

## WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES



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STATE OF WISCONSIN  
BEFORE THE MEDICAL EXAMINING BOARD

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IN THE MATTER OF :  
DISCIPLINARY PROCEEDINGS AGAINST : **FINAL DECISION AND ORDER**  
 :  
ROBERT C. TURNER, M.D., :  
RESPONDENT. : **ORDER 0001892**

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Division of Enforcement Case #10 MED 324

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

Robert C. Turner, M.D.  
1900 N Dewey Ave  
Reedsburg WI 53959

Wisconsin Medical Examining Board  
P.O. Box 8935  
Madison, WI 53708-8935

Department of Safety and Professional Services  
Division of Enforcement  
P.O. Box 8935  
Madison, WI 53708-8935

PROCEDURAL HISTORY

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 Robert Craig Turner (dob 9/9/53) 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 #31859, first granted on 1/23/91. Respondent is an internist, and is certified by the American Board of Internal Medicine, with a subspecialty certificate in cardiovascular disease.

PATIENT B

2. On 1/13/09, patient B, a woman born in 1983, established care with Respondent, and did not disclose any drug or alcohol abuse or treatment. At her initial office visit, the patient

reported being on oxycodone 7.5 mg/APAP 325 mg, for low back pain which first appeared during her pregnancy, approximately one year previous.

3. On 1/15/09, the patient telephoned the clinic and reported that the gabapentin was not helping, and requesting to try something different. There is no record of any response. There is a notation that the patient was scheduled for epidural steroid injection on 1/20/09, and that she was instructed to stop ibuprofen five days before the injection.

4. On 1/19/09, Respondent reviewed imaging results with the patient, which included herniated disk disease and mild central canal stenosis. He prescribed oxycodone 7.5/APAP 325, take 2 every four hours, #360. He charted that he had given the patient gabapentin for her pain, which had not helped; there is no notation of this in his earlier charting.

5. On 1/22/09, the patient telephoned the clinic requesting additional medication at night, which would be longer-lasting. She reported having a lot of pain at night, and that the injection was now scheduled for 1/26/09. The patient was referred to the pain management clinic.

6. On 1/26/09, the patient returned to care following her epidural steroid injection, which she reported as being ineffective, and further reported that the medication was inadequate. Respondent advised her to take one oxycodone every two hours, rather than two every four hours. The patient signed a medication agreement, and Respondent charted that he was concerned about "addiction." He provided her with an additional prescription for oxycodone extended release, 10 mg, take one at bedtime, #30. The patient was required to provide a urine sample.

7. On 1/28/09, the patient telephoned the clinic and reported that the oxycodone with Tylenol had been upsetting her stomach, and that she would prefer just oxycodone. Respondent noted that this change could not be made until her next month's refill.

8. On 1/30/09, Respondent reviewed the results of the urine toxicology, which showed methadone, which she was not prescribed at that time. Respondent charted that he planned that every time the patient received a prescription from his office, a urine drug screen would be done. Notwithstanding this statement, no drug screens were performed until 4/16/09.

9. On 2/2/09, the patient returned to care. Respondent reviewed the results of the urine test, and the patient reported that she had obtained some methadone while assisting her father clean out the effects of her late stepmother, who had died of small cell carcinoma. The patient reported that she felt that the methadone was more effective than the oxycodone products. The patient also stated that she had been taking two or three of the extended release oxycodone at bedtime, instead of the prescribed one. Respondent referred the patient to a pain specialist, and prescribed methadone 10 mg, BID, #60, do not fill until 2/19/09. No urine sample was obtained, and there is no evidence in the chart that the patient ever saw a pain specialist.

10. On 2/3/09, the patient was informed that she had an appointment for another epidural steroid injection on 2/10/09; the procedure was ultimately conducted on 2/13/09.

11. On 2/13/09, the patient telephoned the clinic and requested an additional supply of oxycodone, "just enough to get through until 2/19" when the patient was scheduled to return to care. This request was refused by Respondent.

12. On 2/19/09, the patient returned to care. Respondent charted that he had reviewed recommendations from the University of Wisconsin Hospital chronic pain management handout, including the dosing of methadone, interval dosing, risks and consequences of dependency, and long-term management of patients on chronic opioid therapy. Respondent then prescribed methadone 20 mg, BID, #56. Respondent charted that his goal for dosing was 3-5 mg every 6 to 8 hours. No urine sample was obtained.

13. On 2/19/09, the patient was telephoned and informed that her epidural steroid injection was scheduled for 2/27/09.

14. On 3/19/09, the patient telephoned the clinic to request a prescription for methadone, and additionally requested if she could get more than a well one-month prescription so that she did not have to drive to the clinic each month. Respondent wrote a prescription for a one-month supply of methadone, 20 mg b.i.d., #120, and denied the request for multiple prescriptions.

15. On 4/14/09, the patient telephoned the clinic to request an additional prescription for methadone, and requested two such prescriptions, one for this month and one for the next month to save on travel time. Respondent wrote a note that the patient must provide a urine sample before the next description was given, and that the script was to be filled on 4/18/09, for one month.

16. On 4/16/09, the patient telephoned the clinic and requested a prescription for two weeks only. There is a notation in the chart that the patient provided a urine sample, and was given a prescription.

17. On 4/29/09, the patient telephoned the clinic and requested an additional prescription for methadone. She requested that two prescriptions be provided to her, one written for two weeks later. She also reported that her previous prescription was "short" by 4 pills. There is a notation in the chart that the patient would be required to provide a urine sample before receiving the prescriptions, and a further notation that on 5/1/09, the patient did provide a urine sample, and was given the prescriptions.

18. The 5/1/09 urine drug screen was positive for cocaine,

19. On 5/12/09 the patient saw another physician in Respondent's clinic. The patient reported that her current therapy of methadone 20 mg twice a day, was no longer adequate. This physician declined to change her medication regimen, and recommended exercise and a trial of chiropractic therapy.

20. On 5/14/09, the patient telephoned the clinic to request a two-week refill of her methadone prescription, together with a request to speak with Respondent directly. An appointment was made for the patient to have an office visit on 5/16/09.

21. On 5/16/09, the patient returned to care. In response to the results of the 5/1 urine drug screen, the patient denied using cocaine. In his chart note, Respondent stated that he did not believe that the patient's clinical presentation was consistent with cocaine use. Respondent charted that he planned to do unannounced drug screening every 6 months.

22. No drug screening was done from 5/1/09 to at least 1/29/11.

23. The chart further reveals that Respondent followed up with a laboratory to determine whether a false positive could have occurred. After being assured that there was confirmatory testing, the patient was notified that there would be no further methadone prescriptions.

24. On 5/26/09, the patient telephoned the clinic regarding her methadone prescription. The patient was informed that she would not receive such a prescription; the patient agreed that she had received a letter to this effect. There is a notation that the patient had an appointment with Respondent on 5/29/09, but there is no chart note of such an office visit.

25. On 6/2/09, Respondent charted that he reviewed notes from the patient's previous provider, including prescriptions for oxycodone, hydrocodone, a low dose of gabapentin, Lidoderm® patch, and ibuprofen.

26. On 6/12/09, the patient returned to care. Respondent charted that he had seen the patient on 6/2/09, although there is no internal evidence of this in the chart note of that date. Respondent charted that the patient had agreed to see a counselor to discuss "a mechanism by which we can withdraw her from narcotic use for pain management." Respondent charted that massage and acupuncture therapy would not be covered by the patient's insurance.

27. On 6/18/09, Respondent was informed that the patient did not appear for her scheduled appointment with a counselor. The patient had another appointment to see an AODA counselor on 6/24/09.

28. On 6/19/09, the patient returned to care. The patient reported that she had seen a counselor on 6/17, and been referred to a psychotherapist specializing in AODA. The patient reported taking her medication as prescribed.

29. On 6/25/09, the patient returned to care. Respondent charted discussing with the patient the fact that the patient was late for her first counseling session, and missed her second session, and then had to reschedule her next session twice. Respondent charted that he informed the patient that compliance with counseling was required. The patient reported a new complaint of "lower left back pain, twisting burning type of pain unaccompanied by changing bowel habits or urinary habit. The skin demonstrates on rash of herpes zoster. There was no traumatic event." Respondent ordered a CT, CBC, urinalysis, and C&S, and a comprehensive panel. No urine drug screen was ordered. The patient was given a prescription for methadone 10 mg, take 2, BID, #60.

30. On 6/30/09, Respondent was informed by the counseling center that the patient had again rescheduled her initial session, which was now set for 7/2.

31. On 7/10/09, the patient returned to care. The patient reported now being on Badger Care, and requested a trial of acupuncture: Respondent agreed to see if this resource was available. Respondent charted that he reviewed the intake summary from the counseling center, and noted that the next counseling session was scheduled for 7/15. The patient was given a prescription for methadone 10 mg, take 2, BID, #60.

32. On 7/15/09, Respondent charted that he had reviewed a therapy note from the counselor, and stating that: "I will now start to lower her methadone by one pill every prescription and I'm going to refer her to Dr. [...] at her narcotic withdrawal clinic to receive Suboxone therapy." Notwithstanding this note, no such referral could be found in Respondent's chart.

33. On 7/23/09, the patient returned to care. Respondent charted that Badger Care had declined to cover acupuncture. Respondent's note states: "we have exhausted physical therapy, pain clinic consultation, ESI therapy, massage therapy, and physical therapy and she is receiving narcotic drug dependency counseling through the Pauquette Center. She requests a referral for lumbosacral spinal surgery. [...] I review with her that I want to initiate a plan for withdrawal of methadone. I review that every two weeks I will be removing one pill from her therapy. [...] So, today I review with [the patient closed packet that I am lowering her prescription down to just 59 tablets today. On next visit it will be 58 and so on. I review with her signs and symptoms of narcotic withdrawal and I discussed with her referring her to Dr. [...] at the [...] for Suboxone therapy at the appropriate time interval. [...] I will be seeing her back on August 6, 2009 at which time 58 tablets of methadone will be dispensed."

34. Respondent's chart reflects that the patient was referred to an orthopedic surgeon, and to a second orthopedic surgeon at the spine clinic at the University of Wisconsin Hospital.

35. On 8/6/09, the patient returned to care. Respondent charted that he reiterated his previous advice, including his intent to refer for buprenorphine therapy. Respondent charted that he prescribed 58 tablets of methadone 10 mg, take 2, BID.

36. On 8/13/09, Respondent received copies of counseling notes which reflected that the patient had kept counseling appointments for 7/30, and 8/12. However, the patient was 30 minutes late to the latter appointment.

37. On 8/19/09, the patient returned to care, and reported that she would be having another epidural steroid injection the following day. She further reported that she would be doing physical therapy. Respondent charted, in part: "I review with her that I will hang tight on her methadone taper, dispensing 58 tablets today in light of the fact that she is making progress in seeking some treatment for her back pain that is other than a narcotic therapy."

38. On 8/20/09, the patient underwent a right sacroiliac joint injection with anesthetic and Celestone®. At the time of discharge, the patient reported an improvement in her pain from a 6-7, to a 5.

39. On 8/24/09, the patient telephoned the clinic to report that the epidural steroid injection from the previous week is "hurting and painful" and that she was not better at all. There

is a further notation that the procedure chart was obtained and reviewed, and that Respondent would discuss it with the patient at her next visit, then scheduled for 9/2.

40. On 8/31/09, the patient telephoned the clinic to report that her back pain was getting worse, and requesting to be seen. The patient was seen on that day, and Respondent charted that although the procedure had apparently been properly performed, the patient's pain was increased and not reduced by the procedure. Respondent further charted that the patient was continuing with physical therapy and counseling, but had experienced increased financial and personal stress. After reviewing him a medical and nonmedical issues, Respondent charts: "I had been reducing her methadone, trying to lessen her narcotic dependency, but now with this exacerbation and heightened pain it appears we are going to have to increase her narcotic therapy which I am reluctant to do, but it appears that it is going to be necessary. She was taking her methadone 10 mg, two tablets, three times per day. [*Note: this is incorrect, as she had been taking two tablets, twice per day.*] I had been trying to cut her back. She says during the procedure of SI joint injection she had received IV fentanyl and that helped her pain. She was wondering if topical fentanyl might not be an option for her. Reviewed that it is an option. We could try Duragesic patch 25 µg per 72 hours, dispense 10 today. I refilled the methadone at 10 mg, two by mouth, BID, dispense 60 today, and I will see her back in two weeks and check on her clinical status." And: "Addendum: [Patient] got home and found that one of the boxes of the Duragesic patch was reportedly empty. We called the pharmacy. They said that this could happen. We called the company. They said that this could happen, but unlikely. She did have one box of five patches of 25 µg per 72 hours, one box was empty. I did dispense 10 and I recorded that on the green sheet in her chart. So now we are left with the dilemma that she is short. She will be seeing me back in two weeks, and the patches that she has should last her for two weeks, so I will just hang tight until that time."

41. On 9/9/09, the patient returned to care. Respondent charted that the pharmacy had informed him that Badger Care would not pay for another dispensing of a prescription for the fentanyl patch unless the dosage was changed. Respondent charted that he did not feel that it was appropriate to increase her dosage, and that therefore the patient would have to do without. The patient was provided with a prescription for methadone 10 mg, take two, BID, #50, fill on September 14. Respondent was advised to open the fentanyl patch box at the pharmacy, the next time.

42. On 9/14/09, the patient returned to care. Respondent charted that he again discussed with her the issue of the empty box of fentanyl patches. He noted: "the pharmacy has reinstated her \$130 that she had paid for the empty box of Duragesic and she presents today to have those five Duragesic patches re-dispensed at 25 µg per 72 hours." There was no discussion of the financial pressure that had been previously discussed, or the fact that the patient was on Badger Care, a program available only to low income individuals. There was no discussion of how the patient could have come up with such a sum of money, or why it would have been necessary, if she is on Badger Care. Respondent did chart: "I review that she has had failed personal relationships and that she has had five court appearances, theft and removal of property, possession of a controlled substance, and three felony bail jumping charges. I discussed with her that mixing narcotics in this situation is not good. We discussed ways of getting away from narcotic therapy, as I do not think it is good medicine for her. Today, I refilled her Duragesic 25

µg per 72 hours dispensing five. I do not refill the methadone. Today, we discussed that on the next clinic visit when she is due for a refill on her methadone, 9/28/09, that we will reduce the methadone to 10 mg, two in the morning and one at night."

43. On 9/16/09 Respondent received copies of the counseling notes, showing that the patient kept her 9/3 appointment, but was 30 minutes late. The patient did not call, and did not show up, for her 9/16 appointment.

44. On 9/24/09, the patient returned to care and. Respondent charts, in part: "I refilled her methadone 10 mg, two, BID, dispensing 59 tablets, reducing the number of tablets dispensed every two weeks by one tablet every two weeks. Her prescription is not due to be refilled on [until] 9/28/09. I will see her back on 10/12/09. I also refilled her Duragesic 25 µg per 72 hours, dispense five patches and do not refill until 9/28/09."

45. Also on 9/24/09, Respondent was informed that the patient had kept her counseling appointment of that date. On 10/8/09, Respondent was informed that the patient had kept her counseling appointment of 10/7.

46. On 10/12/09, the patient returned to care. Respondent charted that he had reviewed the counseling note from 10/7/09, and that the patient will be seen at the spine clinic at the University of Wisconsin hospital on 10/22. He charts: "with regards to physical therapy, she is no longer able to do physical therapy because she is getting too much pain with the physical therapy. We discussed that our goal is to try cut down on the narcotic requirement and I have been titrating back on the number of methadone dispensed every two weeks. We are down to 58 dispensed on 10/12/09 and Duragesic at 25 µg per 72 hours dispensed five on 10/12/09." The patient also signed a two-page consent form, containing information about opioids, a second form entitled "long-term controlled substances therapy for chronic pain," and a third form entitled "chronic opioid analgesic therapy agreement." The patient also filled out a questionnaire concerning the history of her pain and treatment.

47. On 10/22/09, the patient telephoned the clinic to report that her fentanyl patch looked different, and was not as effective. Also on this date, the patient underwent a transforaminal epidural steroid injection with anesthetic and Celestone®. At the time of discharge, the patient reported a decrease in pain from a level of 7.5, to a level of 5.5.

48. On 10/26/09, the patient returned to care, and Respondent notes that he has the chart from her 10/21 appointment at the UW spine clinic. She had received another epidural steroid injection and Respondent charts: "It helped for a day, but now she is having recurrent pain." Respondent refilled the fentanyl with a prescription for five patches, and also gave her a prescription for 57 methadone 10 mg tablets.

49. On 11/9/09, the patient telephoned the clinic requesting an immediate appointment. The patient was offered an appointment. The patient then telephoned and reported that she had food poisoning and was unable to come in, but requested that her pain medications be refilled. Respondent declined to do so. The patient then telephoned again and stated that she was in withdrawal. Respondent advised the patient to go to an emergency room.

50. On 11/11/09, the patient returned to care for her scheduled appointment. Respondent reviewed her history, including a recent recommendation from the University of Wisconsin Spine Clinic that she consider discectomy. Respondent required the patient to give a urine sample, which was tested on site, and was found to be presumptively positive for methadone and oxycodone. Respondent charted: "Her urine drug tox screen shows the methadone and the oxycodone metabolized which would be appropriate for her current clinical condition. No other toxins are found." There is no explanation for why oxycodone was, or should have been, found. No follow-up testing of the sample was discovered in the chart. There was no discussion in the chart note of the events of 11/9. Respondent prescribed five fentanyl patches, 25 µg per 72 hours, and #56 methadone 10 mg, take two, BID.

51. On an exact date unknown, but believed him to be shortly after 11/11/09, Respondent received the report of the Sauk Prairie Memorial Hospital Physical Therapy Department, showing that the patient had appeared for physical therapy on 9/2 and 9/8, and had failed to appear for her appointment on 9/17. The patient then appeared 15 minutes late for her 9/21 appointment, and brought her toddler to the appointment. The patient canceled her 9/23 appointment, and did not reschedule or return.

52. On 11/12/09, Respondent received a report from the patient's counselor that the patient had failed to show up for her appointment on that day.

53. On 11/23/09, the patient returned to care. Respondent again notes: "On 11/11/09 a urine drug tox screen identified the methadone and the narcotic in her urine from the medicines that I prescribed her." Respondent prescribed an additional five fentanyl patches, 25 µg per 72 hours, and #55 methadone 10 mg, take two, BID.

54. On 11/24/09, Respondent was informed that the patient had canceled her counseling appointment, and rescheduled it for 12/2/09.

55. On 12/2/09, Respondent received a report from the patient's counselor that the patient had kept her counseling appointment that day.

56. On 12/7/09, the patient returned to care. Respondent used an instrument known as the Diagnosis/Intractability/Risk/Efficacy scale, to assist in determining whether the patient was an appropriate candidate for long term opioid analgesia. The patient's score was marginal. There is no discussion regarding the counseling. Respondent prescribed five Duragesic patches, 25 µg per 72 hours, and 54 methadone 10 mg, take two, BID.

57. Respondent continued to treat the patient in a similar manner, decreasing the number of methadone tablets prescribed by one, every two weeks, through March, 2010.

58. On 4/6/10, the patient returned to care and reported to Respondent that the fentanyl patch was no longer helping her. Respondent charts, in part: "discussed changing methadone to 10 mg, take two twice a day and one at noon. Discussed tachyphylaxis with narcotics. Still reports a lot of back pain." Respondent then prescribed methadone 10 mg, take two, twice a day, and one at noon, #70.

59. Respondent continued to prescribe this medication for the patient, in this amount, through 5/15/10.

60. On 5/26/10, the patient returned to care. Respondent's note states, in part: "early for visit and methadone refill. Discussed methadone withdrawal. [...] Patient agreed to methadone withdrawal. Methadone 10 mg, take two in the morning, one at noon, and two in the evening, dispense 69. Withdrawal one methadone per prescription."

61. Respondent then decreased the number of tablets prescribed by one, every two weeks, through 6/29/10.

62. On 7/26/10, the patient returned to care. The patient reported having moved to an organic dairy farm, where she had obtained employment and housing. Respondent then agreed to see her monthly, and to prescribe a month's supply of medication rather than the two week supply, as he had been. Respondent continued to prescribe methadone in this same manner, decreasing the number of tablets prescribed by two each month, through September, 2010.

63. On 9/24/10, Respondent was informed by the pharmacy that the patient attempted to fill a forged prescription, which had been created on a blank stolen from his office. The prescription purported to be for methadone 10 mg, #144. On that day, Respondent charted, in part: "reviewed with [patient] this script is forged and reemphasized the need to wean from methadone as it goes against her." Respondent then charted a review of the patient's personal stressors, and noted his decision not to press charges.

64. On 10/5/10, the patient returned to care. Respondent noted that the patient had been seen in the emergency room for symptoms of withdrawal on 10/1/10 a period Respondent charted, in part: "reviewed narcotics are ruining her life." Respondent then issued a prescription which his chart note recites as "dated 10/8/10" for #124 methadone 10 mg.

65. Respondent continued to prescribe methadone in the same manner, decreasing the number of tablets prescribed by two each month, through the end of 2010.

66. A reasonable physician would have conducted frequent urine drug screens on this patient, would have required her to bring her medication in for pill counts at every visit, would have consulted collateral sources, and would, in any event, have ceased prescribing opioids to this patient and referred her for pain management no later than July, 2009. A reasonable physician would have withdrawn the patient from methadone at a rate based on the daily dosage, not the monthly, and would have completed withdrawal within 30 days, and would have followed up on referral for buprenorphine therapy. A reasonable physician would not have misinformed the patient that tachyphylaxis occurs with opioids.

## PATIENT C

67. Commencing on 7/25/09, Respondent provided care and treatment to patient C, a man born in 1971. The patient's chief complaint, as stated in Respondent's chart, was "chronic pain management of low back pain due to bulging disc." The patient's initial history questionnaire stated that he was on a hydrocodone 7.5 mg product, take one every four hours as needed, that he had quit smoking six years previous, and had never used alcoholic beverages or illegal drugs. The patient stated that he has bulging discs in his back, confirmed by MRI scan. The patient stated that his previous physician was unwilling to provide more than 60 dosage units per month, and that this was insufficient to control his pain. The patient reported taking six tablets per day: two upon rising, one at noon, one in the late afternoon, and two at bedtime. Respondent charted that he thoroughly reviewed the risks of opioid use, examined the patient, ordered a urine drug screen and medication agreement form, discussed acetaminophen dosing limits, and prescribed hydrocodone 7.5/APAP 500 mg, #210, "to cover seven tablets daily." The in-office drug screen result was positive for opiates and oxycodone, and negative for all other substances. There is no record of confirmatory tests.

68. The patient returned to care on 8/8/09. He reported that his use was six tablets per day. The patient further reported that he was experiencing breakthrough pain at work, and that a coworker had given him one methadone tablet which the patient found significantly helpful. Respondent charted that he reviewed records from the patient's previous prescriber, and that he discussed the violation of the medication agreement. Respondent charted: "I review once again that methadone and hydrocodone are narcotics and that over time their efficacy tends to wane. These medications do not build you up, they tend to drag you down and waste the body over the years of use and the need for higher doses and escalating pain therapy will occur. These medications create other problems for her [*sic*] other than just managing your pain. They create additional problems, difficulty functioning, narcotic dependency, bowel and bladder trouble, difficulty with sleeping and rest and general debility." Respondent then prescribed methadone 10 mg, TID, #90, and charted: "we will not dispense hydrocodone any longer. He will have to call monthly to have the methadone refill. I will ask my nurses to refill his methadone, but not refill the hydrocodone unless I am specifically requested to do so." No urine drug testing was conducted.

69. The Board specifically finds that there is no medical evidence to support the statement that opioids or opiates "waste the body over the years of use," or that they create "general debility."

70. Respondent's "pain medication flow sheet" contains an entry that on 8/24/09, a prescription for hydrocodone/APAP, 7.5/325 mg, take 1-2 every six hours as needed, #240, no refills, was issued on Respondent's order.

71. On 9/8/09, the patient returned to care. Respondent charted: "I am seeing him in follow-up for his prescription of methadone for the management of low back pain 10 mg TID, and the medication is refilled today, dispensing 90. It was last filled on 8/8/09. I place in his green sheet the methadone 10 mg, one TID, dispensed 90. He is due for a refill on September 24 of his

hydrocodone that he takes for breakthrough pain, hydrocodone 7.5/APAP 500, two every six hours as needed for pain, none dispensed today."

72. On 9/21/09, Respondent charted: "[patient] calls for a refill on his hydrocodone today. Note is made that he is due for a refill on 9/24/09. I have done a CCAP to look to see if there is any criminal activity with regards to selling narcotics on the Street and as best as I can tell the gentleman is clean and has no record. I will refill his hydrocodone today."

73. The Pain Medication Flow Sheet states that prescriptions were issued for methadone on 10/8/09, and for hydrocodone on 10/24/09.

74. On 11/9/09, the patient returned to care. Respondent charted: "I discussion of [*sic*] trying to get off of narcotics therapy because I feel in the long run it is not good for him due to the high risk of dependency, escalating doses of narcotics, bowel obstruction, aspiration, and a general degrading and diminishing of his general health status." Respondent then charted a plan to: "abandon hydrocodone, substitute with tramadol 50 mg, two every six hours, continue methadone 10 mg TID, dispense 90."

75. On 12/17/09, the patient returned to care, and reported being improved on the tramadol. The patient's methadone prescription was renewed.

76. On 1/6/10, the patient returned to care and reported that the tramadol was not helping, and that he desired to return to hydrocodone. Respondent charted that the patient had bilateral paraspinal muscle spasms, and otherwise appeared to be ill and in pain, with increased low back pain despite having doubled his methadone dosage. Respondent prescribed hydrocodone 7.5/APAP 325, take two every six hours, #240. There is no discussion in the chart concerning the patient's the length or effect of the methadone dosage change, or how many tablets patient may have had remaining.

77. On 1/13/10, the patient returned to care. Respondent charted that the patient had returned to work and no longer looked like he was in pain.

78. Respondent's medication flow sheet shows that on 2/5/10, the patient's hydrocodone prescription was renewed, and on 2/16/10, the patient's methadone prescription was renewed. These prescriptions were renewed on similar days in March, April, and May, 2010.

79. On 6/10/10, the patient returned to care and reported being able to work full time. Respondent charted that the patient wished to decrease his hydrocodone by 50%, and filled out a new set of pain questionnaires and agreement. Respondent's medication flow sheet shows that a prescription for hydrocodone 7.5/325, take one every six hours, #120, was issued.

80. The flow sheet shows that the patient's methadone and hydrocodone prescriptions were renewed in June, July, and August, 2010.

81. On 8/25/10, the patient returned to care, and reported that the hydrocodone has not helped and that he wished to discontinue it. The patient reported that he was recently arrested for

giving two of his hydrocodone pills to a friend who was in postoperative pain. The patient reported that he had been placed on two years' probation with 30 days in jail. Respondent charted: "reviewed this is in violation of pain contract. Discussed no more Vicodin now. Discussed weaning from methadone. Working to strengthen low back muscles and wean from methadone." An entry was made in the pain medication flow sheet, discontinuing the hydrocodone prescription. There is no indication that CCAP was rechecked.

82. The flow sheet reveals a 9/18/10 prescription for methadone 10 mg, take one TID, #90; another such prescription was issued on 10/18/10, although #88 were prescribed.

83. On 10/26/10, the patient returned to care and reported that he had been taking his methadone twice a day, instead of three times a day.

84. On 10/28/10, the patient returned to care, reporting an increase in his low back pain. Respondent charted his plan as: "Add gabapentin 300 mg at bedtime, reducing methadone to 10 mg b.i.d."

85. On 11/9/09, the patient provided a urine sample which was positive for methadone and opiates, based on the in-office result. The sample was not sent out for confirmatory testing. This is the last urine drug screen performed.

86. The flow sheet reveals that on 11/19/10, Respondent authorized a prescription for methadone 10 mg, take one TID, #86.

87. On 11/29/10, the patient returned to care and reported a recent knee injury. The patient further reported that the gabapentin was helping with his pain, but causing mental status changes. Respondent then charted that the patient had "failed gabapentin for low back pain management secondary to mental status changes." And: "On methadone 10 mg TID, desires to reduce to 10 mg b.i.d., will see back for refill 12/18."

88. On 12/8/10, the patient returned to care and reported taking methadone 10 mg b.i.d. The patient complained of increasing pain and pressure and his low back. Respondent prescribed nabumetone 500 mg, take two per day.

89. On 12/17/10, the patient returned to care and reported that his current medications were nabumetone 500 mg, take two per day, and methadone 10 mg b.i.d. Respondent charted that the patient had increased back pain and was unable to sleep or complete his shift at work. Respondent then prescribed methocarbamol 500 mg, take two every six hours.

90. The flow sheet reveals that on 12/19/10, Respondent authorized a prescription for methadone 10 mg, take one TID, #84.

91. On 1/8/11, the patient returned to care and reported that his only medication was methadone 10 mg b.i.d. The patient reported having an epidural steroid injection, which helped. The patient reported that he was working full time and reducing his methadone, and was not requesting a refill at this time. The patient reported that his sleep was disrupted, and Respondent

prescribed amitriptyline 25 mg at bedtime "for poor sleep and back pain management, gradual [*sic*] increase the dose as tolerated."

92. On 1/15/11, the patient returned to care and reported that his medications at that time were methadone 10 mg b.i.d., and amitriptyline 25 mg at bedtime. Patient reported an exacerbation in his low back pain when he rolled over in bed, resulting in his missing work for two days. The patient reported having weaned himself off methadone completely, but stated that he now needed to return to methadone 10 mg TID due to this increase in pain. The patient reported that the amitriptyline helped him with his sleep, but not the back pain. Respondent then prescribed methadone 10 mg, TID, #90, fill on 1/19; and hydrocodone 5/APAP 500, take two every six hours, #32; and recommended repeating the epidural steroid injection.

93. On 2/5/11, the patient returned to care and reported that he was doing well on the current regimen of methadone and amitriptyline. Respondent's flow sheet shows that on 2/19/11, Respondent renewed the patient's methadone prescription with 90 tablets.

94. On 3/19/11, the patient returned to care and reported that he was currently taking methadone 10 mg TID, hydrocodone 5/500, two every six hours, and amitriptyline 25 mg. The patient reported an increase in low back pain, and requested an increased dose of methadone. Respondent recommended increasing amitriptyline to 50 mg, and a Lidoderm® patch to be applied in the morning, and removed in the afternoon or evening. Respondent also recommended back strengthening exercises. The flow sheet records a prescription for methadone 10 mg, take two in the morning and two in the afternoon, and one at bedtime, #150. There is no discussion of where the patient may have obtained hydrocodone.

95. On 4/16/11, the patient returned to care and again reported his medications as methadone 10 mg TID, hydrocodone 5/500, take two every six hours, and amitriptyline 50 mg at bedtime. Respondent charted that the patient had stopped hydrocodone altogether. The patient reported taking five tablets of methadone per day, but that his back pain was somewhat reduced and that he would attempt to reduce to three times a day in the next month. The flow sheet demonstrates that 150 methadone were prescribed on this date.

96. On 5/14/11, the patient returned to care and reported being on methadone 10 mg TID, and amitriptyline 50 mg at bedtime. Respondent charted that the patient desired to decrease methadone to 10 mg TID and: "back pain – Tolerating taper of methadone well – will decrease methadone 2 in a.m., 2 in p.m., 1 at bedtime, to TID. Dispense 90 tabs 5/14/11." Respondent's flow sheet also reflects this change in the number prescribed.

97. The flow sheet demonstrates that on 6/3/11, Respondent ordered a prescription for methadone 10 mg TID #90.

98. The patient returned to care on 6/9/11. Respondent charted: "Had successfully cut down on methadone 10 mg, 2 in AM, 2 in PM, 1 at bedtime, to 1, TID, but now exacerbation. Failed aleve, Tylenol, ibuprofen. Had to have early refill methadone 6/3/11. Now taking methadone 10 mg, 2:00 AM, 5:30 AM, and 1 5:00 PM." Respondent then prescribed duloxetine 30 mg to improve pain control, and provided a 30 day supply of samples.

99. On 6/16/11, the patient returned to care, and reported that his medications were methadone 20 mg in the morning, and 10 mg at bedtime, amitriptyline 50 mg at bedtime, and duloxetine 30 mg daily. Respondent charted that the patient awoke previous two days with increased low back pain and was unable to move, resulting in his missing work. Massage, heat, and ice had failed to relieve his stiffness. Respondent prescribed meloxicam 15 mg, and provided a work excuse.

100. On 6/27/11, the patient returned to care and reported an increase in low back pain, resulting in inability to work. The patient requested a course of hydrocodone. Respondent discontinued the patient's meloxicam, recommended a repeat epidural steroid injection, then prescribed hydrocodone 7.5/APAP 325, take one every six hours, #120.

101. The flow sheet shows that on 7/3/11, Respondent authorized a prescription for methadone 10 mg, take one, TID, #90.

102. On 7/28/11, the patient returned to care. The patient reported that it had been a "bad month" and that he had missed eight days of work. The recommended epidural steroid injection occurred on 7/12/11. The patient reported that he had stopped the hydrocodone because it was not helping, and "requests to stop taper of methadone due to flareup and increase in pain, and requests returned to methadone 10 mg, take 2 in a.m., 2 in p.m., one at bedtime, dispense 150." Respondent agreed to this plan, and advised the patient to return in three months.

103. A reasonable physician would have conducted urine drug testing several times per year, would have required the patient to bring in his medications for pill counts, would not have misinformed the patient regarding the long-term effects of opioids, would not have renewed a prescription for a purported breakthrough medication at a rate which indicated that the patient was taking it at the maximum rate every day, would have followed up on the apparent consumption of unprescribed hydrocodone in March and April, 2011, would have sent any positive urine sample out for confirmatory testing, and would not have insisted that a compliant patient attempt to reduce or stop a medication which was effective. If gabapentin was to be given a reasonable trial, Respondent would have attempted the dosage of 1800-4800 mg per day.

#### PATIENT D

104. On 3/16/06, patient D, a man born in 1949, established care with Respondent. The patient history questionnaire stated that the patient was a laborer with a disability claim pending that he quit smoking three years previously, did not drink, and did not use illegal drugs. The patient reported having pins in his right knee, and 18 years of chronic pain following an auto collision which hospitalized him for one year. The patient reported having used in various opioids for pain, but none since 2002. The patient signed a "Chronic Opioid Analgesic Therapy Agreement." Respondent's chart note indicates that he had seen the patient some years previous, apparently at a different clinic. The patient's chief complaint is left low back pain, recently treated with tramadol which interferes with sleep. Respondent prescribed tramadol 50 mg, take two every six hours, #240, and requested that the patient returned in a month; Respondent also requested past medical records.

105. The patient continued to see another physician in Respondent's clinic until February, 2008, for various medical problems.

106. The patient next returned to Respondent's care on 12/8/10, with several complaints including shoulder pain secondary to rotator cuff injuries on both sides. The patient reported being prescribed Suboxone, but that Medicare would not pay for this medication after one year. The patient requested methadone 20 mg, QID. The patient signed an extensive history questionnaire, and a "Chronic Opioid Analgesic Therapy Agreement." Respondent noted that the patient is a recovering alcoholic. Respondent issued a prescription for methadone 20 mg, QID, #120, and instructed the patient to return in three months.

107. The patient's previous clinic sent the patient's last 3 years of records to Respondent in December, 2010. Respondent's records showed he received those records. Those records showed the patient's medical history included IV heroin addiction; polysubstance abuse; alcohol addiction; chronic shoulder pain; chronic knee pain; hepatic cirrhosis; and continuous opioid type dependence.

108. On 1/8/11, and 2/8/11, Respondent renewed the prescriptions for methadone.

109. On 3/8/11, the patient returned to care and reported that he was taking 20 mg of methadone, QID. There is no discussion in the chart about Respondent's actual pain levels. Respondent prescribed methadone 40 mg, TID, #360.

110. On 4/4/11, Respondent created the following chart entry: "have [patient's name] in to see me in the next week for follow up. It is okay to refill his script for 4/4/11 but make sure I do not refill 5/4/11 until I have seen him."

111. On 4/5/11, a member of Respondent's staff charted: "Dr. Turner okay with patient being seen in June for follow-up on pain med."

112. On 4/8/11, Respondent authorized a prescription for methadone 40 mg, QID, #480. No explanation is given for this change in dosage.

113. On 6/8/11, the patient returned to care. Respondent charted: "follow-up chronic pain management. Patient suffers severe 10/10 pain in low back, left shoulder, right leg and abdomen. Manage his pain with methadone 40 mg Q I D. Here for refill on pain meds. Has tried and failed Suboxone. History of hepatitis C and asked to avoid acetaminophen." Respondent further chartered that he reviewed alternatives, and: "need to transition from methadone to non-narcotic prescriptions of pain." Respondent renewed the patient's prescription for methadone 40 mg Q I D, #480, and asked the patient to return in two months.

114. The flow sheet indicates that on 7/8/11, the methadone prescription was renewed.

115. The patient returned to care on 8/8/11. The patient reported increasing back and abdominal pain, and attending AA meetings every day. The patient's prescription was renewed; no discussion was charted regarding any type of taper, or alternative therapy.

116. The flow sheet indicates that these prescriptions were renewed on 9/8/11, and 10/8/11.

117. A reasonable physician would have seen the patient at least monthly for the first three months, would have conducted urine drug testing several times per year, would have required the patient to bring in his medications for pill counts, and would not have insisted that a compliant patient attempt to reduce or stop a medication which was effective.

#### PRESCRIPTION PADS

118. On September 24, 2010, March 29, 2011, and May 1, 2012, Respondent has experienced theft of prescription pads or forms from his office or examination room by patients who, on each occasion, were left alone in these rooms, where printed prescription pads were left on a desk or counter.

#### SATISFACTORY COURSE COMPLETED

119. Respondent has demonstrated satisfactory completion of an acceptable course in appropriate prescribing of controlled substances: *Intensive Course in Controlled Substance Management*, offered by the Case Western Reserve University School of Medicine, Continuing Medical Education Program, May 8-11, 2012. He received 31 hours of category I continuing medical education credit.

#### CONCLUSIONS OF LAW

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

B. The conduct described in ¶¶2-118, above, violated Wis. Adm. Code § Med 10.02(2)(h). 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 Robert C. Turner, 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 provided in Wis. Stat. § 448.02(3)(e), and is restricted as follows:

- a. Respondent shall be allowed to prescribe opioids or opiates for more than 10 consecutive days at a time without seeing and re-evaluating the patient, or for more than 30 days in any 12 month period for any patient, only under the oversight of a Professional Mentor approved by the Board.

- b. Respondent is responsible for obtaining a Professional Mentor acceptable to the Board. A Professional Mentor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Department (including but not limited to any bartering relationship, mutual referral of patients, etc.). A Professional Mentor shall be actively practicing in Respondent's field of practice, hold a valid Wisconsin license, shall be board certified by an ABMS-recognized board in a specialty relevant to Respondent's field of practice, and shall have read this Final Decision & Order and agree to be Respondent's Professional Mentor.
- c. Oversight by the Professional Mentor shall include semi-monthly meetings, review of charts selected by the Professional Mentor, and any other actions deemed appropriate by the Professional Mentor to determine that Respondent is practicing in a professional and competent manner. The meetings required by the terms herein may be in person, telephonic or by any other means deemed satisfactory by the Professional Mentor to accomplish the goals set forth in this Order, but for the first three months, all meetings shall be in person, and thereafter, at least one meeting per month shall be in person.
- d. Respondent shall arrange for his Professional Mentor to provide formal written reports to the Department Monitor on a quarterly basis, as directed by the Department Monitor. These reports shall assess Respondent's work performance. Respondent's Professional Mentor shall immediately report to the Department Monitor and the Respondent's Supervising Health Care Provider any conduct or condition of the Respondent which may constitute unprofessional conduct, a violation of this Order, or a danger to the public or patient. If a report indicates poor performance, the Board may institute appropriate corrective limitations, or may revoke a stay of the suspension, in its discretion.
- e. The Professional Mentor may designate another qualified physician or other health care provider acceptable to the Board to exercise the duties and responsibilities of the Professional Mentor in an absence of more than three weeks.
- f. In the event that the Professional Mentor is unable or unwilling to continue to serve as Respondent's professional mentor, the Board may in its sole discretion select a successor Professional Mentor.
- g. The Professional Mentor shall have no duty or liability to any patient or third party, and the Mentor's sole duty is to the Board.
- h. The Limitation shall be removed from Respondent's license and Respondent will be granted a full, unrestricted license after satisfying the Board or its designee that he has eight consecutive satisfactory reports from the professional Mentor, and appears before the Board and satisfies the Board that his prescribing of opioids and opiates will not be a danger to the health safety or welfare of patient or public.

IT IS FURTHER ORDERED, that Respondent shall store all paper prescription forms in a manner designed to obstruct theft. Paper prescription pads or forms shall be kept in a locked and secure cabinet or drawer, unless Respondent is personally carrying them in his hand or a pocket of a garment which he is wearing. This shall not be deemed a limitation upon Respondent's license, but failure to comply is unprofessional conduct under Wis. Admin. Code § Med 10.02(2)(b). Nothing herein shall prohibit any clinic or location where Respondent practices from implementing a secure password access computer system for the recording and generation of prescriptions at a centralized location nor prevent Respondent from utilizing such a system.

IT IS FURTHER ORDERED, that Respondent shall pay the COSTS of investigating and prosecuting this matter of \$3,600, within four months of this Order.

IT IS FURTHER ORDERED, that pursuant to Wis. Stats. §§ 227.51(3) and 448.02(4), violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit payment of the costs as set forth above, the Respondent's license may, in the discretion of the board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has paid them in full, including any accrued interest.

Dated this June 20, <sup>2012</sup>~~2010~~.

WISCONSIN MEDICAL EXAMINING BOARD

by: Sheldon Wasserman, MD  
a member of the Board *SR*

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