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STATE OF WISCONSIN

BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF

DISCIPLINARY PROCEEDINGS AGAINST

NICHOLAS L. OWEN, MD,	**FINAL DECISION AND ORDER**
RESPONDENT.	96 Med 304/358, 98 Med 23
	LS 9811301 MED

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

Nicholas L. Owen, M.D.
16350 Alverno Drive
Brookfield, WI 53005.

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

Department of Regulation and Licensing
Division of Enforcement
P.O. Box 8935
Madison, WI 53708-8935

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

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

FINDINGS OF FACT

1. Nicholas Loyd Owen (DOB 1/30/34) is duly licensed in the state of Wisconsin to practice medicine and surgery (license #15029). This license was first granted on July 15, 1964. Dr. Owen's area of practice of record with the Medical Examining Board is internal medicine, and his current practice consists of caring for approximately 300 geriatric patients, all of whom are in nursing homes, are residents of CBRFs, or are homebound. He is not licensed in any other jurisdiction.
1. On December 27, 1993, the Wisconsin Medical Examining Board imposed disciplinary action against the license of Dr. Owen. A true and correct copy of the Board's December 27, 1993 Order is attached and incorporated by reference into this document as Exhibit A.
2. Although respondent denies that any of the conduct set forth below was unprofessional, in consideration of his age and the expenses and uncertainties of litigation, he has agreed to wind up his practice, surrender his registration, and retire, effective November 1, 1999.

COUNT I: 96 MED 304

3. By Order dated August 31, 1995, the Board extended until July 15, 1996 the time for Dr. Owen to complete a medical recordkeeping education program required pursuant to the Board's December 27, 1993 Order. A true and correct copy of the Board's August 31, 1995 Order is attached and incorporated by reference into

this document as Exhibit B.

4. Dr. Owen failed to successfully complete the education program referred to above.

COUNT II: 96 MED 358, Patient L.B.

5. On and between January 7, 1993, and September, 1993, respondent was the primary treating physician for patient L.B., a female born in 1964. Respondent had seen the patient occasionally before that date for examinations since 1980, and was her family physician.
6. On 1/7/93, the patient presented with symptoms of persistent dizziness, hyperventilation, and nausea. The patient appeared to have the flu, and this was respondent's initial diagnosis. The patient was hospitalized for dehydration on 1/14/93, and on multiple later occasions.
7. Respondent tried a number of medications over the ensuing months, and noted that the patient did not experience significant relief from her symptoms despite a variety of regimens. Respondent suspected that some of the patient's problems were emotional or stress related. The patient was noted to have a number of medication allergies. During this time, respondent's working diagnosis for the patient was chronic idiopathic labyrinthitis, and gastritis.
8. Respondent's treatment of the patient including ordering a relatively new drug, ondansetron (Zofran®) intra-venously as an anti-emetic, on a daily basis. Respondent had not used this medication before.
9. Respondent's treatment of the patient included ordering dexamethasone, beginning on 8/3/93, while the patient was hospitalized. The purpose of using this medication was to reduce the side effects from the ondansetron, namely headaches and grogginess. Respondent ultimately ordered 10mg, four times per day. Respondent had not used this medication before.
10. The manufacturer's maximum recommended dosage at that time was 9mg/day.
11. Respondent did not discuss the risks, benefits, and alternatives to the use of dexamethasone with the patient before administering it, nor did the patient give informed consent to its use.
12. Respondent did not order any tests to monitor the functioning of the patient's adrenal gland, during dexamethasone therapy.
13. On 8/19/93, respondent's partner ordered the dexamethasone dosage reduced to 7.5mg, four times per day. Respondent was then on medical leave following knee surgery which occurred on 8/19/93, until after the patient was discharged from the hospital on 8/28/93.
14. The patient discontinued the use of dexamethasone on September 2, 1993, without tapering its administration; respondent, upon being informed of this by the patient, did not advise her to taper.
15. On 9/6/93, the patient was admitted to hospital with a major acute staphylococcus infection which had been masked by the use of dexamethasone, and resulting in severe shock.

COUNT III: 98 MED 23, Patient W.H.

16. On 11/4/84, respondent was consulted by telephone by hospital staff regarding patient W.H., a male born in 1919, who was hospitalized at the time. The patient was a regular patient of respondent's partner, and respondent was consulted about the patient only because he was "on call" to provide coverage for his partner, as is customary in medical practice.
17. The patient was a retired police detective with mild Parkinson's, who had not consumed any alcoholic beverage since 1972. He was hospitalized on 10/28/84, for knee replacement, which was performed on 10/29/84 by respondent's partner. Following a blood pressure spike and a bout of confusion, agitation and restlessness, and hallucination, his Sinemet was discontinued. The mental symptoms cleared. His own physician then ordered gradual re-introduction of this anti-Parkinson's medication. The patient's regular physician left a note in the hospital chart dated 10/30/84 asking to be called if the patient exhibited any symptoms of confusion or hallucination.
18. On the morning of Sunday, 11/4/84, respondent visited the patient in the hospital as a part of making his daily rounds to see the patients that he and his partners had in the hospital. He ordered chlordiazepoxide, 50mg every 4 hours as needed for agitation, and Propanolol® 40mg every 4 hours until the patient's diastolic blood pressure was less than 100. Respondent did not call the patient's own physician.
19. Respondent's progress note made that morning reads: "Full-blown delirium with tremor which may be mostly parkinsonism, + Librium, blood pressure increased, + Propanolol, good oral intake, progress diet, worry re: alcohol."
20. The patient was discovered to be in a coma later that day, and later developed pneumonia (probably as a result of inhaling vomitus following administration of the chlordiazepoxide) and other complications, including cortical brain damage, from which the patient gradually recovered to a point of minimally adequate function in the activities of daily life after a long convalescence. The patient did suffer permanent injuries mentally and physically.

<u>CONCLUSIONS OF LAW</u>

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

B. The conduct described in Count I, above, constitutes a violation of §448.02(3), Wis. Stats., and Wis. Adm. Code § Med 10.02(2)(b).

C. The conduct described in Count II, above, is unprofessional conduct and subjects respondent to discipline pursuant to § Med 10.02(2)(h) and (u), Wis. Adm. Code.

D. The conduct described in Count III, above constitutes negligence in treatment and is subject to discipline pursuant to § 448.02(3)(b), Wis. Stats.

ORDER

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

IT IS FURTHER ORDERED, that the SURRENDER of the registration to practice medicine and surgery of Nicholas L. Owen, MD, is ACCEPTED, effective November 1, 1999.

IT IS FURTHER ORDERED, that respondent's license is LIMITED as provided in §448.02(3)(e), Wis. Stats., and in the following respect: respondent shall accept no new patients between the date of this Order and November 1, 1999.

IT IS FURTHER ORDERED, that respondent shall pay partial costs of investigating and prosecuting this matter in the amount of $2025, within 60 days of this Order.

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

Dated this September 23, 1999.

WISCONSIN MEDICAL EXAMINING BOARD, by:

s/

by: Ronald Grossman, M.D.

a member of the Board