STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

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| IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST | : | |
| MERNE ASPLUND, M.D., RESPONDENT. | : | FINAL DECISION AND ORDER |

The parties to this proceeding for the purposes of sec. 227.53, Wis. Stats., are:

Merne Asplund, M.D.
1518 Main Street
Bloomer, WI 54724

Wisconsin Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708

Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708

The Wisconsin Medical Examining Board received a Stipulation submitted by the parties to the above-captioned matter. The Stipulation, a copy of which is attached hereto, was executed by Merne Asplund, M.D., Respondent; William A. Adler, attorney for Respondent; and Judith Mills Ohm, attorney for Complainant, Department of Regulation and Licensing, Division of Enforcement. The Board has reviewed the Stipulation, considers it acceptable and adopts it. Accordingly, the Board makes the following Findings of Fact, Conclusions of Law and Order:

## FINDINGS OF FACT

1. Merne Asplund, M.D., Respondent herein, date of birth August 12, 1928, is a physician licensed and registered to practice medicine and surgery in the State of Wisconsin pursuant to license #11754, which was granted on February 4, 1954.

2. Respondent engages in the general practice of medicine.

## COUNT I

3. Respondent provided medical care and treatment to Patient A in Respondent's office, for a variety of medical problems, from October 1964 until October 1985. Respondent also treated Patient A when Patient A was hospitalized for various medical problems during that time period.

4. On October 18, 1985, Patient A, a 76 year old male, was admitted to Bloomer Community Memorial Hospital with acute dyspnea and weakness. Respondent was the attending physician throughout Patient A's hospitalization. On October 18, Respondent noted that Patient A was dyspneic with chronic passive congestion (CPC), Patient A's respiratory rate was 45 per minute, Patient A had slight cyanosis of the nail beds and Patient A had atrial fibrillation. Respondent ordered oxygen for Patient A, at 3 liters per minute, by nasal catheter, a pro-time test, electrolytes, serum Digoxin level, BUN, blood sugar, a cardiac monitor, Digoxin .25 mg, Lasix 40 mg, T.I.D. and a hold on Warfarin. The cardiac monitor tracing showed atrial fibrillation and frequent PVC's, up to 16 per minute. The nurses frequently notified Respondent of the monitor rate and rhythm.

5. On October 19, 1985, Respondent noted that Patient A was less tachypnic. Respondent also noted that "atrial fibrillation continues with many PVC". At 12:16 p.m., the nurses' notes indicate that Patient A's cardiac monitor was tracing intermittent ventricular tachycardia. Respondent was notified of this and ordered that Patient A's care be continued as is at present. At approximately 5:30 p.m., Respondent was notified that Patient A's cardiac monitor was tracing ventricular tachycardia. The nurses did not receive any new orders from Respondent. Patient A was occasionally short of breath on October 19.

6. On October 20, 1985, at about 12:30 a.m., a nurse notified Respondent of Patient A's monitor tracings and low urinary output. No new orders were received from Respondent. At 3:10 a.m., a nurse notified Respondent of Patient A's status and requested permission to start an IV. No new orders were received from Respondent. Patient A was very short of breath, with rapid and labored respirations. Patient A continued to receive 3 liters per minute of oxygen. Respondent's progress note for October 20 indicates that the "night nurses suggest that we are dealing with flutter fibrillation rather than bursts of ventricular tachycardia". Respondent noted that Patient A still had tachypnea, especially without oxygen.

7. On October 21, 1985, Patient A continued to be very short of breath with labored respirations. Patient A's oxygen was continued at 3 liters per minute. Patient A's total intake by mouth was 750 cc. and Patient A voided 392 cc. on October 21. Respondent's progress note indicated "urine output is poor". At about 4:45 a.m., Respondent ordered an IV for Patient A, normal saline, to keep open. At approximately 10:30 p.m., Respondent ordered a lactated ringers solution, by IV, at 100 cc. per hour.

8. On October 21, 1985, at 8:00 a.m., a nurse indicted that the monitor showed atrial fibrillation with varying rate and QRS formations. At approximately 9:30 a.m., the cardiac monitor was discontinued, per Respondent's order. Respondent's progress note indicates that Patient A's CPC was the major problem and not Patient A's arrhythmia.

9. On October 22, 1985, Patient A's estimated total intake by mouth was 990 cc. and estimated output was 420 cc. Respondent ordered that Patient A's IV be discontinued. Respondent noted that CPC was still Patient A's major problem. At approximately 11:45 p.m., Respondent noted that Patient A was unable to void and Respondent was unable to catheterize Patient A. Respondent noted that he did get about two ounces of clear yellow urine; Respondent then placed a trocar but got no urine back. Respondent noted that if Patient A's urine output did not increase, he would do a cystostomy in the morning.

10. Patient A continued to be short of breath and received oxygen, three liters per minute, on October 22, 1985.

11. On October 23, 1985, Respondent was preparing to do a cystostomy on Patient A, when Patient A voided about 100 cc. of coffee-colored urine. Respondent noted that he could not feel Patient A's bladder and decided to defer the cystostomy.

12. On October 23, 1985, Patient A's estimated total intake by mouth was 1200 cc. and estimated output was 650 cc. The nurses' notes for October 23 indicate that at approximately 6:00 p.m., Patient A was up on the edge of the bed and reading the paper, offering no complaints.

13. On October 24, 1985, the nurses' notes indicate that Patient A's respirations were labored, up to 32 per minute at times. Patient A continued to receive oxygen at the rate of three liters per minute. The nurses' notes also indicate that at 2:00 p.m., Patient A was unable to void and felt no urge to void or bladder fullness. At approximately 9:00 p.m., Respondent was notified that the patient had not been able to void for several hours. No new orders were received from the Respondent. Patient A's estimated total intake by mouth was 1025 cc. and estimated output was 45 cc. on October 24.

14. On October 24, 1985, a chest x-ray was taken of Patient A. The x-ray report indicates that the chest x-ray was compared to the previous chest x-ray taken on October 18. The roentgenologist noted that there appeared to have been some improvement. The impression was that the patient had improving congestive heart failure.

15. On October 25, 1985, at approximately 3:20 a.m., Respondent was notified of Patient A's continued inability to void and that Patient A complained of abdominal pain and that his abdomen was distended. Respondent ordered the nurse to attempt catheterization. The nurse was unable to catheterize Patient A. The nurse noted that Patient A did void 15 cc. amber urine in the urinal and was incontinent of approximately 30 cc. of urine. Patient A's estimated total intake by mouth was 700 cc. and estimated output was 235 cc. on October 25.

16. On October 25, 1985, at approximately 8:00 a.m., Patient A was short of breath with oxygen at three liters per minute. At approximately noon, Respondent wrote orders to try Patient A without oxygen. The nurses' notes indicate that Patient A was short of breath at rest and with exertion. Patient A's oxygen was restarted at approximately 7:30 p.m., at three liters per minute.

17. On October 25, 1985, at approximately 11:05 p.m., Patient A was found by the nurse with no respirations, no blood pressure and no radial or apical pulse present. Patient A died on October 25, 1985.

18. Respondent noted the cause of death for Patient A to be congestive heart failure.

19. Respondent's conduct in providing medical care and treatment to Patient A fell below the minimum standards of competence established in the profession in the following respects:

a. Respondent failed to take steps to diagnose the cause of Patient A's dyspnea, despite the fact that Patient A was extremely dyspneic when he was admitted to the hospital and continued to be dyspneic throughout his hospitalization. Respondent did not order blood gases for Patient A to determine whether Patient A was hypoxic. Respondent ordered that Patient A's oxygen be discontinued on October 25, 1985, despite the fact that Patient A was very dyspneic at that time. Respondent failed to seriously evaluate the possibility that Patient A could have a pulmonary problem, such as a pulmonary embolus.

b. Respondent failed to take steps to diagnose the cause of Patient A's deteriorating medical condition. Respondent assumed that Patient A was failing because of overwhelming myocardial decompensation and that Patient A died of congestive heart failure. However, the chest x-rays of Patient A taken on October 18 and 24, 1985, do not completely support the assumption that myocardial decompensation was the primary cause of Patient A's deteriorating medical condition.

c. Respondent failed to properly diagnose and treat Patient A for his problems with decreased urinary output. Respondent failed to seek consultation with a urologist when Respondent found that Patient A was not voiding, did not have an enlarged bladder and when placing a catheter did not produce urine. Respondent failed to order a urinalysis for Patient A, which could have provided information regarding Patient A's fluid status. On October 23, 1985, Respondent planned to do a cystostomy, a surgical incision into the urinary bladder, without taking adequate steps to determine the cause for Patient A's problems with decreased urinary output.

d. Respondent failed to adequately evaluate and respond to Patient A's intake and output reports, which indicated a decreased level of urinary output. Respondent failed to consider that Patient A's decreased urinary output could have been because Patient A was dehydrated because he was not receiving an adequate fluid intake.

e. Respondent failed to adequately diagnose and treat Patient A for his cardiac problems. Respondent failed to order a 12-lead EKG or any cardiac enzymes for Patient A, to determine whether Patient A had suffered a myocardial infarction and to obtain additional information regarding the current status of Patient A's cardiac condition. When Patient A's cardiac condition did not improve, Respondent failed to offer Patient A the opportunity to be referred to a cardiologist.

f. On October 21, 1985, Respondent ordered that Patient A should receive a lactated ringers solution, by IV. Lactated ringers solution has a high solute load and it was inappropriate for Respondent to order this for a patient in congestive heart failure.

20. Respondent's conduct in providing medical care and treatment to Patient A created the following unacceptable risks to the patient:

a. Respondent's failure to take steps to diagnose the cause of Patient A's dyspnea created the unacceptable risk that the cause of Patient A's dyspnea would not be determined and that Patient A could have a pulmonary embolus which, if untreated, could result in heart failure and death.

b. Respondent's failure to take steps to determine the cause of Patient A's deteriorating medical condition created the unacceptable risk that the cause of Patient A's deteriorating medical condition would not be determined, that Patient A's medical condition would continue to deteriorate and that Patient A would die.

c. Respondent's failure to properly diagnose and treat Patient A for his problems with decreased urinary output and Respondent's failure to adequately evaluate and respond to Patient A's intake and output reports created the unacceptable risk that Patient A would suffer renal failure, become dehydrated, or both, and that Patient A would die.

d. Respondent's failure to properly diagnose and treat Patient A for his cardiac problems created the unacceptable risk that Patient A would continue to suffer from cardiac problems, which could further progress to ventricular fibrillation, and that Patient A would die.

e. Respondent's use of lactated ringers solution, which has a high solute content, created the unacceptable risk that Patient A's congestive heart failure would become worse and that Patient A would die.

## COUNT II

21. Respondent provided medical care and treatment to Patient B in Respondent's office, for a variety of medical problems, from December 1955 until September 1985. Respondent also treated Patient B when Patient B was hospitalized for various medical problems, including several myocardial infarctions, during that time period.

22. On September 25, 1985, Patient B, a 77 year old male, was admitted to Bloomer Community Memorial Hospital with chest pains and dyspnea. Respondent was the attending physician throughout Patient B's hospitalization. In the admission record, Respondent noted that Patient B had an acute onset of chest pain approximately one hour before being hospitalized, with radiation to the left side of the anterior chest but not into the neck or arm. Respondent noted that Patient B had been seen in Respondent's office approximately five days to one week before the admission, complaining of severe dyspnea. Respondent recorded that Patient B's lungs sounded congested, but Respondent did not hear moist rales in the bases. Respondent's impression was that Patient B had "atherosclerotic cardiovascular disease, functional class IV. Rule out an acute MI".

23. On September 25, 1985, Respondent entered the following orders for Patient B: oxygen, cardiac enzymes, electrolytes, cardiac monitor, EKG, Digoxin level, IV Lasix 40 mg, morphine sulfate, Digoxin .25 mg every day, and foley catheter. Patient B received three liters to six liters per minute of oxygen, by nasal catheter. Respondent's impression regarding the EKG was that two PVC's were seen, but no specific changes of an acute MI were present on the remaining tracing. Respondent's progress note for September 25 indicated that the patient was tachypnic and had moisture in his lung bases.

24. On September 26, 1985, Respondent's progress note indicates that Patient B's CPK was slightly elevated. Respondent noted "MI confirmed". Respondent also noted that Patient B's lungs were clear with no moisture. Patient B continued to receive oxygen at the rate of six liters per minute. The nurses' notes indicate that Patient B's respirations were slightly labored. At approximately 7:00 p.m., the nurses' notes indicate that Patient B was very restless, confused and agitated, and that he thought someone or everyone was trying to kill him, including a family member. Patient B also pulled apart his IV tubing. At approximately 10:40 p.m., the nurse notified Respondent of Patient B's continued restlessness, wheezing, and what sounded like rales. Respondent ordered that the nurse should decrease the lidocaine and slow the IV rate for Patient B.

25. On September 27, 1985, Respondent ordered a chest x-ray at the bedside for Patient B. The x-ray report indicates that the heart was enlarged, there were congestive changes, there appeared to be pleural fluid and an alveolar infiltrate in the axillary segment of the right upper lobe. The roentgenologist suggested that a superimposed inflammatory process or an area of pulmonary infarction would be considerations.

26. On September 27, 1985, Patient B had rusty sputum with dyspnea. Patient B continued to receive oxygen by nasal catheter. Patient B was restless, agitated and disoriented for much of the day on September 27. Patient B pulled out his oxygen catheter and his IV several times on September 27.

27. On September 28, 1985, Respondent noted that Patient B's lungs were full of rales all over. Respondent noted that he favored the diagnosis of pulmonary infarction and believed anti-coagulants were indicated. Respondent ordered a pro-time stat, and ordered that if the results were 85% or more, then give 25 mg Warfarin. The results of the pro-time test were control-11.4, 49%, ratio-1.30. Respondent then ordered that Patient B should receive 15 mg Coumadin rather than 25 mg.

28. On September 28, 1985, Patient B continued to receive oxygen at six liters per minute. Patient B was somewhat restless on September 28 and continued to cough up grayish and rusty sputum.

29. On September 29, 1985, Respondent wrote an order to try Patient B without oxygen. The oxygen was discontinued at approximately 10:30 a.m., but restarted because of Patient B's increased shortness of breath. Respondent also ordered that Patient B should receive five mg Coumadin, and a pro-time chart should be set up, with the pro-times beginning the next day and continuing daily.

30. A chest x-ray of Patient B was taken on September 29, 1985. It indicated extensive pulmonary alveolar consolidation involving almost the entire right upper lobe and other areas of pulmonary consolidation. The roentenologist's report stated that the findings suggest two processes, namely cardiac decompensation with pulmonary interstitial edema as well as supraimposed alveolar consolidation, which may be secondary to pulmonary edema, infection or even hemorrhage.

31. The nurses' notes for September 29, 1985, at 10:15 p.m., indicate that Patient B became agitated and pulled out the oxygen catheter and attempted to pull out the IV and foley catheter. Respondent was notified of this. Respondent's progress notes indicate that Patient B was hypoxic and thus disoriented. Respondent ordered Sparine, 25-50 mg at bed time, for Patient B. The nurses' notes indicate a late entry for 10:15 p.m., which states that Patient B had audible wheezing, rales throughout the lungs, and was occasionally bringing up brown phlegm.

32. On September 30, 1985, at 8:00 a.m., Patient B's oxygen was off. Patient B's respirations were deep and slightly labored. Patient B's oxygen was restarted at six liters per minute at approximately 10:30 a.m. The nurses' note indicates that Patient B had mottling of his lower extremities that morning, which had been noticed at approximately 10:00 a.m., by Respondent and the nurse. The mottling was better once the oxygen was restarted.

33. Respondent's progress note for September 30, 1985, indicates that Patient B's lungs are slightly clearer; the patient has few basal rales but right lung is out (no breath sounds). Respondent ordered that the Sparine be discontinued and oxygen be restarted.

34. On September 30, 1985, at approximately 2:35 p.m., Patient B's family contacted the nurse and stated that Patient B should be checked. A code blue was called. The code was stopped at 2:46 p.m., per Respondent's order. Patient B died on September 30, 1985. Respondent's progress note for September 30 states that Patient B's death was due to myocardial insufficiency.

35. On the hospital admission sheet, Respondent listed the final diagnoses for Patient B as pulmonary embolism and myocardial decompensation secondary to atherosclerotic cardiovascular disease, functional class IV.

36. Respondent's conduct in providing medical care and treatment to Patient B fell below the minimum standards of competence established in the profession in the following respects:

a. Respondent failed to take timely steps to properly diagnose and treat Patient B for dyspnea, despite the fact that Patient B was extremely dyspneic when he was admitted to the hospital, was dyspneic and hypoxic during his hospitalization and was severely dyspneic when Respondent treated Patient B in his office approximately one week before Patient B was admitted to the hospital. Respondent did not order blood gases for Patient B to determine whether Patient B was hypoxic. Respondent ordered that Patient B's oxygen be discontinued on September 29, 1985, despite the fact that Patient B was very dyspneic and disoriented at that time. Respondent failed to timely consider that Patient B could be suffering from pneumonia or a pulmonary embolus.

b. Respondent failed to take timely steps to diagnose the cause of Patient B's deteriorating medical condition. Respondent assumed that Patient B was failing because of myocardial insufficiency. However, the results of the cardiac enzymes and the EKG's do not support the assumption that myocardial insufficiency was the primary cause of Patient B's deteriorating medical condition.

c. Respondent failed to adequately monitor Patient B's electrolytes when Respondent was ordering diuretics for Patient B.

37. Respondent's conduct in providing medical care and treatment to Patient B created the following unacceptable risks to the patient:

a. Respondent's failure to take timely steps to diagnose and treat Patient B for dyspnea and Respondent's failure to timely consider that Patient B could have pneumonia or a pulmonary embolus created the unacceptable risk that Patient B's dyspnea would not be timely diagnosed and treated and that Patient B could have pneumonia or a pulmonary embolus, either of which could result in heart failure and death, if untreated.

b. Respondent's failure to take timely steps to diagnose the cause of Patient B's deteriorating medical condition created the unacceptable risk that the cause of Patient B's deteriorating medical condition would not be determined, that Patient B's medical condition would continue to deteriorate and that Patient B would die.

c. Respondent's failure to adequately monitor Patient B's electrolytes when he ordered diuretics for Patient B created the unacceptable risk that Patient B would develop an electrolyte abnormality, which could lead to a serious arrhythmia or could allow Patient B to develop a syndrome of low serum sodium, which could further diminish his mental functioning.

38. Since the time Respondent provided medical care and treatment to Patients A & B in 1985, Respondent has taken a number of continuing medical education courses in the subjects identified as problem areas in the Disciplinary Complaint.

## CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction over this disciplinary proceeding, pursuant to sec. 448.02(3), Wis. Stats.

2. The Medical Examining Board is authorized to resolve this disciplinary proceeding by Stipulation and without a hearing, pursuant to sec. 227.44(5), Wis. Stats.

3. Respondent's acts and omissions, as set forth in the Findings of Fact, constitute violations of sec. 448.02(3), Wis. Stats., and sec. MED 10.02(2)(h), Wis. Adm. Code.

4. The Medical Examining Board is authorized to assess the costs of this proceeding against Dr. Asplund, pursuant to sec. 440.22, Wis. Stats.

## ORDER

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

IT IS FURTHER ORDERED, effective the date of this Order, that Dr. Merne Asplund's license to practice medicine and surgery in the State of Wisconsin is hereby limited, to the extent that he shall comply with the following terms, conditions and requirements:

1. Dr. Asplund shall take and successfully complete a home study educational program developed and administered by the University of Wisconsin, School of Medicine, Continuing Medical Education Program by no later than 6 months after the effective date of this Order. The educational program is designed to address the educational needs of Dr. Asplund as indicated by the results of a structured assessment program conducted by the University of Wisconsin, School of Medicine, Continuing Medical Education Program. The assessment program focused on the problem areas identified in the Disciplinary Complaint. Further information regarding the content of the educational program is contained in Exhibit 1, attached to this Order. Dr. Asplund shall complete this educational program in addition to his required continuing medical education credits under sec. 448.13, Wis. Stats.

2. Dr. Asplund shall permit the individuals conducting the home study educational program to report to the Medical Examining Board on Dr. Asplund's progress in the program and on the results of any written or oral evaluations. The individuals conducting the home study course shall certify to the Medical Examining Board the results of their evaluation, specifically whether Dr. Asplund has achieved the course objectives for the program.

3. If Dr. Asplund does not successfully complete the educational program under paragraph 1, then the Medical Examining Board may impose additional retraining requirements upon Dr. Asplund regarding the same areas of study.

4. Dr. Asplund shall allow a physician selected by the University of Wisconsin, School of Medicine, Continuing Medical Education Program, in cooperation with the Medical Examining Board, to review the aspects of his practice that were identified as problem areas by the assessment program, for a period of six months.

a. The period of review shall commence during the time period when Dr. Asplund is participating in the educational program under paragraph 1, on a date to be specified by the reviewing physician. The reviewing physician will serve under the direction and supervision of Dr. Thomas Meyer, the Director of the University of Wisconsin Continuing Medical Education Program.

b. The reviewing physician will file written quarterly reports with Dr. Meyer setting forth the results of each review. If the reviewing physician finds deficiencies in Dr. Asplund's practice, then the reviewing physician shall note the deficiencies in the report to Dr. Meyer, who shall immediately report this to the Medical Examining Board. If the Medical Examining Board believes that the deficiency is significant and substantive, then the Medical Examining Board shall conduct further investigation of the reported deficiency and may conduct further disciplinary proceedings against Dr. Asplund's license based on that investigation.

c. If the reviewing physician is unable to continue the periodic review of Dr. Asplund's practice, then Dr. Meyer shall designate a new reviewing physician and promptly advise the Medical Examining Board of his or her identity. Dr. Meyer shall submit a final report to the Medical Examining Board at the conclusion of the period of review summarizing the reviewing physician's conclusions regarding Dr. Asplund's practice.

6. Dr. Asplund is responsible to pay for the costs of the educational program under paragraph 1 and for the reasonable expenses incurred by the reviewing physician under paragraph 4, including the charges for professional time required.

6. At the conclusion of the period of review under paragraph 4, the Medical Examining Board may order Dr. Asplund to appear before the Board to address any issues that the Board believes need to be clarified before the Board determines whether to reinstate Dr. Asplund's unlimited license to practice medicine and surgery.

IT IS FURTHER ORDERED, that partial costs of the proceeding, in the amount of $2,860.00, are assessed against Dr. Asplund, pursuant to sec. 440.22(2), Wis. Stats. Dr. Asplund shall pay this amount to the Department of Regulation and Licensing by no later than 60 days after the effective date of this Order.

IT IS FURTHER ORDERED that, pursuant to the authority of sec. 448.02(4), Wis. Stats., should the Medical Examining Board determine that there is probable cause to believe that Merne Asplund, M.D., has violated the terms of this Final Decision and Order, the Medical Examining Board may order that the license of Merne Asplund, M.D., to practice medicine and surgery in the State of Wisconsin be summarily suspended pending investigation of the alleged violation.

Dated at Madison, Wisconsin, this 20 day of March, 1991.

Michael P. Mehr, M.D.
Secretary
Medical Examining Board

JMO:kcb
ATY-1381

Personal Continuing Medical Education Course
Merne Asplund, M.D.

## Educational Objective

Improve Dr. Asplund's ability to interpret electrocardiograms, so that he can better identify the causes of cardiac arrhythmias.

## Learning Activities

1. Home study course: review of a modern text on EKG's.

2. Reviewing physician: overreading of all the EKG's Dr. Asplund performs for a period of 6 months, or until Dr. Asplund's readings reach 90% compliance with the reviewing physician's readings, whichever time period is shorter.

## Evaluation

Discussion with reviewing physician regarding his or her overreading of the EKG's performed by Dr. Asplund, to address any areas of concern. The reviewing physician shall prepare reports for Dr. Thomas Meyer regarding the results of the review. Dr. Meyer shall prepare a final report for the Medical Examining Board regarding the review.

Exhibit 1

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

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| IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST | : | |
| | : | STIPULATION |
| MERNE ASPLUND, M.D., RESPONDENT. | : | |

It is hereby stipulated between Merne Asplund, M.D., Respondent, personally and by his attorney, William A. Adler; and Judith Mills Ohm, attorney for the Complainant, Wisconsin Department of Regulation and Licensing, Division of Enforcement, as follows:

1. Merne Asplund, M.D., Respondent herein, 1518 Main Street, Bloomer, Wisconsin, is a physician licensed and currently registered to practice medicine and surgery in the State of Wisconsin, pursuant to license #11754.

2. A formal disciplinary proceeding against Dr. Asplund was commenced before the Wisconsin Medical Examining Board on August 2, 1990, by filing a Notice of Hearing and Complaint upon Dr. Asplund.

3. The parties have conducted discovery and have named witnesses to support their respective positions in this proceeding.

4. Dr. Asplund is aware of and understands each of his rights, including the right to a hearing on the allegations against him, at which time the State has the burden of proving the allegations by clear and convincing evidence; the right to confront and cross-examine the witnesses against him; the right to call witnesses on his behalf and to compel their attendance by subpoena; the right to testify in his own behalf; the right to file objections to any proposed decisions and to present briefs or oral arguments to the officials who are to render the final decision; the right to petition for a rehearing; the right to appeal a final decision to the Wisconsin court system; and all other rights afforded him under the United States Constitution, the Wisconsin Constitution and the Wisconsin Statutes and Administrative Code.

5. Dr. Asplund freely, voluntarily, and knowingly waives each and every one of the rights set forth in paragraph 4, for the purpose of resolving the pending disciplinary proceeding without the necessity for a formal evidentiary hearing.

6. For the purposes of this Stipulation, Dr. Asplund withdraws his Answer to the Complaint and agrees that the Wisconsin Medical Examining Board may enter the attached Final Decision and Order.

7. This Stipulation and attached Final Decision and Order will be submitted directly to the Medical Examining Board for consideration. The parties agree to waive the right to a Proposed Decision from the Administrative Law Judge assigned to this disciplinary proceeding.

8. The attorneys for the parties and the Medical Examining Board member appointed to serve as the advisor for this case may appear before the Board in order to argue in favor of acceptance of this Stipulation.

9. If any term of this Stipulation and attached Final Decision and Order is not accepted by the Wisconsin Medical Examining Board, then no term of this Stipulation shall be binding in any manner on any party, and the matter shall be remanded to the Administrative Law Judge for further proceedings.

10. If the Medical Examining Board accepts this Stipulation, then the attached Final Decision and Order shall become effective on the date the Order is signed.

Dated this 18 day of March, 1991.

Merne Asplund, M.D., Respondent

Dated this 19 day of March, 1991.

William A. Adler
Attorney for Respondent

Dated this 11th day of March, 1991.

Judith Mills Ohm
Attorney for Complainant
Department of Regulation and Licensing
Division of Enforcement

JMO:kcb
ATY-1380

## NOTICE OF APPEAL INFORMATION

(Notice of Rights for Rehearing or Judicial Review, the times allowed for each and the identification of the party to be named as respondent)

The following notice is served on you as part of the final decision:

1. Rehearing.

Any person aggrieved by this order may petition for a rehearing within 20 days of the service of this decision, as provided in section 227.49 of the Wisconsin Statutes, a copy of which is attached. The 20 day period commences the day after personal service or mailing of this decision. (The date of mailing of this decision is shown below.) The petition for rehearing should be filed with the State of Wisconsin Medical Examining Board.

A petition for rehearing is not a prerequisite for appeal directly to circuit court through a petition for judicial review.

2. Judicial Review.

Any person aggrieved by this decision has a right to petition for judicial review of this decision as provided in section 227.53 of the Wisconsin Statutes, a copy of which is attached. The petition should be filed in circuit court and served upon the State of Wisconsin Medical Examining Board.

within 30 days of service of this decision if there has been no petition for rehearing, or within 30 days of service of the order finally disposing of the petition for rehearing, or within 30 days after the final disposition by operation of law of any petition for rehearing.

The 30 day period commences the day after personal service or mailing of the decision or order, or the day after the final disposition by operation of the law of any petition for rehearing. (The date of mailing of this decision is shown below.) A petition for judicial review should be served upon, and name as the respondent, the following: the State of Wisconsin Medical Examining Board.

The date of mailing of this decision is March 22, 1991.

WLD:dms
886-490

**227.49 Petitions for rehearing in contested cases.** (1) A petition for rehearing shall not be a prerequisite for appeal or review. Any person aggrieved by a final order may, within 20 days after service of the order, file a written petition for rehearing which shall specify in detail the grounds for the relief sought and supporting authorities. An agency may order a rehearing on its own motion within 20 days after service of a final order. This subsection does not apply to s. 17.025 (3) (e). No agency is required to conduct more than one rehearing based on a petition for rehearing filed under this subsection in any contested case.

(2) The filing of a petition for rehearing shall not suspend or delay the effective date of the order, and the order shall take effect on the date fixed by the agency and shall continue in effect unless the petition is granted or until the order is superseded, modified, or set aside as provided by law.

(3) Rehearing will be granted only on the basis of:

(a) Some material error of law.

(b) Some material error of fact.

(c) The discovery of new evidence sufficiently strong to reverse or modify the order, and which could not have been previously discovered by due diligence.

(4) Copies of petitions for rehearing shall be served on all parties of record. Parties may file replies to the petition.

(5) The agency may order a rehearing or enter an order with reference to the petition without a hearing, and shall dispose of the petition within 30 days after it is filed. If the agency does not enter an order disposing of the petition within the 30-day period, the petition shall be deemed to have been denied as of the expiration of the 30-day period.

(6) Upon granting a rehearing, the agency shall set the matter for further proceedings as soon as practicable. Proceedings upon rehearing shall conform as nearly may be to the proceedings in an original hearing except as the agency may otherwise direct. If in the agency's judgment, after such rehearing it appears that the original decision, order or determination is in any respect unlawful or unreasonable, the agency may reverse, change, modify or suspend the same accordingly. Any decision, order or determination made after such rehearing reversing, changing, modifying or suspending the original determination shall have the same force and effect as an original decision, order or determination.

**227.52 Judicial review; decisions reviewable.** Administrative decisions which adversely affect the substantial interests of any person, whether by action or inaction, whether affirmative or negative in form, are subject to review as provided in this chapter, except for the decisions of the department of revenue other than decisions relating to alcohol beverage permits issued under ch. 125, decisions of the department of employe trust funds, the commissioner of banking, the commissioner of credit unions, the commissioner of savings and loan, the board of state canvassers and those decisions of the department of industry, labor and human relations which are subject to review, prior to any judicial review, by the labor and industry review commission, and except as otherwise provided by law.

**227.53 Parties and proceedings for review.** (1) Except as otherwise specifically provided by law, any person aggrieved by a decision specified in s. 227.52 shall be entitled to judicial review thereof as provided in this chapter.

(a) Proceedings for review shall be instituted by serving a petition therefor personally or by certified mail upon the agency or one of its officials, and filing the petition in the office of the clerk of the circuit court for the county where the judicial review proceedings are to be held. Unless a rehearing is requested under s. 227.49, petitions for review under this paragraph shall be served and filed within 30 days after the service of the decision of the agency upon all parties under s. 227.48. If a rehearing is requested under s. 227.49, any party desiring judicial review shall serve and file a petition for review within 30 days after service of the order finally disposing of the application for rehearing, or within 30 days after the final disposition by operation of law of any such application for rehearing. The 30-day period for serving and filing a petition under this paragraph commences on the day after personal service or mailing of the decision by the agency. If the petitioner is a resident, the proceedings shall be held in the circuit court for the county where the petitioner resides, except that if the petitioner is an agency, the proceedings shall be in the circuit court for the county where the respondent resides and except as provided in ss. 77.59 (6) (b), 182.70 (6) and 182.71 (5) (g). The proceedings shall be in the circuit court for Dane county if the petitioner is a nonresident. If all parties stipulate and the court to which the parties desire to transfer the proceedings agrees, the proceedings may be held in the county designated by the parties. If 2 or more petitions for review of the same decision are filed in different counties, the circuit judge for the county in which a petition for review of the decision was first filed shall determine the venue for judicial review of the decision, and shall order transfer or consolidation where appropriate.

(b) The petition shall state the nature of the petitioner's interest, the facts showing that petitioner is a person aggrieved by the decision, and the grounds specified in s. 227.57 upon which petitioner contends that the decision should be reversed or modified. The petition may be amended, by leave of court, though the time for serving the same has expired. The petition shall be entitled in the name of the person serving it as petitioner and the name of the agency whose decision is sought to be reviewed as respondent, except that in petitions for review of decisions of the following agencies, the latter agency specified shall be the named respondent:

1. The tax appeals commission, the department of revenue.

2. The banking review board or the consumer credit review board, the commissioner of banking.

3. The credit union review board, the commissioner of credit unions.

4. The savings and loan review board, the commissioner of savings and loan, except if the petitioner is the commissioner of savings and loan, the prevailing parties before the savings and loan review board shall be the named respondents.

(c) Copies of the petition shall be served, personally or by certified mail, or, when service is timely admitted in writing, by first class mail, not later than 30 days after the institution of the proceeding, upon all parties who appeared before the agency in the proceeding in which the order sought to be reviewed was made.

(d) The agency (except in the case of the tax appeals commission and the banking review board, the consumer credit review board, the credit union review board, and the savings and loan review board) and all parties to the proceeding before it, shall have the right to participate in the proceedings for review. The court may permit other interested persons to intervene. Any person petitioning the court to intervene shall serve a copy of the petition on each party who appeared before the agency and any additional parties to the judicial review at least 5 days prior to the date set for hearing on the petition.

(2) Every person served with the petition for review as provided in this section and who desires to participate in the proceedings for review thereby instituted shall serve upon the petitioner, within 20 days after service of the petition upon such person, a notice of appearance clearly stating the person's position with reference to each material allegation in the petition and to the affirmance, vacation or modification of the order or decision under review. Such notice, other than by the named respondent, shall also be served on the named respondent and the attorney general, and shall be filed, together with proof of required service thereof, with the clerk of the reviewing court within 10 days after such service. Service of all subsequent papers or notices in such proceeding need be made only upon the petitioner and such other persons as have served and filed the notice as provided in this subsection or have been permitted to intervene in said proceeding, as parties thereto, by order of the reviewing court.