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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY	:	
PROCEEDINGS AGAINST	:	FINAL DECISION
	:	AND ORDER
WILLIAM J. FABER, D.O.,	:	LS0211222MED
RESPONDENT	:	

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

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Ave.
Madison, WI 53708-8935

William J. Faber, D.O.
6529 West Fond du Lac Avenue
Milwaukee, WI 53218

Medical Examining Board
1400 East Washington Ave.
Madison, WI 53703

This proceeding was initiated by a complaint prepared by the Division of Enforcement of the Department of Regulation and Licensing and filed with the Medical Examining Board on November 22, 2002. An answer was filed on December 9, 2002 on behalf of Dr. Faber by Attorney Raymond M. Roder. The disciplinary proceeding was conducted on April 30 and May 1, 2003. Dr. Faber appeared in person and represented by Mr. Roder. The Medical Examining Board was represented by Attorney James Polewski of the Department's Division of Enforcement.

The Administrative Law Judge, John N. Schweitzer (ALJ), filed his Proposed Decision on July 14, 2003. Mr. Polewski filed his Objections to the Proposed Decision on August 12, 2003; and Mr. Roder filed Respondent's Response to the objections on August 21, 2003. On August 25, 2003, Mr. Polewski filed his Motion to Strike a Portion of Dr. Faber's Response; and Mr. Roder filed his Response to the Division of Enforcement's Motion on August 27, 2003.

Mr. Polewski and Mr. Roder appeared before the board on September 24, 2003, for oral arguments on the objections, and the board considered the matter on that date. As a part of its deliberations, the board interviewed the ALJ, Mr. Schweitzer, as to his impressions of the witness' credibility, particularly his impressions regarding witness demeanor.

Based upon the entire record in this case the Medical Examining Board makes the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. The Dr. Faber, William J. Faber, D.O., is licensed to practice medicine and surgery in Wisconsin, under license number 20986, first granted on July 15, 1977.
2. Nancy Meyer first visited Dr. Faber's clinic on May 24, 1999. Ms. Meyer's presenting complaints included migraine headaches, for which she sought prolotherapy treatment.
3. Prior to contacting Dr. Faber, Ms. Meyer had sought medical treatment for migraine headaches over a period of approximately six years, from her primary care physician, Dr. Phillip Bain, and from approximately 20 other health care practitioners. At various times, Dr. Bain prescribed Valium, Xanax, alprazolam, Oxycontin, and Wellbutrin for Ms. Meyer, and the other treatments she tried included cranial sacral therapy, massage, homeopathic medicine, aromatherapy, crystals, osteopathy, and spiritual psychology. [tr. pp. 13-19]
4. Dr. Faber obtained Ms. Meyer's informed consent to a course of prolotherapy treatments that could involve twelve to thirty sessions, or even more.
5. Between May 24, 1999 and July 28, 1999, Dr. Faber treated Ms. Meyer with a series of prolotherapy injections to various points in her neck and back to address defects and instabilities in her back, and to address other complaints, especially her migraine headaches. At some point during the course of treatment, Ms. Meyer informed Dr. Faber that she also suffered uterine ligament pain, and Dr. Faber provided trigger point injections to Ms. Meyer in the area of her pubic symphysis.
6. Dr. Faber routinely used a single syringe and needle for multiple injections at multiple sites during a single office visit.
7. There is insufficient evidence to establish that using a single syringe and needle for multiple injections at multiple sites during a single office visit is below the medical standard of care.
8. Dr. Faber routinely swabs the sites of injections with alcohol.
9. It was not proven by a preponderance of the evidence that Dr. Faber failed to clean the site of an injection.
10. It was not proven by a preponderance of the evidence (a) that performing an injection through a site which has not been cleansed exposes the patient to the unacceptable risk of introducing infectious agents into the body and causing disease, (b) that the medical standard of care is always to swab the site of an injection, or (c) that it is less than minimally competent practice of medicine to perform an injection through a site which has not been cleansed.
11. Dr. Faber provided no more than 12 prolotherapy treatments to any part of Ms. Meyer's body. [tr. p.

12. Although he obtained Ms. Meyer's consent to a course of 12 to 30 prolotherapy treatments, or even more, it was not proven that Dr. Faber planned a series of more than 12 prolotherapy treatments without reassessing the patient's response to treatment and the need for further treatment.

13. It was not proven by a preponderance of the evidence (a) that by proposing a plan of 12 to 30 prolotherapy treatments, Dr. Faber "intended the continuance of therapy after the point that it would be clear to a minimally competent practitioner that the therapy was ineffective for the patient's condition", (b) that contemplating a course of prolotherapy treatment that exceeds 12 treatments to any portion of a patient's body exposes the patient to unreasonable risks of iatrogenic disease, unnecessary pain, ineffective treatment, and pointless expense, (c) that the medical standard of care is never to provide more than 12 prolotherapy treatments, or (d) that providing more than 12 prolotherapy treatments constitutes less than minimally competent practice of prolotherapy.

14. On Wednesday, July 28, 1999, Dr. Faber provided a series of injections to Ms. Meyer, including trigger point injections to her pubic symphysis.

15. On Friday, July 30, 1999, a day when Dr. Faber was not in the office, Ms. Meyer or her husband telephoned Dr. Faber's office at 9 A.M. to report pain in her pubic area. The call was taken by Dr. Faber's medical assistant, Catherine Rogers. Ms. Meyer called again at 3:30 P.M. Ms. Rogers advised Ms. Meyer that she could go to the emergency room if she wished. Ms. Rogers passed the message on to Dr. Faber at 4 P.M. [ex. 1, pp. 29-30; tr. pp. 29-33]

16. Dr. Faber called Ms. Meyer at 5 P.M. on Friday, July 30, 1999. Ms. Meyer reported pain and a fever of 102°, and Dr. Faber recommended that she use aspirin and apply ice to the painful area. Without examining her, he empirically prescribed the antibiotic Keflex® for her. [ex. 1, p. 30; tr. p. 33]

17. On Saturday, July 31, 1999, Ms. Meyer or her husband telephoned Dr. Faber to report continued and increased pain in her pubic area. Dr. Faber advised Ms. Meyer to continue to apply ice to the area of the pain and swelling, and to continue with the antibiotic he had prescribed.

18. On Sunday, August 1, 1999, Ms. Meyer telephoned Dr. Faber to report continued pain and swelling in her pubic area, and continued fever. Without examining her, Dr. Faber prescribed a second antibiotic, Vibramycin®, for her.

19. There is insufficient evidence to establish whether Dr. Faber, in his telephone conversations with Ms. Meyer on July 30, July 31, and August 1, 1999, did or did not tell Ms. Meyer that she could go to the emergency room for treatment.

20. In light of the nature of Ms. Meyer's complaint of pain and swelling in her symphysis pubis, and her complaint of a temperature of 102 degrees; and given that Dr. Faber had injected that specific site on July 28, 1999; it was below the minimum standard of medical care to have failed to ensure that Ms. Meyers underwent a medical examination prior to or shortly after prescribing antibiotics.

21. Beginning antibiotic therapy for an infection and fever of unknown etiology in the circumstances set forth in paragraph 20 without examining the patient exposes the patient to the unreasonable risk of harm by impairing the ability to accurately identify and treat the cause of the infection and fever.

CONCLUSIONS OF LAW

1. The Medical Examining Board has jurisdiction in this matter under sec. 448.02, Stats., and ch. Med 10, Wis. Admin. Code.
2. In his treatment of Nancy Meyer in 1999, William J. Faber, M.D., has violated section Med 10.02(2)(h) of the Wisconsin Administrative Code by engaging in practice or conduct which tended to constitute a danger to the health, welfare, or safety of his patient.

ORDER

NOW, THEREFORE, IT IS ORDERED that William J. Faber, M.D. be, and hereby is, reprimanded.

IT IS FURTHER ORDERED that the license of William J. Faber, M.D., be, and hereby is, limited as follows:

1. Within thirty (30) days of the date of this order Dr. Faber shall initiate arrangements to undergo an assessment to evaluate Dr. Faber's current abilities to practice medicine at his current practice, given the facts of this case. The assessment shall be performed under the direction of the University of Wisconsin Continuing Medical Education Program (UW-CME) or another assessment provider acceptable to the Board, and may include peer interview and oral or written examination.
2. Dr. Faber shall initiate the assessment process and shall timely complete all portions of the process for which he is responsible (including payment of all required fees), as requested by the assessment provider.
3. If recommended by the assessment, Dr. Faber shall participate in and successfully complete an educational program established through the assessment provider to address any shortcomings found in the assessment process. If an educational program is recommended, the following shall apply:
 - a. The educational program shall include a post-intervention assessment which may be six [6] to twelve [12] months following the completion of the didactic portion of the program.
 - b. Dr. Faber shall complete this program within the time parameters established by the assessment provider, but no later than two years from the effective date of this Order.
 - c. In the event that the assessment provider states that it is unable to develop an educational program which adequately addresses the issues identified in the assessment, the program shall notify the Board of this fact, and the matter shall be returned to the Division of Enforcement for further consideration and action. The results of the assessment shall be admissible as evidence in any subsequent proceedings in this action.
4. Dr. Faber shall be responsible for all costs incurred for the UW-CME and assessment(s) and all training under the terms of this Order, and shall timely pay all fees when due.
5. The assessment provider shall certify to the Board the results of the assessments and educational

programs upon their completion. The didactic portion of the program(s) and the post-intervention assessment(s) shall be separately certified.

EXPLANATION OF VARIANCE

The board has accepted the ALJ's Findings of Fact with three exceptions. Finding of Fact paragraph 7, as set forth in the Proposed Decision, states as follows:

7. Using a single syringe and needle for multiple injections at multiple sites during a single office visit is within the medical standard of care.

The board instead substitutes the following language:

7. There is insufficient evidence to establish that using a single syringe and needle for multiple injections at multiple sites during a single office visit is below the medical standard of care.

The critical expert testimony on this issue was offered by Dr. Mark Timmerman, who testified in part as follows:

Q. (by Mr. Polewski) Dr. Timmerman, Nancy Meyer suggest -- Nancy Meyer testified that Dr. Faber did multiple injections on her with the same needle and same syringe and -- area of her body. Do you recall that?

A. Yes.

Q. Is that substandard medical practice for prolotherapy?

A. No.

Q. Is that in fact something that you do?

A. Yes.

Q. Is that considered to be just what prolotherapy is and how it's performed?

A. I believe most of us who do prolotherapy use a needle -- single needle for multiple injections.

Q. You have no criticism of Dr. Faber for using a single needle for multiple injections in -- as Dr. Seitzinger described it in his deposition and as Nancy Meyer described it this morning?

A. That's correct.

Q. No -- no criticism?

A. No criticism. (Tr., page 148)

The cited testimony certainly establishes that it is not below the standard of medical practice to utilize a single syringe and needle for multiple injections at a single site, and the board readily accepts that conclusion. But the testimony does not specifically address the question of utilizing a single syringe and needle for multiple injections at multiple sites. And neither the testimony of the complaining witness nor of Dr. Seitzinger, which is the testimony that Dr. Timmerman was evaluating, clarify the point. In the latter case, whether Dr. Seitzinger opined that single needle use for multiple injections at multiple sites is appropriate is unknown because Dr. Seitzinger's transcript is not a part of the record. In terms of Ms. Meyer's testimony, she was not sufficiently specific in her description of the process utilized by Dr. Faber to conclude that she was describing multiple injections at multiple sites with but a single syringe and needle.

Conversely, there is not evidence in this record that establishes that using the same needle at multiple sites is below the acceptable standard of medical practice. The board's amended finding reflects the uncertainty of the record in that regard.

The second variation from the Proposed Decision is at Finding of Fact paragraph #19. The Proposed Decision suggests the following finding:

19. In all of his telephone conversations with Ms. Meyer on July 30, July 31, and August 1, 1999, Dr. Faber advised Ms. Meyer that she could go to the emergency room for treatment.

The board instead makes the following finding:

19. There is insufficient evidence to establish whether Dr. Faber, in his telephone conversations with Ms. Meyer on July 30, July 31, and August 1, 1999, did or did not tell Ms. Meyer that she could go to the emergency room for treatment.

Ms. Meyer testified that in her conversations with Dr. Faber on these dates, Dr. Faber never discussed the possibility of her going to the emergency room. Ms. Meyer's husband, who testified that he was in the same room with his wife when the conversations took place, also testified that in reporting the conversations, Ms. Meyer had never indicated that Dr. Faber had suggested that she could go to the emergency room.

Dr. Faber's testimony was that he suggested that Ms. Meyer go to the emergency room and that she refused (tr., p. 394), and his handwritten office notes of his conversations with Ms. Meyer indicate that he did so (Exhibit 1, pp. 173, 174). But these notes did not appear in the records submitted to Ms. Meyer's insurer, even though the insurer's request was for all of her records. On balance, and based on the entire record, the board concludes there is insufficient evidence to find that Dr. Faber did or did not suggest that Ms. Meyer could visit the emergency room.

In terms of Dr. Faber's prescribing antibiotics over the telephone for Ms. Meyers based upon his telephone conversations with her on July 30, July 31, and August 1, 1999, the ALJ found at paragraph 20 as follows:

20. It was not proven by a preponderance of the evidence (a) that beginning antibiotic therapy for an infection and fever of unknown etiology exposes the patient to the unreasonable risk of impairing the ability to accurately identify and treat the organism responsible for the infection and fever, thereby exposing the patient to the unreasonable risks of delayed or ineffective treatment, (b) that the medical standard of care is never to prescribe antibiotics for a fever of unknown etiology, but to examine the patient, culture for bacteria, and wait for the test results before prescribing antibiotics, or (c) that beginning antibiotic therapy for an infection and fever of unknown etiology is less than minimally competent practice of medicine.

The board instead substitutes the following findings:

20. In light of the nature of Ms. Meyer's complaint of pain and swelling in her symphysis pubis, and her complaint of a temperature of 102 degrees; and given that Dr. Faber had injected that specific site on July 28, 1999; it was below the minimum standard of medical care to have failed to ensure that Ms. Meyers underwent a medical examination prior to or shortly after prescribing antibiotics.

21. Beginning antibiotic therapy for an infection and fever of unknown etiology in the circumstances set forth in paragraph 20 without examining the patient exposes the patient to the unreasonable risk of harm by impairing the ability to accurately identify and treat the cause of the infection and fever.

Dr. Lytle Pomeroy, one of Dr. Faber's experts, testified in part as follows:

Q. (by Mr. Roder) Okay. What is -- first of all, what is your experience in your medical practice with antibiotics?

A. I don't have to prescribe them very often, but I do sometimes.

Q. And have you had occasion to prescribe them when the patient wouldn't present?

A. Yes, there are -- are empiric times when you don't have any choice.

Q. Okay. And what -- give me -- give us some examples in your own practice where you have had this empiric choice, if you will, to make for prescribing antibiotics?

A. The patient lives a long distance away, from Flagstaff or Tucson or some other part of Arizona, and they can't get in to see me. It's a problem that isn't bad enough to go to the emergency room, it's obvious they're going to need an antibiotic. If they need to go to the emergency room, of course I tell them to go to the emergency room. But listen to their symptoms and tell them that they need an antibiotic and I'll call it in.

Q. What if you thought that they should go to the emergency room but said they weren't capable of doing it, would you forego prescribing an antibiotic in that circumstance?

A. No. I would still prescribe it because I don't want to take a chance that the person is going to

have a more severe problem because of not having the antibiotic. It's better -- if they can get the antibiotic and get it started, maybe they can go the emergency room the next day or the day after that. Maybe they don't have any transportation, some - but somebody can deliver the antibiotic to the house. Then I'd go ahead and prescribe them. (tr., pp. 265-266)

Carole Brown, M.D., who has practiced both as an emergency room physician and as a family practice physician, also testified for Dr. Faber. A portion of her testimony on what has been described as the empiric prescribing of antibiotics is as follows:

Q. (by Mr. Roder) You've heard the testimony in this proceeding regarding standard of practice as offered by Dr. Timmerman on the subject of prescribing antibiotics in the circumstances in which Nancy Meyer called in to Dr. Faber's office. In a similar circumstance, how would you operate?

A. I would err on the side of taking care of the patient. In other words, I would prescribe an antibiotic. I had -- I had just -- if I had just treated the patient and there were no hope for me to see her again within the next day or so, I would have prescribed.

Q. Is it your opinion, to a reasonable degree of medical certainty, that the practice that you -- or the judgment that you just described that you would make in these circumstances, is practicing at or above the minimum standard of care?

A. It is at or above the minimum standard of care.

Q. Are -- are there any circumstances, so to speak, that one might describe as being conditions that you want to see present before you empirically prescribe an antibiotic?

A. A reason for or signs of infection.

Q. Okay. And what - included in what would be signs of infection, what would you include there?

A. Redness, pain, swelling, if we're talking about skin. (tr., pp. 300-301)

That testimony contrasts sharply with the testimony of Dr. Mark Timmerman, complainant's expert.

Q. (by Mr. Polewski) to a reasonable -- do you have an opinion, to a reasonable degree of medical certainty, whether it is -- it was appropriate for Dr. Faber to prescribe antibiotics to Nancy Meyer without examining her that weekend?

A. No. It was inappropriate.

Q. Why?

A. Again, it's -- it's -- like I said before, you need to develop a diagnosis in order to prescribe a

medication, certainly an antibiotic, and you need to be able to evaluate the patient in order to form an impression for a diagnosis.

Q. Do you believe, to a reasonable degree of medical certainty, that a minimally competent physician could form a presumptive diagnosis without examining Nancy Meyer, given the conditions that she said she had?

A. That no, it would not be reasonable to make a diagnosis for Nancy Meyer over the telephone based on her symptoms.

Q. Are there ever times when there are exceptions to general rule of examining a patient before you prescribe antibiotics?

A. Yes.

Q. What are those exceptions?

A. One example is if the patient and the physician are both clear about the diagnosis.

Q. From your understanding of the condition that Nancy Meyer was experiencing in that last weekend of July 1999, do you have an opinion, to a reasonable degree of medical certainty, whether it would be appropriate to prescribe antibiotics to her at that time without examining her in person?

A. My opinion is -- the answer is yes. And my opinion would be that it would be inappropriate, given those circumstances, to prescribe antibiotics over the phone.

Q. What -- is there any risk to prescribing antibiotics over the phone to Nancy Meyer under those circumstances?

A. Yes.

Q. What is the risk?

A. One of the things that we learn early in medical training is not to mask -- not to mask the signs and symptoms of a disease so that you may treat inappropriately. For instance, someone has an infection and you prescribe it with an antibiotic that won't kill the infection but might mask the ability to culture that -- that infection later on.

Q. -- tell me a little bit about mask the ability to culture the organism later on?

A. Yeah. If you use the wrong antibiotic, it can make a subsequent culture negative. In other words, it kills enough of the bacteria so you can't really grow the bacteria well in a culture, but it's not the right antibiotic so you can still have the bacteria growing and then creating in fact possibly a

resistant -- the resistant forms of the bacteria may be able to grow and in fact replicate, causing a worse infection than you had initially.

Q. Is it a reasonable risk assessment on the part of a minimally competent physician to prescribe an antibiotic over the phone in those circumstances?

A. No.

Q. Why not?

A. Well, once again, then if the patient doesn't get better you've already in effect ruined your chance for a good diagnosis afterwards.

Q. Based on your education, training and experience and all the materials you've read, do you have an opinion, to a reasonable degree of -- of medical certainty, whether Dr. Faber's prescription of antibiotics to Nancy Faber (sic) that weekend in July of 1999, met the minimally competent standard of practice of medicine?

A. Yes, I feel --

A. I understand. Yes, I feel that it is below the minimally acceptable standards to have prescribed antibiotics for her in that case.

Q. And the basis of that opinion is?

A. Once again, for reasons of not harming the patient further and because you need to make a diagnosis of form an impression before any treatment plan, it was an inappropriate behavior.

Q. Does it make any difference to your opinion that Nancy Meyer -- excuse me. Let me start over again. Would it make any difference to your opinion if Dr. Faber had requested Nancy Meyer to come in and she had refused?

A. No.

Q. Why not?

A. Because that didn't change the fact that the diagnosis was still unknown and therefore the treatment should not have been prescribed for her.

Q. Are you saying -- would it be -- strike that. If Nancy Meyer had been asked to come in and had refused, what was the minimally competent response -- would be the minimally competent response to a request for antibiotics?

A. To direct her to her primary physician or to urgent care or an emergency room.

Q. Would it -- would it be acceptable, in your opinion, to a reasonable degree of medical certainty, to prescribe antibiotics to Nancy Meyer in the circumstance that she refused to come in for an examination?

A. No.

Q. For the reasons previously stated?

A. Correct. (tr., pp. 162-173)

The board accepts Dr. Timmerman's opinion, and therefore finds that it was below the minimum standard of medical care to have failed to ensure that Ms. Meyer underwent a medical examination prior to prescribing antibiotics or, if that was not possible, promptly after the antibiotic was prescribed.

Having made the findings that it has, the board has varied from the ALJ's proposed Conclusions of Law. The Proposed Decision sets forth the following Conclusions of Law:

I. The Medical Examining Board is the legal authority responsible for issuing and controlling credentials for persons licensed to practice medicine and surgery in Wisconsin, under ch. 448, Stats., and it has jurisdiction over the subject-matter of a complaint alleging unprofessional conduct, under sec. 15.08(5)(c), Stats., sec. 448.02, Stats., and ch. Med 10, Wis. Admin. Code. The Medical Examining Board has personal jurisdiction over Dr. Faber, based on his holding a credential issued by the board, and based on notice under sec. 801.04 (2), Stats.

II. In his treatment of Nancy Meyer in 1999, Dr. William J. Faber did not violate section Med 10.02 of the Wisconsin Administrative Code by engaging in any practice or conduct which tended to constitute a danger to the health, welfare, or safety of his patient.

The board has substituted the following Conclusions of Law:

1. The Medical Examining Board has jurisdiction in this matter under sec. 448.02, Stats., and ch. Med 10, Wis. Admin. Code.

2. In his treatment of Nancy Meyer in 1999, Dr. William J. Faber has violated section Med 10.02(2)(h) of the Wisconsin Administrative Code by engaging in practice or conduct which tended to constitute a danger to the health, welfare, or safety of his patient.

The substantive change is found at Conclusion of Law paragraph #2. Having concluded that it was below the minimum standard of medical care to have prescribed antibiotics for Ms. Meyer without examining her, it follows that such practice violates § Med 10.02(2)(h), Wis. Admin. Code.

Finally, the ALJ recommended that the matter be dismissed. Having found that Dr. Faber has violated the board's rules of conduct, that result is inappropriate, and the board deems that discipline is required. Moreover, the board does not consider a mere reprimand to properly address what the board considers to be a significant failure by Dr. Faber to appropriately address what was rapidly becoming an emergent situation. That Dr. Faber proceeded to prescribe antibiotics without examining the patient either before or shortly thereafter for the purpose of reaching a working diagnosis unquestionably subjected Ms. Meyer to the risk of harm. The fact that he proceeded without adequate basis for his actions is demonstrated by his presumptive differential diagnosis, which was pelvic inflammatory disease versus mycoplasma versus food poisoning versus osteitis pubis versus osteomyelitis. These conditions are sufficiently disparate that it is clear that Dr. Faber did not know what he was treating, and it is equally clear that to have proceeded in those circumstances was a substantial departure from acceptable standards of medical care.

It is well established that the objectives of licensing discipline are the protecting the public, promoting the rehabilitation of the licensee and deterring other licensees from engaging in similar misconduct. *State v. Aldrich*, 71 Wis. 2d 206 (1976). Punishment of the licensee is not an appropriate consideration. *State v. McIntyre*, 41 Wis. 2d 481 (1968). The board concludes that the deterrence objective is adequately addressed by a formal reprimand, but that public protection requires that Dr. Faber's undergo an assessment to evaluate his current abilities to practice medicine at his current practice. Should the University of Wisconsin Continuing Medical Education Program or another assessment provider acceptable to the Board conclude that Dr. Faber may safely continue in his current practice, then the public protection objective has been met. Should the assessment result in a recommendation that some remedial training be provided, then the Order requires that Dr. Faber participate in and successfully complete an educational program established through the assessment provider to address any shortcomings found in the assessment process.

Dated this 24th day of October, 2003.

STATE OF WISCONSIN

MEDICAL EXAMINING BOARD

Alfred L. Franger, MD

Secretary