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STATE OF WISCONSIN

BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY :

PROCEEDINGS AGAINST : **FINAL DECISION AND ORDER**

: LS0302191MED

RAYMOND H. PURDY, M.D., :

RESPONDENT :

The parties to this action for the purposes of § 227.53, Wis. Stats., are:

Raymond H. Purdy, MD

1245 E. Washington Ave.

Madison, WI 53703

Wisconsin Medical Examining Board

P.O. Box 8935

Madison, WI 53708-8935

Department of Regulation and Licensing

Division of Enforcement

P.O. Box 8935

Madison, WI 53708-8935

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Respondent Raymond H. Purdy (dob 7/17/54) is and was at all times relevant to the facts set forth herein a physician and surgeon licensed in the State of Wisconsin pursuant to license #24743, first granted on 7/2/82. Respondent is a board-certified internist, but does not practice traditional internal medicine. Respondent's practice is generally limited to providing manipulative therapy, in which he has received substantial training, but he does prescribe medications including controlled substances to a portion of his patients. Respondent prescribes Schedule II and III narcotics to a very small percentage of his patients.

2. On and after 7/1/99, respondent treated Andrew R., a male patient born in 1977. The patient complained of chronic back pain secondary to a series of car accidents and head injuries from sports activities, and was referred by the UW Pain Clinic. The patient was using acupuncture and was taking long-acting oxycodone, 120 mgs, 4 times per day. The patient also reported a diagnosis of ADD.

3. Respondent treated the patient with manipulation and medications; these included adding alprazolam 1mg PRN for panic attacks, Benadryl® 25 mg for sleep, orphenadrine, and cyclobenzaprine. Over time, respondent added diazepam 5mg, 4 times per day, and discontinued cyclobenzaprine and alprazolam. However, the patient's pharmacy reported that the patient was taking twice the prescribed dosage of diazepam. Respondent then attempted to substitute long-acting morphine for both the oxycodone to achieve better pain control. The patient reported good results from diazepam 10mg, 4 times a day, and respondent continued that dosage.

4. Respondent then changed the opioid to a combination of long acting oxycodone and long-acting morphine, to reduce urinary retention. The patient was then taking 200mg oxycodone twice a day, and 200mg of the morphine at midday. At this time, the patient was still being seen by the UW Pain Clinic. In March, 2000, the patient determined to come into respondent's care exclusively, and respondent agreed to do all of the patient's medication prescribing. At that time, the patient was taking 400mg long-acting oxycodone twice per day, 10-12mg hydromorphone at midday, 10mg diazepam 4 times per day, and clonidine.

5. At no time did respondent have the patient sign an agreement to use only one physician and one pharmacy for all controlled substances, and containing the other safeguards common in such agreements.

6. By the end of March, 2000, respondent had increased the hydromorphone to 20mg, twice per day. By the end of April, respondent had added long-acting morphine 400mg at midday to the patient's regimen. In May, respondent added carisoprodol 350mg, four times per day, to the patient's medications. Also in May, the patient began to receive ketamine from the UW Pain Clinic by injection, in an trial to see if his opioids could be reduced. In June, the patient's oxycodone was increased to 640mg, three times per day, the hydromorphone was ended, and clonidine 0.2mg/day; the patient was instructed to "try to taper" the diazepam, but the chart's subsequent entries do not reveal whether this was done. In July, the patient's medications were adjusted by respondent to 800mg long-acting oxycodone, three times per day, plus the hydromorphone, morphine, and carisoprodol listed above, and by the end of July, the diazepam was actually increased to 10mg, 5 times per day. At a time not stated in the chart, but before July 25, 2000, the patient's morphine was also discontinued.

7. In early August, 2000, the patient reported increasing levels of pain without any idea why this was occurring; respondent increased the patient's dosage to 960mg, three times per day. One week later, this was increased to 1000mg, three times per day. Two weeks later, the patient reported taking 1200mg, three times per day, and respondent continued his prescription at that dosage level.

8. In September, the patient reported being diagnosed with a urinary tract infection at a hospital emergency department, where he was treated with Levaquin; his carisoprodol was apparently discontinued and the patient reported increased back spasms. Respondent then prescribed an increase in diazepam to 20mg, three times per day, with 10mg in between for spasms. One week later, the patient reported that he was now taking 1400mg oxycodone, three times per day, and stated that the results were better; respondent continued the patient at that dosage level. The patient continued to take ketamine 250mg/day, and respondent altered the diazepam to 20mg, 5 times per day. One week later, the patient reported being "miserable last couple of days" and that he had increased his own dosage to 1800mg, three times per day, and reported that the ketamine was having no effect. Respondent then increased the oxycodone to 2000mg, three times per day, plus a liquid immediate-release preparation of oxycodone for breakthrough pain, 600mg, twice per day.

9. In early October, the patients medications are reported in respondent's progress notes as being long-acting oxycodone 2000mg, three times per day, ketamine 250mg/day, diazepam, 20mg, 5 times per day, liquid oxycodone 600mg PRN for breakthrough pain, 2-3 times per day, and clonidine. On October 10, respondent

noted in his chart: "Doing better with current med regimen now that he is no longer crushing Oxycontin tabs." In November, respondent added Adderall® (amphetamine/dextroamphetamine preparation) 10mg, twice a day, to the patient's regimen, for ADHD, but did not chart the signs or symptoms of such condition or other reason for this diagnosis.

10. In January, 2001, the patient reported discontinuing the ketamine on his own, without adverse effect. In February, the patient reported his usage as being long-acting oxycodone 2000mg, three (frequently two, sometimes one) times per day, liquid oxycodone 600mg three times per day as needed, Adderall® 20-30mg/day, diazepam 20mg 5 times per day, and clonidine 0.2mg/day. At the end of February, the patient reported his use as being 2000mg long-acting oxycodone per day, with no use of the liquid oxycodone, but there is nothing in the progress notes about any change in the prescribed amounts or dosage instructions.

11. In March, 2001, the patient reported taking 2000mg long-acting oxycodone once or twice per day, with occasional use of 600mg liquid oxycodone, diazepam 20mg 5 times per day, Adderall® 30mg/day, and clonidine 0.2mg/day.

12. On May 29, 2001, respondent changed the patient's benzodiazepines from diazepam 100mg/day to 50mg/day, and adding lorazepam 2mg, three times per day, for anxiety. No reason for this change in noted in the progress note. The patient reported no benefit from this change after one week, and the lorazepam was discontinued, and respondent's note states: "continue diazepam" but does not state whether this means at the 50mg or 100mg level. However, on 7/1/01, respondent's progress note states that diazepam is to be continued at 100mg/day.

13. On 8/1/01, the patient reported that he had successfully tapered himself off of the clonidine, and that he had tried Desoxyn® (methamphetamine) and found it to be better than the Adderall®. There is no indication of where the patient obtained this schedule II stimulant. Respondent then discontinued the Adderall® and prescribed methamphetamine 5mg, take two tablets, twice a day. The other prescriptions were continued.

14. On 9/4/01, the patient reported that his home had been subject to an attempted burglary and that he was worried about a possible theft of his medications.

15. On 12/4/01, respondent reported that he was taking 5-10mg methamphetamine rather than the 20mg prescribed. On 1/15/02, the patient reported having taken a "drug holiday" from the amphetamine for three weeks, and then recently resumed its use. The patient speculated that this was reducing his pain level.

16. On 2/13/02, respondent was informed that the patient's home had been burgled and a safe where the long-acting oxycodone was kept was stolen. Respondent was informed that the patient reported over 15,000 tablets of OxyContin® 40mg were in the safe. Two days later, respondent was informed that the liquid oxycodone was also stockpiled and hidden in another place, not the safe, and was not stolen. On 2/19/02, respondent prescribed 2250 tablets of 40mg OxyContin®. The next day, following a telephone conversation with the pharmacist, respondent re-wrote the prescription to delay dispensing of this quantity until 2/26/02.

17. In the weeks following, respondent's progress notes indicate that the patient's use is "stable" or "less" but do not state what the use is.

18. Throughout this period, respondent was seeing the patient weekly for manipulation treatments which are incompletely described. Respondent did not ask the patient to rate his pain on a scale of 1-10 or use another recognized pain scale, instead such descriptors as "about the same" or "not doing so well" or "feels rough" or "up and down" or "feels better" are used without any exploration of what these might mean; there is no way of tracking the long-term progress of the patient. Respondent did not have functional goals established for the patient, and there was no equivalent way of tracking whether the patient's functioning was improving or not, over time. Respondent did not keep a "Med Sheet" or equivalent record in his chart, and did not have any

way of readily comparing the patient's use with what had been prescribed, and thus respondent could not compute what quantity of these medications the patient may have had on hand, nor was respondent able to readily ascertain from his records what his most recent dosage instructions were. At no time were any toxicology studies obtained on the patient's urine or blood by respondent, nor did respondent obtain any such lab results from any other practitioner or source.

19. Also stolen from the patient because they were in the safe were 15 vials of ketamine; the patient told the investigating deputies that the ketamine had "never" worked for him. Investigation by the Dane County Sheriff's department produced substantial evidence that patient was, in fact, selling and trading some of his medications for street drugs and cash.

20. On December 4-7, 2002, respondent took and satisfactorily completed the 40 hour course entitled "Intensive Course in Controlled Substances Management" at Case Western Reserve University School of Medicine.

CONCLUSIONS OF LAW

A. The Wisconsin Medical Examining Board has jurisdiction to act in this matter pursuant to §448.02(3), Wis. Stats. and is authorized to enter into the attached Stipulation pursuant to §227.44(5), Wis. Stats.

B. The conduct described in ¶2-18, above, violated § Med 10.02(2)(h) and (za), Wis. Adm. Code. Such conduct constitutes unprofessional conduct within the meaning of the Code and statutes.

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED, that the attached Stipulation is accepted.

IT IS FURTHER ORDERED, that Raymond H. Purdy, M.D., is REPRIMANDED for his unprofessional conduct in this matter.

IT IS FURTHER ORDERED, that the license to practice medicine and surgery of respondent is LIMITED as set forth in §448.02(3)(e), Wis. Stats., and as follows:

1. Respondent shall not prescribe any medications for the patient described in the Findings of Fact, above. This limitation is permanent.

2. Respondent shall not prescribe any controlled substance until after he has taken and passed the following (respondent shall take both the pre and post tests, even if the course makes such tests optional, and such scores shall be reported to the Board): the 24 hour course entitled "Prescribing Controlled Drugs: a Continuing Medical Education course for physicians and other prescribing professionals" at Vanderbilt University Center for Professional Health. This limitation is STAYED for four months from the date of this Order to permit respondent to complete this course: the limitation shall then come into effect automatically and without further board action unless respondent has provided proof to staff that he has satisfactorily completed the required course. Respondent shall cause the course sponsors to report directly to the Board, through the Department Monitor, his performance in the course.

3. Respondent shall, within 12 months of this Order, participate in and successfully complete within 12 months of the date of this Order, an educational program established through the University of Wisconsin Continuing Medical Education program (which may conduct any program through the Medical College of Wisconsin or another CME provider) in recordkeeping, and approved by the Board or its designee.

a. Under the tutelage of a mentor selected by the program, respondent shall review a text selected by the mentor dealing with medical recordkeeping, and shall introduce the mentor's recommended improvements into his system over the period of the program in both his office and hospital records. All of respondent's records may be reviewed and discussed periodically with the mentor, as the mentor shall determine. The review may include not only the adequacy of documentation, but any other quality of care or related issue.

b. The mentor shall agree to report any matter which may constitute a danger to the health, safety or welfare of patient or public, any violation of law, and any unprofessional conduct, to the Board, whenever it comes to the mentor's attention.

c. Respondent's progress and the outcome of the program shall be reported directly to the department monitor, who may discuss respondent's progress with the mentor. The UW-CME shall certify to the Board the results of the program upon completion.

d. If respondent does not successfully complete the program or does not successfully achieve the objectives of the program, this matter shall be referred to the Board to determine any additional appropriate discipline for the conduct set out in the Findings of Fact. Respondent will have the opportunity to present argument to the Board on that issue. The Board will receive the results of respondent's performance in the program as evidence in determining appropriate discipline.

IT IS FURTHER ORDERED, that respondent shall pay the COSTS of investigating and prosecuting this matter of $1350 within 60 days of this Order.

IT IS FURTHER ORDERED, that pursuant to §448.02(4), Wis. Stats., if the Board determines that there is probable cause to believe that respondent has violated any term of this Final Decision and Order, the Board may order that the license and registration of respondent be summarily suspended pending investigation of the alleged violation.

Dated this February 19 , 2003.

WISCONSIN MEDICAL EXAMINING BOARD

Sidney Johnson

A Member of the Board