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STATE OF WISCONSIN

BEFORE THE MEDICAL EXAMINING BOARD

In The Matter Of The Disciplinary

Proceedings Against

DALE M. BUEGEL, M.D.,	**FINAL DECISION AND ORDER**
RESPONDENT	**LS9810231MED**

PARTIES

The parties in this matter under § 227.44, Stats., and for purposes of review under § 227.53, Stats., are:

Dale M. Buegel, M.D.

4428 N. Maryland

Shorewood, WI 53211

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

This proceeding was commenced by the filing of a Notice of Hearing and Complaint on October 26, 1998. Respondent's Answer was filed on December 15, 1998. This case was initially assigned to Administrative Law Judge Donald Rittel. On August 17, 1999, this case was reassigned to Administrative Law Judge Ruby Jefferson-Moore. The hearing in this matter was held on August 24-27, 1999 and September 7 and 9, 1999. Attorney Arthur Thexton appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. Attorney Donald R. Peterson, Peterson, Johnson & Murray, S.C., appeared on behalf of the respondent. Final closing arguments were filed on January 28, 2000, and the Administrative Law Judge filed her Proposed Decision on June 23, 2000. Objections were filed by both sides and oral arguments on the objections were heard by the board on August 24, 2000. The board deliberated on the matter on that date.

Based upon the entire record herein, the makes the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Dale M. Buegel (d.o.b. 12/16/50), 4428 N. Maryland, Shorewood, Wisconsin 53211, was at all time material to the Complaint filed in this matter a physician and surgeon licensed by the State of Wisconsin, license #21620, which was first granted on July 14, 1978.

2. Dr. Buegel is a psychiatrist and a pain clinician in solo practice.

3. Between February 1992 and July 1995, Dr. Buegel provided treatment to V.C., a female born in 1957. VC was referred to Dr. Buegel by Gary Olson, D.D.S., a dental specialist in temporomandibular joint dysfunction ("TMJ") and its associated problems. VC was referred to Dr. Buegel for treatment of myofascial pain dysfunction syndrome related to her TMJ.

4. At the initial visit, on February 19, 1992, VC's presenting symptoms included pain, migraine headaches, stress,

jaw and neck joint problems. A physical examination, which included a comprehensive musculoskeletal examination, was conducted and charted, but did not include height and weight or vital signs.

5. Dr. Buegel's initial impression was: "1) myofascial pain dysfunction syndrome secondary to torticollis; 2) craniomandibular dysfunction secondary to #1; 3) somatic dysfunction thoracic, cervical, cranial, lumbar; 4) scalene spasm produces symptoms of left thoracic outlet syndrome. Likely secondary to first rib restrictions, and 5) tolerance to Vicodin, Valium."

6. Dr. Buegel's initial plan was: "1) withdraw from Valium to permit use of second class of analgesics to allow break from opiates; 2) Robaxin for muscle spasm; 3) Tolectin for anti-inflammatory; 4) use Phrenilin when off Valium to get drug holidays from opiates;

5) discontinue caffeine - may in fact contribute to torticollis, and physical therapy. Jill at Associates Physical Therapists Milwaukee. Myofascial release techniques and evaluate for TENS."

7. Respondent's history notes for February 19, 1992, states that VC had a hysterectomy at 19, but was not taking estrogen because of migraines. He noted that VC was taking Valium 5mg, 5-8 per day for six months, and Vicodin ES, 5-8 per day for six months, and that VC had less and less effect from those medications.

8. Dr. Buegel's February 19, 1992, chart note for VC included the following information regarding VC's medication: "Valium: 5 mg. 5-8 per day, 6 months. Vicodin ES: 5-8 per day, 6 months. Has had less and less effect from above." On February 19, 1992, Dr. Buegel prescribed the following medications for VC: 100 Robaxin, 500 mg.; 50 Tolectin, 400 mg.; 100 Valium 5mg (take 1-2 every 4 hours maximum seven daily and in five days maximum six daily), one refill; and 100 Vicodin-ES (every 4 hours as needed for severe pain), one refill.

9. At, or following VC's initial visit on February 19. 1992, Dr. Buegel failed to:

a) Perform an assessment of VC's pain and chart the results accordingly.

b) Perform an assessment of VC's management of her pain and chart the results accordingly.

c) Perform an assessment of signs and symptoms that interfere with pain, such as depression and sleep quality, and chart the results accordingly.

d) Perform an assessment of VC's medication use and chart the results accordingly. Dr. Buegel failed to make a determination regarding whether VC was at risk for potential harm as a result of using medications; failed to inquire as to whether VC had a history of drug use or medication use or misuse; failed to inquire as to whether VC had a family history of drug use or misuse, and failed to order a MMPI, or some other psychological assessment, for VC to document the usefulness of drugs, including but not limited to the use of opiates, on a long-term basis.

e) Perform an assessment of other organ systems and chart the results accordingly. Dr. Buegel did not assess VC's history of problems with renal or liver disease; he did not perform a neurologic examination, as far as testing sensation, reflexes, strength testing; he did not perform a gait assessment or look at VC's movement and movement quality and her ability to go from sitting to standing and he did not check her circulatory or other organ systems for pulses, hair loss on extremities or nail beds refilling.

f) Perform an assessment for opioid therapy and chart the results accordingly. Dr. Buegel noted in his chart that VC had been taking Valium and Vicodin for months and that the medications had less and less effect, but he did not perform an assessment of VC to determine whether she was an appropriate patient for chronic opioid therapy.

g) Substitute another agent for Valium and Vicodin and chart the results accordingly. Dr. Buegel noted in his chart that VC had been taking Valium and Vicodin for months and that the medications had less and less effect, but he continued to prescribe the medications without substituting a different agent.

h) Perform a mental status examination and chart the results accordingly. Dr. Buegel did not perform a mental status examination for VC at the time of the initial history and physical to determine the patient's ability to think, to follow directions and to cooperate with care instruction given to her.

i) Document his rationale in the patient's chart for prescribing Phrenilin for the patient. Dr. Buegel prescribed Phrenilin for VC as a substitute for Valium to provide VC with a drug holiday from opiates. Phrenilin is a barbiturate mixed with acetaminophen, which also has potential for being an addictive and abused medication.

10. Dr. Buegel's March 26, 1992, chart note for VC reads as follows:

Fed up, angry, pain. Things not working. Angry at my life, tears.

Compazine stopped me from throwing up.

Headaches still there.

Did not fill Sinequan - will fill today.

Percodan for two weeks.

Discontinue Tolectin as aspirin works better for her.

Retreat, neuromuscular therapy. See dentist as soon as possible.

Return to clinic in one week.

11. At, or following VC's visit on March 26, 1992, Dr. Buegel failed to:

a) Assess VC's symptoms and document the results accordingly. Dr. Buegel did not assess or document where the patient's symptoms were located, where she was in her continuum of symptoms; her vital signs were not taken and there is no indication whether she was dehydrated, whether her blood pressure was low, whether she was orthostatic or whether she was febrile. There was no testing for abdominal tenderness. There was no indication of her appearance. Did she appear dehydrated? Was there tinting of the skin with just pinching of the skin? In looking at her eyes, was there any discoloration or were her conjunctivas clear or were they jaundiced?

b) Perform a mental health assessment of VC and document the results accordingly. VC reported that she was "fed up, angry, pain, things not working, angry at my life, in tears", Dr. Buegel did not investigate further the patient's mood and did not try to address what the sources of her anger. He did not inquire as to how VC was coping with her anger or ask her about "what things were not working". Was the pain management not working? Was the mood control not working? " Was there a sleep disorder? Dr. Buegel also did not evaluate VC for depression.

c) Assess VC's headaches and document the results accordingly. VC reported to Dr. Buegel that her "headaches still there". Dr. Buegel did not inquire about the nature of the patient's headaches. Were the headaches "a piercing behind the eye headache"? Was there a "muscle tension" headache? Did the symptoms "start in the neck and then refer and develop a secondary headache?" Dr. Buegel did not treat VC for her headaches and he did not document a treatment plan in the patient's chart.

d) Document the quantity of aspirins recommended for VC. Dr. Buegel's chart note reads: "Discontinue Tolectin as aspirin works better for her." Dr. Buegel did not document in the patient's chart what quantity of aspirin the patient is referring to and what is being recommended for the patient. On March 26, 1992, Dr. Buegel wrote a prescription for VC for Percodan, which also contains aspirin.

e) Prescribed Percodan for VC, without assessing whether the medication was appropriate treatment for VC's chronic pain.

12. On March 26, 1992, Dr. Buegel wrote the following note in VC's chart " Discontinue Tolectin as aspirin works better for her". On April 2, 1992, Dr. Buegel prescribed 100 Tolectin, 400 mg for VC without documenting in the patient chart his reasons for prescribing the medication or his rationale for care.

13. On April 29, 1992, Dr. Buegel wrote a prescription for 90 Vicodin for VC without documenting in the patient chart why the prescription was being given. There is no documentation in the note of April 30, 1992 that the patient was on Vicodin or why the medication had been prescribed for the patient.

14. On May 6, 1992, Dr. Buegel wrote the following prescription for Percodan for VC "one PO Q four hours, PRN severe pain. On May 13, 1992, Dr. Buegel wrote the following prescription for VC " one or two PO Q four hours, PRN severe pain". The prescription written by Dr. Buegel on May 13, 1992 authorizes a doubling of the medication dose without documenting in the patient chart why the change was being made.

15. On May 22, 1992, Dr. Buegel noted the following in VC's chart: "Bleeding urine. Still throwing up." On that same day, Dr. Buegel wrote a prescription for VC for 100 Percodan and 100 Phrenilin. Dr. Buegel did not document in the patient chart his rationale for the on-going increased dose of Percodan; what kind of symptoms the patient was having; what kind of care was going to be rendered to follow-up with the symptoms of bleeding and throwing up or what the recommended follow-up with the patient would be to address her concerns.

16. On June 3, 1992, Dr. Buegel prescribed the following for VC: Percodan, 2 tablets PO Q four hours, PRN pain, quantity 120; Demerol 100 milligrams, one PO, Q 4 hours, PRN severe pain (not at same time as Percodan), #80; Vistaril, 50 mg. and 80 Valium 10 mg. Dr. Buegel did not document in the patient chart the reasons the medications were being prescribed; what the patient's pain was; the quality of the pain; the quantity of the pain, or what he intended the medication to do for treatment of her pain.

CONCLUSIONS OF LAW

1. The Medical Examining Board has jurisdiction in this matter pursuant to s. 448.02 (3) Wis. Stats., and s. MED 10.02 (2) Wis. Adm. Code.

2. Respondent's conduct in failing to properly assess VC's medical condition and document the results accordingly, as described in Findings of Fact 9-16 herein, was below the minimum standards of the medical profession, exposed the patient to risks to which a minimally competent physician would not have exposed a patient and constituted a danger to the health, welfare and safety of the patient, in violation of s. MED 10.02 (2) (h), Wis. Adm. Code.

3. Respondent's conduct in failing to properly assess VC's medical condition and document the results accordingly, as described in Findings of Fact 9-16 herein, constitutes negligence in treatment and is subject to discipline under s. 448.02 (3) (b), Stats.

ORDER

NOW, THEREFORE, IT IS ORDERED that the license of Dale M. Buegel to practice medicine and surgery in the state of Wisconsin shall be, and hereby is, LIMITED for an indefinite period of time as follows:

1. Respondent shall, no later than one year from the date of this Order, take and successfully complete:

   a. The 45-hour course in Proper Prescribing of Controlled Dangerous Substances sponsored by Forensic and Educational Consultants of Margate, New Jersey, or an equivalent course approved in advance by the Board or its designee.
   b. An educational program established through the University of Wisconsin Continuing Medical Education program (which may conduct any program through the Medical College of Wisconsin or another CME provider) in record keeping, or another similar program approved in advance by the Board or its designee.

(c) Respondent shall arrange for the course sponsors approved above to certify to the Board the results of the course work upon completion and to release all records of his performance and attendance.

(d) Respondent shall be responsible for all costs associated with taking the course work required under this Order and shall pay the cost of any examination required for successfully completion of the course work.

2. Respondent shall maintain patient health care records in his practice of medicine in accordance with the requirements set forth in s. Med 21.03, Wis. Adm. Code. Respondent shall arrange for the review of his patient records by a physician satisfactory to the board for a period of six months. At the end of six months, respondent shall be responsible for submission to the board of a report by the reviewing physician setting forth the reviewing physician's opinion whether the records meet the minimum requirements of s.Med 21.03, Code.

3. Upon a showing by respondent of complete, successful and continuous compliance for a period of two (2) years with the conditions and limitations set forth in this Order, the Board may grant a petition by respondent for return to full licensure.

IT IS FURTHER ORDERED that pursuant to s. 440.22 Wis. Stats., one-half the costs of this proceeding shall be assessed against respondent, and shall be payable to the Department of Regulation and Licensing.

This order is effective on the date on which it is signed on behalf of the Medical Examining Board.

EXPLANATION OF VARIANCE

The board has accepted in their entirety the ALJ's recommended Findings of Fact and Conclusions of Law. Two modifications have been made to the recommended Order, however. First, paragraph 2 of the Order, as set forth in the Proposed decision, requires that respondent maintain his patient health care records consistent with the requirements of sec. Med 21.03, Code. The board has modified this paragraph to require that for a period of six months, respondent arrange for review of his records by another physician satisfactory to the board to establish that he is in fact fulfilling this requirement.

Second, the ALJ recommended that the full costs of the proceeding be assessed against the respondent. The Complaint in this matter consisted of three counts and 153 paragraphs, alleging numerous violations involving respondent's treatment of three patients. The ALJ found violations as to only one of the three counts, and the

board therefore deems it appropriate that only half the costs of the proceeding be assessed.

Dated this 7th day of September, 2000.

STATE OF WISCONSIN

MEDICAL EXAMINING BOARD

Darold Treffert, M.D.

Secretary