madison, WI President of the Wisconsin Academy of Physician Assistants testified in opposition of the proposed rule and submitted written comments. Specifically, Mr. Wilson opposed the wording of s. Med 8.08. He argued the current language of the proposed rule made it difficult for practitioners to determine the frequency of the periodic review of the physician assistant practice. He asked for language specifying

the periodic review would take place annually. He also supported Mark Grapentine and Lou Falligant's recommended changes to the proposed rule.

Mr. Clark Collins of Sun Prairie, WI and a member of the Wisconsin Academy of Physician Assistants appeared in support of the proposed rule with minor changes. He supported the changes recommended by Lou Falligant.

Ms. Anne Hletko of La Crosse, WI, a member of the Wisconsin Academy of Physician Assistants provided written comments and testified in support of the rule and submitted written comments. She favored the increase in physician-to-physician assistant ratios, the addition of the personal appearance for credential review and the elimination of the term substitute supervising physician. She suggested amending the definition of "supervising physician" to include physicians that practice in the federal health care system and are not licensed in Wisconsin. Ms. Hletko opposed the co-signature requirement in s. Med 8.08.

Ms. Judith F. Warmuth of Madison, WI, Vice President Workforce representing the Wisconsin Hospital Association provided written comments and appeared in support of the increase in physician-to-physician assistant ratios. Ms. Warmuth, asked the Board to clarify the wording of s. Med 8.10. She stated that the WHA is often asked by its members, how many physician assistants may be concurrently supervised. She asserted that it was unclear whether the current language allowed physicians to supervise two PAs in total or to supervise two PAs who are providing patient care. She suggested that adding the words "during the time the physician assistants are providing patient care" would clarify the terms "concurrently supervise." These suggestions lead to a discussion of the supervisory role of physicians and identifying a physician assistant's supervising physician.

Mr. Michael D. Richards of La Crosse, WI Executive Director of External Affairs representing Gundersen Lutheran provided written comments in support of the proposed rule. Mr. Richards stated that the increase in physician-to-physician assistant ratios would result in greater flexibility in clinical staffing arrangements and help in addressing provider shortages in key areas.

Ms. Lisa Simpson of Windsor, WI provided written comments encouraging the Board to "simplify not complicate the regulations".

BOARD'S RESPONSE TO PUBLIC COMMENTS:

In response to the public comments received the Board replaced the phrase "medicine and surgery" found in s. Med 8.05 (2) (e) with the phrase "as a physician assistant" to indicate physician assistants must be competent to practice as a physician assistant rather than competent to practice medicine and surgery. Med 8.08 was repealed in its entirety in response to public comments suggesting the removal of complexity from the rule. The definitions for adequate supervision, general supervision and supervising physician were deleted from the rule in order to avoid duplication of the same principle. Med 8.10 was amended to address the issue of how many physician assistants may be "concurrently" supervised. The phrase "on duty physician assistants" replaced the term "concurrently" to clarify the time frame in which physicians are supervising physician assistants.

VI. RESPONSE TO LEGISLATIVE COUNCIL STAFF RECOMMENDATIONS:

Comment 2. i. (1): The section title could be simplified, for example, as: “**Prescribing authority and written guideline.**” The subsections of s. Med 8.08 could also be given titles, to facilitate locating material within the somewhat lengthy section.

Response: Med 8.08 has been repealed.

Comment 5 d.: In s. Med 8.05 (2) (e), must all applicants be minimally competent to practice surgery?

Response: Physician assistants must be competent to practice as a physician assistant rather than medicine and surgery. The phrase “medicine and surgery” found in s. Med 8.05 (2) (e) has been replaced with “as a physician assistant.”

Comment 5 e.: In s. Med 8.10 (3), what is included in “telecommunication”?

Response: The intent of the term “telecommunication” as it is used in s. Med 8.10 (3) is to require that the physician assistant and physician shall have the capability of establishing communication by any electronic means including telephone, Skype or some other electronic means.

Comment 5 f. : In s. Med 8.10 (4), the new language is somewhat redundant, considering that sub. (3) provides that the physician must be available to be contacted by the physician assistant. Also, the requirements of the provision are vague and would, therefore, be difficult to enforce. In particular, what is meant by “including competent medical practice”?

Response: Med 10.04 was deleted

All of the other recommendations in the clearinghouse report were accepted and incorporated into the final draft of the proposed rule.

VII. REPORT FROM THE SBRRB AND FINAL REGULATORY FLEXIBILITY ANALYSIS:

These proposed rules will have no significant economic impact on small businesses, as defined in s. 227.114(1), Stats.

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

IN THE MATTER OF RULE-MAKING	:	PROPOSED ORDER OF THE
PROCEEDINGS BEFORE THE	:	MEDICAL EXAMINING
MEDICAL EXAMINING BOARD	:	BOARD
	:	ADOPTING RULES
	:	(CLEARINGHOUSE RULE 12- 005)

PROPOSED ORDER

The Wisconsin Medical Examining Board proposes an order to repeal Med 8.08; to renumber Med 8.01; to amend Med 8.05 (2) (b) 7., 8.05 (2) (c), 8.07 (1), 8.07 (2) (a) and (e), 8.07 (2) (i); to repeal and recreate Med 8.10; to create Med 8.01 (2), 8.05 (2) (e) and 8.07 (3), relating to physician assistant employment requirements and supervising physician responsibilities.

Analysis prepared by the Department of Safety and Professional Services.

ANALYSIS

Statutes interpreted:

Sections 448.21 (2) and (3), Stats.

Statutory authority:

Sections 15.08 (5) (b), 227.11 (2) (a), 448.05 (5), 448.20 (3) (a), 448.40 (2) (f), Stats.

Explanation of agency authority:

The legislature, via Wis. Stats. §§ 15.08 (5) (b), and 227.11 (2) (a), conferred upon the Medical Examining Board general powers to promulgate rules for the guidance of the profession and to interpret the provisions of statutes it enforces. Section 448.05 (5), Stats. authorizes the Board to promulgate rules that establish licensing and practice standards for physician assistants. Therefore, the Medical Examining Board is both generally and specifically authorized to promulgate these proposed rules.

Section 448.20(3)(a), Stats. confers upon the Council on Physician Assistants the authority to advise the Medical Examining Board on revisions of standards in licensing, practice, education and training of physician assistants.

Related statute or rule:

Sections 448.01 (6), 448.20 (3), Stats., Wis. Admin. Code §MED 10.02(2) (t)

Plain language analysis:

Physician assistants practice as part of a physician-led team with physicians supervising the health care services they provide. Currently, one physician may supervise no more than two physician assistants at one time without permission from the Medical Examining Board (Board). A physician requesting an increase in the numbers of physician assistants to be supervised must submit a written plan for the Board's review. The Board may, in an exercise of its discretion; grant the request if the Board is satisfied that the increased number of physician assistants will not compromise patient safety. The proposed rule purports to change the current regulation by increasing the maximum number of physician assistants a physician may concurrently supervise from 2 to 4. This increase is in line with recent trends in the profession due to widespread physician shortages.

Current law also provides that applicants for licensure as physician assistants may be required to submit to an oral examination. The existing term is outdated and does not reflect that during a personal appearance the Board may also require an applicant to submit to an interview, or a review of credentials, or both. The proposed rule clarifies that the Board may require, as a prerequisite to licensure, successful completion of an oral examination or a personal appearance or both. The proposed rule eliminates other references to outdated terms such as, "substitute supervising physician" found in s. Med 8.10 (2).

SECTION 1. renumbers and amends Med 8.01

SECTION 2. creates a statement of intent and adds it to the authority and purpose provision.

SECTION 3. amends Med 8.05 (2) (b) 7. to remove outdated references to particular mental health disorders.

SECTION 4. amends Med 8.05 (2) (c) to allow a personal appearance as well as an oral examination if required by the application review panel.

SECTION 5. creates Med 8.05 (2) (e) a provision regarding the components of a satisfactory personal appearance.

SECTION 6. amends Med 8.07 (1) by clarifying that a physician assistant's practice may be supervised by one or more supervising physicians.

SECTION 7. amends Med 8.07 (2) (a) and (e) by striking repetitive and ambiguous language.

SECTION 8. adds a provision regarding annual review of physician assistant prescriptive practices.

SECTION 9. creates a provision regarding identifying a physician assistant's supervising physician.

SECTION 10. repeals Med 8.08

SECTION 11. repeals and recreates Med 8.10 by increasing the number of physician assistants a physician may supervise from 2 to 4.

Summary of, and comparison with, existing or proposed federal legislation:

There is no comparative existing or proposed federal rule.

Comparison with rules in adjacent states:

Illinois: The state of Illinois limits the physician assistant to physician ratio to 2:1; unless the supervising physician designates an alternate supervising physician. An alternate supervising physician may supervise more than two physician assistants at the same time when the supervising physician is unable to fulfill the duties. 225 ILL. COMP. STAT. 95/7

Iowa: The state of Iowa limits the physician assistant to physician ratio to 2:1. 645 IAC 326.8 (3) (148 C)

Michigan: The state of Michigan allows a physician assistant to physician ratio of 4:1 when the supervising physician is a solo practitioner who practices in a group of physicians and treats patients on an outpatient basis. Physicians who have privileges at a health facility or agency or a state correctional facility may supervise more than four physician assistants; but the physician assistant to physician ratio is 2:1 if the physician supervises a physician assistant at more than one location. MCLS § 333.17048

Minnesota: The state of Minnesota allows a physician to supervise five physician assistants simultaneously. In the case of an emergency a physician may supervise more than five physician assistants at any given time. MINN. STAT. §147A.01

Summary of factual data and analytical methodologies:

In recognition of physician work-force shortages and at the request of the Council on Physician Assistants, the Medical Examining Board created a work group to research and advise the board on whether or not to increase the supervision ratio of physician assistants to physicians, and if so under what circumstances. The work group consisted of members of the Medical Examining Board, who are licensed physicians, the chairperson of the Council on Physician Assistants and consultation from the State Medical Society, the Wisconsin Council of Physician Assistants and the Wisconsin Hospital Association. Members of the work group examined the statutes and regulations of other states as well as recommendations of the Federation of State Medical Boards, the

American Medical Association, the American Association of Family Practitioners and the American Academy of Physician Assistants.

The national trend, as recognized by the Federation of State Medical Boards and the American Academy of Physician Assistants, is to increase the number of physician assistants a physician may supervise. Both organizations have, as a national model, recommended that regulatory bodies refrain from specifying a particular number of physician assistants a physician may concurrently supervise. Rather, the recommendation is that supervising physicians make the determination based on prevailing standards for competent medical practice, day-to-day realities, and the nature of the physician's actual practice.

The work group presented its findings to the Medical Examining Board with a recommendation that the board increase the physician to physician assistant ratio to 1:5. The board considered several factors including practice setting in which physician and physician assistants carry out their duties and patient care issues such as a growing shortage of health care practitioners in underserved communities. The board emphasized the need for adequate physician supervision of physician assistant's practice and adopted the work group's recommendation to increase the ratio of physician assistants a physician may supervise. However, after extensive discussion, the board decided to authorize a physician to physician assistant supervision ratio of 1:4.

Analysis and supporting documents used to determine effect on small business or in preparation of economic report:

The department finds that this rule will have no effect on small business as small business is defined in 227.114 (1), Stats.

Anticipated costs incurred by the private sector:

The department finds that this rule will incur no additional cost to the private sector.

Fiscal Estimate and Economic Impact Analysis:

The proposed rule is not anticipated to have any fiscal impact on businesses, public utility rate payers, local government units or the state's economy as a whole. The proposed rule was posted on the department's website for 14 days. Comments were solicited. The department did not receive any comments regarding an economic impact from local government units, specific business sectors or public utility rate payers. Therefore, the department finds the proposed rule will have no economic impact.

Effect on small business:

The department finds that this rule will have no effect on small business as small business is defined in s. 227.114 (1), Stats. The Department's Regulatory Review Coordinator may be contacted at Greg.Gasper@wisconsin.gov or by calling (608) 266-8608.

Agency contact person:

Shawn Leatherwood, Paralegal, Department of Safety and Professional Services, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708; telephone 608-261-4438; email at Shancethea.L Leatherwood@wisconsin.gov.

Place where comments are to be submitted and deadline for submission:

Comments may be submitted to Shawn Leatherwood, Paralegal, Department of Safety and Professional Services, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708-8935, or by email to Shancethea.L Leatherwood@wisconsin.gov. Comments must be received on or before February 15, 2012, to be included in the record of rule-making proceedings.

TEXT OF RULE

SECTION 1. Med. 8.01 is renumbered Med 8.01 (1):

SECTION 2. Med 8.01 (2) is created to read:

Med 8.01 (2) Physician assistants provide health care services as part of physician-led teams, the objectives of which include safe, efficient and economical health care. The realities of the modern practice of medicine and surgery require supervising physicians and physician assistants to use discretion in delivering health care services, typically at the level of general supervision. The constant physical presence of a supervising physician is often unnecessary. The supervising physician and the physician assistant are jointly responsible for employing more intensive supervision when circumstances require direct observation or hands-on assistance from the supervising physician.

SECTION 3. Med 8.05 (2) (b) 7. is amended to read:

Med 8.05 (2) (b) 7. ~~Has been diagnosed as suffering from pedophilia, exhibitionism or voyeurism, with any condition that may create a risk of harm to a patient or the public.~~

SECTION 4. Med 8.05 (2) (c) is amended to read:

Med 8.05 (2) (c) An application filed under this chapter shall be reviewed by an application review panel of at least 2 council members designated by the chairperson of the board to determine whether an applicant is required to complete an oral examination or a personal appearance or both under par. (a) (b). If the application review panel is not able to reach unanimous agreement on whether an applicant is eligible for licensure

without completing an oral examination or a personal appearance or both, the application shall be referred to the board for a final determination.

SECTION 5. Med 8.05 (2) (e) is created to read:

Med 8.05 (2) (e) The board may require an applicant to complete a personal appearance for purposes of interview or review of credentials or both. An applicant's performance at a personal appearance is satisfactory if the applicant establishes to the board's satisfaction that the applicant has met requirements for licensure and is minimally competent to practice as a physician assistant.

SECTION 6. Med 8.07 (1) is amended to read:

Med 8.07 Practice. (1) SCOPE AND LIMITATIONS. In providing medical care, the entire practice of any physician assistant shall be under the supervision of one or more a licensed physician or a physician exempt from licensure requirements pursuant to s. 448.03 (2) (b), Stats.. The scope of practice is limited to providing medical care as specified in sub. (2). A physician assistant's practice may not exceed his or her educational training or experience and may not exceed the scope of practice of the supervising physician providing supervision. A medical care task assigned by the supervising physician to a physician assistant may not be delegated by the physician assistant to another person.

SECTION 7. Med 8.07 (2) (a) and (e) are amended to read:

Med 8.07 (2) (a) Attending initially a patient of any age in any setting to obtain a personal medical history, perform an appropriate physical examination, and record and present pertinent data concerning the patient ~~in a manner meaningful to the supervising physician.~~

Med 8.07 (2) (e) Assisting the supervising physician in a hospital or facility, as defined in s. 50.01 (1m), Stats., by assisting in surgery, making patient rounds, recording patient progress notes, compiling and recording detailed narrative case summaries and accurately writing or executing orders ~~under the supervision of a licensed physician.~~

SECTION 8. Med 8.07 (2) (i) is amended to read:

Med 8.07 (2) (i) Issuing written prescription orders for drugs ~~under the supervision of a licensed physician and in accordance with procedures specified in s. Med 8.08 (2)~~ provided the physician assistant has had and initial and at least annual thereafter, review of the physician assistant's prescriptive practices by a physician providing supervision. Such reviews shall be documented in writing, signed by the reviewing physician and physician assistant and made available to the Board for inspection upon reasonable request.

SECTION 9. 8.07 (3) is created to read:

Med 8.07 (3) IDENTIFYING SUPERVISING PHYSICIAN. The physician providing supervision must be readily identifiable by the physician assistant through procedures commonly employed in the physician assistant's practice.

SECTION 10. Med 8.08 is repealed.

SECTION 11. Med 8.10 is repealed and recreated to read:

Med 8.10 Physician to physician assistant ratio. (1) No physician may supervise more than 4 on duty physician assistants at any time unless a written plan to do so has been submitted to and approved by the board. Nothing herein shall limit the number of physician assistants for whom a physician may provide supervision over time. A physician assistant may be supervised by more than one physician while on duty.

(2) A supervising physician shall be available to the physician assistant at all times for consultation either in person or within 15 minutes of contact by telecommunication or other means.

SECTION 12. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin administrative register, pursuant to s. 227.22 (2) (intro.), Stats.

(END OF TEXT OF RULE)

Dated _____

Agency _____

Chairperson
Medical Examining Board

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Shawn Leatherwood		2) Date When Request Submitted: September 6, 2013 <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: September 18, 2013	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? MED 10 Update	
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? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A	
10) Describe the issue and action that should be addressed: The Board will receive an update on the status of MED 10 CR--13-008.			
11) Authorization			
Shawn Leatherwood		09/06/13	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive 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 Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Shawn Leatherwood		2) Date When Request Submitted: August 16, 2013 <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 ▪ 08 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: September 18, 2013	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Wis. Admin. Code Pod 1.02, and 7-Podiatric x-ray assistants	
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: N/A	
10) Describe the issue and action that should be addressed: The Podiatry Affiliated Credentialing Board, pursuant to Wis. Stat. s. 15.085 (b) 1. Submits this proposed rule draft for the Medical Examining Board's review and comment. The MEB may make recommendations for the Podiatry Affiliated Credentialing Board's consideration. Review must occur at least 60 days before a rule draft is submitted to the legislative council staff.			
11) Authorization			
Shawn Leatherwood		August 16, 2013	
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.			

STATE OF WISCONSIN
PODIATRY AFFILIATED CREDENTIALING BOARD

IN THE MATTER OF RULE-MAKING	:	PROPOSED ORDER OF THE
PROCEEDINGS BEFORE THE	:	PODIATRIST AFFILIATED
PODIATRY AFFILIATED	:	CREDENTIALING BOARD
CREDENTIALING BOARD	:	ADOPTING RULES
	:	(CLEARINGHOUSE RULE)

PROPOSED ORDER

An order of the Podiatry Affiliated Credentialing Board to create Pod 1.02 (2m), Pod 1.02 (6m) and Pod 7 (title) relating to podiatric x-ray assistants.

Analysis prepared by the Department of Safety and Professional Services.

ANALYSIS

Statutes interpreted:

s. 462.02 (1) (f), Stats.

Statutory authority:

ss. 15.085 (5) (b), 227.11 (2) (a), 448.695 (3), Stats.

Explanation of agency authority:

The Podiatrist Affiliated Credentialing Board (Board) is generally empowered by the legislature to promulgate rules that will provide guidance within the profession and rules that interpret the statutes it enforces or administers. Section 448.695, Stats., specifically empowers the Board to, "promulgate rules specifying the requirements for a course of instruction related to x-ray examinations by persons under the direct supervision of a podiatrist. . ." The proposed rule intends to specify the education necessary for persons under the direct supervision of a podiatrist. Therefore, the Board is empowered both generally and specifically to promulgate the proposed rule.

Related statute or rule:

Wis. Admin. Code s. Pod 1

Plain language analysis:

The proposed rule deals with statutory authority that requires podiatric assistants have special training in the used of x-ray machines.

Summary of, and comparison with, existing or proposed federal regulation:

The Consumer-Patient Radiation Health & Safety Act of 1981, 42 USC 1001, et seq. establishes federal guidelines for standards of accreditation of educational programs for certain occupations that administer radiologic procedures. The standards are in place to protect the public from excessive exposure to radiation by health care professionals who most often use radiation in the treatment of disease or other medical conditions. The regulations are directed towards radiographers, dental hygienists, dental assistants, nuclear medicine technologists, and radiation therapy technologists.

42 USC § 10003 (5) broadly defines, “persons who administer radiologic procedures” means any person, other than a practitioner, who intentionally administers radiation to other persons for medical purposes and includes medical radiologic technologists (including dental hygienists and assistants), radiation therapy technologists and nuclear medicine technologists.” 42 CFR 75.2 defines radiation therapy technologist as, “a person other than a licensed practitioner who utilizes ionizing radiation-generating equipment for therapeutic purposes on human subjects.” Although non-licensed personnel who assist podiatrists, the topic of these proposed rules, are not specifically addressed, they could be captured under the broad definition of radiation therapy technologists. The federal statute and regulation are comparable to the proposed rule in that they both set forth the education and credentialing standards for the aforementioned professions.

Comparison with rules in adjacent states:

Illinois: Illinois regulates radiologist assistants and limited diagnostic radiographers who pass the American Registry of Radiologic Technologists (ARRT). Radiologist assistants must also pass the Certification Board for Radiology Practitioner Assistants (CBRPA) exam. Ill Admin. Code tit. 32 §401.70

Iowa: Iowa defines a podiatric X-ray equipment operator as one who “performs radiography of only the foot and ankle using dedicated podiatric equipment”. IAC 641-42.2 (136C). Podiatric X-ray equipment operators must obtain “8.0 hours of classroom instruction to include radiation safety, equipment operation, patient care and anatomy.”

Michigan: Michigan does not regulate podiatric x-ray assistants.

Minnesota: Minnesota regulates limited x-ray operators. They may only practice medical radiography on limited regions of the body as long as he or she has successfully passed the American Registry of Radiologic Technologists (ARRT) exam, or the American Chiropractic Registry of Radiologic Technologists (ACRRT) exam. Minn. Stats. 144.121 subd. 5a.

Summary of factual data and analytical methodologies:

The Board ensures the accuracy, integrity, objectivity and consistency of the data used in preparing the proposed rule and related analysis.

Analysis and supporting documents used to determine effect on small business or in preparation of economic impact analysis:

These proposed rules do not have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. The Department's Regulatory Review Coordinator may be contacted by email at Greg.Gasper@wisconsin.gov, or by calling (608) 266-8608

Fiscal Estimate and Economic Impact Analysis:

The Fiscal Estimate and Economic Impact Analysis are attached.

Effect on small business:

These proposed rules do not have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. The Department's Regulatory Review Coordinator may be contacted by email at Greg.Gasper@wisconsin.gov, or by calling (608) 266-8608.

Agency contact person:

Shawn Leatherwood, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8935, Madison, Wisconsin 53708; telephone 608-261-4438; email at Shancethea.Leatherwood@wisconsin.gov.

Place where comments are to be submitted and deadline for submission:

Comments may be submitted to Shawn Leatherwood Department of Safety and Professional Services, Division of Policy and Development, 1400 East Washington Avenue, Room 151, P.O. Box 8935, Madison, WI 53708-8935, or by email to Shancethea.Leatherwood@wisconsin.gov. Comments must be received on or before October 24, 2013 to be included in the record of rule-making proceedings.

TEXT OF RULE

SECTION 1. Pod 1.02 (2m) is created to read:

Pod 1.02 (2m) "Direct supervision" means a physician has assumed responsibility for directing, supervising, and inspecting the work of the person being supervised and the supervising physician is physically present on the same premises as the person being supervised, with face-to-face contact as necessary.

SECTION 2. Pod 1.02 (6m) is created to read:

Pod 1.02 (6m) "Podiatric x-ray assistant" means a person who is under the direct supervision of a licensed podiatric physician to perform only those radiographic functions that are within the scope of practice of a podiatric physician licensed under s. 448.61, Stats., and the podiatric physician is competent to perform.

SECTION 3. Pod 7.01 (title) is created to read:

CHAPTER POD 7
PODIATRIC X-RAY ASSISTANT

Pod 7.01 Podiatric x-ray assistant under direct supervision of a podiatrists. A podiatric physician may not delegate x-ray tasks to an unlicensed person unless the delegate has successfully completed a course of instruction for podiatric x-ray assistants approved by the board. Patients must be informed that the podiatric x-ray assistant is practicing under the supervision of the podiatric physician. A course of instruction for podiatric x-ray assistants is approved by the board if all of the following are true:

- (1) The instructor is a physician or radiographer whose license to practice in Wisconsin is current and unlimited.
- (2) The program consists of at least 8 hours of instruction.
- (3) The course of instruction addresses; and attendees demonstrate knowledge and understanding of all of the following topics:
 - (a) terminology
 - (b) science of radiation in x-rays
 - (c) radiation exposure and monitoring including dose limits for exposure to ionizing radiation.
 - (d) health risks of radiation exposure
 - (e) safety techniques to minimize radiation exposure to staff and patients as low as reasonably achievable (ALARA)
 - (f) anatomy and function of foot and leg
 - (e) positioning for podiatric x-rays
 - (g) equipment operation technique and quality control, including analog and digital

(h) infection control

(i) legal and ethical issues

(4) A podiatric physician who uses the services of a podiatric x-ray assistant shall keep at each practice site, a copy of documentation that the podiatric x-ray assistant satisfactorily completed a course of instruction that meets the requirements set out above.

SECTION 4. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin administrative register, pursuant to s. 227.22 (2) (intro.), Stats.

(END OF TEXT OF RULE)

Dated _____

Agency _____

Chairperson

Podiatry Affiliated Credentialing Board



STATE OF WISCONSIN

Department of Safety and Professional Services
1400 E Washington Ave.
Madison WI 53703

Mail to:
PO Box 8935
Madison WI 53708-8935

Email: dsps@wisconsin.gov
Web: <http://dsps.wi.gov>
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Governor Scott Walker Secretary Dave Ross

Positions Statements Related to Physicians Issued by the Medical Examining Board

UNDER WHAT CIRCUMSTANCES MAY A PHYSICIAN DELEGATE TO A NON-PHYSICIAN AN ACT THAT CONSTITUTES THE PRACTICE OF MEDICINE AND SURGERY?

Wis. Stat. § 448.03(2)(e) permits physicians to delegate to any unlicensed person an act that constitutes the practice of medicine and surgery. The physician must have the power to “direct, decide and oversee the implementation” of the patient service. The physician must, in fact, direct, supervise and inspect the delegated service.

Because a delegate is not licensed, a delegate performs the medical act under the authority of the physician’s license. Therefore, for regulatory purposes, the physician is responsible for the acts of the delegate.

As explained below, the supervising physician:

- must be competent to perform the act being delegated;
- must insure that the delegate is minimally competent to perform the act;
- and must make it clear to the patient and others that the delegate is an unlicensed person, performing the act under the supervision of the physician.

Wisconsin Admin. Code § MED10.02(2)(h) prohibits a physician from engaging in any practice or conduct that falls below the level of minimal competence and that places a patient at unacceptable risk of harm. The same rule directs that a physician may not aid or abet another person in incompetently placing a patient at unacceptable risk of harm.

Therefore, to competently supervise and oversee a delegate, the physician must be competent to perform the act in question, and must have reasonable evidence that the delegate is minimally competent to perform the act under the circumstances.

Wisconsin Admin. Code § MED10.02(2)(t) requires that a physician identify a delegate as being unlicensed and acting under the supervision of the physician. Failure to do so is considered “aiding or abetting the unlicensed practice of medicine” or representing that the unlicensed persons are licensed.

Although not specifically required in law, professional standards may require written protocols concerning delegated medical acts. If such practice standards exist, and a written protocol does not exist, physicians could be deemed to be in violation of Wis. Stat. Admin. Code § 10.02(2)(h). Hospitals are required to specify in by-laws those classes of employees that may accept and carry out physician orders – this may also include delegated acts. See Wis. Admin Code ch DHS 124.

MUST A PHYSICIAN BE PRESENT IN THE ROOM WHEN A DELEGATED MEDICAL ACT IS PERFORMED BY AN UNLICENSED PERSON?

As explained in response to question no. 1 above, the performance of a delegated medical act must be “directed, supervised and inspected” by a licensed physician. For the Board’s purposes, the physician is responsible for the act in question, and must insure that, under the circumstances present with each act, the delegate is competent to perform the act. The circumstances of each delegated act include the level of supervision under which the act is performed.

The law does not specify any particular level of supervision for acts performed by an unlicensed person under the physician’s supervision.

Therefore, the level of supervision a physician must provide an unlicensed person performing a delegated act is within the discretion of the supervising physician. Adequate supervision of a delegated act does not necessarily require that the physician be present when the act is performed if the physician reasonably determines that his or her absence does not place a patient at unacceptable risk of harm under the circumstances. For example, a simple procedure, with minimal risk of minimal harm and in the hands of an experienced delegate may require only general supervision, ie, the physician is not required to be physically present but is available by telephone. In some circumstances, a physician may require direct supervision, meaning the physician is present in the building and immediately available to assist in the procedure; in other cases, the physician may determine that direct face-to-face supervision is required to insure an adequate level of patient safety.

UNDER WHAT CIRCUMSTANCES MAY A NON-PHYSICIAN WHO IS A LICENSED HEALTH CARE PROFESSIONAL PERFORM ACTS CONSTITUTING THE PRACTICE OF MEDICINE AND SURGERY?

Some acts constituting the practice of medicine and surgery may also fall within the scope of practice of another license, such as a license to practice nursing or a license to practice as a physician assistant. In the case of a licensed professional, the licensed non-physician generally performs the act under the authority of his or her own license and attendant requirements (which may include physician supervision). Therefore, a nurse may independently perform acts within the scope of a license to practice nursing even if the act is also within the scope of a license to practice medicine and surgery.

Conversely, physician assistant licenses require PA's to perform medical services under the supervision of a physician. A physician assistant may not practice independently and may not independently perform acts outside the scope of a license to practice as a physician assistant. Therefore, for regulatory purposes, the responsibility to insure adequate physician supervision is the responsibility of both the supervising physician and the physician assistant, and for the Board's purposes, both are responsible for the service provided.

For guidance on scope of practice for licensed professionals, please see statutes and administrative rules pertaining to the relevant profession(s).

MAY A PHYSICIAN PRACTICE MEDICINE WITHIN A PARTNERSHIP OR SERVICE CORPORATION?

Wisconsin Stat. § 448.08(4) provides that two or more physicians may, in the practice of medicine and surgery, enter into professional partnerships or service corporations. Please see Wis. Stat. § 448.08 concerning business practices for physicians and if additional guidance is necessary, you may wish to consult private counsel.

WHAT ARE THE DISCLOSURE REQUIREMENTS FOR A PHYSICIAN WHO SELF-IDENTIFIES AS "BOARD CERTIFIED"?

Wisconsin Admin. Code § MED 10.02(w) requires truthful disclosure of any claim to board certification or similar phrase. If a physician--by affirmative conduct or by omission--misrepresents themselves as board certified in a particular specialty area, by a particular certifying organization or without current certification, the Board may determine that the physician has engaged in unprofessional conduct and the physician may be subject to disciplinary action.

WHAT IS THE LENGTH OF TIME THAT A PHYSICIAN IN WISCONSIN MUST RETAIN PATIENT MEDICAL RECORDS?

Wisconsin Admin. Code § MED 21.03, Minimum Standards for Patient Health Care Records, requires that a physician or a physician's assistant shall maintain patient health care records for a period of not less than five (5) years after the date of the last entry, or for such longer period as may be otherwise required by law. Wisconsin Stat. § 146.819 also concerns preservation or destruction of patient health care records.

ARE SILICONE INJECTIONS LEGAL IN WISCONSIN?

There is no statutory or administrative code that specifically prohibits the use of silicone injections. While the U.S. Food and Drug Administration banned silicone injections in 1992, there may be recent developments in technology and the practice of medicine that were not addressed in the 1992 ban. Physicians must not engage in any practice or procedure that violates state or federal law or that falls below the level of minimal competence and creates an unacceptable risk of harm. Physicians may wish to consult private counsel if they have any question concerning legality of any medical device or medication.

MAY A PHYSICIAN DELEGATE TO AN UNLICENSED PERSON DISPENSING OF SAMPLE MEDICATIONS TO A PATIENT?

Yes, a physician may delegate an unlicensed person to dispense sample medications to a patient subject to legal requirements, including controlled substances and record-keeping requirements. See general requirements for physician delegation in FAQ No. 1 and the rule concerning prescribing at Wis. Admin Code ch. MED 17.

WHERE MAY ONE FIND GUIDANCE ON PHYSICIAN DISPENSING OF MEDICATIONS?

In addition to Wis. Stat chs. 448 and 961, persons with questions concerning physician dispensing of medication may wish to consult Wisconsin Admin. Code ch. MED17, as well as PHAR ch. 8. Another relevant resource is the United States Drug Enforcement Administration's Practitioner's Manual which is available online at:

www.deadiversion.usdoj.gov/pubs/manuals/pract/index.html

DOES WISCONSIN RECOGNIZE NATUROPATHIC DOCTORS?

Wisconsin law does not recognize naturopathic physician education and training. A doctor that is registered and licensed as a naturopathic physician in another state is not qualified for licensure as a physician in Wisconsin unless he or she meets the licensure requirements set forth in Wis. Ch. 448 and Wis. Admin. Code ch. MED 1.

WHAT ARE THE REQUIREMENTS FOR MAINTAINING A VALID WISCONSIN MEDICAL LICENSE AFTER RETIRING OR OTHERWISE VOLUNTARILY REFRAINING FROM THE ACTIVE PRACTICE OF MEDICINE?

Maintaining a medical license requires a renewal fee and completion of 30 hours of biennial continuing medical education. See Wis. Admin. Code chs. MED 13 and 14. Wisconsin law does not authorize a license specifically for retired or inactive physicians. To maintain a license to practice medicine and surgery all requirements for full licensure must be met, including fees and biennial continuing education.

In deciding whether or not to allow a medical license to lapse during any period of inactivity, physicians may wish to review Wis. Admin. Code § MED 1.06(1)(a)11, which permits the Board to require an oral examination prior to issuing or reinstating the license of any physician who, prior to application, has not engaged in practice for a period of three years or more. At oral examination, the Board can be expected to inquire about activities the physician has undertaken to maintain professional competence. The Board may require additional competency evaluation, or training—including a residency—or both, prior to permitting the inactive physician to become licensed.

MAY WISCONSIN PHYSICIANS PRESCRIBE EITHER NON-CONTROLLED OR CONTROLLED SUBSTANCES FOR THEMSELVES OR THEIR FAMILY MEMBERS?

Wisconsin Stat. § 961.38(5) criminalizes self-prescribing of controlled substances as well as the act of taking a controlled substance without a valid prescription.

Wisconsin law does not explicitly prohibit self-prescribing of non-controlled substances, nor prescribing medications for family members. Despite the absence of specific statutory prohibitions, the Board may consider whether the circumstances of any particular prescription constitute unprofessional conduct under Wis. Admin. Code § 10.02(2)(h)(contrary to minimally competent practice and creating an unacceptable risk of harm to the physician or family member). Finally, physicians should consider whether prescribing controlled substances to a family member comports with requirements of the federal Drug Enforcement Administration (DEA).

In addition to insuring patient safety, physicians are responsible for all other requirements of competent and lawful practice, including but not limited to record keeping as required in Wis. Stat. § 146.816 and Wis. Admin. Code ch. 21.

HAS THE WISCONSIN MEDICAL EXAMINING BOARD ADOPTED SPECIFIC GUIDELINES FOR PHYSICIANS WHO ARE TREATING CHRONIC PAIN OR PRESCRIBING CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN?

No, the Board has not officially adopted or issued any specific guidelines *per se*; however, the Board has indicated that if a physician follows the Model Guidelines for Use of Controlled Substances for Treatment of Pain adopted by the Federation of State Medical Board (FSMB), the physician would be practicing within the standard of care of a competent physician.

The current FSMB guidelines can be referred to by clicking [here](#).

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Nicholas Tank		2) Date When Request Submitted: 8/27/2013 <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: 9/18/2013	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? Fall Newsletter – Discussion	
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: Discussion on the Fall Newsletter for the Medical Examining Board			
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: <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. 			

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3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 9/18/2013	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? Permission to Attend the 2013 Wisconsin Radiological Society (WRS) Fall Board Meeting. Presentation on "Recent Changes in MED 10 and Licensing Updates" – Saturday, November 2, 2013 – [REDACTED]	
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: [REDACTED] requires permission from the board to attend the 2013 Wisconsin Radiological Society (WRS) Fall Board Meeting for their presentation on "Recent Changes in MED 10 and Licensing Updates" on Saturday, November 2, 2013			
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.			

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From: Simons, Kenneth [<mailto:ksimons@mcw.edu>]
Sent: Wednesday, August 14, 2013 5:59 PM
To: Pamela Huffman (FSMB); Ryan, Thomas - DSPS
Cc: Gregory Snyder, MD
Subject: RE: INQUIRY RE: 2014 FSMB member board visit_WI
Importance: High

I absolutely think we can accomplish this in 2014. Mr. Ryan and I will look for a suitable date. We will let you know re: dinner.

Best regards,

Ken

Kenneth B Simons, MD
Interim Senior Associate Dean for Academic Affairs
Associate Dean for Graduate Medical Education and Accreditation
Executive Director and DIO MCWAH
Medical College of Wisconsin
Phone: 414-955-4577
Fax: 414-955-6528

In the time of your life, live - so that in that wondrous time you shall not add to the misery and sorrow of the world, but shall smile to the infinite variety and mystery of it." William Saroyan

Confidentiality Notice: This e-mail message, including any attachments, is for the sole use of the intended recipient and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

From: Pamela Huffman (FSMB) [<mailto:phuffman@fsmb.org>]
Sent: Tuesday, August 13, 2013 4:04 PM
To: Simons, Kenneth; Thomas Ryan
Cc: Gregory Snyder, MD
Subject: INQUIRY RE: 2014 FSMB member board visit_WI

Good afternoon Dr. Simons:

I am following up with you today regarding your recent communication with Dr. Greg Snyder, who serves as the Liaison Director to your Board.

As you know, the FSMB makes every effort to schedule a face-to-face visit with our member boards on a three-year rotation, or sooner should a Board's circumstances warrant the same. Our records indicate our last visit with the *State of Wisconsin Dept of Safety & Professional Services* was January 19, 2011 when Drs. Galicano Inguito and Humayun Chaudhry attended your board meeting.

Do you feel scheduling a visit during one of your 2014 board meetings will be possible?

The FSMB representatives will include Dr. Snyder, or another member of our board of directors if a scheduling conflict is encountered, accompanied by a member of our executive staff.

The FSMB presentation takes approximately one hour, including time for questions/discussion. Topics would include any requested issues currently facing your Board as well as pertinent FSMB updates.

In addition, being cognizant of your ethics regulations, perhaps an informal FSMB-hosted dinner the evening before the meeting could be scheduled.

I would certainly appreciate your thoughts on the possibility of scheduling a site visit and look forward to hearing from you. Please do not hesitate to contact me if you have any questions.

Warmest regards,
Pam

Pamela Huffman
Executive Administrative Assistant
Leadership Services

Federation of State Medical Boards
400 Fuller Wiser Road | Suite 300 | Euless, TX 76039
817-868-4060 direct | 817-868-4258 fax
phuffman@fsmb.org | www.fsmb.org



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

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3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 9/18/2013	5) Attachments: <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? Federation of State Medical Boards Nominations – Discussion and Consideration	
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 Federation of State Medical Boards requires nominations of Candidates for Elective Office and is extending this opportunity to the Wisconsin Medical Examining Board. It has provided an informational item for the Board to review and consider to this end.			
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.			

INSTRUCTIONS FOR RECOMMENDING CANDIDATES FOR NOMINATION TO FSMB ELECTED POSITIONS

Eligibility

Any person who is or will be a Fellow of the FSMB **at the time of the election on April 26, 2014** is eligible for nomination. The Bylaws of the FSMB define Fellows as: *An individual member who as a result of appointment holds full time membership on a Member Medical Board shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of 36 months thereafter.*

Core Competencies of Candidates

A candidate for elective office should:

- Support the vision, mission, values and strategic goals of the FSMB;
- Possess a positive outlook on the role and function of state medical boards in the medical regulatory field;
- Bring a broad, national perspective to specific issues;
- Have adequate time and commitment necessary to fulfill the responsibilities of the office (*please see attached "Responsibilities of Elected Positions"*);
- Demonstrate personal integrity.

Letter of Recommendation - Contents

The letter of recommendation to the Nominating Committee should specify (1) the name of the candidate to be considered; (2) the office for which the candidate is being recommended; (3) a description of the candidate's ability to demonstrate the core competencies as stated above; (4) the candidate's agreement to the submission of his/her name for potential nomination; (5) the candidate's affirmation that he/she is aware of the time commitment required for the position to which he/she may be elected; and (6) the candidate's mailing address, daytime telephone number, fax number and email address.

Attachments to Letter of Recommendation

The following materials should accompany the letter of recommendation:

1. **Candidate's General Information Questionnaire (attached).** In the interest of uniformity and fairness to all candidates, the Nominating Committee requests that the information contained on the Candidate's General Information Questionnaire be limited to the space provided, *except where otherwise stated.*
2. **Signatory Form (attached).** The candidate must submit a signed confirmation that the candidate 1) will be a Fellow as defined by the FSMB Bylaws at the time of the election on Saturday, April 26, 2014; 2) is aware of the time commitment required for the position to which he/she may be elected; and 3) is disclosing any potential conflict(s) of interest.
3. **Candidate's photograph – color or black/white.** Copies of the photos will be included in the Nominating Committee meeting agenda book. If the nominee is selected, the photos will also be used in the Election Manual that is distributed at the Annual Meeting and placed on the Candidates Website. **Questions regarding photos should be directed to David Hooper, Sr. Director of Marketing, at 817-868-4070 or dhooper@fsmb.org.**
4. **Personal statement by the candidate (sample attached) – in WORD version no greater than 500 words.** The candidate should state why he/she wants to serve in the particular position in which he/she will be campaigning for election; how he/she fulfills the core competencies of candidates, and what he/she will contribute to FSMB. The personal statement will be included in the Election Manual and placed on the Candidates Website.

5. *Electronic* copy of the candidate's curriculum vitae (CV) (a maximum of five pages) and a one-page bio or summary CV. Please provide relevant information including important appointments, honors and awards received, etc. **Please note that these documents will be published on the Candidates Website; therefore, social security numbers and all other private information must be removed prior to forwarding with letters of recommendation.**

Deadline for Submission of Letters and Materials

The members of the Nominating Committee request that all recommendations for nominations be submitted in writing by mail, fax or email to:

Lance A. Talmage, MD, Chair
Nominating Committee
c/o Pat McCarty, Director of Leadership Services
Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Euless, TX 76039-3855
Fax: (817) 868-4167
Email: pmccarty@fsmb.org

The National Office should receive letters and accompanying materials by **January 6, 2014**. **No nominations will be accepted after January 6.**

A confirmation acknowledging receipt of nominations will be sent within one week. If you do not receive confirmation, please contact Pat McCarty at (817) 868-4067 or at the email above.

RESPONSIBILITIES OF ELECTED POSITIONS

Board of Directors

The FSMB Board of Directors is responsible for the control and administration of the FSMB and reports to the House of Delegates; the Board provides leadership in the development and implementation of the FSMB's Strategic Goals and the Board's Annual Action Plan; the Board is responsible for governing and conducting the business of the corporation, including supervising the President/CEO; and, under the leadership of the Chair and President/CEO, represents the FSMB to other organizations and promotes recognition of the FSMB as the premier organization concerned with medical licensure and discipline. The Board of Directors is the fiscal agent of the corporation.

GENERAL RESPONSIBILITIES

The Board of Directors is responsible for the following:

1. Set goals, objectives and priorities necessary to achieve the FSMB Strategic Goals.
2. Set goals, objectives and critical success factors for the President/CEO.
3. Ensure effective management of the FSMB's financial resources.
4. Approve systems for assessing and addressing needs of member boards.
5. Implement adopted Board of Directors professional development and self-assessment plans.
6. Promote use of FSMB services among targeted customer groups.
7. Enhance communication with and among member boards.
8. Enhance support and education for member board executives and their staff.

TIME COMMITMENT

The Board of Directors will meet five times during the 2014-2015 fiscal year:

April 27, 2014 – Denver, CO (immediately following the Annual Meeting)

July 2014 – site and actual dates TBD

October 2014 – Washington, DC and actual dates TBD

February 2015 – site and actual dates TBD

April 21-26, 2015 – Fort Worth, TX (in conjunction with the Annual Meeting)

Newly elected directors will also be asked to participate in a New Directors Orientation scheduled June 1-2, 2014 at the FSMB Eules, TX Office.

The dates above include travel days.

Nominating Committee

COMMITTEE CHARGE

The charge of the Nominating Committee as currently set forth in the FSMB Bylaws is to submit a slate of one or more nominees for each of the offices and positions to be filled by election at the Annual Meeting of the House of Delegates. The Committee will mail its slate of candidates to Member Boards not fewer than 60 days prior to the meeting of the House of Delegates.

Tasks of the Committee include:

1. Soliciting recommendations for candidates for elected positions from Member Boards and Fellows of the FSMB.
2. Assertively recruiting individuals who have the core competencies set forth on page 2 and who represent diversified backgrounds, experiences and cultures.
3. Educating potential candidates on core competencies for FSMB leadership roles and the responsibilities associated with respective leadership positions.
4. Reviewing letters of recommendation and supporting material of each individual nominated or recruited as a candidate for election.
5. Verifying that candidates have the core competencies for FSMB leadership positions.
6. Verifying that queries of FSMB Board Action Data Bank have been completed on physician candidates and that no actions have been reported which could call into question an individual's fitness for FSMB leadership.
7. Affirming that all candidates for elected leadership have disclosed any potential conflicts of interests.
8. Considering the importance of public representation on the FSMB Board of Directors and assuring the slate of candidates provides for election of adequate/qualified public representation.
9. Selecting and narrowing the slate of candidates to those who best demonstrate the core competencies; have the necessary qualifications and eligibility for a position; and bring valuable talents and perspectives to the FSMB.
10. Preparing a report to the House of Delegates that includes a slate of nominees for positions to be filled by election at the House of Delegates annual business meeting.
11. Determining process for notifying candidates of the Nominating Committee's decisions as soon as possible following the Committee meeting and providing the Nominating Committee report the FSMB Board of Directors.

TIME COMMITMENT

Members of the Nominating Committee serve two-year terms. The Committee will have its kick-off session in Denver, CO on the morning of Sunday, April 27, 2014 directly after the FSMB's Annual Meeting. The Committee will meet again via teleconference in July 2014 (date to be determined) and at the FSMB Eules, TX Office in January 2015.

CANDIDATE'S GENERAL INFORMATION QUESTIONNAIRE

*PLEASE TYPE OR PRINT AND LIMIT YOUR INFORMATION TO THE SPACE PROVIDED
(except where otherwise stated)*

GENERAL

NAME: _____

CANDIDATE FOR: _____

MAILING ADDRESS: _____

DAYTIME TELEPHONE: _____

EMAIL AND/OR FAX: _____

EDUCATION

UNDERGRADUATE: _____

MEDICAL SCHOOL/GRADUATE SCHOOL: _____

POSTGRADUATE EDUCATION: _____

CURRENT POSITION: _____

AREA OF SPECIALIZATION: _____

FEDERATION ACTIVITIES

BOARD and/or COMMITTEES: _____

OTHER FSMB ACTIVITIES: _____

CANDIDATE SIGNATORY PAGE

STATE MEDICAL BOARD ACTIVITIES

On which state medical board are you currently serving?

If not serving, when did you leave the board? Month _____ Day _____ Year _____

How long have you served (did you serve) on your state medical board?

- I will be a Fellow as defined by the FSMB Bylaws at the time of the election on Saturday, April 26, 2014 and understand that only an individual who is a Fellow at the time of the individual's election shall be eligible for election. The Bylaws of the FSMB defines Fellow as:
An individual member who as a result of appointment holds full time membership on a Member Medical Board shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of 36 months thereafter.
- I am aware of the time commitment for the position I wish to be elected.
- I am disclosing any potential conflict(s) of interest.

SIGNATURE: _____

Potential Conflict(s) of Interest

SAMPLE PERSONAL STATEMENT [500 words or less]

Please provide this document in WORD format

NAME: _____

CANDIDATE FOR: [Chair-elect, Board of Directors or Nominating Committee]

[SAMPLE TEXT – please describe your own experiences using your own words]

I am a candidate for [elective office]. Since beginning my medical career in a small rural town over 20 years ago, I have been involved in professionalism and upholding the higher standards of being a physician. Currently, I am the Chairman of the Department of [specialty] at the School of Medicine in [city].

My experiences with medical licensure began in the 90's when I was appointed to the advisory committee for athletic trainers of the [state medical board]. Subsequently, I was appointed as a member of the [state medical board] in 2009. I was elected Vice President in 2010 and have been serving as President since 2011.

Since being appointed to the [state medical board], I have been serving the [state medical board] in a number of capacities, which have included [committee/workgroups, etc.].

Additionally, I have worked as [other professional experiences and associations].

It is with great anticipation that I am running for [elective office]. I have the energy, enthusiasm and experience to represent the FSMB. My qualifications are broad and strong, which will allow me to function well within a system that is focused on licensure, discipline and protection of the public.

FEDERATION OF STATE MEDICAL BOARDS
Responsibilities of Appointed Positions

Audit Committee

COMMITTEE CHARGE

The primary charge of the Audit Committee, as currently set forth in the FSMB Bylaws, Article VIII, Section B, is to review the audit of the corporation and the accompanying financial statements.

Tasks of the Committee include:

1. Reviewing the auditor's report with particular attention to material deficiencies and recommendations.
2. Reviewing the annual Statement of Financial Position, Statement of Activities and Statement of Cash Flows resulting from the audit process.

TIME COMMITMENT

Members of the Audit Committee serve one-year terms. Due to advances in technology and common practice of audit committees within the U.S., the Audit Committee traditionally meets via teleconference two to four times during the year, with the potential for one face-to-face meeting.

Bylaws Committee

COMMITTEE CHARGE

The charge of the Bylaws Committee, as currently set forth in the FSMB Bylaws, Article VIII, Section C, is to continually assess the Articles of Incorporation and the Bylaws and receive all proposals for amendments thereto. The Committee will, from time to time, make recommendations to the House of Delegates for changes, deletions, modifications and interpretations to the Bylaws.

Tasks of the Committee include:

1. Receiving requests for amendments or revisions from the Board of Directors or from Member Boards. Upon receiving requests, the Committee drafts Bylaws language that is appropriate in style and placement. The Bylaws Committee members may also propose amendments or revisions to the Bylaws, and draft language that is appropriate for inclusion.
2. Advising the House of Delegates with regard to each modification they have drafted, citing in their report to the House their choice to support, oppose or remain neutral regarding the language they have drafted. Members of the Committee may give testimony in support of their position before a Reference Committee.
3. Interpreting the Bylaws upon request of the Board of Directors, Member Boards or others.
4. Reviewing the Bylaws and Articles of Incorporation on a continual basis.

TIME COMMITMENT

Members of the Bylaws Committee serve one-year terms. The Committee will meet once by teleconference or as many times as is needed.

Editorial Committee

COMMITTEE CHARGE

The charge of the Editorial Committee, as currently set forth in the FSMB Bylaws, Article VIII, Section D, is to advise the Editor-in-Chief on editorial policy for the FSMB's official publication (*Journal of Medical Regulation*) and otherwise assist the Editor-in-Chief in the performance of duties as appropriate and necessary.

Tasks of the Committee include:

1. Reviewing all articles submitted for publication in a timely manner.
2. Supplying the names of at least two authors (four is preferred) who are able to write an article(s) for the *Journal*.
3. Writing or working with the *Journal* Editor-in-Chief to create an editorial for the *Journal*.
4. Serve as ongoing ambassadors for the *Journal* during any appropriate business meetings or discussions with colleagues — distributing the PDF Call for Papers in printed or electronic form whenever and wherever appropriate.

TIME COMMITMENT

Members of the Editorial Committee serve three-year terms. The Committee will meet once each year at FSMB headquarters or other location and will also meet via teleconference two to four times each year. The Committee will also be asked to read manuscripts throughout the year.

Education Committee

COMMITTEE CHARGE

The charge of the Education Committee as currently set forth in the FSMB Bylaws, Article VIII, Section E is to assist in the development of educational programs for the FSMB. This includes the Annual Meeting program as well as webinars, teleconferences and other educational offerings.

Tasks of the Committee include:

1. Providing consultation and recommendations in the development and review of the FSMB's annual education agenda.
2. Identifying and prioritizing educational topics in accordance with the mission, vision, core values and goals of the FSMB.
3. Evaluating education trends and opportunities to provide quality educational programming to FSMB membership.

TIME COMMITMENT

Members of the Education Committee serve one-year terms. The Committee will meet several times per year either in person or via teleconference. The frequency of regular meetings will be determined by need, but will occur at least quarterly.

Ethics and Professionalism Committee

COMMITTEE CHARGE

The charge of the Ethics and Professionalism Committee as currently set forth in the FSMB Bylaws, Article VIII, Section F is to address ethical and professional issues pertinent to medical regulation.

Tasks of the Committee include:

1. Addressing ethical and/or professional concerns expressed by state medical boards.
2. Researching data pertinent to the issues and/or obtaining input from experts in the particular subject areas being considered.
3. Developing model policies for use by state medical boards to be submitted for approval by the FSMB House of Delegates.

TIME COMMITMENT

Members of the Ethics and Professionalism Committee serve one-year terms. The Committee will meet several times per year either in person or via teleconference. The frequency of regular meetings will be determined by need.

Finance Committee

COMMITTEE CHARGE

The charge of the Finance Committee as currently set forth in the FSMB Bylaws, Article VIII, Section G is to review the financial condition of the FSMB, review and evaluate the costs of the activities and/or programs to be undertaken in the forthcoming year, and recommend a budget to the Board of Directors for its recommendation to the House of Delegates at the Annual Meeting, and perform such other duties as are assigned to it by the Board of Directors.

Tasks of the Committee include:

1. Assessing prior financial performance in comparison to budget.
2. Reviewing the draft budget for alignment with organizational goals, programs and services.
3. Approving the budget for recommendation to the Board of Directors.

TIME COMMITMENT

Members of the Finance Committee serve one-year terms. The Committee will meet several times per year either in person or via teleconference. The frequency of regular meetings will be determined by need.

Special Committees

Special Committees are appointed by the Chair as necessary and are established for a specific purpose. Special Committees usually meet three times per year, in person and via teleconference, and continue their work for about two years. Special Committees for 2014-2015 are to be determined.

From: Ryan, Thomas - DSPS
Sent: Tuesday, September 03, 2013 8:25 AM
To: Tank, Nicholas - DSPS
Subject: FW: Request for letter of Recommendation to the FSMB Nominating committee 7 endorsement of Wisconsin MEB

Hello Nick: Please add this e-mail and the attachments to the next MEB agenda with the FSMB appointment materials. Thanks.

From: Sridhar Vasudevan [<mailto:drsivasudevan@gmail.com>]
Sent: Monday, September 02, 2013 8:52 PM
To: 'Simons, Kenneth'; Ryan, Thomas - DSPS
Cc: drsivasudevan@gmail.com
Subject: Request for letter of Recommendation to the FSMB Nominating committee 7 endorsement of Wisconsin MEB

Dear Dr. Simons:

This is a follow up of my call to you in August.

I have, sent in the information to the Federation of State Medical Boards (FSMB), to be considered by the FSMB nomination committee for the position of member of the Board of Directors (BOD). I have sent them:

1. The "candidate's General Information Questionnaire
2. My Personal statement
3. A brief CV (maximum of five pages) and Biography

I am requesting:

1. A letter from you, as Chair a letter of recommendation supporting my candidacy.
2. This item be placed on the September agenda of the Wisconsin MEB—requesting the Board endorse my candidacy
3. Any advice -- from either of you.

The letter of recommendation to the nominating committee (according to directions from FSMB), should specify:

1. The name of the candidate to be considered (Sridhar V. Vasudevan, M.D.)
2. The office for which the candidate is recommended (Member of the FSMB Board of Directors)
3. A description of the candidate's ability to demonstrate 'core competencies' (Support the vision, mission, values & strategic goals of FSMB; Possess a positive outlook on the role and function of state medical boards in the medical regulatory field; Bring a broad, national perspective to specific issues; Have adequate time and commitment necessary to fulfill the responsibilities of the office AND Demonstrates personal integrity.)
4. The candidate's agreement to the submission of his name for potential nomination (yes, I am in agreement),
5. The candidate's affirmation that he is aware of the time commitment required for the position to which he may be elected (I am aware and have the time to commit to this position); and

6. The candidate's mailing address, daytime telephone number and email address.

I have attached both my "Brief CV" that I sent to the FSMB and the Long CV-that gives you an understanding of my past and current academic, clinical and leadership activities. I have read the "Responsibilities of Elected Position"-and believe that I have the time, passion, national and local perspective and the motivation to serve in this role, if nominated and elected. I am in agreement to have my name submitted for the nomination to the position as member of the BOD of FSMB. I understand and affirm that I have the time to meet the commitments of this position. My address and contact information are given below-but are included in the brief CV , as well.

Please call me if you have any questions. Sheldon Wasserman, M.D., the past chair of Wisconsin MEB, now serves on the FSMB nominating committee and has encouraged me to place my name for this nomination and has agreed to be supportive.

I hope, the Board and you would endorse me for this position and you will write a letter supporting this nomination. I am requesting Mr. Thomas Ryan, place this on the future agenda of our MEB meeting.

Thank you in advance.

Sridhar V. Vasudevan, M.D.
drsivasudevan@gmail.com

P.O. Box 240860
Milwaukee, Wisconsin 53224

Tel: 262-285-3888

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Joshua Archiquette		2) Date When Request Submitted: 9/6/13 <small>Items will be considered late if submitted after 4:30 p.m. and less than 8 work days before the meeting.</small>	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 9/18/2013	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Informational Items Maintenance of Licensure	
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? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Informational item for the Board's consideration.			
11) Authorization			
Joshua Archiquette		9/6/13	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive 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 Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

Maintenance of licensure moving forward

By [Jon H. Sutton](#)

PUBLISHED July 1, 2013 • [Print-Friendly](#)

For many years, the Federation of State Medical Boards (FSMB) has been actively pursuing the development of a maintenance of licensure (MOL) program. Numerous committee and stakeholder meetings have centered on the concept and how the state medical boards can take it from the theoretical to the implementation level. Because licensure is critical to surgical practice, it is important that surgeons have some understanding of how changes in licensing are likely to affect them in the coming years, or at least what they may have to do to maintain licensure.

Many physicians may not yet know what MOL is or why it is necessary, as they may have heard or read only generalities about the topic. With that in mind, this article presents a more in-depth overview of MOL.

Describing MOL

Simply stated, MOL is a process by which licensed physicians periodically provide, as a condition of license renewal, evidence that they are actively participating in a program of continuous professional development. This activity should be relevant to areas of practice, measured against objective data sources, and aimed at improving performance over time.*

According to the FSMB, the rationale for developing and implementing a MOL system is an outgrowth of the health care system's evolving emphasis on improving patient safety and quality outcomes. Continuous quality improvement has become a staple of policymakers, especially with the adoption of health system reform. In addition, state medical boards have long recognized their responsibility to protect the public and promote quality health care by ensuring that only qualified individuals receive a license to practice medicine and deliver health care.†

Status of MOL

In 2010, the FSMB House of Delegates adopted a framework for MOL. Under this paradigm, physicians would periodically provide evidence of participation in professional development and lifelong learning activities based on the general competencies model: medical knowledge, patient care, interpersonal and communication skills, practice-based learning and improvement, professionalism, and systems-based practice.

Three major components of effective lifelong learning are included in this framework:

- Reflective self-assessment through which physicians participate in an ongoing process of self-evaluation and practice assessment with subsequent successful completion of tailored educational or improvement activities
- Assessment of knowledge and skills, which calls for physicians to demonstrate the knowledge, skills, and abilities necessary to provide safe, effective patient

care within the framework of the general competencies as they apply to their individual practice

- Performance in practice, meaning physicians should demonstrate accountability for their performance using a variety of methods that incorporate reference data to evaluate their practices and guide improvement*

The FSMB adopted five guiding principles to further assist in the development of MOL. Based on these guidelines, MOL should do the following:

- Support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
- Demonstrate administrative feasibility and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards.
- Avoid compromising patient care or creating barriers to physician practice.
- Offer flexible support for physician compliance with MOL requirements and provide options for meeting requirements.
- Balance transparency with privacy protections.‡

Every time a new program or process affecting physicians is discussed, legitimate concerns are expressed regarding compliance, such as whether the new system will create additional practice burdens, and so on. To address some of these concerns, the FSMB came up with a list of explanatory comments to reassure physicians that MOL is not intended to impose an additional level of regulatory bureaucracy, which includes the following:

MOL is being constructed in a way that is carefully integrated and coordinated with activities of other organizations. The FSMB is working closely with the American Board of Medical Specialties, which administers the Maintenance of Certification (MOC) program for physicians; however, MOC will not be required as a part of the future MOL system. Similarly, Osteopathic Continuous Certification (OCC) will not be required for MOL. The three systems are independent. The FSMB is recommending, however, that physicians engaged in MOC or OCC be recognized as being in "substantial compliance" with the three MOL components: reflective self-assessment, assessment of knowledge and skills, and performance in practice.

MOL is being constructed in a way that minimizes additional burdens for physicians. It will not mandate a high-stakes examination as a part of its structure. For physicians who are not board-certified in a medical or surgical specialty and, therefore, not engaged in MOC or OCC, the FSMB will help identify activities that could satisfy MOL.

MOL is being constructed in a way that takes into account the wide variation in clinical activity among physicians. Licensed physicians in the U.S. include professors, executives of health care organizations, policymakers, and other individuals who are part of a broad spectrum of professional niches. In recognition of the diversity in physicians' professional endeavors, the FSMB is working with health care organizations to create a system that fairly evaluates and assesses the activities of all licensed physicians. Many kinds of professional activities outside of clinical practice may be acceptable for MOL and are being evaluated.‡

These assurances are very important to physicians. One early critique of MOL was that it would result in a significant increase in regulatory burdens, especially for physicians already working hard to keep up with MOC requirements.

Ultimately, it will come down to how state medical boards choose to implement MOL, and at this stage of the process, it seems these boards have little interest in further complicating the licensure process by imposing additional burdens on licensees or on themselves.

Going forward

It will be a while before an MOL system is implemented. The FSMB is currently working with a few state medical boards on MOL pilot projects, and the results will be critical in determining how to roll out the program. One suggestion calls for MOL to be implemented in phases based on the major components of lifelong learning as previously described, starting with reflective self-assessment, then adding assessment of knowledge and skills, and finally including performance in practice, which may be the most difficult of the three to demonstrate and evaluate.

In the meantime, the FSMB has posted a useful [MOL resource Web page](#). The site provides fact sheets, federation reports, and other items and will provide updates over time on MOL implementation.

Of particular interest to surgeons may be [FSMB Board Report 11-3: Report of the MOL Implementation Group](#). In Attachment B of the report is a suggested toolbox for implementation of MOL along with a description of the professional development programs and activities for the three major components of lifelong learning, such as continuing medical education, participation in registries, use of self-assessment tools, and so on. With access to these resources, along with the FSMB's sensitivity to realistic development of MOL requirements and processes, implementation should have limited impact on the practicing surgeon.

*Federation of State Medical Board. Maintenance of licensure: Frequently asked questions. Available at: www.fsmb.org/m_mol_faqs.html. Accessed April 26, 2013.

†Chaudhry H, Cain F, Stax M, Talmage L, Rhyne J, and Thomas J. The evidence and rationale for maintenance of licensure. J Med Reg. Available at: www.fsmb.org/pdf/mol-evidence-article.pdf. Accessed May 6, 2013.

‡Federation of State Medical Board. Maintenance of licensure: A special report. Available at: www.fsmb.org/pdf/mol-new-vision.pdf. Accessed April 26, 2013.

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

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4) Meeting Date: 9/18/13	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Informational Items State Medical Boards – Problem of Unnecessary Care and Treatment	
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? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
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State Medical Boards and the Problem of Unnecessary Care and Treatment

Carl F. Ameringer, PhD, JD

ABSTRACT: The overutilization of medical tests and procedures has been identified as an important reason for the high costs of health care in America. Because the problem of overutilization is so multifaceted and complex, detection has been uneven and deterrence has been erratic. Recognizing the increasing severity of the problem and the adverse effect that overutilization may have on patient safety and care, the medical profession in recent years has increased its efforts to curtail excess treatment. Several national specialty societies, for example, have identified certain tests and procedures that may be unnecessary or overused, and they have disseminated their findings to physicians and patients. The question that this article seeks to address is what role state medical boards should have in reducing unnecessary care and treatment. This article argues that state medical boards, congruent with their mission of public protection, should enhance their oversight, detection, and regulation in this area. Professional ethics and specialty society guidelines could provide the basis for disciplining persistent and egregious offenders.

Sounding an alarm, the Institute of Medicine (IOM) in a September 2012 report called upon the health care community to reduce wasteful and unnecessary spending on health care services.¹ The cause for concern was an estimated \$750 billion loss in 2009, or about 30% of that year's total spending. Pointing to the complexity of the nation's health care system, the IOM contended that the responsibility for addressing the problem "rest[ed] on many shoulders," and that a concerted effort involving payers of health care, individual and institutional providers, consumers, and regulators was needed. Among those that the IOM singled out for assistance were state licensing boards.

The IOM's inclusion of state licensing boards was unusual. Recent efforts to reduce waste and duplication have focused on system-building—organizational integration, data infrastructure, workforce collaboration, and patient-centered care. While these largely systemic approaches to health care delivery should reduce wasteful spending, such measures do not directly address individual accountability for overutilization. Because the health care industry is so labor intensive and because patient care is often episodic and idiosyncratic, the cumulative decisions of physicians can influence the total cost of health care delivery substantially. Doctors, in other words, are important to containing costs in America.

For at least two reasons, state medical boards should embrace the IOM's challenge and join with other groups and organizations that seek to reduce wasteful spending. First, as noted, about 30% of all

health care costs in the United States can be attributed to wasteful spending, much of it on out-patient medical services, a cost component that can be tied closely to physicians' treatment decisions. Second, the overutilization of diagnostic tests and surgical procedures increases the risk of infections, diseases, complications, and poor patient outcomes. This is a matter of public protection.

THE CUMULATIVE DECISIONS OF PHYSICIANS CAN INFLUENCE THE TOTAL COST OF HEALTH CARE DELIVERY SUBSTANTIALLY.

Though state licensing boards can discipline physicians for unprofessional conduct, only thirteen boards have an explicit disciplinary provision in their medical practice acts or statutes that pertains to unnecessary care and treatment. These states are Alabama, Arkansas, California, Colorado, Florida, Kansas, Maryland, Missouri, New Mexico, New York, North Dakota, Vermont, and Wyoming (Table 1). Yet, boards in these states infrequently apply such provisions to offending physicians. Of those that publish their results online, only California, Florida, Missouri, and Vermont regularly appear to discipline licensees for overutilization.²

There are practical reasons for state boards' reluctance. These include difficulties in determining precisely what unnecessary care and treatment entails and in establishing or setting parameters for disciplinary action. Unlike most cases which require peer review to determine a breach of the standard

of care, doctors' technical skills may not be at issue. Because unnecessary care and treatment is so widespread, moreover, boards likely will get pushback from physicians who may view such oversight as anticompetitive.

Notwithstanding these and other challenges, boards have a role to play in controlling the overutilization of health care services. Physicians who routinely order unnecessary tests or perform questionable procedures very likely harm their patients. In many such instances, disciplinary action would seem appropriate.

The High Cost of Medical Services in U.S. Outpatient Settings

Of the three main goals of health policy—increasing access to care, controlling costs, and enhancing quality—cost control clearly has emerged as *the* significant challenge of the twenty-first century.³ The spending gap between the United States and all other countries for which the Organization for Economic Co-operation and Development (OECD) collects data is quite large and is growing. Accounting

for inflation and purchasing power parity, total per capita health expenditures in the United States averaged \$356 in 1970, \$1,102 in 1980, \$2,851 in 1990, \$5,993 in 2003, and \$8,233 in 2010, almost double the amounts in recent years for the next closest spending nations.⁴

THE OVERUTILIZATION OF DIAGNOSTIC TESTS AND SURGICAL PROCEDURES INCREASES THE RISK OF INFECTIONS, DISEASES, COMPLICATIONS, AND POOR PATIENT OUTCOMES. THIS IS A MATTER OF PUBLIC PROTECTION.

Close examination of available OECD data for certain countries for the years 2003–2010 reveals that the United States exceeds spending levels in several provider categories, especially for outpatient medical services (Table 2). While the

Table 1
State Medical Boards with a Specific Disciplinary Provision for Unnecessary Care and Treatment

State Medical Board	Applicable Disciplinary Action
Alabama	Performance of unnecessary diagnostic tests or medical or surgical services
Arkansas	Persistent, flagrant over-charging or over-treating of patients
California	Repeated acts of clearly excessive...use of diagnostic procedures...use of diagnostic or treatment facilities
Colorado	Willful and repeated ordering or performance, without clinical justification, of demonstrably unnecessary laboratory tests or studies; the administration, without clinical justification, of treatment which is demonstrably unnecessary
Florida	Performing or attempting to perform...an unauthorized procedure or a procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition
Kansas	Performing unnecessary tests, examinations or services which have no legitimate medical purpose; charging an excessive fee for services rendered
Maryland	Grossly overutilizing health care services
Missouri	Willfully and continually overcharging or overtreating patients; willfully and continually performing inappropriate or unnecessary treatment, diagnostic tests or medical or surgical services
New Mexico	Excessive treatment of patients
New York	Ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient
North Dakota	A continued pattern of inappropriate care as a physician, including unnecessary surgery
Vermont	Consistent improper utilization of services; consistent use of nonaccepted procedures which have a consistent detrimental effect upon patients
Wyoming	Willful and consistent utilization of medical services or treatment which is inappropriate or unnecessary

Source: Ala. Code sec. 34-24-360 (11),(12); Ark. Code sec. 17-95-409(a)(2)(0); Cal. Code sec. 725-733(a); Colo. Code sec. 12-36-117(1)(bb)(l); Del. Code sec. 1731(b)(18); Fla. Stat. sec. 456.072(1)(bb); Ill. Medical Practice Act of 1987, 225 ILCS 60/22(A)(25); Kan. Stat. sec. 65-2836(aa); Md. Medical Practice Act HO, sec. 14-404(a)(18); Mo. Rev. Stats. 334.100(4)(a),(c); New Mex. Code sec. 16.10.8.8(E); New York Art. 131-A sec. 6530(35); N. Dak. Medical Practice Act sec. 43-17-31.21; Vermont Stats. chap. 23, sec. 1354(a)(16),(18),(19); Wy. Stats. 33-26-402(a)(xviii).

mean expenditure ratios for inpatient vs. outpatient care are 53:47 for Australia, 64:36 for France, 55:45 for Germany, and 50:50 for Japan, they are almost the reverse for the United States and Canada—30:70 and 39:61 respectively (Table 2). Yet, the United States spent \$759 more on inpatient services and \$3,018 more on outpatient services for each person on average than did Canada for the years indicated (Table 2).

What explains the huge gap between the United States and other countries in per capita spending for outpatient medical services? Opinions vary. They range from greater access to the latest technology in the United States to the higher incidence of chronic diseases, from overreliance on specialists

for primary care to greater costs and overhead, and from enhanced exposure to lawsuits for medical malpractice to fee-for-service payment practices and intense market competition.⁵ Combined, these factors significantly have influenced the practice of medicine in America.

Some recent studies have attempted to identify more precisely the distinguishing features or components of greater U.S. spending. According to a 2007 Congressional Research Service report, “intensity of service delivery,” by which the report’s authors mean “the amount of services used in a given health care encounter,” is a distinguishing feature.⁶ It is not the number of doctor-patient encounters that explains why the United States

Table 2
Per Capita Inpatient and Outpatient Medical Expenditures for Selected Countries, 2003–2010

	Year/s	Australia	Canada	France	Germany	Japan	United States
Inpatient Medical Expenditures <i>Measured in U.S. dollars, adjusted for purchasing power parity</i>	2003	919	523	902	832	699	1,171
	2004	980	536	930	864	722	1,231
	2005	1,031	557	980	912	759	1,294
	2006	1,100	586	1,027	970	791	1,355
	2007	1,176	603	1,073	993	838	1,408
	2008	1,209	626	1,124	1,051	885	1,441
	2009	1,289	686	1,175	1,127	927	1,486
	2010	—	711	1,191	1,171	—	1,519
Outpatient Medical Expenditures <i>Measured in U.S. dollars, adjusted for purchasing power parity</i>	2003	831	744	536	698	661	2,607
	2004	908	789	551	728	713	2,789
	2005	940	850	573	730	757	2,962
	2006	987	910	608	782	788	3,116
	2007	1,051	960	631	822	835	3,282
	2008	1,038	1,015	602	880	893	3,456
	2009	1,139	1,094	622	934	889	3,613
	2010	—	1,131	626	961	—	3,740
IP:OP*	2003–2010	53:47	39:61	64:36	55:45	50:50	30:70
IP Difference (US vs. Country)*	2003–2010	262	759	313	373	560	—
OP Difference (US vs. Country)*	2003–2010	2,473	3,018	2,915	2,752	2,965	—

Source: Organization for Economic Cooperation and Development. Health data 2011. U.S. dollars adjusted for purchasing power parity.

Definitions: Expenditure on in-patient care includes all expenditures on curative, rehabilitative, and long-term nursing care for in-patients. An in-patient is a patient who is formally admitted (or “hospitalized”) to an institution for treatment and/or care and stays for a minimum of one night in the hospital or other institution providing in-patient care. Expenditure on out-patient care comprises medical and paramedical services delivered to out-patients. An out-patient is not formally admitted to the facility (physician’s private office, hospital out-patient center or ambulatory-care center) and does not stay overnight. An out-patient is thus a person who goes to a health care facility for a consultation/treatment, and who leaves the facility within several hours of the start of the consultation without being “admitted” to the facility as a patient.

*All calculations are based on the mean for the given years.

spends more. Rather, it is the greater number of services provided — tests run and procedures performed — per encounter, combined with higher than average unit prices for these services. “The United States uses more of the newest technologies and performs several invasive procedures (such as coronary bypasses and angioplasties) more frequently than the average OECD country,” the report’s authors said.

BECAUSE UNNECESSARY CARE AND TREATMENT IS SO WIDESPREAD...BOARDS LIKELY WILL GET PUSHBACK FROM PHYSICIANS WHO MAY VIEW SUCH OVERSIGHT AS ANTICOMPETITIVE.

One way to measure the intensity of service delivery is to divide per capita expenditures by the number of times on average that patients see their doctors. Notwithstanding higher per capita costs in the United States, average annual physician consultations are significantly lower.⁷ This translates to a much

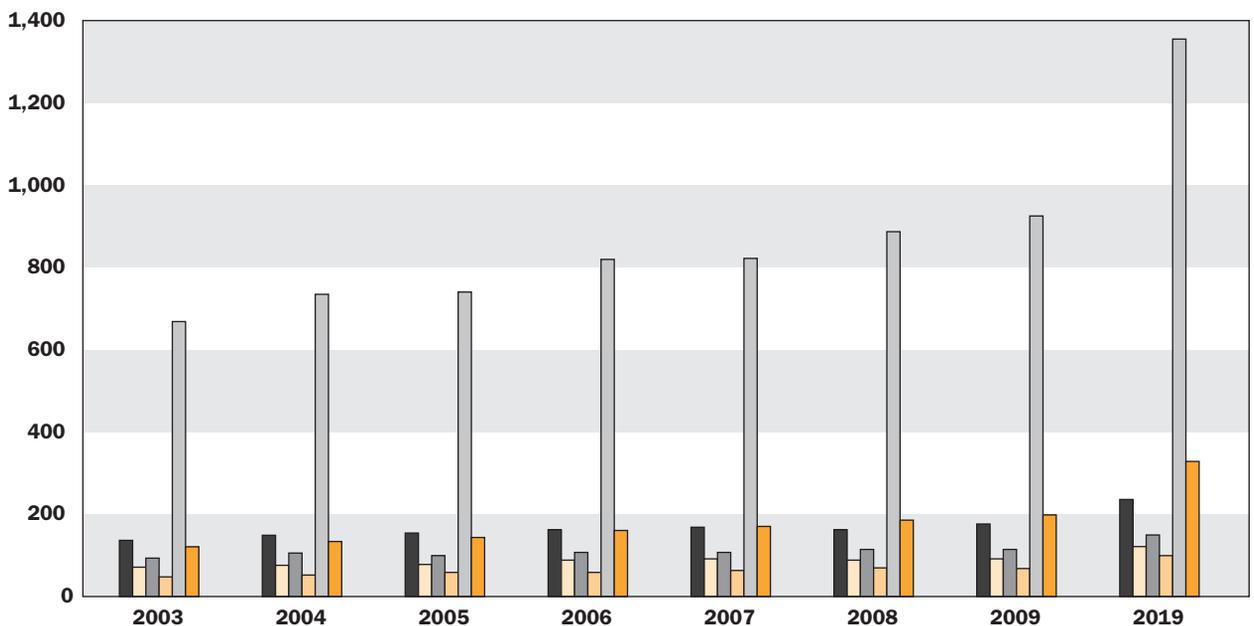
higher level of services per physician-patient encounter. Figure 1 displays the large difference between the United States and other nations as measured by service intensity.

The Threat to Patient Health and Safety

As the above findings demonstrate, U.S. doctors more frequently employ expensive tests and procedures to treat their patients than doctors in foreign countries. Does this mean that many U.S. doctors are over-treating their patients or that a substantial number are conducting unnecessary tests and procedures on them? “Yes,” say many analysts and observers.⁸

Leading health policy analysts Donald Berwick and Glenn Hackbarth estimate that between \$158 billion and \$226 billion of wasteful spending occurs each year because of overtreatment.⁹ Overtreatment, they say “comes from subjecting patients to care that, according to sound science and the patients’ own preferences, cannot possibly help them — care rooted in outmoded habits, supply-driven behaviors, and ignoring science.” Researchers Christine Cassel and James Guest agree with the assessment of Berwick and Hackbarth.

Figure 1
Intensity of Service Delivery (per capita U.S. dollars), 2003–2009, 2019*



Source: Organization for Economic Cooperation and Development. Health data 2011. US dollars adjusted for purchasing power parity.

Note: Per capita dollars reflect out-patient medical expenditures (see Table 2) divided by physician consultations for a given year. Physician consultations represent the number of contacts with an ambulatory care physician divided by the country population. Telephone contacts are excluded.

*Projections based on calculated rate of increase from 2003–2009.

“The initial focus” in reducing costs, Cassel and Guest assert, “should be on overuse of medical resources, which not only is a leading factor in the level of spending on health care but also places patients at risk.”¹⁰

Why do many doctors in the U.S. engage in wasteful spending practices, including the overutilization of health care services? As already mentioned, there are a number of compounding factors, many unique to America. Among these compounding factors, physicians frequently point to the threat of lawsuits to justify excessive tests and procedures. Fear of being sued is a legitimate concern, to be sure, but it should not obscure efforts to curtail unnecessary tests and procedures that enhance doctors’ income at the expense of their patients’ welfare.¹¹

Though monetary incentives always have existed, the medical profession before the 1970s exerted greater influence over practitioners’ economic behavior. For much of the twentieth century, the vast majority of doctors shared similar views, beliefs, and experiences, forging common bonds among them. Most belonged to the American Medical Association and their state and local medical societies; few breached norms of conduct concerning economic and social matters. Professional associations and state medical boards rarely had to take disciplinary action because informal sanctions, loss of referrals or even hospital privileges, were so consequential.¹² Professional norms, values, and ethics, as economist Kenneth Arrow noted in a famous article penned in 1963, checked physicians’ desires to profit at the expense of patients and fellow colleagues.¹³ “[T]here is a ‘collectivity-orientation,’ which distinguishes medicine and other professions from business, where self-interest on the part of participants is the accepted norm,” Arrow noted.

The commercialization of medical practice in recent years has attenuated these former countermeasures.¹⁴ Efforts of professional associations to reduce competition among physicians came under intense scrutiny in the late 1970s when policymakers, seeking to control rising costs, applied principles of economic theory to the health care industry. Specifically, courts and federal agencies struck down certain provisions in the AMA Code of Ethics as anticompetitive, sending a stern warning to the AMA, state, and local medical societies to curtail their enforcement activities.¹⁵ The rise of the national specialty societies, coupled with the AMA’s loss of membership and prestige at the end

of the twentieth century, meant that no single organization spoke for physicians on professional matters. A “unified profession has given way to power blocs of specialists” or “fiefdoms,” renowned medical historian Rosemary Stevens concluded.¹⁶

Just as current practitioners face fewer professional constraints than their predecessors, so they encounter greater temptations to violate their ethical responsibilities. A sizeable majority of today’s practicing physicians are board-certified specialists with advanced training in areas such as orthopedics, cardiology, or oncology. Recent technological innovations have allowed many specialists to perform surgery in ambulatory facilities that they themselves own or jointly own with others. Those in medium to large group practices often compete with hospitals and other physician groups along service or product lines based on specific diseases (cancer) or organ systems (heart, spine). Ancillary services, frequently of the diagnostic variety (computed tomography [CT] scan and Magnetic Resonance Imaging [MRI]), can supplement doctors’ incomes substantially.¹⁷

PHYSICIANS WHO ROUTINELY ORDER UNNECESSARY TESTS OR PERFORM QUESTIONABLE PROCEDURES VERY LIKELY HARM THEIR PATIENTS. IN MANY SUCH INSTANCES, DISCIPLINARY ACTION WOULD SEEM APPROPRIATE.

Physician ownership of outpatient facilities has contributed significantly to the sharp increase in costs and procedures. Seth Strobe and colleagues found, for instance, that “the conversion of [physician] non-owners to [physician] owners” was associated with a 53% rise in urological surgeries in Florida surgical centers for the period 1998 to 2002.¹⁸ Louise Pilote and colleagues, moreover, linked the supply of catheterization laboratories to an increase in heart bypass surgeries.¹⁹ Other studies demonstrated that similar increases occurred when physicians acquired diagnostic imaging equipment.²⁰

The substantial rise in the number of outpatient procedures reflected in the Strobe, Pilote, and other studies raises serious concerns about the overutilization of medical services and the increased potential for poor patient outcomes. Researchers have shown, for instance, that unnecessary exposure to ionizing radiation increases the

incidence of cancer,²¹ that excessive prescribing of antibiotics lessens resistance to infections,²² and that overuse of heart stent implantations,²³ spinal-fusions,²⁴ hysterectomies,²⁵ and certain other surgical procedures enhances the risk of complications.²⁶

Not only does overtreatment demonstrate disregard for scarce resources and for best practices; it also shows indifference toward patients' best interests. By way of example, the Maryland Board of Physicians in 2011 revoked the license of Mark Midei, a Baltimore cardiologist, for the unnecessary and fraudulent implantation of cardiac stents.²⁷ By his own admission, Midei performed about 800 stent operations in 2005 and 1,200 in 2007.²⁸ Such a large and increasing number of stent implantations prompted investigations by a Maryland hospital and a U.S. Senate Committee into Midei's medical practice.²⁹

Though the Maryland board found Midei guilty of "gross overutilization of health care services," the decision to revoke Midei's license hinged on his falsification of laboratory tests. "Dr. Midei's willful creation of false percentage numbers for the degree of occlusion of coronary arteries is indefensible and amounts to a deliberate and willful fabrication of medical records," the board determined.³⁰ The Maryland board's emphasis on falsified tests underlay its determination to revoke Midei's license. Unfortunately, the board's opinion failed to more precisely address the problem of unnecessary care and treatment. Under the circumstances, the Maryland board missed an important opportunity to put physicians on notice that unnecessary surgery alone might call for disciplinary action.

The Need for State Licensing Board Intervention

What can the medical profession do, if anything, to discourage unwarranted and profligate spending? More than it is doing now, certain medical ethicists have insisted. "[T]he myth that physicians are innocent bystanders merely watching health care costs zoom out of control cannot be sustained," Howard Brody has asserted.³¹ "Physicians cannot afford to ignore the profound logic of the link between care for individual patients and the costs of care," Christine Cassel and Troyen Brennan have contended.³²

The justification for disciplining doctors who enhance their income at the expense of their patients' well-being seems apparent. Physicians who perform unnecessary tests and procedures violate all four recognized principles of medical ethics—nonmaleficence, beneficence, autonomy, and

justice.³³ There is no need for ordering these principles, for placing more emphasis on any particular one of them. Efforts to stem overtreatment protect patients from harm, promote the fair distribution of scarce resources, and enhance the profession's standing.

in 2002, the American Board of Internal Medicine (ABIM) Foundation, along with the European Federation of Internal Medicine and the American College of Physicians, issued a global Charter on Medical Professionalism for the twenty-first century.³⁴ The Charter put forth three "fundamental principles" (patient welfare, patient autonomy, and social justice) and a "set of professional responsibilities" to guide physicians' interactions with patients, health care organizations, and society. Overutilization and wasteful spending received prominent attention. "The provision of unnecessary services not only exposes one's patients to avoidable harm and expense but also diminishes the resources available for others," the Charter's authors stated.

Following issuance of the Charter, several medical specialty societies sought to identify tests and procedures often overused in their respective specializations. After an exhaustive period of review, nine societies in April 2012 issued their "top five" questionable tests and procedures.³⁵ An additional eight specialty societies plan to release their top five in the near future.

The recent pronouncements of the national specialty societies should aid efforts of state medical boards to identify and discipline licensees for gross overutilization, unnecessary treatment, and wasteful spending. Because most physicians today are board certified in at least one specialty area, few doctors lack knowledge of evidence-based standards and guidelines concerning questionable tests and procedures. Those doctors who *consistently* ignore recognized standards and guidelines, placing their financial interests above their patients' welfare, warrant disciplinary action.

Recommendations

Few boards have the resources, the inclination, or the mandate to pursue licensees for unnecessary care and treatment. "We view ourselves as a catcher's mitt in that we do not seek out infractions, but rather respond to 1,500 reports that come to us each year," explained one board member. "From my own experience," another board member stated, certain specialists "are sometimes able to over-

utilize various tests and procedures without much consequence or notice because they manage to do so just within the range of acceptable medical practice and, therefore, below the radar of peers, hospital administrators or state regulators.”³⁶

For these and other reasons, state medical boards face at least two significant barriers to disciplinary action: (1) the asserted need to receive information concerning potential abuse before investigating, and (2) the ability of most offenders to provide some justification, however tenuous, for their treatment decisions. Notwithstanding these obstacles, boards can and should take certain steps to stem overtreatment and, in so doing, meet their obligations to protect the public.

First, boards should signal their intention to discipline egregious offenders, to show that overtreatment is a serious problem and that disciplinary action may be warranted. A good place to start would be for boards to amend their respective state laws or medical practice acts to include a specific ground for “clearly excessive treatment of patients.” The Federation of State Medical Boards should take the lead in this endeavor. The Federation’s *Model Medical and Osteopathic Act* does not include a specific disciplinary ground for overutilization; nor do medical practice acts in more than 60% of states (see Table 1). States that lack a specific ground currently charge offenders under a “catchall” provision, such as unprofessional conduct, substandard care, or fraudulent activity. Such “catchall” provisions are poor substitutes for more targeted laws that would increase awareness of the problem and boards’ intent to discipline egregious offenders.

Second, state medical boards and the Federation should issue guidelines or recommendations on excessive care and treatment. In related areas, the Federation has issued guidelines, white papers, or has teamed with others to produce books or tracts on matters such as opioid prescribing.³⁷ The Federation could build on these related efforts by examining, collaborating with, and potentially incorporating the recently-released findings of several national specialty societies under the auspices of the ABIM Foundation and others as previously mentioned.

Conclusion

Few patients are capable of making informed decisions about the efficacy of diagnostic tests and medical procedures. Most patients require their physicians’ help and assistance. Because doctors figure prominently in the selection of medical services,

they are key to controlling health care costs in a fragmented delivery system. Though state medical boards cannot easily address widespread medical practices that lead to overspending, they can support the efforts of national specialty societies to establish evidence-based standards. Moreover, they can revise, if needed, their respective grounds for disciplinary action to more clearly identify and more easily discipline offending physicians. ■

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