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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE PETITION FOR SUMMARY SUSPENSION AGAINST	:	
	:	DLSC Case No. 15 MED 002
DAVID J. HOULIHAN, M.D., RESPONDENT.	:	000403

ORDER OF SUMMARY SUSPENSION

The Petition for Summary Suspension of David J. Houlihan, M.D.'s license and registration to practice medicine and surgery, dated March 14, 2016, was noticed to be presented on March 16, 2016 before the Wisconsin Medical Examining Board. At that time, Attorney Yolanda McGowan appeared for the Petitioner, the Department of Safety and Professional Services, Division of Legal Services and Compliance. The Respondent appeared in person along with his attorney, Frank Doherty.

The Wisconsin Medical Examining Board, having considered the sworn March 14, 2016 Petition for Summary Suspension, the Affidavit of Yolanda McGowan as evidence, the Affidavit of Regina Reynolds and attached exhibits (A-E) as evidence, and the Affidavit of Mailing of Meena Balasubramanian swearing that a true and accurate copy of the Notice of Presentation of Petition for Summary Suspension dated March 14, 2016, a Petition for Summary Suspension dated March 14, 2016, an Affidavit of Yolanda McGowan dated March 14, 2016, an Affidavit of Regina Reynolds and attached exhibits (A-E) dated March 14, 2016, and a Petition for Designation of Hearing Official dated March 14, 2016, had been mailed via certified and regular U.S. Mail, as well as electronic mail, to the Respondent and to his attorney, Frank M. Doherty, and having heard the arguments of counsel, hereby makes the following:

FINDINGS OF FACT

1. Respondent David J. Houlihan, M.D. (DOB February 4, 1964), is licensed in the state of Wisconsin to practice medicine and surgery, having license number 35991-20, first issued on September 23, 1994, with registration current through October 31, 2017.

2. Respondent's most recent address on file with the Department is W5119 Knobloch Road, La Crosse, WI 54601.

3. At all times pertinent to this matter, Respondent practiced medicine at the Veterans Administration Medical Center located in Tomah, Wisconsin (Tomah VA). Respondent's practice specialty is psychiatry.

4. Respondent's medical practice at Tomah VA began in 2002 as an outpatient psychiatrist.

5. Respondent continued to serve as an outpatient psychiatrist while assuming various management roles at Tomah VA, including Clinical Director of Mental Health, Acting Chief of Staff, Chief of Staff, and Acting Medical Center Director.

6. Effective January 16, 2015, Respondent's clinical privileges at Tomah VA were summarily suspended based upon concerns that Respondent's clinical practice did not meet the accepted standards of practice and potentially constituted an imminent threat to patient welfare.

7. Effective November 9, 2015, Tomah VA terminated Respondent's employment and revoked his clinical privileges.

8. Respondent's employment was terminated and his clinical privileges were revoked based on the determination that:

a. Respondent failed to provide appropriate medical care to at least 22 patients between 2005 and 2014, and

b. Respondent engaged in professional misconduct involving eight reported incidents of abuse of authority occurring between 2008 and 2013.

9. The Department opened case number 15 MED 002 to investigate the reported overdose/mixed drug toxicity death of a Tomah VA patient. The investigation is ongoing.

15 MED 002

10. At all times pertinent to 15 MED 002, Respondent was the Chief of Staff at Tomah VA. In his role as Chief of Staff, Respondent provided and directed or supervised the provision of healthcare services to veterans of the United States Military.

11. In or around 2003, Patient A (a male born in 1978) presented to Tomah VA to establish care. He returned to Tomah VA in 2005 requesting treatment for addiction. He reported using/abusing opioids he received from a friend.

12. From 2005 through 2013, Patient A was seen intermittently at Tomah VA for treatment of addiction and numerous significant mental health diagnoses including PTSD, generalized anxiety disorder, ADHD, and Bi-polar I Disorder.

13. In October 2013, Patient A reported to Tomah VA officials that he had recently used opioids and was afraid of a complete relapse.

14. On April 8, 2014, following trials of various treatment alternatives, Tomah VA psychiatrist Dr. K.[1] prescribed Patient A 8 mg of Suboxone® to be taken once daily following the

[1] Dr. K., upon information and belief, is not, was not, and has never been licensed as a physician by the State of Wisconsin Medical Examining Board, and is not a subject of this investigation.

patient's reported cravings for "pain pills." A seven-day supply of Suboxone® was mailed to Patient A on the same date.

15. On April 16, 2014, Patient A contacted Tomah VA and reported experiencing bad side effects from using Suboxone®, including bright red discoloration and burning sensations on his face; itching and swelling of his hands; trouble swallowing, and the sensation that his throat was swelling. Patient A requested termination of the Suboxone® prescription.

16. On April 23, 2014, Patient A contacted Tomah VA requesting additional Suboxone® medication, but at a significantly lower dosage. On April 24, 2014, Patient A received a seven-day supply of 2 mg of Suboxone®.

17. On April 28, 2014, Patient A again contacted Tomah VA and requested additional Suboxone® after reportedly taking his seven-day supply in four days. Dr K. refused to provide additional Suboxone® until Patient A presented for weekly urine drug screens, and attended meetings with a Tomah VA case manager, and alcohol or other drug support groups.

18. On April 30, 2014, Patient A notified Tomah VA that he no longer wanted Suboxone® as he had researched it and "it was not for him."

19. On May 28, 2014, Patient A was admitted to Tomah VA for anxiety and suicidal threats. He was discharged on June 30, 2014, then re-admitted on July 11, 2014, having reportedly taken benzodiazepines at a higher rate than prescribed.

20. At the time of the above-described discharge and re-admission, Patient A's list of outpatient medications included, in part: clonazepam, diazepam, diphenhydramine, duloxetine HCL, hydroxyzine pamoate, temazepam, tramadol, and zolpidem.[2] These medications were prescribed to Patient A by Dr. D., an inpatient psychiatrist at Tomah VA, and an active participant in the care and treatment of Patient A.[3]

21. On July 23, 2014, Patient A asked to be discharged from Tomah VA against medical advice for what he characterized as a lack of treatment when he was "going crazy." On July 25, 2014, Patient A was discharged from Tomah VA and transferred, at his request, to the Veterans Administration Medical Center in Madison, WI.

22. On August 10, 2014, Patient A returned to Tomah VA and was re-admitted following reports of suicidal thoughts, feeling out of control, and complaints of low back pain. Dr. D. developed an interdisciplinary treatment and education plan which included tapering down the benzodiazepines Patient A was taking.

23. On August 22, 2014, while Patient A was still receiving inpatient care at Tomah VA, Respondent saw Patient A for an outpatient appointment for "Pharmacy Management" and

[2] Medications prescribed to Patient A and referenced herein will be more specifically described in an exhibit to Investigator Reynolds' Affidavit in support of this petition.

[3] Dr. D. is a Wisconsin-licensed physician and co-Respondent in 15 MED 002. Separate disciplinary action is being pursued against Dr. D. based upon Dr. D.'s role in the care and treatment of Patient A.

"Further Evaluation." Respondent anticipated assuming Patient A's care upon his expected discharge from inpatient treatment.

24. On August 28, 2014, Dr. D. consulted Respondent for what Dr. D. documented in Patient A's healthcare chart as Patient A's request "...to go back on Suboxone® in hopes that it will help alleviate his chronic pain and potentially decrease his overall level of anxiety...." Dr. D. charted Respondent's agreement to restart Suboxone® at a dosage of 8 mg twice daily.

25. On August 29, 2014, Respondent prescribed Patient A 8 mg of Suboxone® twice daily.

26. On the morning of August 29, 2014, Patient A was administered the first of three doses of Suboxone® in a 24 hour period. The second dose was administered the same evening and the third dose, the following morning.

27. On the afternoon of August 30, 2014, Patient A was found unresponsive in his Tomah VA hospital room, and was pronounced dead a few hours later.

28. When Respondent prescribed Suboxone® for Patient A, he did not adjust or cause to be adjusted, any of the medications Patient A was receiving at the time, which included:

a. atomoxetine 80 mg daily,
b. diazepam 20 mg 3x daily,
c. diphenhydramine HCL 50 mg as needed,
d. duloxetine 60 mg 2x daily,
e. hydroxyzine pamoate 50 mg as needed,
f. quetiapine fumarate 50 mg 2x daily as needed,
g. quetiapine fumarate 100 mg daily at night as needed,
h. temazepam 30 mg every night, and
i. tramadol 50mg 4x daily as needed.

29. When prescribing Suboxone® to Patient A, Respondent did not inquire into, or otherwise assess whether Patient A was at increased risk of harm for a potentially severe allergic reaction to receiving 8 mg of Suboxone®.

30. When Respondent prescribed Suboxone® to Patient A, Patient A's history of frequently adjusting and/or discontinuing medications on his own; taking medications that were not prescribed for him; taking excessive amounts of benzodiazepines and other medicines, and obtaining controlled substances illegally was reflected in the patient's Tomah VA healthcare record.

31. Patient A had no active opioid prescriptions at the time Respondent prescribed him Suboxone®, and had reported no opioid use since October 2013, and no opioid addiction since 2010.

32. When prescribing Suboxone® to Patient A, Respondent did not in any way document the prescription order, including its risks and benefits.

33. When prescribing Suboxone® to Patient A, Respondent did not inform Patient A:

a. of the risks and benefits of treatment with Suboxone®, particularly in a patient with a reported allergic reaction to Suboxone®, and of other available alternate, viable modes of treatment and about the benefits and risks of these treatments.

b. of the significant risks associated with adding Suboxone® to the list of other controlled substance medications Patient A was receiving, and of other available alternate, viable modes of treatment and about the benefits and risks of these treatments.

c. of the risks and benefits of treatment with Suboxone® in a patient who had no active opioid addiction or who was not otherwise using or abusing opioids.

d. that Suboxone® for the use of pain and/or anxiety was not an FDA-approved use of Suboxone®, or of the risks and benefits associated with using Suboxone® for the treatment of pain or anxiety.

34. A minimally competent and reasonable physician would have known that adding Suboxone® to the treatment plan of a patient already receiving multiple other controlled substances with sedating properties would subject the patient to an unacceptable risk of adverse health consequences, up to, and including over-sedation, increased respiratory depression, mixed-drug toxicity, and/or death.

35. A minimally competent and reasonable physician would have known that a patient simultaneously receiving diazepam, Suboxone®, temazepam, and tramadol, or any combination of two or more of these controlled medications at the same time, would subject the patient to an unacceptable risk of adverse health consequences, up to, and including increased respiratory depression, over-sedation, mixed-drug toxicity, and/or death.

36. A minimally competent and reasonable physician would have known that with Patient A's history of dependence on and abuse/misuse of controlled substances, that prescriptions for multiple and significant dosages of controlled substances would subject Patient A to an unacceptable risk of adverse health consequences, up to, and including increased respiratory depression, over-sedation, mixed-drug toxicity, and/or death.

37. A minimally competent and reasonable physician treating Patient A:

a. would have reduced, discontinued or otherwise modified Patient A's controlled substance medications to reduce the unacceptable risk of adverse health consequences to the patient,

b. would not have added an additional controlled substance with sedative properties (Suboxone®) to the medications the patient was already receiving, and/or

c. would have utilized extreme caution and careful monitoring of the patient to protect against an unacceptable risk of harm due to increased respiratory depression and other risks of adverse health consequences created by the concurrent administration of multiple benzodiazepines and opioids.

38. A minimally competent and reasonable physician would have assessed the risks and benefits, and evaluated the appropriateness of prescribing 8 mg of Suboxone® twice daily to a patient with reported allergic reactions to Suboxone® which included facial redness, throat swelling, and difficulty swallowing.

39. A minimally competent and reasonable physician would have informed Patient A of the potential for complications regarding treatment with Suboxone® alone, and in combination with the other controlled substance medications Patient A was receiving, particularly in a patient with no active opioid abuse or use, and a reported potentially severe allergic reaction to Suboxone®.

40. Respondent David J. Houlihan, M.D., failed to act as a minimally competent and reasonable physician in the care and treatment of Patient A.

41. Respondent David J. Houlihan, M.D., by the conduct described herein, was negligent in his treatment of Patient A.

42. Respondent David J. Houlihan, M.D., departed from or failed to conform to the standard of minimally competent medical practice as previously described, creating the unacceptable risk that Patient A would suffer adverse health consequences, up to, and including death. By said conduct, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(2)(b) (Oct. 2013)[4].

43. Respondent David J. Houlihan, M.D., by prescribing or ordering prescription medication in a manner that is inconsistent with the standard of minimal competence as previously described, created the unacceptable risk that Patient A would suffer adverse health consequences, up to, and including death. By said conduct, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(2)(c) (Oct. 2013).

44. Respondent David J. Houlihan, M.D., by providing care and treatment to Patient A without informing him about the risks and benefits of treatment as previously described, and about the availability of other alternate medical modes of treatment and the risks and benefits of these treatments, created the unacceptable risk that Patient A would suffer adverse health consequences, up to, and including death. By said conduct, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(2)(j) (Oct. 2013).

45. Respondent David J. Houlihan, M.D., by failing to establish and maintain timely patient health care records as previously described, engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(3)(e) (Oct. 2013).

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[4] All references to Chapter Med of the Wisconsin Administrative Code are to the version of the Code in effect at the time of the alleged conduct: November 2002 for conduct occurring prior to October 1, 2013, and October 2013 for conduct occurring on and after October 1, 2013.

46. Respondent routinely provided care outside the scope of a general psychiatric practice by providing pain management services as the primary focus of treatment to patients presenting with mental health complaints.

47. Respondent, as an outpatient-clinic psychiatrist, acted in many instances as the sole health care provider for patients presenting with complaints of chronic pain. Respondent prescribed various combinations of controlled substances, in dosages greatly exceeding the recommended daily amount, for periods extending 12 years, and to patients who had no primary healthcare provider. Respondent did not refer these patients to primary care, pain management, or other providers, nor did he consult with any specialists in treating patients with chronic pain complaints.

48. When treating patients presenting with chronic pain complaints, Respondent routinely prescribed opioids in doses that greatly exceeded the recommended maximum daily amount, and without sufficient supporting documentation.

49. Respondent treated patients complaining of chronic pain with high doses of controlled substances in direct contradiction of written recommendations by other, more qualified providers, and/or without consulting other, more qualified providers.

50. Respondent David J. Houlihan, M.D., failed to act as a minimally competent and reasonable physician by practicing outside the scope of general psychiatry in his treatment of patients presenting with complaints of chronic pain. Respondent David J. Houlihan, M.D., has practiced, is practicing, and/or is attempting to practice under a license when unable or unwilling to do so with reasonable skill and safety, and has thereby created, is creating, and/or will create an unacceptable risk of harm to patients or the public. By said conduct, Respondent engaged in, is engaging in, or will engage in unprofessional conduct as defined by Respondent David J. Houlihan, M.D., by prescribing or ordering prescription medication in a manner that is inconsistent with the standard of minimal competence is creating, and/or will create the unacceptable risk that patients have suffered, are suffering or will suffer adverse health consequences, up to, and including risk of accidental death or injury due to over-sedation, substance abuse, mixed-drug toxicity or other adverse side effects.

51. Respondent David J. Houlihan, M.D., practiced medicine beyond the scope of his license, practiced medicine when unable or unwilling to do so with reasonable skill and safety, departed from or failed to conform to the standard of minimally competent medical practice, and performed medical acts without required informed consent, thereby creating the unacceptable risk that patients would suffer adverse health consequences from lack of appropriate chronic pain management, including risk of injury or death due to over-sedation, substance abuse, inadequate treatment of chronic pain, and adverse side effects of medications used alone or in combination with others.

52. On multiple occasions between 2008 and 2013, Respondent engaged in inappropriate, unfair, and intimidating actions which fostered an environment in which Tomah VA staff felt unable to openly communicate concerns about potentially unsafe prescribing practices, and deliberately refrained from communicating with or consulting with Respondent

about patient care issues to avoid hostility and confrontation. Respondent's disruptive behavior was the result of Tomah VA staff members questioning Respondent's prescriptive practices.

53. Respondent's conduct was disruptive, threatening, or harsh, or was otherwise reasonably expected to adversely impact the quality of health care rendered to patients by members of Tomah VA's pharmacy, social work, and physician assistant staff in the performance of their duties.

54. A minimally competent and reasonable physician would not engage in repeated or significant disruptive behavior or interaction with hospital personnel that could reasonably be expected to adversely impact the quality of health care rendered.

55. Respondent David J. Houlihan, M.D., failed to act as a minimally competent and reasonable physician in his interactions with hospital personnel and use of his authority as Tomah VA Chief of Staff.

56. Respondent David J. Houlihan, M.D., by engaging in repeated or significant disruptive behavior or interactions with hospital personnel, or otherwise abusing his authority as Tomah VA Chief of Staff as previously described, created an unacceptable risk that the quality of patient care at Tomah VA would be adversely impacted. Respondent's conduct tends to constitute a danger to the health, welfare, or safety of patient or public.

57. Based upon the foregoing, there is probable cause to believe that:

a. Respondent is unable or unwilling to practice medicine and surgery with reasonable skill and safety, and that it is necessary to suspend Respondent's license immediately to protect the public health, safety, or welfare.

b. Respondent is engaging in, has engaged in, or is likely to engage in unprofessional conduct or negligence in treatment, and as such, is subject to discipline pursuant to Wis. Stat. § 448.02(3).

58. Based upon the above findings of fact contained in paragraphs 1 through 57, there is probable cause to believe that the Respondent has committed unprofessional conduct and that it is necessary to suspend the Respondent's license and registration, immediately, to protect the public health, safety, or welfare.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction over this matter pursuant to Wis. Stat. § 448.02(3) and has authority to summarily suspend the license and registration of Respondent David J. Houlihan, M.D., to practice medicine and surgery in the state of Wisconsin, pursuant to Wis. Stat. § 448.02(4) and Wis. Admin. Code ch. SPS 6.

2. Sufficient notice of this proceeding has been given to Respondent David J. Houlihan, M.D. as required by Wis. Admin. Code § SPS 6.05.

3. There is probable cause to believe that Respondent David J. Houlihan, M.D, has engaged in unprofessional conduct as defined by Wis. Admin. Code §§ Med 10.02(2)(h), (i), (j), (q), (u) and (za) (Nov. 2002) and Wis. Admin. Code §§ Med 10.03(2)(a), (b), (c), (e,) and (j) and 10.03(3)(e) (Oct. 2013), and is therefore, subject to discipline pursuant to Wis. Stat. § 448.02(3).

4. It is necessary to immediately suspend Respondent David J. Houlihan, M.D.'s license and registration to practice medicine and surgery, to protect the public health, safety, or welfare.

ORDER

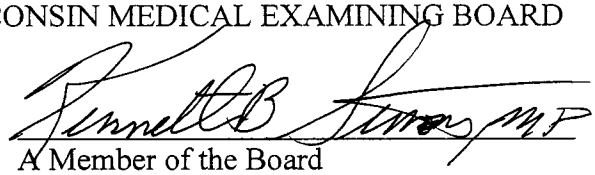
1. That pursuant to Wis. Stat. § 448.02(4), the license and registration issued to Respondent David J. Houlihan, M.D. (license no. 35991-20), to practice medicine and surgery in the state of Wisconsin, is summarily SUSPENDED, effective immediately upon actual notice of this summary suspension order to David J. Houlihan, M.D.; or upon service of this Order of Summary Suspension upon David J. Houlihan, M.D., pursuant to Wis. Stat. § 801.11, whichever is sooner, and shall remain in effect until the effective date of a Final Decision and Order issued in a disciplinary proceeding against Respondent, unless otherwise ordered by the Wisconsin Medical Examining Board.

2. A notice of hearing commencing disciplinary proceedings under Wis. Admin. Code § SPS 2.06 against Respondent David J. Houlihan, M.D., shall be filed with the Division of Hearing and Appeals by the Department of Safety and Professional Services, Division of Legal Services and Compliance within ten (10) days of the issuance of this Order.

3. Respondent David J. Houlihan, M.D., is hereby notified of his right, pursuant to Wis. Stat. § 448.02(4)(b) and Wis. Admin. Code § SPS 6.09, to request a hearing to show cause why this summary suspension order should not be continued and is further notified that any request for a hearing to show cause should be filed with the Wisconsin Medical Examining Board, 1400 East Washington Avenue, Post Office Box 8366, Madison, Wisconsin 53708-8366.

4. In the event that Respondent David J. Houlihan, M.D., requests a hearing to show cause why the summary suspension should not be continued, that hearing shall be scheduled to be heard on a date within 20 days of receipt by the Wisconsin Medical Examining Board of Respondent's request for hearing, unless Respondent requests or agrees to a later time for the hearing.

WISCONSIN MEDICAL EXAMINING BOARD

By:  3/16/2016

A Member of the Board — Date