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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY	:	
PROCEEDINGS AGAINST	:	FINAL DECISION
	:	AND ORDER
STUART M. SUSTER, M.D.,	:	LS0210291MED
RESPONDENT.	:	

The State of Wisconsin, Medical Examining Board, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Medical Examining Board.

The rights of a party aggrieved by this Decision to petition the department for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated this 18th day of August, 2004.

_____

Member of the Board
Medical Examining Board

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST

STUART M. SUSTER, M.D.,
RESPONDENT

PROPOSED DECISION
Case No. LS0210291MED

PARTIES

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

Stuart M. Suster, M.D.
929 North Astor Street, #608
Milwaukee, WI 53202

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 29, 2002. The Answer was filed on December 4, 2002. The hearing was held on December 1-5 and December 15-18, 2003. The transcript for the last day of the hearing was filed on January 20, 2004. Closing arguments were filed by March 23, 2004. Attorney Arthur Thexton appeared in this matter on behalf of the Department of Regulation and Licensing, Division of Enforcement. At least from December 3, 2002 to August 22, 2003, Dr. Suster was represented by legal counsel in this matter. Dr. Suster has appeared pro se in this matter since August 22, 2003.

Based upon the record herein, the Administrative Law Judge recommends that the Medical Examining Board adopt as its final decision in this matter the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Stuart M. Suster (d.o.b., 05/05/59), 929 North Astor, #608, Milwaukee, WI 53202, was, at all time material to the Complaint filed in this matter, a physician and surgeon licensed by the state of Wisconsin, license #32820, which was first granted on November 20, 1991. Dr. Suster is a physiatrist.

Count I: Controlled Substances and Dispensing Violations

2. Between 1995 and April 2002, Dr. Suster possessed controlled substances in his office for the purpose of dispensing to patients. During that same time period, Dr. Suster confiscated controlled substances from patients for violation of contracts he had with them and he acquired controlled substances from patients because of his determination that the patients were over or under medicating, diverting or combining prescription drugs with illegal substances.

3. Dr. Suster did not, at any time after the opening of his office in Wauwatosa, Wisconsin and April 2, 2002, take any inventory of controlled substances, as defined by 21 CFR 1304.11.

4. Dr. Suster's office procedures were reviewed by a representative of the Wisconsin Independent Physicians Group

(now known as Independent Physicians Network) on one or more occasions since he has been practicing in Wauwatosa, Wisconsin. The reviews were followed by a written summary of the findings and recommendations of the representative. At least one of the written documents provided to Dr. Suster informed him that he needed to do biennial inventories of his controlled substances on hand.

5. Dr. Suster's medical practice was audited and investigated by James Arana, a diversion investigator with the Drug Enforcement Administration (DEA) in the U. S. Department of Justice. As a result of his investigation and audit of Dr. Suster's medical practice, Mr. Arana discovered that there were hundreds of pills of controlled substances which Dr. Suster's office had purchased that Dr. Suster could not account for.

6. In 2001, Dr. Suster saw Patient Tammy M. for chronic pain. Tammy M. has been a registered nurse since 1999.

7. Tammy M has a history of migraine headaches. When she saw Dr. Suster in October 2001, she mentioned that she was out of her migraine medication, Fiorinal, and that she needed a prescription. Dr. Suster provided Tammy M, with a plastic bag containing a number of loose Esgic® pills, a prescription medication, not in a childproof container, without labeling or dosage instructions, and not in sampling packaging.

Count II: Violation of Board Order, Board Process

8. On November 14, 2001, the Wisconsin Medical Examining Board issued an Interim Decision & Order against Dr. Suster requiring, among other things:

> IT IS FURTHER ORDERED, that pursuant to §448.02 (3)(a), Wis. Stats., within 30 days of this Order, respondent shall submit to a 5 day comprehensive residential evaluation at Rogers Memorial Hospital under the supervision of Professional Recovery Network, or such other facility and evaluator as may be acceptable to the Board. Respondent shall release all records and reports to the Board and its agents, and permit the Board and its agents to discuss the matter with the evaluators and staff of PRN and the hospital.

9. Dr. Suster submitted to an evaluation at a facility acceptable to the Board in December 2001 pursuant to the Board's Order, dated November 14, 2001. Upon arrival at the facility and during his stay there, Dr. Suster refused to release his records or the report of the evaluation directly to the Board, and required the facility to send its report to his attorney only. Dr. Suster's authorization to release the facility's evaluation report and records to the Board is dated January 9, 2003.

10. On July 3, 2002, the Division of Enforcement submitted a request to Dr. Suster for the health care records of Marty L. Dr. Suster did not provide Marty L's health care records to the Division of Enforcement until October 1, 2002.

COUNT III: Sexual Misconduct/Boundary Violations

11. On and between February 3, 2000 and May of 2001, respondent provided professional services to Janet A. During this time, respondent engaged in the following activity in his office with the patient: while alone with the patient in a treatment room respondent without warning or consent from the patient touched and fondled the patient's breasts. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

12. On and between June, 2001, and July, 2001, respondent provided professional services to patient Marilyn B. During this time, respondent engaged in the following activity in his office with the patient: while alone with the patient in a treatment room while she was receiving electrostimulation treatment in a reclining chair, he leaned over her, and with his arms on her chest, kissed her forehead. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

13. Between March of 2001 and May of 2001, respondent provided professional services to Maria B. During that time, respondent engaged in the following activity in his office with the patient: while alone with the patient in a treatment room when she was receiving electrostimulation treatment in a reclining chair, respondent leaned over the patient and kissed her on the cheek. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

14. In the month of April 2000, respondent provided professional services to patient Vicki B. During that time, respondent engaged in the following activity in his office, with the patient: during an office visit respondent kissed the patient on the cheek without her initiating such contact or giving any indication that it would be welcome. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

15. Between March 1, 2000 and April 4, 2000, respondent provided professional services to Melanie C. During that time, respondent engaged in the following activity in his office with the patient: while alone with the patient in a treatment room when she complained of chest pain, the respondent, without any warning, grabbed the patient's breasts. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

16. Between July 10, 2001 and September 8, 2001, respondent provided professional services to Kim G. During that time respondent engaged in the following activity in his office with the patient: the patient reported having pain in her leg. While alone in a treatment room with the patient, respondent without warning or consent from the patient touched the patient's breast, stating it was part of her treatment. In fact, it was not a part of her treatment and had no medical necessity or appropriateness under the circumstances. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

17. During December, 1996 and between 5/9/1997 through 9/3/1997, respondent provided professional services to Mary G. During that time, respondent engaged in the following activity in his office with the patient: the patient reported having an implant in her back and being unable to wear underclothes. While alone with the patient in a treatment room, respondent had the patient take off her clothes, put on a gown, and bend over in front of him. Respondent also without warning touched the patient's breast, stating it was part of her treatment. In fact, it was not a part of her treatment and had no medical necessity or appropriateness under the circumstances. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

18. Between 3/1/99 and 12/27/99, respondent provided professional services to Mary G2 (Gr). During that time, respondent engaged in the following activity in his office with the patient: while he was providing the patient with physical therapy alone in a treatment room, respondent had the patient lie supine on a table as he bent her legs back and proceeded to rub his genital area on the side of her body. The patient did not consent to such contact with respondent's genital area, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

19. During June of 2001, respondent provided professional services to Chrissy H. During that time, respondent engaged in the following activity in his office with the patient: while alone with the patient, respondent told the patient how beautiful she was, asked her whether she had an active sex life, and stated several times that she was with the "wrong man." Respondent also without warning, or consent from the patient, kissed the patient on her head, rubbed her legs, and fondled her breast, although no breast examination was charted. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

20. Between February of 2000 and November of 2000, respondent provided professional services to Patricia R. During that time, respondent engaged in the following activity in his office with the patient: while with the patient in a treatment

room, respondent told the patient how long his penis was, encouraged the patient to divorce her husband, and rubbed his genital area against the patient when staff members were not looking. The patient did not initiate, welcome, or consent to any of this speech or contact with respondent's genital area. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

21. Between February or March of 2000 and September or October of 2000, respondent provided professional services to Kristi S. During that time, respondent engaged in the following activity in his office with the patient: while alone with the patient in a treatment room respondent asked the patient about her sex life and whether she had read the Kama Sutra. Respondent also discussed in great detail different sexual intercourse positions found in the Kama Sutra. The patient did not initiate, welcome, or consent to such speech, nor did it have any medical purpose.

22. Between December of 2000 and December of 2001, respondent provided professional services to Cindy M. During that time, respondent engaged in the following activity in his office with the patient: while alone with the patient in a treatment room while she was receiving a neck adjustment for a migraine headache, respondent kissed the patient several times on the forehead and face. The patient did not initiate, welcome, or consent to such contact, and it had no medical purpose. During other visits, respondent also made inappropriate sexual comments to the patient including telling the patient in graphic detail about how in India people "sodomized" elephants so often that the government had to make the practice illegal. The patient did not initiate, welcome, or consent to such speech or contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

23. Between February of 1995 and December of 2000, respondent provided professional services to Linda R. During that time, respondent engaged in the following activity in his office with the patient: while in a treatment room with the patient as the patient laid supine on an examining table, respondent leaned over the patient and rubbed her shoulder, placed her head into his chest, and without warning or consent from the patient touched the patient's breast nipple. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

24. On July 20, 2001 respondent provided professional services to Linda B. During that time, respondent engaged in the following activity in his office with the patient: respondent had the patient put on a gown that was open in the back and made her walk away from him twice, thus exposing her unclothed back and buttocks to him. There was no medical necessity for the patient to be so exposed. The patient was upset and tearful at this humiliation and sat down, at which time respondent leaned over the patient and pulled her head into his chest; the patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

25. On and between February 9, 2001 and March 28, 2001, respondent provided professional services to Mimi S. During that time, respondent engaged in the following activity in his office with the patient: while alone with the patient in a treatment room respondent began to badger the patient with questions and comments at which point she started to cry. Then respondent leaned over the patient where she was seated and pulled her head into his chest and hugged her. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

26. On and between September 1998 and June, 1999, respondent provided professional services to Jeanne K. During that time, respondent engaged in the following activity in his office with the patient: while alone with the patient in a treatment room respondent told the patient that he would make her feel better; he told he not to worry, and then approached her and kissed her on her forehead. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

27. On a different occasion, respondent commented to patient Jeanne K that she had big breasts and she should keep them covered up as someone could "take it the wrong way."

28. On May 31 and June 5, 2001, respondent provided professional services to patient Robert S. On June 5, 2001, respondent engaged in the following activity in his office, with the patient: the patient reported being constipated, and to having a history of constipation. Respondent stated that he needed to give the patient a rectal examination to check for blockage. Immediately after the digital rectal examination and without warning the patient of what was to happen, respondent grabbed and fondled the patient's scrotum. The patient objected, and respondent stated that he had to check for blockage there, too. In fact, there was no medical necessity or appropriateness to any such contact with the patient's scrotum. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. Respondent did not note any rectal or scrotal examination in the patient's chart. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over him.

COUNT IV: Solicitation

29. On October 10, 2001, respondent provided a consultation to Kim K. At that time, respondent recommended the patient take pain medication and undergo Dynatron treatments for her chronic pelvic pain. When the patient declined, respondent told the patient that she should undergo the treatments, and if she did not, she would think of him when her husband is sick and tired of her and divorces her because she can't have sex anymore.

COUNT V: Threats to Injure

30. Between May of 2001 and October of 2001, respondent provided professional services to Christine O. During the time, respondent engaged in the following activity in his office with the patient: when the patient asked respondent to take her off the medications he prescribed because of their side effects, respondent demanded that she take a blood test to see if she was in fact taking the medication. After the patient took the blood test, respondent insisted that the results showed she was not taking her medication. The patient denied this, and stated that she was taking her medications. Respondent began to argue with the patient and the patient's husband who was with her at the time; respondent threatened to go to get his gun if they did not leave his office.

31. Between 1999 and 2000, respondent provided professional services to Mary G. During that time, respondent engaged in the following activity in his office with the patient: when the patient's husband went with her to see respondent during an office visit, respondent became irate and started yelling at the patient's husband to get out of the office, grabbed the patient's walking cane, and chased the patient's husband out of the office building, brandishing the cane as if to strike him.

32. Between August of 2001 and October of 2001, respondent provided professional services to Tammy M. On October 29, 2001, respondent engaged in the following activity in his office with the patient: in a dispute about the patient's bill, respondent waived the bill in the patient's and her husband's faces yelling the sum they owed and shouting "you're dead, Tammy, you're dead" and (to her husband) "you're a dead man"; respondent also yelled "I'm going to take everything you've got," all in an effort to require the payment of his bill.

33. Between June of 2001 and August of 2001, respondent provided professional services to Vicky S. During that time respondent engaged in the following activity in his office with the patient: while in a dispute with the patient and her husband about their request for a new report for her disability application, respondent became angry and started to yell at the patient and her husband. Respondent then physically pushed the patient toward the treatment room's exit door and threatened to "castrate" the patient's husband if he and his wife did not leave his office immediately.

COUNT VI: Abuse of License, Obstructing

34. On and between July and October 2001, respondent provided professional services to Angela M. During this time, the patient was prescribed opioids for pain by respondent, which the patient took as directed. Respondent also prescribed electrostimulation treatments and administered them to the patient in his office. In September, 2001, the patient requested that the
electrostimulation treatments be discontinued because they were ineffective and because they were causing leg numbness and panic attacks; she also asked to have her opioids reduced because they were making her drowsy and unable to work. Respondent then became angry and stated that he was the only person who knew what was good for her, and that if she did not do as he prescribed, then respondent would have the patient "committed," by which he meant, and the patient understood him to mean, involuntarily committed to a mental institution.

35. On June 21, 2001 and June 28, 2001, respondent provided professional services to patient Chrissy H in his office. The patient had a 16-year history of migraine headaches, and on June 21, 2001, was diagnosed with a number of conditions; respondent prescribed medications and suggested a course of electrostimulation therapy. Between June 21, 2001 and June 28, 2001, the patient telephoned respondent's office with problems concerning her medications. Respondent, at the second office visit on June 28, 2002, denied that the patient had telephoned his office (although staff documented two such calls in the patient's record), called the patient a "liar" and stated that he could have her "committed," by which he meant, and the patient understood him to mean, involuntarily committed to a mental institution.

36. On and between December 2000, and December 2001, respondent provided professional services to Cindy M. During this time, the patient was awaiting a kidney transplant and was in great pain; respondent had prescribed a number of controlled substances and felt that she was experiencing significant side effects of drowsiness and depression. She asked respondent to reduce the dosages of the medications, which were causing these effects, and said that she was unable and unwilling to take the quantities prescribed. Respondent then stated that the patient was unstable and needed psychiatric help, and that if the patient did not follow his instructions concerning her treatment, he would have her "committed," by which he meant, and the patient understood him to mean, involuntarily committed to a mental institution.

37. On and between July and December, 2001, respondent provided professional services to Robert V, including electrostimulation therapy. On January 8, 2002, the patient telephoned respondent's office to say that the patient would not be returning to his care. The patient informed Dr. Suster's staff that he had obtained an electrostimulation device for home use. Shortly thereafter, respondent telephoned the patient and said that if the patient did not continue with respondent, the patient's life would be ruined by unbearable pain and he would be unable to walk. The patient responded by saying "hey, if it gets that bad, I'm going to find myself a gun and I'll shoot myself."

38. Following the telephone conversation with Robert V, respondent telephoned the sheriffs department of the county where the patient resided, and stated that he was concerned about the patient being suicidal, based upon the comment made by the patient during the telephone conversation described above. Respondent had no reason to believe that the patient was mentally ill in any respect, nor was it reasonable to believe that the patient was truly suicidal, under the circumstances. The sheriffs department dispatched a deputy to the patient's home, who interviewed the patient; the patient was in fact using his home electrostimulation device, was laughing and in good spirits, and assured the deputy that he would never commit suicide, that he did not in fact have any reason or means to do so, and that the statement made to respondent was not intended to be serious. The deputy reported that the patient was not suicidal, and did not detain the patient.

39. When respondent learned that the patient had not been detained, he telephoned the Chief Deputy of the sheriff's department, and insisted that the patient be detained for examination under ch. 51, Stats, noting that he was a doctor and his judgment should prevail. Respondent was overbearing and rude to the Chief Deputy, and berated him at length. As a direct result of respondent's insistence, the patient was detained and transported to Mendota Mental Health Institute in Madison, for examination. The patient was held overnight and released the next morning by the institution, which found no cause to detain the patient.

COUNT VII: Fraud #1: Upcoding

40. At least between 2000 and 2002, respondent used a treatment mode known as electrostimulation therapy. This

therapy involves placing electrodes on the surface of the patient's skin and allowing small electrical currents to pass through the patient's skin at the point where the electrodes are placed, using a device known as the "Dynatron." In billing for this service, respondent uses a billing code from a system developed by the American Medical Association, which is commonly used in the medical field, known as "Current Procedural Terminology" (CPT). Respondent has customarily used CPT code number 64560 for his surface placement of electrodes for electrostimulation therapy.

41. CPT code 64560 is defined as: "Percutaneous implantation of neurostimulator electrodes: autonomic nerve."

42. At no time did Dr. Suster pierce or open the skin, or implant anything beneath the surface of the skin for any patient who was billed under this code.

43. The correct code for the placement of the electrodes for the Dynatron device is CPT code number 64550: "Application of surface (transcutaneous) neurostimulator."

44. Respondent billed $440 or more for each office visit where a patient received neurostimulation, using CPT code 64560. Respondent billed these treatments to the following and other third party payers, and to individual patients, including but not limited to:

a) UnitedHealth Group was billed by respondent for approximately $234,520, under this code between January 12, 2001 and June 27, 2002.

b) Humana was billed by respondent for approximately $411,560 under this code between 1/1/99 and 9/1/02.

c) Blue Cross/Blue Shield of Wisconsin/CompCare was billed by respondent for approximately $350,240 under this code between 1999 and 9/1/02.

d) WPS was billed by respondent for approximately $367,000 under this code between 1996 to July 2002.

e) Claim Management Services, Inc. (acting on behalf of a number of employer group health plans) was billed by respondent for approximately $153,735 under this code between 1/1/99 and 9/15/02.

f) WEA Trust (Wisconsin Education Association Insurance Trust) was billed by respondent for approximately $40,000 under this code between 3/1/01 and 7/10/02.

g) Blue Cross/Blue Shield of Minnesota was billed by respondent for approximately $26,000 under this code between 1/1/99 and 8/30/02.

h) Medicaid was billed by respondent for approximately $43,424.64 under this code between 4/1/01 and 12/31/01.

i) Westport Benefits (acting on behalf of Charter Communications Employee Health Care Plan) was billed by respondent for approximately $25,000 under this code between 10/24/01 and 12/31/01, a period of approximately 10 weeks, all for one patient (Greg 0, see below).

j) Blue Cross/Blue Shield of Illinois was billed by respondent for approximately $11,000 under this code, between 6/1/01 and 10/31/01.

45. If respondent had used CPT code 64550, his established office charge was $250 per visit.

Count VIII: Fraud #2: Insurance Billing in excess of Cost to Patient/False Statements

46. On January 14, 2002, the respondent provided professional services to patient Lauri J. Following this initial consultation, the respondent billed the patient's credit card $250 for the office visit and $750 for a diagnostic test. When the patients objected to these charges the respondent removed or refunded the charges and then billed her insurance provider $2,484.

47. On and between October 5, 2001 and February 22, 2002, respondent provided professional services to patient Greg 0. During that time the respondent engaged in the following activity in his office with the patient: the respondent told the patient that respondent was tired of dealing with insurance companies and that the patient would have to pay $10,000 up front for the cost of office visits and Dynatron treatments. The respondent also told the patient that the patient could then bill the insurance provider and get back the $10,000 from his insurance. However, respondent billed the patient's insurance provider $37,630 for the same services.

48. On September 24, 2001, the respondent provided professional services to patient Patricia L. Respondent obtained a $3,000 line of credit for the patient and explained to her that he would bill the account $250 a day for each Dynatron treatment she received. However, after the patient's first visit the respondent billed both the account and the patient's insurance provider $1,000 for the same visit.

49. On November 1, 2001, respondent provided professional services to Lynnann C in the form of an initial evaluation. Respondent initially told the patient that the fee for this visit would be $250, which would be charged to a credit card. Respondent then caused to be billed to the patient's credit card not only the agreed $250, but an additional sum of $750. When the patient complained to the credit card company, the company reversed the charge. Respondent billed the patient's insurance company approximately $4700 for the same services.

50. On November 1, 2002, respondent provided an initial consultation to patient Laurie J. At the time the patient made the appointment, she was told that the fee was $250, and she gave her credit card number to respondent's staff. After her visit, respondent's staff told her on the telephone that they would bill her insurance directly, but instead her credit card was billed for $250, and another of the patient's credit cards was billed $750 for an additional test performed. The patient protested. Respondent then refunded the credit card charges. Respondent billed her insurance $2484 for the same services.

51. On October 31, 2001, respondent provided professional services in the form of an initial evaluation of Pam D. Before this appointment, respondent requested that the patient provide her credit card number, stating that it would be charged $250 only if she failed to appear for her appointment. Notwithstanding this promise, respondent charged her account the day she made the appointment. The patient did appear for her evaluation as scheduled.

52. The evidence does not establish that respondent billed a total of more than 24 hours of physician-patient contact time to third party payers on the following dates: October 27, 2000, November 3, 2000, November 7, 2000 or December 5, 2000.

COUNT IX: Practice Below Minimum Standards/Patient Vicki S.

53. On and between June 19, 2001 and August 7, 2001, respondent provided professional services to Vicki S, who was born in 1957. At the time of the initial evaluation, respondent conducted a "neuroselective sensory CPT examination", also referred to as sensory nerve testing. Respondent diagnosed the patient with peripheral polyneuropathy, reflex sympathetic dystrophy syndrome, autonomic dysfunction, and sleep disorder. Except for sleep disorder, these diagnoses are not supported by the results of the sensory nerve testing done by respondent or anything else in the patient's initial evaluation record.

54. Respondent's dictated history and physical examination for an initial evaluation of patient Vicki S, a new patient, was incomplete. Except for some comments in relation to nerve testing, the documentation in the patient's chart did not include any comments on what testing and treatment had been done prior to that point in time.

55. It is below the minimum standards of the profession for a physician to fail to
to document an adequate history at the time of a patient's initial visit. By failing to document an adequate history at the time of patient Vicki S's initial visit, Dr. Suster exposed Patient Vicki S to unreasonable risks of harm, including the risk of doing treatment that is inappropriate; the risks of not considering all of the possible contraindications for treatment and the risk that if a subsequent treating physician provides care and treatment to the patient that physician would not know what had been done regarding the patient's care or why. A minimally competent physician would have documented an adequate history of the patient.

56. The patient was treated with a series of electrostimulation treatments, from June 25, 2001 to August 7, 2001, using the Dynatron device. Respondent did not document in the patient's chart the rationale for doing the treatments or for continuing the treatments that long. Respondent also did not make or chart a re-evaluation of the patient following a reasonable trial period to determine if his treatment plan was successful.

57. It is below the minimum standards of the profession for a physician to fail to
perform and chart a reassessment of a patient undergoing electrostimulation treatments following a reasonable trial period to determine if the treatment plan is successful. By failing to perform and chart a reassessment of a patient undergoing

electrostimulation treatments following a reasonable trial period, Dr. Suster exposed Patient Vicki S to unreasonable risks of harm, including the risk of providing inappropriate treatment that is not cost effective; the risk of potential side effects of medication and the risk of not establishing other diagnoses. A minimally competent physician would have performed and charted a reassessment of the patient's treatment.

58. Respondent prescribed Kadian for patient Vicki S on June 19, 2001, the first day that he saw the patient. Respondent did not note an adequate justification in the patient's chart for prescribing Kadian.

59. Respondent prescribed oxycodone for patient Vicki S on June 25, 2001. Respondent did not note in the patient's chart why oxycodone was being prescribed.

60. Respondent prescribed Paxil for patient Vicki S on July 23, 2001. Respondent did not document in the patient's chart why Paxil was being prescribed. There is no documentation in the patient's chart indicating that the patient has depression.

61. It is below the minimum standards of the profession for a physician to prescribe a medication, including a controlled substance, without noting an adequate justification for the medication in the patient's chart. By prescribing a medication without noting an adequate justification for the medication in the patient's chart, Dr. Suster exposed Patient Vicki S to unreasonable risks of harm, including the risk of side effects caused by the medication; the risk of sedation and the risk that the medication may affect the patient's ability to drive a vehicle. A minimally competent physician would have noted adequate justification for the medication in the patient's chart.

62. Respondent switched patient Vicki S to a Duragesic on July 23, 2001. Respondent did not document in the patient's chart why he was switching Vicki S to a Duragesic, what the indications for the medication were or what he was attempting to treat.

Count X: Practice Below Minimum Standards/Maria B

63. Between March 2001 and August 2001, respondent provided professional services to Maria B.

64. On March 28, 2001, respondent performed a physical examination of Maria B during her initial visit. Respondent's impression was 1) Headaches; 2) Cervicalgia and cervicogenic headaches; 3) Thoracic spine pain, and 4) Sleep disorder. His recommendations were: "Begin oral analgesic medication and neurostimulation following informed consent which we presented medication, neurostimulation, osteopathic manipulation therapy and injection therapy to her."

65. Respondent did not document in the patient's chart his physical examination of the patient and did not document the patient's history.

66. It is below the minimum standards of the profession for a physician to fail to
to document an adequate history and physical examination at the time of a patient's initial visit. By failing to document an adequate history and physical at the time of Maria B's initial visit, Dr. Suster exposed Maria B to unreasonable risks of harm, including the risk of doing treatment that is inappropriate; the risks of not considering all of the possible contraindications for treatment and the risk that if a subsequent treating physician provides care and treatment to the patient that physician would not know what had been done regarding the patient's care or why. A minimally competent physician would have documented an adequate history and physical examination in the patient's chart.

67. The neurostimulation therapy that respondent provided to Maria B was given daily over a period of 44 days. Respondent did not perform a reassessment of the patient to determine whether the therapy was working.

68. It is below the minimum standards of the profession for a physician to fail to perform and chart a reassessment of a patient undergoing electrostimulation treatments following a reasonable trial period to determine if the treatment plan is successful. By failing to perform and chart a reassessment of a patient undergoing electrostimulation treatments following a reasonable trial period, Dr. Suster exposed Patient Maria B to unreasonable risks of harm, including the risk of providing inappropriate treatment that is not cost effective; the risk of potential side effects of medication and the risk of not establishing other diagnoses. A minimally competent physician would have performed and charted a reassessment of the patient's treatment.

69. Respondent did not document in the patient's chart whether the neurostimulation treatments that he provided to Maria B resulted in any long-term improvements or the reason why he discontinued the treatments.

70. Respondent did not document the patient's use of analgesics, such as Ibuprofen and Acetaminophen, in the patient's chart.

71. Respondent did not document in the patient's chart his comments on what the patient told him about what her prior x-rays showed; what he saw on the x-rays or whether he ordered x-rays.

72. Respondent did not obtain the patient's prior x-ray films or reports and did not order new films.

73. It is below the minimum standards of the profession for a physician to fail to obtain the patient's prior x-ray films or reports or to fail to order new films. By failing to obtain the patient's prior x-ray films or reports or order new films, Dr. Suster exposed Patient Maria B to unreasonable risks of harm, including the risk of an improper diagnosis or the risk of a diagnosis being missed. A minimally competent physician would have obtained the patient's prior x-ray films or reports or ordered new films.

74. Respondent administered a series of facet joint injections to Maria B without using x-ray guidance and contrast dye or fluoroscopy.

75. It is below the minimum standards of the profession for a physician to administer facet joint injections without using x-ray guidance and contrast dye or fluoroscopy. By administer facet joint injections without using x-ray guidance and contrast dye or fluoroscopy, Dr. Suster exposed Patient Maria B to unreasonable risks of harm, including the risk of penetrating the

spinal canal and causing a spinal fluid leak or infection; the risk of causing a serious infection such as meningitis and the risk of deflating a lung (pneumothorax). A minimally competent physician would have used x-ray guidance and contrast dye or fluoroscopy when administering facet joint injections.

76. Respondent provided Proliferant (Prolo) Therapy to Maria B on June 21, 2001. Respondent did not include a note in the patient's chart summarizing and evaluating the patient's condition following the trial period.

Count XI Practice Below Minimum Standards/Patient G2

77. Between March 9, 1999 and January 4, 2001, respondent provided professional services to Mary G2 (Gr). Mary G2 saw respondent for migraine headaches and back pain.

78. On March 9, 1999, respondent performed an initial evaluation and conducted a physical examination of Mary G2. Respondent's "Comprehensive Consultation", dated March 9, 1999 diagnosed the patient with headaches, cervicalgia, thoracic spine pain, shoulder enthesopathy, low back pain, hip enthesopathy, and multiple joint enthesopathy.

79. Respondent's documentation of the evaluation and physical examination that he performed on the patient on March 9, 1999, did not comment on imaging or other diagnostic studies that had been done prior to respondent's evaluation of the patient.

80. During the course of respondent's treatment of Mary G2, respondent administered a series of facet joint injections to Mary G2 without using x-ray guidance and contrast dye or fluoroscopy.

81. It is below the minimum standards of the profession for a physician to administer facet joint injections without using x-ray guidance and contrast dye or fluoroscopy. By administering facet joint injections without using x-ray guidance and contrast dye or fluoroscopy, Dr. Suster exposed patient Mary G2 to unreasonable risks of harm, including the risk of penetrating the spinal canal and causing a spinal fluid leak or infection; the risk of causing a serious infection such as meningitis or the risk of deflating a lung (pneumothorax). A minimally competent physician would have used x-ray guidance and contrast dye or fluoroscopy.

82. During the course of respondent's treatment of Mary G2, respondent administered a series of sacroiliac joint intraarticular injections to Mary G2 without using x-ray guidance and contrast dye or fluoroscopy.

83. It is below the minimum standards of the profession for a physician to administer a series of sacroiliac joint intraarticular injections without using x-ray guidance and contrast dye or fluoroscopy. By administering a series of sacroiliac joint intraarticular injections without using x-ray guidance and contrast dye or fluoroscopy, Dr. Suster exposed patient Mary G2 to unreasonable risks of harm, including the risk of injury to the nerves in the spinal canal. A minimally competent physician would have used x-ray guidance and contrast dye or fluoroscopy.

84. During the course of respondent's treatment of Mary G2, respondent performed osteopathic manipulative therapy (OMT) on the patient. Respondent did not document in the patient's chart what techniques were used, what areas the techniques were done to or what the patient's responses were to the techniques.

85. During the course of respondent's treatment of Mary G2, respondent provided osteopathic manipulative therapy (OMT) to the patient. Respondent did not reassess the patient's treatment following a reasonable trial period (usually after 3-8 visits).

86. It is below the minimum standards of the profession for a physician to fail to perform and chart a reassessment of a patient undergoing osteopathic manipulative therapy (OMT) following a reasonable trial period to determine if the treatment plan is successful. By failing to perform and chart a reassessment of a patient undergoing osteopathic manipulative therapy (OMT), Dr. Suster exposed patient Mary G2 to unreasonable risks of harm, including the risk of not being able to determine any adverse effects that could result from the treatment and the risk that any subsequent treating physicians would not know what treatment was given. A minimally competent physician would have performed and charted a reassessment of the treatment.

87. During the course of respondent's treatment of Mary G2, respondent prescribed medication for the patient, including controlled substances. Respondent's notes did not document in the patient's chart, why the controlled substances were prescribed, the dosage prescribed, when medications were changed or the rationale for the treatment.

88. During the course of respondent's treatment of Mary G2, respondent prescribed Valium and hydrocodone for the patient. Respondent did not document in the patient's chart, the dosage of the hydrocodone.

89. It is below the minimum standards of the profession for a physician to prescribe hydrocodone, a controlled substance, without documenting the dosage of the medication in the patient's chart. By prescribing hydrocodone, a controlled substance, without documenting the dosage of the medication in the patient's chart, Dr. Suster exposed patient Mary G2 to unreasonable risks of harm, including the risk of side effects caused by the medication; the risk of sedation and the risk that the medication may affect the patient's ability to drive a vehicle. A minimally competent physician would have documented the dosage of the controlled substance in the patient's file.

90. During the course of respondent's treatment of Mary G2, respondent provided electrostimulation therapy to the patient. Respondent's treatment note on 9/20/00 does not document the physical findings of the physical examination of the patient's lower extremities.

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.

Count I: Controlled Substances and Dispensing Violations

2. Respondent's failure to make and keep and have available for inspection any biennial inventories, as required under 21 CFR 1304.11 and s. Phar 8.02 (2), Code and as described in Findings of Fact 3 and 4 herein, constitutes a violation of s. Med 10.02 (2) (p) and (z), Code.

3. Respondent's failure to keep a legible, complete and accurate dispensing log for controlled substances, as required under s. Med 17.05 (2) (b) 2 and as described in Findings of Fact 5 herein, constitutes a violation of s. Med 10.02 (2) (p) and (z), Code.

4. Respondent's failure to keep records of and account for all controlled substances received, dispensed, or otherwise disposed of, as required by 21 CFR 1304.21, s. Phar 8.02 (1) and Med 17.05 (2), Code, and as described in Findings of Fact 5 herein, constitutes a violation of s. Med 10.02 (2) (p) and (z), Code.

5. Respondent's conduct in dispensing Esgic to patient Tammy M in violation of s. Med 17.03 and 17.04, Code and as described in Findings of Fact 7 herein, constitutes a violation of
s. Med 10.02 (2) (a), Code.

Count II: Violation of Board Order, Board Process

6. Respondent's conduct in failing to release all records and reports directly to the Board of the results of his evaluation facility as required by the Interim Decision and Order of the Medical Examining Board, dated November 14, 2001, and as described in Findings of Fact 8 and 9 herein, constitutes a violation of s. Med 10.02 (2) (b), Code.

7. Respondent's conduct in failing to provide Marty L's health care records to the Division of Enforcement, as required under s. 146.82 (2) (a) and 146.83 (4) (b), Stats., and as described in Findings of Fact 10 herein, constitutes a violation of s. Med 10.02 (2) (z), Code.

Count III: Sexual Misconduct/Boundary Violations

8. Respondent's conduct in touching patient Janet A's breast without the patient's consent, in violation of s. 940.225 (3m), Stats., and as described in Findings of Fact 11 herein, constitutes a violation of s. Med 10.02 (2) (z), Code.

9. Respondent's conduct in touching patient Melanie C's breast without the patient's consent, in violation of s. 940.225 (3m), Stats., and as described in Findings of Fact 15 herein, constitutes a violation of s. Med 10.02 (2) (z), Code.

10. Respondent's conduct in touching patient Kim G's breast without the patient's consent, in violation of s. 940.225 (3m), Stats., and as described in Findings of Fact 16 herein, constitutes a violation of s. Med 10.02 (2) (z), Code.

11. Respondent's conduct in touching patient Mary G's breast without the patient's consent, in violation of s. 940.225 (3m), Stats., and as described in Findings of Fact 17 herein, constitutes a violation of s. Med 10.02 (2) (z), Code.

12. Respondent's conduct in rubbing his genital area against the side of patient Mary G2's (Gr) body without the patient's consent, in violation of s. 940.225 (3m), Stats., and as described in Findings of Fact 18 herein, constitutes a violation of s. Med 10.02 (2) (z), Code.

13. Respondent's conduct in touching Chrissy H's breast, rubbing her legs and kissing her on the forehead without the patient's consent, in violation of s. 940.225 (3m), Stats., and as described in Findings of Fact 19 herein, constitutes a violation of s. Med 10.02 (2) (z), Code.

14. Respondent's conduct in rubbing his genital area against patient Patricia R's body without the patient's consent, in violation of s. 940.225 (3m), Stats., and as described in Findings of Fact 20 herein, constitutes a violation of s. Med 10.02 (2) (z), Code.

15. Respondent's conduct in touching patient Linda R's breast nipple without the patient's consent, in violation of s. 940.225 (3m), Stats., and as described in Findings of Fact 15 herein, constitutes a violation of s. Med 10.02 (2) (z), Code.

16. Respondent's conduct in touching patient Robert S's scrotum without the patient's consent, in violation of s. 940.225 (3m), Stats., and as described in Findings of Fact 28 herein, constitutes a violation of s. Med 10.02 (2) (z), Code.

Count IV: Solicitation

17. Respondent's conduct in soliciting Patient Kim K to undergo Dynatron treatment for chronic pain, as described in Findings of Fact 29 herein, constitutes a violation of s. Med 10.02 (2) (o), Code.

Count V Threats to Injure

18. Respondent's threats to patient Christine O and her husband that he would "get his gun" if they did not leave his office, in violation of s. 943.30 (1), Stats., and as described in Findings of Fact 30 herein, constitutes a violation of s. Med 10.02 (2) (z), Code.

19. Respondent's conduct in chasing Mary G's husband out of his office brandishing a cane as if to strike him, in violation of s. 943.30 (1), Stats., and as described in Findings of Fact 31 herein, constitutes a violation of s. Med 10.02 (2) (z), Code.

20. Respondent's threats to patient Tammy M that "you're dead, Tammy, you're dead" and to Tammy M's husband, "you're a dead man" all in an attempt to require the payment of a bill, in violation of s. 943.30 (1), Stats., and as described in Findings of Fact 32 herein, constitutes a violation of s. Med 10.02 (2) (z), Code.

21. Respondent's threat to patient Vicky S's husband that he would "castrate" the patient's husband if he did not leave his office and his actions in pushing Vicki S out of his office, in violation of s. 943.30 (1), Stats., and as described in Findings of Fact 33 herein, constitutes a violation of s. Med 10.02 (2) (z), Code.

Count VI: Abuse of License, Obstructing

22. Respondent's threat to have patient Angela M involuntarily committed to a mental institution for not taking medication as he prescribed, in violation of s. 943.30 (1), Stats., and as described in Findings of Fact 34 herein, constitutes a violation of s. Med 10.02 (2) (intro) and
s. Med 10.02 (2) (z), Code.

23. Respondent's threat to have patient Chrissy H involuntarily committed to a mental institution for not taking medication as he prescribed, in violation of s. 943.30 (1), Stats., and as described in Findings of Fact 35 herein, constitutes a violation of s. Med 10.02 (2) (intro) and
s. Med 10.02 (2) (z), Code.

24. Respondent's threat to have patient Cindy M involuntarily committed to a mental institution for not taking medication as he prescribed, in violation of s. 943.30 (1), Stats., and as described in Findings of Fact 36 herein, constitutes a violation of s. Med 10.02 (2) (intro) and Med 10.02 (2) (z), Code.

25. Respondent's conduct in having patient Robert V committed to a mental institution, as described in Findings of Fact 37-39 herein, constitutes a violation of s. Med 10.02 (2) (intro), Code.

Count VII: Fraud #1: Upcoding

26. Respondent's use of CPT code 64560 to bill insurance carriers for eletrostimulation therapy (neurostimulation treatment), as described in Findings of Fact 40-45 herein, constitutes a violation of s. Med 10.02 (2) (m), Code.

Count VIII: Fraud #2: Insurance Billing in Excess of Cost to Patient/False Statements

27. Respondent's conduct in charging medical fees to patients' credit cards and/or line of credits without the patients' consent, as described in Findings of Fact 46, 48-51 herein, constitutes a violation of s. Med 10.02 (2) (m), Code.

28. Respondent's conduct in billing insurance providers for medical services in excess of the amount that he actually charged the patients for the same service, as described in Findings of Fact 46-50 herein, constitutes a violation of s. Med

10.02 (2) (m), Code.

29. Respondent's conduct in billing insurance providers for medical services after he obtained payment from the patients for the same services, as described in Findings of Fact 46-50 herein, constitutes a violation of s. Med 10.02 (2) (m), Code.

Count IX: Practice Below Minimum Standards/Patient Vicki S.

30. Respondent's conduct, in failing to document an adequate history at the time of Vicki S's initial visit, was below the minimum standards of care established by the medical profession; exposed the patient to risks to which a minimally competent physician would not expose a patient, and constituted a danger to the health, welfare and safety of the patient, in violation of s. 448.02 (3), Stats., and s. MED 10.02 (2) (h), Code.

31. Respondent's conduct, in failing to perform and chart a reassessment of Vicki S's electrostimulation treatments following a reasonable trial period, was below the minimum standards of care established by the medical profession; exposed the patient to risks to which a minimally competent physician would not expose a patient, and constituted a danger to the health, welfare and safety of the patient, in violation of s. 448.02 (3), Stats., and s. MED 10.02 (2) (h), Code.

32. Respondent's conduct, in prescribing medications, including controlled substances, without noting an adequate justification for the medications in the patient's chart, was below the minimum standards of care established by the medical profession; exposed the patient to risks to which a minimally competent physician would not expose a patient, and constituted a danger to the health, welfare and safety of the patient, in violation of s. 448.02 (3), Stats., and s. MED 10.02 (2) (h), Code.

Count X: Practice Below Minimum Standards/Maria B.

33. Respondent's conduct, in failing to document an adequate history and physical examination at the time of Maria B's initial visit, was below the minimum standards of care established by the medical profession; exposed the patient to risks to which a minimally competent physician would not expose a patient, and constituted a danger to the health, welfare and safety of the patient, in violation of s. 448.02 (3), Stats., and s. MED 10.02 (2) (h), Code.

34. Respondent's conduct, in failing to obtain the patient's prior x-ray films or reports or to fail to order new films was below the minimum standards of care established by the medical profession; exposed the patient to risks to which a minimally competent physician would not expose a patient, and constituted a danger to the health, welfare and safety of the patient, in violation of s. 448.02 (3), Stats., and s. MED 10.02 (2) (h), Code.

35. Respondent's conduct, in failing to perform and chart a reassessment of a patient undergoing electrostimulation treatments following a reasonable trial period, was below the minimum standards of care established by the medical profession; exposed the patient to risks to which a minimally competent physician would not expose a patient, and constituted a danger to the health, welfare and safety of the patient, in violation of s. 448.02 (3), Stats., and s. MED 10.02 (2) (h), Code.

36. Respondent's conduct, in administering facet joint injections without using x-ray guidance and contrast dye or fluoroscopy, was below the minimum standards of care established by the medical profession; exposed the patient to risks to which a minimally competent physician would not expose a patient, and constituted a danger to the health, welfare and safety of the patient, in violation of s. 448.02 (3), Stats., and s. MED 10.02 (2) (h), Code.

Count XI: Practice Below Minimum Standards/Mary G2.

37. Respondent's conduct, in administering facet joint injections to Mary G2 without using x-ray guidance and contrast dye or fluoroscopy, as described in Findings of Fact 81 herein, was below the minimum standards of care established by the medical profession; exposed the patient to risks to which a minimally competent physician would not expose a patient, and constituted a danger to the health, welfare and safety of the patient, in violation of s. 448.02 (3), Stats., and s. MED 10.02 (2) (h), Code.

38. Respondent's conduct, in administering a series of sacroiliac joint intraarticular injections to Mary G2 without using x-ray guidance and contrast dye or fluoroscopy, , as described in Findings of Fact 83 herein was below the minimum standards of care established by the medical profession; exposed the patient to risks to which a minimally competent physician would not expose a patient, and constituted a danger to the health, welfare and safety of the patient, in violation of s. 448.02 (3), Stats., and s. MED 10.02 (2) (h), Code.

39. Respondent's conduct, in failing to perform and chart a reassessment of Mary G2 during the time she underwent osteopathic manipulative therapy (OMT), as described in Findings of Fact 86 herein, was below the minimum standards of care established by the medical profession; exposed the patient to risks to which a minimally competent physician would not expose a patient, and constituted a danger to the health, welfare and safety of the patient, in violation of s. 448.02 (3), Stats., and ss. MED 10.02 (2) (h) and (za), Code.

40. Respondent's conduct, in prescribing hydrocodone, a controlled substance, to Mary G2 without documenting the dosage of the medication in the patient's chart, as described in Findings of Fact 89 herein, was below the minimum standards of care established by the medical profession; exposed the patient to risks to which a minimally competent physician would not expose a patient, and constituted a danger to the health, welfare and safety of the patient, in violation of s. 448.02 (3), Stats., and ss. MED 10.02 (2) (h), and (za), Code.

ORDER

NOW, THEREFORE, IT IS ORDERED that the license (#32820) of Stuart M. Suster to practice medicine and surgery in the state of Wisconsin be, and hereby is, REVOKED.

IT IS FURTHER ORDERED that pursuant to s. 440.22 Wis. Stats., the full cost 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.

OPINION

The Division of Enforcement alleges in its Complaint that by engaging in the conduct described therein, Dr. Suster violated numerous provisions in chs. Med 10 and 17 and Phar 8, Wis. Adm. Code. Dr. Suster denies that the violations occurred. Dr. Suster elected not to testify at the hearing. Except for the violations alleged in paragraphs 23 and 61 of the Complaint, the evidence presented establishes that the violations occurred.

Count I: Controlled Substances and Dispensing Violations

I. Allegations

A. Failure to Make Biennial Inventories, Maintain an Accurate Dispensing Log and to Account for Controlled Substances.

The Division of Enforcement alleges in paragraphs 2 and 3 of its Complaint that on and between 1995 and April 2, 2002, Dr. Suster possessed controlled substances in his office for the purpose of dispensing to patients, and has acquired controlled substances from patients whom he determined to be no longer appropriate to take such controlled substances. During that time, he failed to make and keep and have available for inspection any biennial inventories, as required by 21 CFR § 1304.11 and § Phar 8.02 (2), Wis. Adm. Code; failed to keep a legible, complete, and accurate dispensing log for such substances as required by § Med 17.05 (2) (b) 2, Wis. Adm. Code, and failed to keep records of, and is unable to account for, all controlled substances received, dispensed, or otherwise disposed of, as required by 21 CFR § 1304.21 and § Phar 8.02 (1) and Med 17.05 (2), Wis. Adm. Code. The Complaint further alleges that such conduct is unprofessional conduct pursuant to § Med 10.02 (2) (p) and (z), Wis. Adm. Code.

B. Failure to Comply With Packaging and Labeling Requirements

The Division alleges in paragraphs 4 and 5 of its Complaint that on October 16, 2001, Dr. Suster provided patient Tammy M. with a plastic bag containing a number of loose Esgic ® pills, a prescription medication, not in a child proof container, without labeling or dosage instructions, and not in sample packaging, in violation of s. Med.10.02 (2) (a), 17.03 and 17.04, Code.

II. Applicable Law

A. Failure to Make Biennial Inventories, Maintain an Accurate Dispensing Log and to Account for Controlled Substances.

Med 10.02 Definitions. (2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(a) Violating or attempting to violate any provision or term of ch. 448, Stats., or of any valid rule of the board.

(p) Administering, dispensing, prescribing, supplying, or obtaining controlled substances as defined in s. 961.01 (4), Stats., otherwise than in the course of legitimate professional practice, or as otherwise prohibited by law.

(z) Violating or aiding and abetting the violation of any law or administrative rule or regulation the circumstances of which substantially relate to the circumstances of the practice of medicine.

Med 17.05 Recordkeeping.

(2) Controlled Substances. (a) Records required by the federal controlled substances act and ch. 961, Stats., shall be maintained at the location where the drug is received, distributed or dispensed and be available for inspection by authorized persons for at least 5 years from the date of such record.

(b) Controlled substances dispensed by a practitioner shall be recorded as follows:

1. As provided in this section; and

2. On a separate log, in a separate bound log book in which each schedule of controlled substances dispensed is recorded separately and in chronological order with the following information:

a. The name of the substance.
b. Dosage form and strength of the substance.
c. Name and address of the person for whom dispensed.
d. Date of dispensing.
e. Quantity dispensed.
f. Name or initials of practitioner who dispensed the substance.

Phar 8.02 Records. (1) Any pharmacy, practitioner, or other federal drug enforcement administration registrant, as referenced in ch. 961, Stats., shall maintain complete and accurate records of each controlled substance received, manufactured, distributed, dispensed or disposed of in any other manner.

21 CFR Sec. 1304.11 Inventory requirements.

(a) General requirements. Each inventory shall contain a complete and accurate record of all controlled substances on hand on the date the inventory is taken, and shall be maintained in written, typewritten, or printed form at the registered location.

21 CFR Sec. 1304.21 General requirements for continuing records.

(a) Every registrant required to keep records pursuant to Sec. 1304.03 shall maintain on a current basis a complete and accurate record of each such substance manufactured, imported, received, sold, delivered, exported, or otherwise disposed of by him/her, except that no registrant shall be required to maintain a perpetual inventory.

21 CFR Sec. 1304.03 Persons required to keep records and file reports.

(b) A registered individual practitioner is required to keep records, as described in Sec. 1304.04, of controlled substances in Schedules II, III, IV, and V which are dispensed, other than by prescribing or administering in the lawful course of professional practice.

21 CFR Sec. 1304.04 Maintenance of records and inventories.

(f) Each registered manufacturer, distributor, importer, exporter, narcotic treatment program and compounder for narcotic treatment program shall maintain inventories and records of controlled substances as follows:

(1) Inventories and records of controlled substances listed in Schedules I and II shall be maintained separately from all of the records of the registrant; and

(2) Inventories and records of controlled substances listed in Schedules III, IV, and V shall be maintained either separately from all other records of the registrant or in such form that the information required is readily retrievable from the ordinary business records of the registrant.

(g) Each registered individual practitioner required to keep records and institutional practitioner shall maintain inventories and records of controlled substances in the manner prescribed in paragraph (f) of this section.

B. <u>Failure to Comply With Packaging and Labeling Requirements</u>

Med 10.02 Definitions. (2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(a) Violating or attempting to violate any provision or term of ch. 448, Stats., or of any valid rule of the board.

Med 17.03 Packaging. A prescription drug dispensed by a practitioner shall be dispensed in a child–resistant container if it is a substance requiring special packaging under 16 CFR 1700.14 (1982) of the federal poison prevention packaging act.

Med 17.04 Labeling. (1) A prescription drug dispensed by a practitioner shall contain a legible label affixed to the immediate container disclosing:

(a) The name and address of the facility from which the prescribed drug is dispensed;

(b) The date on which the prescription is dispensed;

(c) The name of the practitioner who prescribed the drug or device;

(d) The full name of the patient;

(e) The generic name and strength of the prescription drug dispensed unless the prescribing practitioner requests omission of the name and strength of the drug dispensed; and,

(f) Directions for use of the prescribed drug and cautionary statements, if any, contained in the prescription or required by law.

(2) Nonapplication of Labeling Requirements. The labeling requirement specified in sub. (1) does not apply to complimentary samples dispensed by a practitioner in original containers or packaging supplied to the practitioner by a pharmaceutical manufacturer or distributor.

16 CFR Sec. 1700.14 Substances requiring special packaging.

(a) Substances. The Commission has determined that the degree or nature of the hazard to children in the availability of the following substances, by reason of their packaging, is such that special packaging meeting the requirements of Sec. 1700.20 (a) is required to protect children from serious personal injury or serious illness resulting from handling, using, or ingesting such substances, and the special packaging herein required is technically feasible, practicable, and appropriate for these substances:

(10) Prescription drugs. Any drug for human use that is in a dosage form intended for oral administration and that is required by Federal law to be dispensed only by or upon an oral or written prescription of a practitioner licensed by law to administer such drug shall be packaged in accordance with the provisions of Sec. 1700.15 (a), (b), and (c), except for the following:

(i) Sublingual dosage forms of nitroglycerin.

(ii) Sublingual and chewable forms of isosorbide dinitrate in dosage strengths of 10 milligrams or less.

(iii) Erythromycin ethylsuccinate granules for oral suspension and oral suspensions in packages containing not more than 8 grams of the equivalent of erythromycin.

(iv) Cyclically administered oral contraceptives in manufacturers' mnemonic (memory-aid) dispenser packages that rely solely upon the activity of one or more progestogen or estrogen substances.

(v) Anhydrous cholestyramine in powder form.

(vi) All unit dose forms of potassium supplements, including individually-wrapped effervescent tablets, unit dose vials of liquid potassium, and powdered potassium in unit-dose packets, containing not more than 50 milliequivalents of potassium per unit dose.

(vii) Sodium fluoride drug preparations including liquid and tablet forms, containing not more than 110 milligrams of sodium fluoride (the equivalent of 50 mg of elemental fluoride) per package or not more than a concentration of 0.5 percent elemental fluoride on a weight-to-volume basis for liquids or a weight-to-weight basis for non-liquids and containing no other substances subject to this Sec. 1700.14 (a)(10).

(viii) Betamethasone tablets packaged in manufacturers' dispenser packages, containing no more than 12.6 milligrams betamethasone.

(ix) Pancrelipase preparations in tablet, capsule, or powder form and containing no other substances subject to this Sec. 1700.14 (a)(10).

(x) Prednisone in tablet form, when dispensed in packages containing no more than 105 mg. of the drug, and containing no other substances subject to this Sec. 1700.14 (a)(10).

(xi)-(xii) [Reserved]

(xiii) Mebendazole in tablet form in packages containing not more than 600 mg. of the drug, and containing no other substance subject to the provisions of this section.

(xiv) Methylprednisolone in tablet form in packages containing not more than 84 mg of the drug and containing no other substance subject to the provisions of this section.

(xv) Colestipol in powder form in packages containing not more than 5 grams of the drug and containing no other substance subject to the provisions of this section.

(xvi) Erythromycin ethylsuccinate tablets in packages containing no more than the equivalent of 16 grams erythromycin.

(xvii) Conjugated Estrogens Tablets, U.S.P., when dispensed in mnemonic packages containing not more than 32.0 mg of the drug and containing no other substances subject to this Sec. l700.14 (a) (10).

(xviii) Norethindrone Acetate Tablets, U.S.P., when dispensed in mnemonic packages containing not more than 50 mg of the drug and containing no other substances subject to this Sec. 1700.14 (a) (10).

(xix) Medroxyprogesterone acetate tablets.

(xx) Sacrosidase (sucrase) preparations in a solution of glycerol and water.

(xxi) Hormone Replacement Therapy Products that rely solely upon the activity of one or more progestogen or estrogen substances.

III. Summary of Evidence

A. Failure to Make Biennial Inventories, Maintain an Accurate Dispensing Log and to Account for Controlled Substances.

1. Testimony of Investigator James Arana

Mr. Arana is a diversion investigator with the Drug Enforcement Administration (DEA), in the U. S. Department of Justice. He started with the DEA in 1998, in the administrative section, where he was in charge of doing audits of official government car reports throughout the entire Chicago field division, which included certain areas in Wisconsin. In addition, he was in charge of the MasterCard travel program that is designed to assure that government MasterCards are used for official government purposes. In 2000, he was hired by the DEA as an investigator. From June 2000 through August 2000, Mr. Arana received training at the DEA academy in Quantico, Virginia relating to diversion and investigated studies and he learned about the Controlled Substances Act. He was assigned to the Milwaukee DEA office in November of 2000 and has worked there since that time. *Tr. p. 2288-2289*.

In reference to this case, Investigator Arana was authorized by the DEA to testify only to certain matters that are identified in the DEA's letter of authorization, stamp dated March 15, 2003 (refer to Exhibit 71). He testified that as a result of his investigation and audit of Dr. Suster's medical practice, he discovered that there were hundreds of pills of controlled substances which Dr. Suster's office had purchased that Dr. Suster could not account for. *Tr. p. 2288-2305*.

2. Admissions

Dr. Suster admitted the following:

(1) That, between 1995 and April 2002, he possessed controlled substances in his office for the purpose of dispensing to patients. *Respondent's Answers to State's Second Interrogatories, Interrogatory 3; Exhibit 10.*

(2) That, between 1995 and April 2002, he confiscated controlled substances from patients for violation of contracts. *Respondent's Answers to State's Second Interrogatories, Interrogatory 3; Exhibit 10.*

(3) That, between 1995 and April 2004, he acquired controlled substances from patients because of over or under medicating, diverting or combining with illegal substances. *Respondent's Answers to State's Second Interrogatories, Interrogatory 3; Exhibit 10.*

(4) That he did not, at any time after the opening of his office in Wauwatosa, Wisconsin and April 2, 2002, take any inventory of controlled substances, as defined by 21 CFR 1304.11.
State's First Requests for Admissions.

(5) That his office procedures were reviewed by a representative of the Wisconsin Independent Physicians Group (now known as Independent Physicians Network) on one or more occasions, since he has been practicing in Wauwatosa, Wisconsin. The reviews were followed by a written summary of the findings and recommendations of the representative. At least one of the written documents provided to Dr. Suster informed him that he needed to do biennial inventories of his controlled substances on hand. *State's First Requests for Admissions.*

B. Failure to Comply With Packaging and Labeling Requirements

1. Testimony of Patient Tammy M.

Tammy M. resides in New Berlin, Wisconsin. She has been a registered nurse since 1999. In 2001, Patient Tammy M. saw Dr. Suster for chronic pain. She was referred to Dr. Suster by a friend. She had gone to see other physicians and had MRIs done, but no one could really find the answer as to why she was hurting. The nerve pain was so bad that there were days that she could not wear clothes because just the touching of the clothes on her skin caused her pain.

Tammy M. testified, in reference to receiving Esgic® pills from Dr. Suster, that per Dr. Suster's contract agreement, when a patient sees Dr. Suster, the patient cannot see other physicians for anything. She said that she had a history of migraines, and that she had run out of her migraine medication. When she saw Dr. Suster during one of her many visits, she mentioned that she was out of her migraine medication, Fiorinal, and that she would need a

prescription. She said that she did not talk with Dr. Suster personally about the medication, but she talked with him through one of his medical assistants. The medical assistant gave her a plastic bag with some pills loose in it. She said that the pills were the "blue" Esgic® brand, which is a pharmaceutical equivalent of Fiorinal. The pills were dispensed in a plastic bag, not in a bottle. The pills were loose in the bag and there was not any type of label attached or affixed to the bag. According to Tammy M., Esgic Plus is a prescription-only medication. It contains acetaminophen, "butabarbital", caffeine, and codeine. She said that she later showed the bags with the pills in it to her husband, John M. and to a friend, Sandra Weeks. *Exhibit 21*.

COUNT II: Violation of Board Order, Board Process

I. Allegations

A. Failure to Release Records and Reports to the Board

The Division of Enforcement alleges in paragraphs 6 and 7 of its Complaint that on November 14, 2001, the Wisconsin Medical Examining Board issued an Interim Decision & Order requiring Dr. Suster to release his records of report of a comprehensive residential evaluation. The Order reads, in part, as follows:

> IT IS FURTHER ORDERED, that pursuant to §448.02 (3)(a), Wis. Stats., within 30 days of this Order, respondent shall submit to a 5 day comprehensive residential evaluation at Rogers Memorial Hospital under the supervision of Professional Recovery Network, or such other facility and evaluator as may be acceptable to the Board. Respondent shall release all records and reports to the Board and its agents, and permit the Board and its agents to discuss the matter with the evaluators and staff of PRN and the hospital.

The Division also alleges that Dr. Suster submitted to an evaluation at a facility acceptable to the Board in December, 2001, pursuant to the Order. However, upon arrival at the facility and during his stay there, respondent refused to release his records or the report of the evaluation directly to the Board, and required the facility to send its report to his attorney only. The Complaint further alleges that Dr. Suster's conduct, as described above, violated § Med 10.02 (2) (b), Wis. Adm. Code, and that such conduct constitutes unprofessional conduct within the meaning of the Code and Statutes.

B. Delay in Responding to Investigative Request for Information

The Division of Enforcement alleges in paragraphs 8 and 9 of its Complaint that on July 3, 2002, a formal request was submitted to Dr. Suster by the Department of Regulation and Licensing for the patient health care record of Marty L, formerly a patient of Dr. Suster. The file was not received until October 1, 2002.

The Division further alleges that Dr. Suster's conduct, as described above, violates § Med 10.02 (2) (z), Wis. Adm. Code, in that it violates §146.82 (2) (a) and 146.83 (4) (b), Wis. Stats., and is unprofessional conduct within the meaning of the Code and Statutes.

II. Applicable Law

146.82 Confidentiality of patient health care records.

(2) Access Without Informed Consent. (a) Notwithstanding sub. (1), patient health care records shall be released upon request without informed consent in the following circumstances:

5. In response to a written request by any federal or state governmental agency to perform a legally authorized function, including but not limited to management audits, financial audits, program monitoring and evaluation, facility licensure or certification or individual licensure or certification. The private pay patient, except if a resident of a nursing home, may deny access granted under this subdivision by annually submitting to a health care provider, other than a nursing home, a signed, written request on a form provided by the department. The provider, if a hospital,

shall submit a copy of the signed form to the patient's physician.

146.83 Access to patient health care records.

(4) No person may do any of the following:

(b) Conceal or withhold a patient health care record with intent to prevent or obstruct an investigation or prosecution or with intent to prevent its release to the patient, to his or her guardian appointed under ch. 880, to his or her health care provider with a statement of informed consent, or under the conditions specified in s. 146.82 (2), or to a person with a statement of informed consent.

Med 10.02 Definitions. (2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(b) Violating or attempting to violate any term, provision, or condition of any order of the board.

(z) Violating or aiding and abetting the violation of any law or administrative rule or regulation the circumstances of which substantially relate to the circumstances of the practice of medicine.

III. Summary of Evidence

A. Failure to Release Records and Reports to the Board

1. Testimony of Barbara Anderson

Barbara Anderson is the Director of Continuing Care at Talbott Recovery. Talbott Recovery is a chemical dependency treatment facility that provides long-term treatment for healthcare and other professionals. Talbott also provides assessment services, a 96-hour assessment for individuals who need to determine whether they have a chemical dependency problem for a Board, a physicians' group or hospital. They assess chemical dependency; look at access to diagnoses and look at any depressive diagnosis. Since the time Dr. Suster's assessment was performed, Talbott has added a program for disruptive professionals.

As Director of Continuing Care, Ms. Anderson works with patients on communications between them and their referral sources and in transferring their care "back home" when they complete treatment. She does not actually perform assessments, but gathers the information for the physician who is in charge of performing the assessment.

Ms. Anderson testified that Dr. Suster was referred to Talbott for evaluation by Arthur Thexton (the Division's prosecuting attorney) for a 96-hour assessment based upon an Order issued by the Wisconsin Medical Board and that Dr. Suster did present himself at Talbott for the evaluation.

Ms. Anderson further testified that she met with Dr. Suster on December 17, 2001. They reviewed releases and he signed them. After Dr. Suster signed the releases, she shared with him that when he was referred to Talbott, Mr. Thexton told her that the assessment would not be a confidential assessment. She said that, based upon Talbott's policies, she wanted him to sign a release for her to give information to the Wisconsin Board. At that point, Dr. Suster took the releases back from Ms. Anderson and said he wanted to think about them.

On December 18, 2001, Ms. Anderson discovered Dr. Suster's releases under her door. She said that she chose to meet with him prior to making any phone calls to be sure whether the releases under her door meant that he was consenting to

her utilizing them. She said that Dr. Suster did not give her a release to give information to the Wisconsin Medical Board, but only to get information from Mr. Thexton. Finally, Ms. Anderson testified that now there is a release in Dr. Suster's chart that is dated January 9, 2003. She received that release in the mail from Mr. Thexton along with some documents.

2. Admissions

Dr. Suster admitted the following:

(A) That he directed the Talbott facility to release the report and records to his attorney for transmittal to the Medical Examining Board. *Answers to State's Second Interrogatories, Interrogatory 7; Exhibit 10.*

(B) That he authorized Talbott to discuss the report with the Medical Examining Board upon the Board's receipt of the report at its discretion. *Answers to State's Second Interrogatories, Interrogatory 7; Exhibit 10.*

(C) That he redirected the consent previously signed to his attorney as a conduit to the Board. *Answers to State's Second Interrogatories, Interrogatory 7; Exhibit 10.*

B. Delay in Responding to Investigative Request for Information

On July 3, 2002, the Division of Enforcement submitted a request to Dr. Suster for the health care records of Marty L. Dr. Suster did not provide Marty L's health care records to the Division of Enforcement until October 1, 2002. *State's First Requests for Admissions, Par. 6, 7.*

COUNT III: Sexual Misconduct/Boundary Violations

I. Allegations

The Division of Enforcement alleges the following in paragraphs 10-29 of its Complaint:

10. On and between February 3, 2000 and May of 2001, respondent provided professional services to Janet A. During this time, respondent engaged in the following activity in his office with the patient: while alone with the patient in a treatment room respondent without warning or consent from the patient grabbed and fondled the patient's breasts. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

11. On and between June, 2001, and July, 2001, respondent provided professional services to patient Marilyn B. During this time, respondent engaged in the following activity in his office, with the patient: while alone with the patient in a treatment room while she was receiving electrostimulation treatment in a reclining chair, he leaned over her, and with his arms on her chest, kissed her forehead. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

12. Between March of 2001 and May of 2001, respondent provided professional services to Maria B. During that time, respondent engaged in the following activity in his office with the patient: while alone with the patient in a treatment room when she was receiving electrostimulation treatment in a reclining chair, respondent leaned over the patient and kissed her on the cheek. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

13. In the month of April 2000, respondent provided professional services to patient Vicki B. During that time, respondent engaged in the following activity in his office, with the patient: during an office visit respondent kissed the patient on the cheek without her initiating such contact or giving any indication that it would be welcome. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own

sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

14. Between March 1, 2000 and April 4, 2000, respondent provided professional services to Melanie C. During that time, respondent engaged in the following activity in his office with the patient: while alone with the patient in a treatment room when she complained of chest pain, the respondent, without any warning, grabbed the patient's breasts. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

15. Between July 10, 2001 and September 8, 2001, respondent provided professional services to Kim G. During that time respondent engaged in the following activity in his office with the patient: the patient reported having pain in her leg. While alone in a treatment room with the patient, respondent without warning or consent from the patient grabbed the patient's breasts, stating it was apart of her treatment. In fact, it was not a part of her treatment and had no medical necessity or appropriateness under the circumstances. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

16. During December, 1996 and between 5/9/1997 through 9/3/1997, respondent provided professional services to Mary G. During that time, respondent engaged in the following activity in his office with the patient: the patient reported having an implant in her back and being unable to wear underclothes. While alone with the patient in a treatment room, respondent had the patient take off her clothes, put on a gown, and bend over in front of him. Respondent also without warning, grabbed the patient's breasts, stating it was apart of her treatment. In fact, it was not a part of her treatment and had no medical necessity or appropriateness under the circumstances. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

17. Between 3/1/99 and 12/27/99, respondent provided professional services to Mary G2. During that time, respondent engaged in the following activity in his office with the patient: while he was providing the patient with physical therapy alone in a treatment room, respondent had the patient lie supine on a table as he bent her legs back and proceeded to rub his genital area on the side of her body. The patient did not consent to such contact with respondent's genital area, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

18. During June of 2001, respondent provided professional services to Chrissy H. During that time, respondent engaged in the following activity in his office with the patient: while alone with the patient, respondent told the patient how beautiful she was, asked her whether she had an active sex life, and stated several times that she was with the "wrong man." Respondent also without warning, or consent from the patient, kissed the patient on her head, rubbed her legs, and fondled her breasts, although no breast examination was charted. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

19. Between February of 2000 and November of 2000, respondent provided professional services to Patricia R. During that time, respondent engaged in the following activity in his office with the patient: while with the patient in a treatment room, respondent told the patient how long his penis was, encouraged the patient to divorce her husband, and rubbed his genital area against the patient when staff members were not looking. The patient did not initiate, welcome, or consent to any of this speech or contact with respondent's genital area. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

20. Between February or March of 2000 and September or October of 2000, respondent provided professional services to Kristi S. During that time, respondent engaged in the following activity in his office with the patient: while alone with the patient in a treatment room respondent asked the patient about her sex life and whether she had read the Kama Sutra. Respondent also discussed in great detail different sexual intercourse positions found in the Kama Sutra. The patient did not initiate, welcome, or consent to such speech, nor did it have any medical purpose.

21. Between December of 2000 and December of 2001, respondent provided professional services to Cindy M.

During that time, respondent engaged in the following activity in his office with the patient: while alone with the patient in a treatment room while she was receiving a neck adjustment for a migraine headache, respondent kissed the patient several times on the forehead and face. The patient did not initiate, welcome, or consent to such contact, and it had no medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her. During other visits, respondent also made inappropriate sexual comments to the patient including telling the patient in graphic detail about how in India people "sodomized" elephants so often that the government had to make the practice illegal. The patient did not initiate, welcome, or consent to such speech, nor did it have any medical purpose.

22. Between February of 1995 and December of 2000, respondent provided professional services to Linda R. During that time, respondent engaged in the following activity in his office with the patient: while in a treatment room with the patient as the patient laid supine on an examining table, respondent leaned over the patient and rubbed her shoulder, placed her head into his chest, and without warning or consent from the patient grabbed the patient's breast nipple. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

23. On and between September 12, 1997 and January 2, 1998, respondent provided professional services to Karen T. During that time, respondent engaged in the following activity in his office with the patient: the patient reported having bruises all over her body and suffering from seizures as a result an automobile accident. While examining the patient, respondent without warning or consent from the patient rubbed the patient's breasts, stating he thought she was faking her seizures. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

24. On July 20, 2001 respondent provided professional services to Linda B. During that time, respondent engaged in the following activity in his office with the patient: respondent had the patient put on a gown that was open in the back and made her walk away from him twice, thus exposing her unclothed back and buttocks to him. There was no medical necessity for the patient to be so exposed. The patient was upset and tearful at this humiliation and sat down, at which time respondent leaned over the patient and pulled her head into his chest; the patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact and the conduct preceding and precipitating it was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

25. On and between February 9, 2001 and March 28, 2001, respondent provided professional services to Mimi S. During that time, respondent engaged in the following activity in his office with the patient: while alone with the patient in a treatment room respondent began to badger the patient with questions and comments at which point she started to cry. Then respondent leaned over the patient where she was seated and pulled her head into his chest and hugged her. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

26. On and between September 1998 and June, 1999, respondent provided professional services to Jeanne K. During that time, respondent engaged in the following activity in his office with the patient: while alone with the patient in a treatment room respondent told the patient that he would make her feel better; he told he not to worry, and then approached her and kissed her on her forehead. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over her.

On a different occasion, respondent was administering prolotherapy injections to respondent's back, he commented that she had big breasts and she should keep them covered up as someone could "take it the wrong way."

27. On May 31 and June 5, 2001, respondent provided professional services to patient Robert S. On June 5, 2001, respondent engaged in the following activity in his office, with the patient: the patient reported being constipated, and to having

a history of constipation. Respondent stated that he needed to give the patient a rectal examination to check for blockage. Immediately after the digital rectal examination and without warning the patient of what was to happen, respondent grabbed and fondled the patient's scrotum. The patient objected, and respondent stated that he had to check for blockage there, too. In fact, there was no medical necessity or appropriateness to any such contact with the patient's scrotum. The patient did not initiate, welcome, or consent to such contact, nor did it have any medical purpose. The purpose of this contact was respondent's own sexual gratification and/or the sexual humiliation or degradation of the patient for the purpose of establishing control over him. Respondent did not note any rectal or scrotal examination in the patient's chart.

28. Such conduct violated § Med 10.02 (2) and (h), Wis. Adm. Code, and is unprofessional conduct, in that it was sexual in nature and was not engaged in for the benefit of the patient, but rather solely for the gratification of respondent. "Sexual or romantic interactions between physicians and patients detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well being." (AMA Ethical Opinion E-8.14: Sexual Misconduct in the Practice of Medicine.) Such conduct was below the minimal standards of the profession and exposed the patient to risks of harm to which a minimally competent physician would not have exposed the patient. Any reasonable and minimally competent practitioner would avoid those dangers by not engaging in such conduct.

29. Except as to the conduct relating to Kristi S. (which consisted of speech only), such conduct violated § Med 10.02 (2)(z), Wis. Adm. Code, in that it constitutes Fourth Degree Sexual Assault pursuant to §940.225 (3m), Wis. Stats., and is unprofessional conduct.

II. Applicable Law

Med 10.02 Definitions. (2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(h) Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public.
(z) Violating or aiding and abetting the violation of any law or administrative rule or regulation the circumstances of which substantially relate to the circumstances of the practice of medicine.

940.225 Sexual assault.

(3m) Fourth Degree Sexual Assault. Except as provided in sub. (3), whoever has sexual contact with a person without the consent of that person is guilty of a Class A misdemeanor.
(4) Consent. "Consent", as used in this section, means words or overt actions by a person who is competent to give informed consent indicating a freely given agreement to have sexual intercourse or sexual contact. Consent is not an issue in alleged violations of sub. (2) (c), (cm), (d), (g), (h), and (i). The following persons are presumed incapable of consent but the presumption may be rebutted by competent evidence, subject to the provisions of s. 972.11 (2):

(b) A person suffering from a mental illness or defect which impairs capacity to appraise personal conduct.
(c) A person who is unconscious or for any other reason is physically unable to communicate unwillingness to an act.

(5) Definitions. In this section:

(b) "Sexual contact" means any of the following:

1. Intentional touching by the complainant or defendant, either directly or through clothing by the use of any body part or object, of the complainant's or defendant's intimate parts if that intentional touching is either for the purpose of sexually degrading; or for the purpose of sexually humiliating the complainant or sexually arousing or gratifying the defendant or if the touching contains the elements of actual or attempted battery under s. 940.19 (1).

III. Summary of Evidence

———The following patients testified at the hearing or by deposition that they were touched by Dr. Suster in an inappropriate manner while receiving medical treatment[1]:

(1) Janet A (touched on breast). Tr. p. 922
(2) Marilyn B (kissed on forehead). Tr. p. 2042
(3) Maria B (kissed on cheek about a dozen times). Tr. p. 32
(4) Vicki B (kissed on cheek). Tr. p. 2113
(5) Melanie C (touched on breast). Tr. p. 2196
(6) Kim G (touched on breast). Tr. p. 684
(7) Mary G (touched on breast). Tr. p. 2230
(8) Mary G2/GR (rubbed his genital area on the side of G2's body). Tr. p. 847
(9) Chrissy H (kissed on head, rubbed her legs and touched her breast). Tr. p. 1806
(10) Patricia R (rubbed his genital area against her. Also, placed her head into his chest.). Tr. p. 2032
(11) Cindy M (kissed several times on forehead). Tr. p. 278; 338
(12) Linda R (touched on breast; rubbed her shoulder). Tr. p. 1882
(13) Linda B (pulled her head into his chest). Tr. p. 1597
(14) Michelle "Mimi" S (pulled her head into his chest; hugged her). Tr. p. 2248
(15) Jeanne K (kissed on forehead). Tr. p. 226
(16) Robert S (touched on scrotum). Exhibits 45; 46, p. 17-18.

The following patients testified at the hearing or by deposition that Dr. Suster discussed matters of a sexual nature while providing medical treatment to them:

(1) Kristi S (different sexual intercourse positions found in the Kama Sutra). Tr. p. 1934.
(2) Chrissy H (asked if she had active sex life). Tr. p. 1806
(3) Patricia R (told her how long his penis was). Tr. p. 2025, 2026, 2032
(4) Cindy M (how elephants are sodomized in India). Tr. p. 278
(5) Jeannie K (commented that she had big breasts). Tr. p. 226

———The following is a specific example of Dr. Suster's inappropriate contact with a patient:

(1) Patient Maria B.

[Complaint, paragraph 11; Answer, paragraph 11]

Patient Maria B. lives in Milwaukee, Wisconsin. She is a student working on an undergraduate degree in psychology at Alverno College and plans to attend graduate school at Loyola University.

Between March and August of 2001, Patient Maria B. saw Dr. Suster in his professional capacity for back pain. She had been dealing with on-going upper back pain for quite some time and had gone through a variety of different treatments. She first saw Dr. Suster for an initial consultation on March 28, 2001. She explained to Dr. Suster the type of pain that she had been encountering over the years. She was asked to put on a gown; Dr. Suster looked at her spine, and then he told her of a particular treatment that he was using with the Dynatron machine. Then she made appointments to see Dr. Suster daily for a month for Dynatron treatments.

Patient Maria B. testified that while she was receiving the Dynatron treatment, Dr. Suster came up to her while she was sitting in a chair and asked her about her pain level; held her hands, and kissed her on the cheeks. She said that she felt uncomfortable because she had never had a doctor to treat her that way. She said that she did not initiate the contact, did not agree to the contact and did not welcome it. When asked if Dr. Suster had kissed her on the cheeks more than once, she said yes, about a dozen times. *Tr. p. 39-42; 65-67; 117-124.*

When asked why she continued to see Dr. Suster after he kissed her, she said that she had hopes that eventually the

treatment would work. She said that psychologically she was at a point where she did not know what else to do. She had already tried multiple treatments. She said that after having pain for so many years, "you get to a point where you will try anything even to the point of taking painkillers that essentially and ethically is something that I wouldn't have done, but that was to the point of psychological distress that I was at". *Tr. p. 42*.

COUNT IV: Solicitation

I. Allegations

The Division of Enforcement alleges the following in paragraphs 30-31 of its Complaint:

30. On October 10, 2001, respondent provided a consultation to Kim K. At that time, respondent recommended the patient take pain medication and undergo Dynatron treatments for her chronic pelvic pain. When the patient declined, respondent told the patient that she should undergo the treatments, and if she did not, she would think of him when her husband is sick and tired of her and divorces her because she can't have sex anymore.

31. Such conduct violated § Med 10.02 (2) (o), Wis. Adm. Code, and is unprofessional conduct.

II. Applicable Law

Med 10.02 Definitions.

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(o) Engaging in uninvited, in–person solicitation of actual or potential patients who, because of their particular circumstances, are vulnerable to undue influence; or engaging in false, misleading or deceptive advertising.

III. Summary of Evidence

Testimony of Patient Kim K.

Patient Kim K received an undergraduate degree from the University of Wisconsin. Then, she moved to New York and worked there for some time. Now she does some brokerage for a printing company in Waukesha. *Tr. p. 1979-2041.*

Patient Kim K testified that she consulted with Dr. Suster for medical care. Prior to consulting with Dr. Suster, she had been to several other doctors. She said that after she had her son in November 1999, she dislocated her pelvis really badly; that it just wasn't healing right; that she was in a lot of pain for quite some time and that she had really limited capabilities of doing almost anything. She had gone to several doctors and had "pretty much became kind of hopeless about the whole situation". Then her regular doctor said he did not know what else he could do for her and asked if she had ever thought about going to a pain clinic. She said she had no idea what a pain clinic was. Then she heard Dr. Suster in a commercial on the radio.

Patient Kim K went to see Dr. Suster in October 2001. She said that Dr. Suster "did kind of a partial examination". He had her take off her shoes and he looked at her feet, and then he looked at her hands. He explained that he was a chronic pain sufferer as well and he thought that he could really help her, but he wanted to do this test. She said that she had paid $250 when she arrived at his office. Dr. Suster's assistant assured her that insurance would cover that amount and that they would pay her back. Dr. Suster said that the test would be an additional $750. He said that it was absolutely necessary for him to make his diagnosis. So he had two "girls" come in and had her lay on an "examination bed or something", and they had "these like little electrodes or something that they were poking" into her. She was asked to say when she felt it or not.

Patient Kim K further testified that after the examination, Dr. Suster came in, got the results, then went back out, and generated some kind of computer report to show her what he could do for her. Dr. Suster went through the report. She said that she did not really understand the report and that all along Dr. Suster was saying that he could help her and that he understood her situation. She said that she remembers that Dr. Suster asked her "is it painful for you to have sexual intercourse with your husband?" And she said, "Yes, it was painful". At some point, Dr. Suster told her that it could be up to

$5,000 for him to get her out of pain. He said that he had "this guarantee that if you follow my instructions completely that if you don't get out of pain" she would get at least some of her money back. She said that she started thinking that "this would be great". Then, Dr. Suster said, "well, you need to fill out these credit -- these credit things" to see how much credit he could give her. So she filled all those out, and his assistant came out to the waiting room and explained to her that Dr. Suster had said something like, "you know -- I remember him saying that, you have a really shitty insurance company. And this is why you have to pay me up front, because for my small little practice it takes forever for them to pay me back." She said that the assistant "was going on and saying, you know, how terrible insurance companies were and how her father had breast cancer and it wasn't covered and, you know, all this other stuff. So that's why I had to fill out those credit things".

—Then, Patient Kim K went back into the examining room. Dr. Suster came in and basically said, " you're ready to go, and -- and things like that". She asked him "well, exact -- you know, how much is this gonna be?" And he said, well, it's gonna be $10,000. She said, "Well, I thought you said five". And he said, "I never said five". And so then she said, "Well, $10,000 is a lot of money". And he said, "well, you know, can't you afford it?" She said, "well, you know, I mean my husband is making the money right now in our house and I really would need to talk to him about this before I go ahead and do it and – and sign all these papers." Patient Kim K further testified as follows regarding her conversation with Dr. Suster:

> And -- and he said, well, I mean what's the -- what's the deal with your -- with your husband? I mean, look at your ring. How much did that cost? And I said, you know, I don't know. It was a gift for engagement. And he said, well, you know, what kind of a house do you live in? And I said, I mean, I don't understand where you're getting at. And he said, well, do you at least have four bedrooms in your house? And I said, yeah, I have four bedrooms.
>
> Well, where do you live? And, you know, he started asking me these questions about what kind of car I drove and stuff like that. And isn't $10,000 -- isn't $10,000 -- isn't it worth it to spend that money to get you out of pain? And I said, yeah, it would really be worth it if I really knew that it was gonna work, but, you know, I'd like to talk to my insurance company and I'd maybe like to get a second opinion. And -- and, you know, why -- why is it just $10,000? Can't I pay per visit? And that's when he started to get really like heated with me and really kind of argumentative about, you know, I can't believe that -- that you wouldn't want -- you wouldn't want to get out of pain and, you know, he just kept on reinforcing the fact that, you know, isn't your husband sick and tired of this, too, and stuff like that. And then, you know, I started signing some paperwork, and then I realized that I probably shouldn't because I really wanted to talk to my husband first. And -- and then, you know, I said, I really – I'm not comfortable with signing everything right now. I want to go home, talk to my husband. And, you know, he really got irate, and I can't remember everything that he said, but it was just really, you know, mean. And then finally at the end, as we were walking out toward the waiting room, he said, you know, this is your one and only chance. I am not gonna accept you as a patient if -- if you come back here, or something like that. And I said, well, you know, then I guess that's that. And he said, well, you know, when your husband is sick and tired of you not being able to perform your -- perform having sex and he divorces you and leaves you on the street with your two kids, you think of me and you think about the pain that you're in and – and what I could have done for you. And so, you know, I basically got in my car and cried all the way home and, you know, explained the situation to my husband.

Patient Kim K also testified that after she left Dr. Suster's office that day, he called her at her home that night. She said that she talked to him for a couple of minutes and that she was still really upset about the whole thing. She said "you're gonna have to talk to my husband". She said that her husband was probably on the phone with Dr. Suster for 30 minutes, and her

husband was "pretty leery about -- about everything". Her husband asked her if she really wanted to go back in there and she said, "after all of this, no, I don't". She said she was just really kind of scared of him; that she was humiliated by the whole experience and that it was not something that she wanted to go through on a daily basis just to get out of pain.

COUNT V: Threats to Injure

I. Allegations

The Division of Enforcement alleges the following in paragraphs 32-37 of its Complaint:

32. Between May of 2001 and October of 2001, respondent provided professional services to Christine O. During the time, respondent engaged in the following activity in his office with the patient: when the patient asked respondent to take her off the medications he prescribed because of their side effects, respondent demanded that she take a blood test to see if she was in fact taking the medication. After the patient took the blood test, respondent insisted that the results showed she was not taking her medication. The patient denied this, and stated that she was taking her medications. Respondent began to argue with the patient and patient's husband who was with her at the time; respondent threatened to go to get his gun if they did not leave his office.

33. Between 1999 and 2000, respondent provided professional services to Mary G. During that time, respondent engaged in the following activity in his office with the patient: when the patient's husband went with her to see respondent during an office visit, respondent became irate and started yelling at the patient's husband to get out of the office, grabbed the patient's walking cane, and chased the patient's husband out of the office building, brandishing the cane as if to strike him.

34. Between August of 2001 and October of 2001, respondent provided professional services to Tammy M. On 10/29/01, respondent engaged in the following activity in his office with the patient: in a dispute about the patient's bill, respondent waived the bill in the patient's and her husband's faces yelling the sum they owed and shouting "you're dead, Tammy, you're dead" and (to her husband) "you're a dead man"; respondent also yelled "I'm going to take everything you've got," all in an effort to require the payment of his bill.

35. Between June of 2001 and August of 2001, respondent provided professional services to Vicky S. During that time respondent engaged in the following activity in his office with the patient: while in a dispute with the patient and her husband about their request for a new report for her disability application, respondent became angry and started to yell at the patient and her husband. Respondent then physically pushed the patient toward the treatment room's exit door and threatened to "castrate" the patient's husband if he and his wife did not leave his office immediately.

36. Such conduct violated §943.30 (1), Wis. Stats., and constituted unprofessional conduct pursuant to § Med 10.02 (2) (z), Wis. Adm. Code.

37. Independently of whether such conduct violated §943.30, Stats., such conduct was unprofessional conduct not otherwise defined or specified, under § Med 10.02 (2)(intro), Wis. Adm. Code.

II. Applicable Law

Med 10.02 Definitions.

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(z) Violating or aiding and abetting the violation of any law or administrative rule or regulation the circumstances of which substantially relate to the circumstances of the practice of medicine.

943.30 Threats to injure or accuse of crime. (1) Whoever,

either verbally or by any written or printed communication, maliciously threatens to accuse or accuses another of any crime or offense, or threatens or commits any injury to the person, property, business, profession, calling or trade, or the profits and income of any business, profession, calling or trade of another, with intent thereby to extort money or any pecuniary advantage whatever, or with intent to compel the person so threatened to do any act against the person's will or omit to do any lawful act, is guilty of a Class D felony.

III. Summary of Evidence

(A) Testimony of Christine O.

Patient Christine O graduated from Custer High School; went to modeling school for a year, and now takes care of her son.

Patient Christine O first saw Dr. Suster in May of 2001, for endometriosis. She has had endometriosis probably 15 or 16 years. She said that she has severe pain in all areas, pelvic area, back and legs. She called for an appointment. They said insurance would cover it and everything. During the time that she saw Dr. Suster, he prescribed medications for her pain.

Patient Christine O testified that on the last day that she saw Dr. Suster, in September or October of 2001, she told her husband that she wanted to go in and get off of medications. She said that a former worker who worked in Dr. Suster's office told her that she should probably bring her husband in because of the way he (Dr. Suster) "acts with his patients". Dr. Suster asked her to take a blood test so she went to the lab down the street from Dr. Suster's office and had the blood test done. After she returned to Dr. Suster's office, Dr. Suster looked over the test results and told her that that there was no medication in her blood so he could not take her off of the medication. Her husband, James O, told Dr. Suster that he knew that there was medication in her blood because he saw her take it every day. She said that her husband was upset because he wanted her off of the medication. *Tr. p. 2092-2112.*

Patient Christine O further testified as follows:

A. And my husband said, I seen her take it. So then my husband said to him -- well, first Dr. Suster said, well, who are you? And he said, you know, who are you? So it was kind of going back and forth. And he said, I'm her husband. And he didn't pronounce his name right, so he says, well, you know who Christine Oehler is because she's been seeing you almost six months. You should know her last name by now. And then he said -- you know, he told him he was nothing but a drug dealer because he's done nothing but feed me drugs and take away my pain. And then he must have said something about**,** get out of my office, and as my husband said, no, I want you to get her off of this medication. I want you to give her medication, because I know she's taking it. And he kept saying, get out of my office, and he kept saying get out. Then the third time he said -- he must -- when my husband -- we finally -- I finally said, let's -- let's go. We kind of -- I kind of got him out of there. And he said -- he -- he didn't want -- Jim didn't want to leave until I was off the medication, so finally he must have said -- Dr. Suster -- Dr. Suster must have said, you want me to get my gun? And then he said, a little man needs

a big gun.

(B) Testimony of James O

James O has worked at Harley Davidson Motor Company in the tool and dye room for almost eight years. He is married to Patient Christine O.

James O testified that he went to Dr. Suster's office with his wife, Patient Christine O, in October of 2001. He said that she had been seeing Dr. Suster probably for six months and she did not want to go anymore. He said that day she went to tell him (Dr. Suster) that she wanted to get off medication. Dr. Suster sent her out for a blood test. He said that she called him and said she had to go back to Dr. Suster's office and asked if he would go with her. He agreed to. *Tr. p. 2085-2092.*

James O further testified as follows:

Q. Okay. So was this the only time you had been to Dr. Suster's office?

A. Yes, it was.

Q. Okay. Can you -- I want you to tell the story of what happened when you got to the office to the judge, and begin with your driving into the parking lot.

A. Okay. We pulled into the parking lot, and my wife was kind of nervous because figured that he was gonna give her a lot of crap about not want -- wanting to see him anymore. So that's why I agreed to go along. We went inside. They seated us in a room. And Dr. Suster came in and he started out by, you know, saying hello and saying my name wrong, to which I said, hey, she's been coming here six months, you know my name. You know, don't act like you don't know who we are. And he said, okay, you know, why are you here? And my wife had said to him that she didn't want to come and see him anymore and she wanted a medication to get off the medication that he was prescribing her, to which he took out the blood report and said, I don't have to give you the medication. I don't believe there's enough in your system for you to have it. And I said to him, you know, quit screwing around. Just give her the medication so that we -- we can quit coming here. And he said to my wife, give me back the prescriptions I wrote you then. And my wife said to him, I can't. He flushed them down the toilet. To which he responded, well, who the hell are you? And I said, I'm her f'ing husband. Who the hell are you? He said, I'm your doc -- or her doctor. I said, bullshit. You're her drug dealer. To which he responded, get out. And I said, make me. Give her the medicine. He said, get out or I'll call the cops. I said, okay, drug dealer, call the cops. Let's see what they have to say. He said, get out. I said, no, call the cops. He jumped out of his chair and he said, I'll get my gun. I said, what? He said, I'll get my gun. I stood up and I said to him, little man needs a big gun, hey? I said, you're pathetic. Don't ever come out of this office and let me catch you. And we left. That was the last time I saw him.

(C) Testimony of Patient Mary G (GR)

Patient Mary G lives in Milwaukee. She is an airport security screener for the Department of Transportation. Patient Mary G saw Dr. Suster between 1999 and 2000 for pain that she was experiencing in her lower back, shoulders and neck. *Tr. p. 847-849.*

Patient Mary G testified that close to the end of her treatment with Dr. Suster, her husband, Richard G., went in with her during her visit with Dr. Suster. She said that Dr. Suster and her husband had a confrontation about the treatment that was being administrated to her. Her husband was upset that she was on too much medication. She said that Dr. Suster grabbed her cane and threatened her husband and chased her husband out of his (Dr. Suster's) office, down the hall out toward the door and into the parking lot. She said that Dr. Suster was swinging her cane like a golf club and that, from her point of view, it appeared that Dr. Suster was going to strike her husband. She also said that Dr. Suster threatened to call the police; said to them "get off my property" and "get out of the damn parking lot". *Tr. p. 870-873*.

(D) Testimony of Richard G.

Richard G, Patient Mary G's husband, testified that he went to Dr. Suster's office to talk about the medication that Dr. Suster was prescribing for his wife, Mary G. He said that Dr. Suster asked him what he was doing there. Richard G told Dr. Suster that he came in to find out what they could do about Mary G's medication. He said that Dr. Suster "verbally" attacked him; that at some point the discussions became confrontational and that it became a long drawn-out argument.

Richard G further testified that Dr. Suster asked him if he cared. He then asked Dr. Suster if he cared, and he asked Dr. Suster how much did he charge per visit. Richard G said "that's what started this whole thing with the cane. He said that Dr. Suster "went ballistic." He said that Dr. Suster asked him to leave and told him that he was going to call the police. Richard G asked Dr. Suster to answer his question and said, "How much do you charge if you care so much, what are we charging here daily". Dr. Suster said that he was not going to answer the question; that Richard G had to leave and that he would call the police. Richard G said that he was not leaving until he got some answers. Richard G said that he got up and looked behind him and saw Dr. Suster with the cane in his hand, in a raised position, and that Dr. Suster was waving it. He said that as they walked out of Dr. Suster's office, Dr. Suster followed them with the cane. Dr. Suster kept repeating that he would call the police. Richard G said that he thought that Dr. Suster was going to strike him with the cane if he had not left his office. *Tr. p. 879-883.*

(E) Testimony of Tammy M.

Tammy M. resides in New Berlin, Wisconsin. She has been a registered nurse since 1999. In 2001, Patient Tammy M. saw Dr. Suster for chronic pain. She was referred to Dr. Suster by a friend. She had gone to see other physicians and had MRIs done, but no one could really find the answer as to why she was hurting. *Tr. p. 586.*

Patient Tammy M testified that the last day that she saw Dr. Suster, October 29, 2001, she had planned to get a second opinion. She wanted a copy of her charts and prescriptions to wean off her medication. She said that it became a "shouting match at me and calling me names, calling me a drug addict". She said that all she really remembers is just crying and saying "why can't we talk about this professionally". She said that he was very upset with her and was hollering.

At some point during the office visit, one of Dr. Suster's assistant asked Patient Tammy M to fill out a credit application. Patient Tammy M called her husband, John M, on the telephone twice about the matter, and John M told her not to fill out any forms and that he would come to Dr. Suster's office. At some point, Patient M was told that she owed Dr. Suster $33,000. Patient Tammy M testified that during the discussions about her bill, Dr. Suster told her that she was a "dead girl"; that he would have everything that she owned; that she would suffer forever and that that her pain would not be taken care of by anyone in the community. She also testified that Dr. Suster told her husband, John M, that he was a "dead man".

(F) Testimony of John M

John M is Patient Tammy M's husband. He testified that when he arrived at Dr. Suster's office, his wife, Tammy M signaled him to come into the room where she was meeting with Dr. Suster. He said that he went into Dr. Suster's office where some other people were sitting around a table. He asked "what's going on". He said that Dr. Suster told him that his wife owed him $33,000. John M said "oh, really, can I see the bill". He said that Dr. Suster threw the bill at him. He said that he realized what he was dealing with and he said, "Tammy, we're out of here. We don't need this". Tr. p. 661.

John M said that as they were walking out the short hallway into the reception area and to the front doors the following occurred: "Dr. Suster chases after us, and as we're exiting the building toward the car, towards the west, he's waving in the -- just outside the front door in that part of the parking lot, basically waving saying, goodbye, Mr. Marsh, goodbye Tammy Marsh, you're a dead man, Mr. Marsh, Tammy, there's no one that can treat you, your withdrawal will kill you. You'll be sorry. You'll be sorry. I own you. That's when I put my wife in the car, and we drove away".

G. Testimony of Vicki S.

Patient Vicki S works in the residential building industry doing automation analyses and report writing. She saw Dr. Suster for pain management. She suffers from fibromyalgia and chronic fatigue. She testified that prior to a treatment session with Dr. Suster she left some "short-term disability papers" with one of Dr. Suster's assistant and requested that the assistant have Dr. Suster complete the form. She said that when she received the disability papers back, they were not filled out correctly. She felt that Dr. Suster should have stated on the form that she could not go to work because she was sick and because he told her not to drive. *Tr. p. 1702.*

Patient Vicki S. also testified that during a treatment session she asked Dr. Suster about the disability papers. She said that he became enraged and grabbed the wires and ripped them off her. He said "get out" and "I don't' want you here anymore, get out of my office". She said that he went on and on raging and she said "what is happening here". She said that she was getting up out of the chair and trying to get her shoes on and that he just grabbed the papers from her. He started pushing them (her and her husband, Richard S.) out saying "get out of here, I'm so sick of you". She said that she was stunned, shocked and frightened. She said that they were out in the waiting room when Dr. Suster said that "if you don't get out of her right now I'm calling the police". She said that Dr. Suster pushed her to get her out of the office. She said that when he pushed her it was scary and humiliating. She said that Dr. Suster's staff was stunned. Everybody was just stopped. It was dead silent except Dr. Suster yelling and she was "balling her head off". She said that she went back into Dr. Suster's office and got her disability papers back and that when they were in the parking lot, Dr. Suster tried to take the papers from her. She said that Dr. Suster said " I' m going to castrate you here right here in the parking lot. I can castrate you so fast ...." Patient Vicki S. said that it was very much like a nightmare that you can't get out of.

H. Testimony of Richard S.

Richard S., Patient Vicki S's husband, testified that in August 2001 he drove his wife to her appointment with Dr. Suster. He said that his wife tried to explain to Dr. Suster that the short-term disability papers were filled out incorrectly. He said that Dr. Suster became angry and started pulling out the apparatus that he used to place the electrodes on her arms and legs. He said that Dr. Suster very roughly ripped off the apparatus; informed her that she was no longer a patient of his and that they were to leave the premises of his office immediately. He said that Dr. Suster was basically raising his voice and yelling. Richard S said that he asked Dr. Suster for a copy of his wife's medical records and Dr. Suster told him that those were his personal property and that they were not entitled to them. He said that Dr. Suster was saying "come on, just hit me, go ahead, hit me". Richard S said "no, I'm not going to do it". He said Dr. Suster kind of rushed them out of his office while he was yelling at them the entire time. He said that his wife wanted the insurance papers back so he walked in Dr. Suster's office and took them off of his desk. Dr. Suster came out again challenging him to hit him and yelling at them. He followed them outside. Dr. Suster shoveled his wife and grabbed the papers from her. Richard S ran back and grabbed the papers from Dr. Suster, pulled his fist back as if he was going to hit Dr. Suster and Dr. Suster backed away. He said that Dr. Suster started challenging him to hit him again and that Dr. Suster said "come on, I'll castrate you right now, right here. I can castrate you faster than anybody". *Tr. p. 1652-1659.*

COUNT VI: Abuse of License, Obstructing

I. Allegations

The Division of Enforcement alleges the following in paragraphs 38-47 of its Complaint:

38. On and between July and October, 2001, respondent provided professional services to Angela M. During this time, the patient was prescribed opioids for pain by respondent, which the patient took as directed. Respondent also prescribed electrostimulation treatments and administered them to the patient in his office. In September, 2001, the patient requested that the

electrostimulation treatments be discontinued because they were ineffective and because they were causing leg numbness and panic attacks; she also asked to have her opioids reduced because they were making her drowsy and unable to work. Respondent then became angry and stated that he was the only person who knew what was good for her, and that if she did not do as he prescribed, then respondent would have the patient "committed," by which he meant, and the patient understood him to mean, involuntarily committed to a mental institution.

39. On 6/21/01 and 6/28/01, respondent provided professional services to patient Chrissy H in his office. The patient

had a 16 year history of migraine headaches, and on 6/21/01, was diagnosed with a number of conditions; respondent prescribed medications and suggested a course of electrostimulation therapy. Between 6/21/01 and 6/28/01, the patient telephoned respondent's office with problems concerning her medications. Respondent, at the second office visit (6/28/02), denied that the patient had telephoned the office (although staff documented two such calls in the patient's record), called the patient a "liar" and stated that he could have her "committed," by which he meant, and the patient understood him to mean, involuntarily committed to a mental institution.

40. On and between December 2000, and December 2001, respondent provided professional services to Cindy M. During this time, the patient was awaiting a kidney transplant and was in great pain; respondent had prescribed a number of controlled substances and felt that she was experiencing significant side effects of drowsiness and depression. She asked respondent to reduce the dosages of the medications which were causing these effects, and said that she was unable and unwilling to take the quantities prescribed. Respondent then stated that the patient was unstable and needed psychiatric help, and that if the patient did not follow his instructions concerning her treatment, he would have her "committed," by which he meant, and the patient understood him to mean, involuntarily committed to a mental institution.

41. On and between July and December, 2001, respondent provided professional services to Robert V, including electrostimulation therapy. On January 8, 2002, the patient telephoned respondent's office to say that the patient would not be returning to his care. Shortly thereafter, respondent telephoned the patient and said that if the patient did not continue with respondent, the patient's life would be ruined by unbearable pain and he would be unable to walk. In fact, respondent knew that the patient was obtaining treatment elsewhere, and had obtained an electrostimulation device for home use.

42. Following the telephone conversation, respondent telephoned the sheriffs department of the county where the patient resided, and stated that he was concerned about the patient being suicidal, based upon an off-hand comment made by the patient during the telephone conversation described above. Respondent had no reason to believe that the patient was mentally ill in any respect, nor was it reasonable to believe that the patient was truly suicidal, under the circumstances. The sheriffs department dispatched a deputy to the patient's home, who interviewed the patient; the patient was in fact using his home electrostimulation device, was laughing and in good spirits, and assured the deputy that he would never commit suicide, that he did not in fact have any reason or means to do so, and that the statement made to respondent was not intended to be serious. The deputy reported that the patient was not suicidal, and did not detain the patient.

43. When respondent learned that the patient had not been detained, he telephoned the Chief Deputy of the sheriff's department, and insisted that the patient be detained for examination under Ch. 51, Stats, noting that he was a doctor and his judgment should prevail. Respondent was overbearing and rude to the Chief Deputy, and berated him at length. As a direct result of respondent's insistence, the patient was detained and transported to Mendota Mental Health Institute in Madison, for examination. The patient was held overnight and released the next morning by the institution, which found no cause to detain the patient.

44. Respondent's use of his status as a physician to coerce the sheriff's department into depriving a citizen of his liberty for the purpose of retaliating against the patient for leaving his care is unprofessional conduct not otherwise defined or specified under § Med 10.02 (2) (intro), Wis. Adm. Code.

45. Respondent's statements to law enforcement officials stating, in effect, that the patient was a proper subject for civil commitment, were false in that respondent knew that the patient was not mentally ill, and thus the statements constituted obstructing an officer in violation of §946.41(1), Wis. Stats. Such conduct is unprofessional conduct under § Med 10.02 (2) (z), Wis. Adm. Code.

46. Respondent's threat to have the patient civilly committed under the circumstances described in the first three paragraphs of this Count is unprofessional conduct not otherwise defined or specified under § Med 10.02 (2)(intro), Wis. Adm. Code.

47. The conduct described in the first three paragraphs of this Count violated §943.30(1), Wis. Stats., and is unprofessional conduct pursuant to § Med 10.02 (2)(z), Wis. Adm. Code.

II. Applicable Law

Med 10.02 Definitions.

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(z) Violating or aiding and abetting the violation of any law or administrative rule or regulation the circumstances of which substantially relate to the circumstances of the practice of medicine.
943.30 Threats to injure or accuse of crime. (1) Whoever, either verbally or by any written or printed communication, maliciously threatens to accuse or accuses another of any crime or offense, or threatens or commits any injury to the person, property, business, profession, calling or trade, or the profits and income of any business, profession, calling or trade of another, with intent thereby to extort money or any pecuniary advantage whatever, or with intent to compel the person so threatened to do any act against the person's will or omit to do any lawful act, is guilty of a Class D felony.

III. Summary of Evidence

(1) Testimony of Patient Angela M.

Patient Angela M., is a transportation assistant at Patrick Cudahy, Incorporated.

In the summer and early fall of 2001, Patient Angela M. consulted with Dr. Suster for neck and back pain that resulted from a car accident in 1997. Before seeing Dr. Suster, she had been to quite a few doctors trying to deal with her pain.

Patient Angela M said that the treatment that Dr. Suster suggested involved the use of a "neurostim machine", which is also referred to as the Dynatron machine. When she started the treatment, she discontinued her pain medication. She said that she started the machine within a couple days of first seeing him. The first few times she received treatment she had no reaction whatsoever. After a few days the pain in her neck was bad and she asked Dr. Suster if there was something else that they could do. So, she started on pain medication again. She said that throughout the whole time she was receiving treatment she was using the machine (Dynatron) every day and she was on pain medication.

At some point, Patient Angela M started having reactions to the pain medication that Dr. Suster prescribed. She said that basically she could not function and that she could not drive. She said that she did not remember driving to work or driving home from work, and that she would just get "sweats, shakes, and felt nauseous,"". She said that the first time that it happened, she called Dr. Suster and asked if she should go to the emergency room or if she should go to his office. He told her to come to his office. He gave her Xanax to calm her down. She said that she had three episodes where she called Dr. Suster and asked if she should go to the emergency room or come to his office. He told her to come to the office. During one of the three times that she went to his office because of a reaction to the medication, they started talking about the fact that she wanted to get off of the pain medication and she wanted to discontinue treatment on one of the machines because it was not working. She said that Dr. Suster told her that she basically did not know what she needed; that he was the doctor and she was the patient, and that if she did not listen to him he would have no choice but to commit her to a mental institution. She asked about Dr. Suster's tone of voice when he was having the discussion with her, she said that he was "very loud agitated –

angry."".

(2) Testimony of Chrissy H.

Patient Chrissy H lives in West Bend, Wisconsin. She owned her own business for a couple of years and is now a stay-home-mother.

Patient Chrissy H went to see Dr. Suster for migraine headaches. She had been having headaches for about 13 years. She had been to several other health care providers about her headaches. She said that Dr. Suster gave a lot of medications to start on including oxycodone. She started to take them and she could not handle going to work; she was so tired. She called Dr. Suster's office on two different occasions and told them that she could not handle taking the medications. So they scheduled an appointment for her to see Dr. Suster.

During the second visit with Dr. Suster, Patient Chrissy H told Dr. Suster that she could not handle any of the medications. She said that he told her that he was going to put her on different types. She said that he yelled at her. He told her, as he looked at the nurse, "I told you she was going to be the one to give us these troubles, I told you she wouldn't follow my directions". He said if you don't take these medications I could have you committed. Patient Chrissy H said that she did not know what he meant by that at first, but he brought up like a mental hospital or something like "I was psycho or something". She said at that point Dr. Suster was basically trying to tell her she was a druggie or something and that she needed to follow his directions exactly. If she didn't, then he could get her in trouble or have her committed. She said that when he left (the room), she "was just crying very, very hardly. The nurse just looked at me and I know she felt bad for me, and she just said it was going to be okay".

(3) Testimony of Cynthia M.

Patient Cynthia M lives in West Allis, Wisconsin. She has worked primarily in the restaurant and catering business. She is now a senior banquet manager. Over the last three years she has been working towards achieving her bachelor's degree in business. *Tr. p. 278-333*.

Patient Cynthia M testified that she saw Dr. Suster for pain management in the winter of 1999. She said that she was in a car accident in which she was hurt. She also had end stage renal failure and was awaiting a transplant. She looked in the yellow pages and there was a picture of Dr. Suster. She said that when she called his office, they were most compassionate. She made an appointment for an evaluation.

Following the initial evaluation, she entered treatment with Dr. Suster, which consisted of an osteopathic manipulation therapy (OMT) and also a chemical therapy. The chemical therapy included medicine for pain, anxiety, and depression.

At some point in time during the treatment, Patient Cynthia M asked Dr. Suster to reduce her medication dosage because she felt the dosage was too high. She said that she could not take care of her kids and that she was tired all the time, but Dr. Suster insisted that she continue with the dosage. She and her husband, Daniel M went in to discuss the matter with Dr. Suster.

Patient Cynthia M testified that when she and her husband arrived at the office, Dr. Suster started telling her that she was unstable and that she should have psychiatric commitment. She said that she was just taken aback by it and her husband was as well. She said that she was in shock; that she did not know where he was coming from and that she was flabbergasted. She said she thought that Dr. Suster was going to have her committed, but she did not know why. She said that she was sick at the time, but she did not believe she was mentally ill. She said that when they were driving home, she was so upset that her husband had to pull the van over and she had to vomit. It made her very upset. She said she felt Dr. Suster threatened to have her committed to a mental hospital if she did not do what he told her to do. Following Dr. Suster's statement to her, she did more of what he said she should do because she was afraid he was going to have her put in a hospital.

(4) Testimony of Daniel M.

Daniel M, Patient Cynthia M's husband, testified at a deposition held on November 7, 2003. His testimony is contained in the deposition transcript that has been marked as Exhibit 11.

(5) Testimony of Patient Robert V.

Patient Robert V lives in Iron Ridge, Wisconsin. He graduated from the University of Wisconsin in 1966 with a major in economics and investments. He was a stockbroker for three years. Then he moved to California and became a sales representative for Honeywell for about four years. In 1974, he took over a bar and restaurant business owned by his parents. He sold the business and retired in 1994. *Tr. p. 139-225; Exhibits 4-8*.

Patient Robert V consulted with Dr. Suster in July of 2001 regarding his neuropathy pain. He was recommended to go see Dr. Suster by a druggist that he was seeing for some topical salve for his neuropathy pain. His condition was diagnosed in 1988 at the Mayo Clinic. He has been to various places but he could never get a treatment for the pain. He said that he had burning pain and stabbing pain. Sometimes his feet would get real red hot and sometimes they would be cold. It was just an uncomfortable situation. He had gone to John Hopkins, the Cleveland Clinic and the "Scripps" Clinic. He had tried various other remedies and treatment regimens and none of them provided him with satisfactory relief.

When asked to describe the first day that he went to Dr. Suster's office, Patient Robert V said that if he had not been referred by the druggist, he would have left immediately. He said that "the man was strictly interested in how much money I could afford to pay because I was on Medicare, and he didn't take Medicare. We sat there negotiating like I was buying a car. So we arrived at a bargain deal, $10,000, which he says, it will cover you for as long as it takes". He said that Dr. Suster told him that he did not have peripheral neuropathy, but that he had RSD. Patient Robert V said that he had never heard of RSD before, but he understands it is similar to neuropathy. They set up a schedule to start the treatments, which consisted of placing various electrodes on his arms and the part of his body that was primarily affected by the pain, which was on his feet.

At some point in time, Patient Robert V obtained a prescription to purchase his own machine for use at home. He cancelled his appointments with Dr. Suster. Later, he got a call from Dr. Suster's assistant who said Dr. Suster wanted to know how he was doing. He eventually admitted to the assistant that he had his own machine for use at home. A week later, he received a call from Dr. Suster's assistant who said that Dr. Suster wanted to see him. He went in to see Dr. Suster. A friend, Clarence Wendorff, drove him to Dr. Suster's office.

Patient Robert V said that when they went to the office, instead of being a compassionate and caring person, Dr. Suster read him "a riot act you wouldn't believe". He said that Dr. Suster called him a criminal; told him he was violating his contract with him and called the prescription (for the machine he had for use at home) illegal. His friend actually said, "Bob, let's just get out of here. Don't put up with this anymore". Patient Robert V testified that Dr. Suster had him "under control" and had him "petrified and brainwashed". He said that he just was afraid to make the decision, so he said, "well, maybe I'll stay here".

Patient Robert V further testified that after he left Dr. Suster's office he contact the person who had informed him about the machine (home unit) that had been prescribed for him. He said that person told him it was not illegal for him to have the machine. Then, Patient Robert V called Dr. Suster's office and cancelled his appointments for the following day or two. Thereafter, he got a call from Dr. Suster "threatening, saying the pain will be unbearable, you won't be able to live with it, you'll never walk again, their treatments aren't any good, and all of that". Patient Robert V. said that after Dr. Suster "was going through all of this stuff about the pain and all the problems that I'm going to have", he "just turned around and said, hey, if it gets that bad, I'm going to find myself a gun and I'll shoot myself. Because I had to stand up to this guy some time because he had -- so I just decided now is the time I'm going to tell him". He said that shortly after he had said that to Dr. Suster, he said, "I'm not really going to do that. I said, I couldn't do it, wouldn't have the courage, nor would I want to hurt -- I got an 88 year-old mother. I'm not going to do anything like that. I don't even have a gun".

Patient Robert V further testified that about an hour or two later, the Dodge County police came to his house. They said, "We've got a call from a doctor in Milwaukee who said that you were here at your home sitting on your bed and had a

gun and if you were going to be shooting yourself". So the police went into his house. He said that he happened to be there sitting in his recliner taking the treatment (hooked up to my home machine). His mother was also present. He told the police "check out what you got to check out, but I got nothing here, a gun or anything like that, and I'm not thinking of doing any suicide or anything". So they did their check and talked to him, and they said, he did not seem to have any suicidal tendencies. So they were going to go back and report that.

About three hours later the police came back again. They said, "We're very sorry, Bob, but we have to take you in to Mendota. Our top people, the sheriff, and somebody at one of the health deals, I don't know what it's called, but were called by Dr. Suster and they -- after that conversation they told us that we had to come back and get you and take you in". He packed up his bags and packed up his machine, and he went to Mendota in the back of the sheriff's car.

Patient Robert V checked in at Mendota. He said that he did not know what was going to happen. They took his cane away because they said he could use it as a weapon. He was assigned to his room and stayed there for the night. The next morning he met with five psychiatrists and some other social workers. They interviewed him and left. About a half hour after the meeting, he was in his room when someone came down and said, "No problem, you can go home".

COUNT VII: Fraud #1: Upcoding

I. Allegations

The Division of Enforcement alleges the following in paragraphs 48-54 of its Complaint:

48. Respondent has, over the past approximately three years, used a treatment mode known as electrostimulation therapy. This therapy involves placing electrodes on the surface of the patient's skin and allowing small electrical currents to pass through the patient's skin at the point where the electrodes are placed, using a device known as the "Dynatron." In billing for this service, respondent uses a billing code from a system developed by the American Medical Association and in common use in the medical field, known as "Current Procedural Terminology" (CPT). There are many thousands of billing codes, each of which has a particular description. Respondent has customarily used CPT code number 64560 for his surface placement of electrodes for electrostimulation therapy.

49. CPT code 64560 is defined as: "Percutaneous implantation of neurostimulator electrodes: autonomic nerve."

50. At no time did Dr. Suster pierce or open the skin, or implant anything beneath the surface of the skin for any patient who was billed under this code.

51. The correct code for the placement of the electrodes for the Dynatron device is CPT code number 64550: "Application of surface (transcutaneous) neurostimulator."

52. Respondent billed $440 or more for each office visit where a patient received neurostimulation, using CPT code 64560. Respondent has billed many thousands of these treatments to the following and other third party payers, and to individual patients, including but not limited to:

a) United Health Group was billed by respondent for approximately $697,000, under this code between January 12, 2001 through June 27, 2002.

b) Humana was billed by respondent for approximately $630,000 under this code between 1/1/99 and 9/1/02.

c) Blue Cross/Blue Shield of Wisconsin/CompCare was billed by respondent for approximately $380,000 under this code between 1999 and 9/1/02; during this time period no other physician in the United States has billed this company using this code.

d) WPS was billed by respondent for approximately $367,000 under this code between 1996 to July, 2002.

e) Claim Management Services, Inc. (acting on behalf of a number of employer group health plans) was billed by

respondent for approximately $125,000 under this code between 1/1/99 and 9/15/02.

f) WEA Trust (Wisconsin Education Association Insurance Trust) was billed by respondent for approximately $40,000 under this code between 3/1/01 and 7/10/02.

g) Blue Cross/Blue Shield of Minnesota was billed by respondent for approximately $26,000 under this code between 1/1/99 and 8/30/02.

h) Medicare Part B was filled by respondent for approximately $25,000 under this code between 4/1/01 and 12/31/01.

i) Westport Benefits (acting on behalf of Charter Communications Employee Health Care Plan) was billed by respondent for approximately $25,000 under this code between 10/24/01 and 12/31/01, a period of approximately 10 weeks, all for one patient (Greg O, see below).

j) Blue Cross/Blue Shield of Illinois was billed by respondent for approximately $11,000 under this code, between 6/1/01 and 10/31/01.

53. If respondent had used CPT code 64550, his established office charge was $250.

54. Respondent's use of the CPT code 64560 as set forth above was a false statement to the person or entity receiving the bill, made with fraudulent intent, and made in an attempt to obtain a professional fee. Respondent's conduct violated § Med 10.02 (2) (m), Wis. Adm. Code, and is unprofessional conduct.

II. Applicable Law

Med 10.02 Definitions.

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(m) Knowingly making any false statement, written or oral, in practicing under any license, with fraudulent intent; or obtaining or attempting to obtain any professional fee or compensation of any form by fraud or deceit.

III. Summary of Evidence

(1) Admissions

(A) At least between 2000 and 2002, Dr. Suster used a treatment mode known as electrostimulation therapy for the treatment of pain. In billing for this service, Dr. Suster used a billing code from a system developed by the American Medical Association, which is commonly used in the medical field, known as "Current Procedural Terminology (CPT). *Respondent's Answers to State's Second Interrogatories, paragraph 38.*

(B) Dr. Suster billed individuals and third party payers under CPT code 64560 for office visits where patients received electrostimulation therapy (billed as autonomic neurostimulation). Dr. Suster's charge for office visits under CPT Code 64560 was $440. *Respondent's Answers to State's Second Interrogatories, paragraph 38.*

(C) CPT code 64560 is defined as "Percutaneous implantation of neurostimulator electrodes: Autonomic Nerve." *Respondent's Answers to State's Second Interrogatories, paragraph 39.*

(D) At no time did Dr. Suster pierce or open the skin, or implant anything beneath the surface of the skin for any

patient who was billed under CPT code 64560 for neurostimulation. *Respondent's Answers to State's Second Interrogatories, paragraph 40.*

(E) Dr. Suster also billed third party payers under CPT code 64550 where patients received electrostimulation therapy (billed as autonomic neurostimulation). Dr. Suster's charge for office visits under CPT code 64550 was $250.00. *Respondent's Answers to State's Second Interrogatories, paragraphs 42, 43.* [2]

(2) Additional Evidence

The following evidence establishes that Dr. Suster billed third party payers for autonomic neurostimulation therapy under CPT code 64560 for office visits where patients received electrostimulation therapy:

(A) UnitedHealth Group

Between January 12, 2001 and June 27, 2002, Dr. Suster billed UnitedHealth Group $234,520.00 for neurostimulation treatment using CPT code 64560. *Exhibit 41.*

All of the claims that Dr. Suster submitted to UnitedHealth were billed for $440.00. UnitedHealth paid Dr. Suster $130,109.41 for claims that Dr. Suster submitted using CPT code 64560. UnitedHealth has requested a refund from Dr. Suster in the amount of $112,914.93. *Exhibit 41*

In a letter to Mr. Thexton (the prosecuting attorney for the Division of Enforcement), dated October 18, 2002, from UnitedHealth, Patrick Parker stated the following [Exhibit 41]:

> It is the position of UnitedHealth Group that code 64560 is not the correct code for the treatment with the Dynatron as it is depicted in the correspondence UnitedHealth Group has received from your office. Code 64550 should be used because at no time was there placement of an electrode precutaneously (through the skin) through an introducer needle into the tissue to be stimulated.

(B) Humana, Inc.

Between January 4, 1999 and September 1, 2002, Dr. Suster billed Humana $411,560.00 under CPT code 64560 for neurostimulation therapy. *Tr. p. 787; Exhibit 26.*

Most of the claims that Dr. Suster submitted to Humana were billed for $440.00. At least 31 of the claims that Dr. Suster submitted to Humana were billed for $500.00 or more and at least one claim was submitted for $44.00. *Exhibit 26.*

Humana paid Dr. Suster $4,509.79 for the claims that he submitted during that time period. *Exhibit 26.*

(C) Blue Cross/Blue Shield of Wisconsin/CompCare

Between 1999 and September 1, 2002, Dr. Suster billed Blue Cross $350,240.00 under CPT code 64560 for neurostimulation therapy. All of the claims that Dr. Suster submitted to Blue Cross for payment under CPT code 64560 were billed for $440.00. *Tr. p. 402; Exhibit 17.*

Blue Cross paid Dr. Suster $800.00 for the claims that he submitted during that time period. *Exhibit 17, p. 1, 15.*

(D) Wisconsin Physicians Service (WPS)

Between 1996 and July 2002, Dr. Suster billed WPS $366,960.00 under CPT code 64560 for neurostimulation therapy. WPS paid Dr. Suster $860.72 for claims that he submitted during that time period. *Tr. p. 970; Exhibit 31.*

Between 1996 and July 2002, Dr. Suster billed WPS $48.000.00 under CPT code 64550. WPS paid Dr. Suster $212.00 for the claims that he submitted during that time period. *Ex. 31*.

(E) Claims Management Services, Inc.

Between January 1, 1999 and September 30, 2002, Dr. Suster billed Claims Management $153,735.00 under CPT code 64560 for neurostimulation therapy. Claims Management paid Dr. Suster $12,101.58 for the claims that he submitted during that time period. All of the claims, except one, that Dr. Suster submitted were billed for $440.00. One claim was submitted for $175.00. *Tr. p. 1041; Exhibit 33.*

(F) Wisconsin Education Association Insurance Trust (WEA)

Between March 1, 2001 and July 10, 2002, Dr. Suster billed WEA $41, 535 under CPT code 64560 for neurostimulation therapy. All of the claims, except one, were billed for $440.00. One claim was billed for $175.00. WEA paid Dr. Suster $396.00 for the claims that he submitted using CPT code 64560 during that time period. *Exhibit 25.*

(G) Blue Cross/Blue Shield of Minnesota

Between January 1, 1999 and August 31, 2002, Dr. Suster billed Blue Cross $25,960.00 under CPT code 64560 for neurostimulation therapy. All of the claims submitted by Dr. Suster were for $440.00. Blue Cross paid Dr. Suster $188.85 for the claims that he submitted using CPT 64560 during that time period. *Tr. p. 385; Exhibit 13, p. 2, 8.*

(H) Medicare Part B (Medicaid Program)

Between April 1, 2001 and December 31, 2001, Dr. Suster billed Medicaid $43,424.64 under CPT code 64560 for neurostimulation therapy. Medicaid paid Dr. Suster $43,424.64 for the claims that he submitted using CPT code 64560 during that time period. *Tr. p. 378; Ex. 12.*

(I) Westport Benefits

Between October 24, 2001 and December 30, 2001, Dr. Suster billed Westport $25,080.00 under CPT code 64560 for neurostimulation therapy. All of the claims submitted by Dr. Suster were for $440.00. Westport paid Dr. Suster $25,080.00 for the claims that he submitted using CPT 64560 during that time period. *Exhibit 42.*

(J) Blue Cross/Blue Shield of Illinois

Between June 11, 2001 and October 8, 2001, Dr. Suster billed Blue Cross $11,440.00 under CPT code 64560 for neurostimulation therapy. All of the claims submitted by Dr. Suster were for $440.00. Blue Cross paid Dr. Suster $360.00 for the claims that he submitted using CPT 64560 during that time period. *Exhibit 40.*

Count VIII: Fraud #2: Insurance Billing in Excess of Cost to Patient/False Statements

Except as to paragraph 61 of the Complaint, the evidence establishes that the violations occurred.

I. Allegations

The Division of Enforcement alleges the following in paragraphs 55-62 of its Complaint:

55. On January 14, 2002, the respondent provided professional services to patient Lauri J. Following this initial consultation, the respondent billed the patient's credit card $250 for the office visit and $750 for a diagnostic test. When the patients objected to these charges the respondent removed or refunded the charges and then billed her insurance provider $2,484.

56. On and between October 5, 2001 and February 22, 2002, respondent provided professional services to patient

Greg O. During that time the respondent engaged in the following activity in his office with the patient: the respondent told the patient that respondent was tired of dealing with insurance companies and that the patient would have to pay $10,000 up front for the cost of office visits and Dynatron treatments. The respondent also told the patient that the patient could then bill the insurance provider and get back the $10,000 from his insurance. However, respondent billed the patient's insurance provider $37,630 for the same services.

57. On September 24, 2001, the respondent provided professional services to patient Patricia L. Respondent obtained a $3,000 line of credit for the patient and explained to her that he would bill the account $250 a day for each Dynatron treatment she received. However, after the patient's first visit the respondent billed both the account and the patient's insurance provider $1,000 for the same visit.

58. On 11/1/01, respondent provided professional services to Lynnann C in the form of an initial evaluation. Respondent initially told the patient that the fee for this visit would be $250, which would be charged to a credit card. Respondent then caused to be billed to the patient's credit card not only the agreed $250, but an additional sum of $750. When the patient complained to the credit card company, the company reversed the charge. Respondent billed the patient's insurance company approximately $4700 for the same services.

59. On 1/1/02, respondent provided an initial consultation to patient Laurie J. At the time the patient made the appointment, she was told that the fee was $250, and she gave her credit card number to respondent's staff. After her visit, respondent's staff told her on the telephone that they would bill her insurance directly, but instead her credit card was billed for $250, and another of the patient's credit cards was billed $750, supposedly for an additional test performed. The patient protested. Respondent then refunded the credit card charges. Respondent billed her insurance $2484 for the same services,

60. On 10/31/01, respondent provided professional services in the form of an initial evaluation of Pam D. Before this appointment, respondent requested that the patient provide her credit card number, stating that it would be charged $250 only if she failed to appear for her appointment. Notwithstanding this promise, respondent charged her account the day she made the appointment, thus increasing her average daily balance and thus the potential interest she was required to pay on the account. The patient did appear for her evaluation as scheduled.

61. On each of the following dates, respondent billed a total of more than 24 hours of physician-patient contact time to third party payers: October 27, 2000, November 3, 2000, November 7, 2000, and December 5, 2000.

62. The conduct described in each of the paragraphs of this Count violated § Med 10.02 (2) (m), Wis. Adm. Code, and is unprofessional conduct.

II. Applicable Law

Med 10.02 Definitions.

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(m) Knowingly making any false statement, written or oral, in practicing under any license, with fraudulent intent; or obtaining or attempting to obtain any professional fee or compensation of any form by fraud or deceit.

III. Summary of Evidence

Except as to paragraph 61 of the Complaint, the evidence establishes that the violations occurred.

A. Paragraphs 55-60 of the Complaint

The following admissions made by Dr. Suster establish that the violations occurred.

(1) On January 14, 2002, Dr. Suster provided professional services to patient Lauri J. Following this initial consultation, Dr. Suster billed the patient's credit card $250.00 for the office visit and $750.00 for a diagnostic test. Following patient Lauri J's objection, Dr. Suster removed or refunded all or part of the charges and then billed the patient's insurance provider approximately $2,484.00 for the same services. *State's First Requests for Admissions, par. 8-13.*

(2) On and between October 5, 2001 and February 22, 2002, Dr. Suster provided professional services to patient Greg O. During that time, Dr. Suster told patient Greg O that he was tired of dealing with insurance companies and that the patient would have to pay $10,000.00 up front for the cost of office visits and Dynatron treatments. Dr. Suster also told the patient that the patient could then bill the insurance provider and get back the $10,000 from his insurance. Dr. Suster then bill the patient's insurance provider approximately $37,630.00 for the same services. *State's First Requests for Admissions, par. 14-19.*

(3) On September 24, 2001, Dr. Suster provided professional services to patient Patricia L. Dr. Suster obtained a $3,000.00 line of credit for the patient and explained to her that he would bill the account $250 a day for each Dynatron treatment she received. After the patient's first visit, Dr. Suster billed both the patient's account and the patient's insurance provider $1,000 for the same visit. *State's First Requests for Admissions, par. 20-24.*

(4) On November 1, 2001, Dr. Suster provided professional services to patient Lynnann C in the form of an initial evaluation. Dr. Suster initially told the patient that the fee for that visit would be $250, which would be charged to a credit card. Dr. Suster then caused to be billed to the patient's credit card not only the agreed $250, but an additional sum of $750. When the patient complained to the credit card company, the company reversed the charge. Dr. Suster billed the patient's insurance company an amount greater than $1,000 for the same services and approximately $4,700 for all services provided on November 1, 2001. *State's First Requests for Admissions, par. 25-30.*

(5) On January 1, 2002, Dr. Suster provided an initial consultation to patient Laurie J. At the time the patient made the appointment, she was told that the fee was $250, and she gave her credit card number to Dr. Suster's staff. After her visit, Dr. Suster's staff told her on the telephone that they would bill her insurance directly, but instead her credit card was billed for $250, and another of the patient's credit card was billed $750 for an additional test performed. After the patient objected, Dr. Suster refunded the credit card charges. Dr. Suster billed the patient's insurance $2,484 for the same services. *State's First Requests for Admissions, par. 31-39.* [See also, Exhibit 32].

(6) On October 31, 2001, Dr. Suster provided professional services in the form of an initial evaluation of Pam D. Before the appointment, Dr. Suster requested that the patient provide her credit card number, stating that it would be charged $250 only if she failed to appear for her appointment. Dr. Suster then charged the patient's account the day she made the appointment. The patient did appear for her evaluation as scheduled. *State's First Requests for Admissions, par. 40-42.* [See also, Tr. p. 1450; Exhibit 38.]

B. Paragraph 61 of the Complaint

The Division of Enforcement alleges the following:

61. On each of the following dates, respondent billed a total of more than 24 hours of physician-patient contact time to third party payers: October 27, 2000, November 3, 2000, November 7, 2000, and December 5, 2000.

The evidence presented does not establish that the violations occurred.

Testimony of Maggie Behrens

Maggie Behrens is a fraud investigator at Blue Cross and Blue Shield United of Wisconsin and Compcare Blue. *Tr. p. 402.*

Ms. Behrens testified that early in 2001 they (Blue Cross) noticed that Dr. Suster's billing had changed and that he had started using time-implied codes, prolonged physician codes. So they decided to run his billing to see how much time was being billed to them. She said that they also noticed that on specific dates he was billing like four hours or so, and they decided that
because they only held 20 percent of the group share for the insurance, that it might be worthwhile to invite other insurance companies in to run their data to see the total picture. So they did that. Blue Cross, along with WPS, Humana and United Health Care compiled the data and they determined that on given dates, or specific dates Dr. Suster had billed in excess of 24 hours. *Exhibit 18.*

Ms. Behrens said that a time-implied code is a code that has a specific time value in the description of the code. Some codes have a specific time value. When it's a prolonged service face-to-face with the doctor, it actually says the doctor needs to be with the patient for so many minutes. So it has a time value. She said that in determining how much time would be consumed by each particular code, they added up the time-implied units. She gave an example, of a time-implied unit, referring to October 3, 2000 on Exhibit 18. She said that under the 99354, that code is 30 to 74 minutes. They used the 40 minutes because that's the amount of time they assumed Dr. Suster was with the patient. Ms. Behrens further testified as follows [Transcript p. 412]:

> The Witness: Under the code 99354, if you look at October 2nd, there's 40 minutes face-to-face. We allowed 40 minutes. The code allows 30 to 74, and that was based on the amount of time that was indicated.
>
> Q Okay. So this code 99354 implies a face-to-face extended M.D. service, 30 to 74 minutes?
> A Correct.
>
> Q And you figured an average of 40 minutes for such?
> A Right.

Ms. Behrens further testified as follows [Transcript p. 418]:

> Q In your opinion, is the use of a 40-minute estimate for a face-to-face extended M.D. service, 30 to 74 minutes, under code 99354 a conservative value?
> A Yes.
>
> Q And did you obtain the advice of medical consultants in making that determination, that 40 minutes would be a conservative value to use?
> A My boss.
> Q So based on the information compiled by the four companies, how many patient contact hours did Dr. Suster bill the four companies for -- excuse me, your Honor -- on October 27th, 2000?
> A I recall it was -- I don't have the year. It was 1,465 minutes, and I believe that's 27 hours.
>
> Q So the total at the end of each day is in minutes --
> A Yes.

Q -- and we divide by 60?
A Yes.

Q Okay. And how many minutes then did Dr. Suster bill the four companies for patient contact time on November 3rd, 2000?
A It indicates 2,025 minutes.

Q And how about for November 7th, 2000?
A That would be 1,930 minutes.[3]

During cross-examination, Dr. Suster asked Ms. Behrens how she knew that he spent 40 minutes with the patients. Ms. Behrens testified that there was documentation in Dr. Suster's patient records of 40 minutes being spent with the patients. She said that information was included in at least 100 patient records of Dr. Suster's that she reviewed. When asked about her previous testimony indicating that the minutes billed were based on averages and how she determined the average, Ms. Behrens said that she was not sure. Then she stated that her boss actually put the report together. She said that her boss actually calculated the minutes, but that she did not remember how he calculated the minutes. When asked what her boss took an average of, she said that she did not remember. *Tr. p. 510-514*.

Other than Ms. Behrens' testimony, there is no other evidence in the records relating to the amount of time that Dr. Suster actually billed for each patient on the four days alleged in the Complaint. If Ms. Behrens' conclusion that Dr. Suster billed for services in excess of 24 hours is based upon "averages" rather than actual minutes he billed for, the evidence is insufficient to establish that the violation occurred. If Ms. Behrens' conclusion is based upon a review of the patient records, that conclusion is not consistent with her testimony that the findings in the report were based upon "averages".

COUNT IX: Practice Below Minimum Standards/Patient Vicki S.

I. Allegations

The Division of Enforcement alleges the following in paragraphs 63-69 of its Complaint:

63. On and between 6/19/9 1 and 8/7/02, respondent provided professional services to Vicki S, who was born in 1957. At the time of the initial evaluation, respondent conducted a "neuroselective sensory CPT examination" and diagnosed the patient with peripheral polyneuropathy, reflex sympathetic dystrophy syndrome, autonomic dysfunction (multiple), and sleep disorder. These diagnoses are not supported by anything in the patient's initial evaluation record. Respondent's dictated physical examination was inadequate as an initial physical examination.

64. The patient was treated with a series of electrostimulation treatments. There are no notes regarding the patient's specific status in follow-up, and there is no notation concerning whether the patient received any long term benefits from these treatments. These treatments were administered on a daily basis, without adequate justification for this unusual schedule. There are no adequate followup notes reflecting any re-evaluation or appropriate history or physical examination, nor is there any indication that the patient was reassessed after many days of treatment produced little improvement.

65. The patient was prescribed substantial amounts of opioids and other controlled substances and prescription drugs. The patient's chart contains inadequate justification for the prescribing. When respondent changed the patient's dosages or added a medication, he failed to make a note in the chart justifying the change.

66. Respondent's care and treatment of this patient violated § Med 10.02 (2) (h), Wis. Adm. Code, in the following respects:

a) It is below the minimum standard of care for a patient to be prescribed addictive drugs such as opioids or other controlled substances without charting a clear reason for such prescribing, including the reasoning for the types, amounts, and dosages selected. Such prescribing presents a danger to the patient in that the patient can become physically dependent upon

the drugs and upon the physician who prescribes them, or addicted to them, can suffer alteration of mood, and will very likely experience side effects such as sleepiness and inability to safely drive a car and conduct the ordinary activities of daily living without falling or burning oneself. The inappropriate prescription of such drugs is a danger to the public in that such drugs can be diverted to illicit uses. A minimally competent physician would avoid such danger by prescribing non-controlled analgesics or other pain-control methods, if those methods failed then s/he would prescribe only the minimum amount of controlled substances necessary to control the patient's pain, and would clearly chart the rationale for prescribing and modifying the prescription of such drugs.

b) It is below the minimum standard of care for a patient's charted progress note to fail to recite the patient's present medications, and then to include any changes to the regimen, together with the rationale for such a change; this is true even though there is a separate medication sheet and a copy of each prescription in the chart, in that the sheet and prescription copies do not include the reasons for any changes. The potential danger to the patient is that the prescriber cannot recall all the medications and dosage instructions, and will mistake one or more of them if he does not have this information readily at hand at the next visit, resulting in the patient's receiving too much or too little of a medication; also the physician is unlikely to recall all changes or the reasons for all changes, and thus will not be able to properly move the patient along in the therapy. Another danger is that a subsequent treating physician will be unable to understand what has been tried, and why, and therefore be unable to proceed appropriately without having to repeat past treatments, resulting in a delay in progress for the patient. A minimally competent physician would note the patient's medications in the progress note, together with any problems associated with the medications, and would then note any changes (together with the rationale) in the medications.

c) If is below the minimum standard of care for a patient to be diagnosed with peripheral neuropathy, reflex sympathetic dystrophy syndrome, and autonomic dysfunction (multiple) on the basis of the "neuroselective sensory CPT examination" used by respondent, which is not accepted or effective for this purpose. Such diagnosis presents a danger to the patient of incorrect diagnosis, incorrect treatment, delay incorrect diagnosis and treatment, and a worsening of the patient's true condition which has not been diagnosed. A minimally competent physician would have ordered accepted standard tests to confirm a suspected diagnosis of these conditions, before proceeding to treatment.

d) It is below the minimum standard of care for a patient to be treated in the physician's office 7 days a week with electrostimulation. A potential danger of such treatment is that electrostimulation provides only temporary relief, and that it only works in a minority of patients. For those patients for whom it works, it can be performed by the patient at home, with a suitable device which the patient can purchase. It is a basic principle of rehabilitation medicine that the patient must be required to take responsibility for his/her own improvement. By having the patient come in for this treatment every day, respondent is making the patient fully dependent upon the physician for her care and treatment, which will retard the patient's recovery. A minimally competent physician would have ordered a brief trial of such treatment, and if it were successful, then would have prescribed such a device for the patient to purchase and use at home.

67. Respondent's care and treatment of this patient constitutes negligence in treatment.

68. Respondent's conduct in failing to keep a chart which recorded adequate pertinent objective findings related to examination and test results, and an assessment and diagnosis on
followup visits, and to be sufficiently clear and complete to allow interpretation by other practitioners for the benefit of the patient, violated § Med l0.02 (2) (h) and (za), Wis. Adm. Code.

69. The evaluation, charting, care and treatment of this patient are similar to those of many other patients, and are part of a pattern and practice of respondent in providing services, and not an isolated case involving only one patient.

II. Applicable Law

Med 10.02 Definitions.

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(h) Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public.

(za) Failure by a physician or physician assistant to maintain patient health care records consistent with the requirements of ch. Med 21.

III. Summary of Evidence

(A) Patient Vicki S.

Patient Vicki S works in the residential building industry doing automation analyses and report writing. She testified that she suffers from fibromyalgia and chronic fatigue. She saw Dr. Suster between June 19, 2001 and August 7, 2001 for pain management. *Tr. p. 1702; Exhibit 35.*

(B) Testimony of Dr. James Leonard

Dr. Leonard testified at the request of the Division of Enforcement. Dr. Leonard is a physiatrist. He has practiced as a physiatrist at the University of Wisconsin Hospital and Clinics since July 1 of 1989. His primary specialty is physical medicine and rehabilitation, with a subspecialty in pain medicine. He is board certified in physical medicine and rehabilitation by the American Board of Physical Medicine Rehabilitation. He is board certified in pain medicine as a subspecialty by the American Board of Anesthesiology, the American Board of Neurology and the American Board of Physical Medicine Rehabilitation. He is also licensed as a physical therapist. *Tr. p. 1099-1103; Exhibit 34*.

At the request of the Division of Enforcement, Dr. Leonard reviewed the charts of several of Dr. Suster's patients including the chart of patient Vicki S. *Tr. p. 1122*; *Exhibit 35.*

In reference to patient Vicki S, Dr. Leonard testified that what he gathered mainly from the patient's questionnaire is that she was seen for pain in several areas. It appeared it was in the neck area, the mid-back, the low back, the buttock, and also somewhat in the groin area. The initial pain assessment was that she had pain for about ten years. The assessment went through her general health history, her medication history, the rating of the pain on a zero to ten scale; the rating of her activity limitations with the pain and also her listing of some side effects from medications. The patient chart does not include a dictated history. It does include Dr. Suster's dictated physical exam and his impressions and recommendations. *Tr. p. 1123-1124*.

When asked if, in his professional opinion, whether Dr. Suster performed an adequate initial evaluation of a new patient presenting as patient Vicki S. did, Dr. Leonard testified that the questionnaire is adequate. The physical examination is adequate. He said that he did not have enough of a dictated history and a review of previous tests to define if his diagnosis is correct. He said that it is an incomplete history and physical exam. If he was going to see the patient, he would not have enough information to know what the diagnosis was and what had been done. He said that Dr. Suster should have had a dictated history that detailed the patient's complaints more fully than just what the patient filled out on the questionnaire. He should have commented on what testing and what treatment had been done prior to that point in time. There was some comment in relation to the nerve testing that had been done. He said that it is difficult to interpret, and based on that, it is hard for him as an outside reviewer to figure out how Dr. Suster came up with his impressions. *Tr. p. 1125*.

When asked if the diagnosis that Dr. Suster listed on page 36 (067036) of the patient's chart was supported by the data in the chart to that point, Dr. Leonard said that he did not see support for the peripheral polyneuropathy; the reflex synthetic dystrophy syndrome or the autonomic dysfunction. There is support for sleep disorder because she had pain that interfered with her sleep. He also said that the results of the electrodiagnostic testing done by Dr. Suster, as noted on pages 29-35 of the patient's chart, do not support Dr. Suster's diagnosis of peripheral polyneuropathy; reflex synthetic dystrophy syndrome or autonomic dysfunction. *Tr. p. 1125-1126; 1131-1135*.

In reference to documentation of the patient's initial visit, Dr. Leonard testified that in his opinion, the lack of the dictated history is below the minimal standard of competence. Also, the lack of reference to previous testing is below the minimal standard of competence. The exam itself was fine. The reliance upon the nerve testing is controversial. He said that

failure to do an adequate history presents a potential risk to the patient. *Tr. p. 1126-1127*.

In reference to the risks to the patient, Dr. Leonard said there are a couple of things. One, it would present the risk that you were wasting a lot of time and doing treatment that was inappropriate. Two, you don't have all the possible contraindications for treatment. There are side effects for treatment clearly there. And, three, it presents a risk that if someone else came in to take over that case, they wouldn't know what had been done or why. He said that the biggest danger of the patient would be inappropriate treatment because of lack of foundation for a diagnosis. *Tr. p. 1127*.

In reference to Dr. Suster's use of sensory nerve testing as a diagnostic tool, Dr. Leonard testified that it is an investigational tool and that it is an unacceptable test to rely on to base treatment on. He said that current literature reflects that autonomic sensory testing is a promising technology; it has not been validated; it is not standardized and that further research is needed to establish the rationale for its use. Also, the reference values need to be established and the "reproducibility in intraoperator variability" need to be addressed. *Tr. p. 1128-1131; Exhibit 35 p. 29-35; Exhibit 36.*

Dr. Leonard also testified that Dr. Suster's conduct was below the minimum standards in the following respects:

(1) In reference to Dr. Suster's treatment of patient Vicki S with a series of electrostimulation treatments using the Dynatron device, it is below the minimum standard of practice for a physician to fail to make and chart a re-evaluation of the patient following a reasonable trial period to determine if his treatment plan was successful. *Tr. p. 1139*.

(2) In reference to Dr. Suster's treatment of patient Vicki S with a series of electrostimulation treatments using the Dynatron device, it is below the average standard of practice for a physiatrist, once it is established that the treatment is successful and the patient would continue treatment on their own at home, to fail to transition the patient to a home program rather than bringing them in for further treatment. *Tr. p. 1141*.

(3) In reference to Dr. Suster's treatment of patient Vicki S with a series of electrostimulation treatment from, June 25, 2001 to August 7, 2001, his conduct was outside the standard of care in that the rationale for doing the treatment or for continuing the treatment that long was never documented in the patient chart. *Tr. p. 1141*.

(4) In reference to Dr. Suster's prescribing of Kadian for patient Vicki S on the first day that he saw the patient, it is below the minimum standard of competence for a physician to prescribe a medication without noting an adequate justification for it in the patient's chart. *Tr. p. 1143-1144.*

(5) In reference to Dr. Suster's prescribing of oxycodone for patient Vicki S, it is below the minimum standard of competence for a physician to add a medication like oxycodone without a note in the patient's chart explaining why it was being prescribed. *Tr. p. 1147-1148*.

(6) In reference to Dr. Suster's prescribing of Paxil for patient Vicki S, it is outside the standard of care to fail to document in the patient's chart why Paxil was prescribed. *Tr. p. 1152*.

(7) In reference to Dr. Suster's switching patient Vicki S to a duragesic, it is below the minimum standard of competence for a physician to switch from one agent to another agent by stopping one and starting the other, without indicating in the patient's chart why you are switching, what the indications for the medication are and what one is attempting to treat.
Tr. p. 1153-1154.

Finally, Dr. Leonard testified that he reviewed thirty or forty of Dr. Suster's patient charts at the request of the Division of Enforcement. He said that his comments regarding Dr. Suster's inadequate charting appear to be consistently present in every chart that he reviewed. A few of the charts did have a typed history and physical on them, but the follow-up notes were extremely poor. *Tr. p. 1160.*

COUNT X: Practice Below Minimum Standards/Patient Maria B.

I. Allegations

The Division of Enforcement alleges the following in paragraphs 70-78 of its Complaint:

70. On and between 3/28/01 and 8/30/01, respondent provided professional services to Maria B, who was born in 1964. At the time of the initial evaluation, respondent diagnosed the patient with headaches, cervicalgia and cervicogenic headaches, thoracic spine pain, and sleep disorder. Respondent's dictated physical examination was inadequate as an initial note. There are no treatment goals established.

71. The patient was treated with a series of electro stimulation treatments. There are no notes regarding the patient's specific status in follow-up, and there is no notation concerning whether the patient received any long term benefits from these treatments. These treatments were administered on a daily basis, without adequate justification for this unusual schedule. There are no adequate follow-up notes reflecting any re-evaluation or appropriate history or physical examination, nor is there any indication that the patient was reassessed after many days of treatment produced little improvement.

72. The patient was prescribed substantial amounts of opioids and other controlled substances. The patient's chart contains inadequate justification for the prescribing. When respondent changed the patient's dosages or added a medication, he failed to make a note in the chart justifying the change. When the patient discontinued treatment, respondent failed to make adequate arrangements to taper the patient's medications, or to immediately transfer the patient to another prescribing caregiver, to avoid withdrawal.

73. On or about 5/8/01, the electrostimulation treatments ceased, without charted explanation. On 5/16/0 1, a chart note indicates that an initial prescription for diazepam 30mg, to be taken 1-2 hours before "sedation" with 10-20mg "PRN" thereafter, was telephoned to a pharmacy. On 5/17/0 1, a chart note reveals that the patient is to receive "cervical, upper back, shoulder, rib injections and blocks." There is no history, re-evaluation, appropriate physical examination, or treatment goal set forth. Although this is the first note of such injections, it recites that the patient is already 5% improved after having started such injections.

74. Respondent's procedure note for 5/17/0 1, then states that he administered a series of cervical and thoracic spinal facet injections, and says nothing about fluoroscopic (x-ray) guidance. Similar injections were performed on 5/31, 6/11, and 6/29/01, all without any note concerning fluoroscopic guidance. There is only one note in the patient's chart concerning x-rays, and that is for a view taken on 5/17/01. Respondent billed the patient's insurance for these injections using CPT codes 64470, Injection, anesthetic agent and/or steroid, paravertebral fact joint or facet joint nerve; cervical or thoracic, single level, and 64472 for each additional level. The CPT guide states, concerning these codes: "For fluoroscopic guidance and localization for needle placement and injection in conjunction with codes 64470-64484, use code 76005. Respondent did not bill under this code. In fact, respondent did not use fluoroscopic guidance for any of these injections.

75. Respondent's care and treatment of this patient violated § Med 10.02(2)(h), Wis. Adm. Code, in the following respects:

a) It is below the minimum standard of care for a patient to be prescribed addictive drugs such as opioids without charting a clear reason for such prescribing, including the reasoning for the types and amounts selected. Such prescribing presents a danger to the patient in that the patient can become physically dependent upon the drugs and upon the physician who prescribes them, or addicted to them, can suffer alteration of mood, and will very likely experience side effects such as sleepiness and inability to safely drive a car and conduct the ordinary activities of daily living without falling or burning oneself. The inappropriate prescription of such drugs is a danger to the public in that such drugs can be diverted to illicit uses. A minimally competent physician would avoid such danger by prescribing non-controlled analgesics or other pain-control methods, if those methods failed then s/he would prescribe only the minimum amount of controlled substances necessary to control the patient's pain, and would clearly chart the rationale for prescribing and modifying the prescription of such drugs.

b) It is below the minimum standard of care for a patient to be discharged following chronic opioid analgesic therapy without a clear plan for either withdrawing the patient from opioids via tapering, or immediately transferring the patient to another caregiver with prescribing authority. The danger to the patient is that she may go into withdrawal without adequate medical support, unnecessarily. A minimally competent physician would have either transferred the patient to an identified caregiver with prescribing privileges, or have given the patient a clear tapering schedule with an adequate supply of medication,

including instructions on what do to if withdrawal symptoms appeared.

c) It is below the minimum standard of care for a patient's charted progress note to fail to recite the patient's present medications, and then to include any changes to the regimen, together with the rationale for such a change; this is true even though there is a separate medication sheet and a copy of each prescription in the chart, in that the sheet and prescription copies do not include the reasons for any changes. The potential danger to the patient is that the prescriber cannot recall all the medications and dosage instructions, and will mistake one or more of them if he does not have this information readily at hand at the next visit, resulting in the patient's receiving too much or too little of a medication; also the physician is unlikely to recall all changes or the reasons for all changes, and thus will not be able to properly move the patient along in the therapy. Another danger is that a subsequent treating physician will be unable to understand what has been tried, and why, and therefore be unable to proceed appropriately without having to repeat past treatments, resulting in a delay in progress for the patient. A minimally competent physician would note the patient's medications in the progress note, together with any problems associated with the medications, and would then note any changes (together with the rationale) in the medications.

d) It is below the minimum standard of care for a patient to be treated in the physician's office 7 days a week with electrostimulation. A potential danger of such treatment is that electrostimulation provides only temporary relief, and that it only works in a minority of patients. For those patients for whom it works, it can be performed by the patient at home, with a suitable device which the patient can purchase. It is a basic principle of rehabilitation medicine that the patient must be required to take responsibility for his/her own improvement. By having the patient come in for this treatment every day, respondent is making the patient fully dependent upon the physician for her care and treatment, which will retard the patient's recovery. A minimally competent physician would have ordered a brief trial of such treatment, and if it were successful, then would have prescribed such a device for the patient to purchase and use at home.

e) It is below the minimum standard of care to administer facet injections without fluoroscopic guidance. The potential dangers to the patient are that the lining of the spinal cord may be pierced and cerebrospinal fluid may leak or the injected material may enter the cerebrospinal fluid space causing nerve injury or paralysis, blood may hemorrhage into the cerebrospinal fluid space, and infection may enter the cerebrospinal fluid space. A minimally competent physician would avoid these dangers by doing such injections only with fluoroscopic guidance.

f) It is below the minimum standard of care for a physician to administer facet injections in the cervical vertebral area, because this is a procedure which should be used only by experts with years of experience in doing such injections in the thoracic and lumbar areas. The dangers to the patient are that even a small error in placement can result in paralysis or death, as so many nerves run through the cervical vertebrae. A minimally competent physician would refer a patient who needed such injections to a specialist with the requisite training and experience.

76. Respondent's care and treatment of this patient constitutes negligence in treatment.

77. Respondent's conduct in failing to keep a chart which recorded adequate pertinent objective findings related to examination and test results, and an assessment and diagnosis on followup visits, and to be sufficiently clear and complete to allow interpretation by other practitioners for the benefit of the patient, violated § Med 10.02(2) (h) and (za), Wis. Adm. Code.

78. The evaluation, charting, care and treatment of this patient are similar to those of many other patients, and are part of a pattern and practice of respondent in providing services, and not an isolated case involving only one patient.

II. Applicable Law

Med 10.02 Definitions.

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(h) Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public.

(za) Failure by a physician or physician assistant to maintain patient health care records consistent with the requirements of ch. Med 21.

III. Summary of Evidence

(A) Testimony of Patient Maria B.

Patient Maria B. lives in Milwaukee, Wisconsin. She is a student working on an undergraduate degree in psychology at Alverno College and plans to attend graduate school at Loyola University. *Tr. p. 32-33*.

Between March and August of 2001, Patient Maria B. saw Dr. Suster in his professional capacity for back pain. She had been dealing with on-going upper back pain for quite some time and had gone through a variety of different treatments. She first saw Dr. Suster for an initial consultation on March 28, 2001. She explained to Dr. Suster the type of pain that she had been encountering over the years. She was asked to put on a gown; Dr. Suster looked at her spine, and then he told her of a particular treatment that he was using with the Dynatron machine. She said that she had concerns because Dr. Suster wanted to put her on a pain medication right away, which she questioned, because she had a brother who had been addicted to painkillers and essentially overdosed. She said that she was very aware of the type of behavioral challenges within her own family, and that she did not want to go on the pain medication. According to Patient Maria B., Dr. Suster asked if she wanted him to help her with her pain; did she trust him with her pain and was she going to allow him to help her with her pain. She said "yes", "sure". Then she made appointments to see Dr. Suster daily for a month for Dynatron treatments. She also received a prescription for painkillers. *Tr. p. 33-37*.

Based upon information contained in Patient Maria B's medical records, Dr. Suster performed a physical examination of the patient when he saw her on March 28, 2001. His impression was: 1) Headaches; 2) Cervicalgia and cervicogenic headaches; 3) Thoracic spine pain, and 4) Sleep disorder. His recommendations included the following: "Begin oral analgesic medication and neurostimulation following informed consent which we presented medication, neurostimulation, osteopathic manipulative therapy and injection therapy to her". *Exhibit 1, p. 039011*.

When asked to describe her treatment following her initial consultation, Patient Maria B. testified that the Dynatron treatments were daily. When she went in for the treatments, she was hooked up to the Dynatron machine in the common area. She was asked to describe her pain on a scale from one to ten. She said that she had started the pain medication, Oxycodone. Within about 2 weeks of treatment, her pain level stayed at about five or six. She was instructed to increase the pain medication, but she did not. She continued through the rest of the month to finish the month of treatment, and at that time her pain level was about a five or six. She said that Dr. Suster suggested that she have some injections in her back, which she agreed to. She made an appointment and had her first series of injections. *Tr. p. 37*.

(B) Testimony of Dr. James Leonard

Dr. Leonard testified at the request of the Division of Enforcement. Dr. Leonard's qualifications are set forth under Count IX. *Tr. p. 1099-1103; Exhibit 34*.

At the request of the Division of Enforcement, Dr. Leonard reviewed the charts of several of Dr. Suster's patients including the chart of patient Maria B. *Tr. p. 1162-1208*; *Exhibit 1*.

Dr. Leonard testified that at the time of Maria B's initial visit with Dr. Suster, she had been having pain for 13 years. On her pain assessment questionnaire that she filled out, she marked off the cervical spine and the mid to upper thoracic spine as the areas of her pain. On the questionnaire, she noted on the one-to-ten scale how bad her pain was; what made the pain better; what made the pain worse, and she circled several adjectives describing her pain. She noted what type of treatment, such as massage and manipulation, which made her better. She noted the things that made her worse. She described on the one-to-ten scale how much the pain was interfering with her daily activities. He said that he did not see a listing of her medications or a typed history. He did see documentation of a physical examination and Dr. Suster's impressions and recommendations. *Tr. p. 1164-1165; Exhibit 1, p. 17*.

Dr. Leonard said that in his opinion, Dr. Suster's assessment of Patient Maria B was inadequate in that there was not a history that was typed up that gave him a better sense of what the patient was actually being seen for. There was not a review of previous testing. He said that he had difficulty understanding how the conclusions or the impressions were arrived at based on that lack of information. *Tr. p. 1166-1167*.

In reference to the initial evaluation of the patient, Dr. Leonard said that the main thing missing is he did not see a more thorough note and that he did not have a good sense of just what had gone on at that point. He said that the patient has had pain for 13 years. So the progression of that pain and the flow of the problem was not clear to him based on reviewing her questionnaire. That should have been clarified in a note, and that would be the standard of care. He said that he was also concerned that there was no comment on the imaging studies for someone that has had pain for 13 years. *Tr. p. 1170-1171*.

In reference to the neurostimulation treatments that Dr. Suster provided to patient Maria B, Dr. Leonard testified that it is outside the standard of care for a physiatrist to fail to reassess the patient and have a note of such assessment in the chart. He said that it would be reasonable to try the treatment on a trial basis and then reassess the patient. A reasonable trial period would be approximately one to two weeks. The 44-day treatment sessions documented in Maria B's file would be excessive without evidence of a re-evaluation regarding whether or not it was working. Dr. Leonard said that he did not see a re-evaluation of the treatment in Maria B's chart. *Tr. p. 1172-1173; Exhibit 1, p. 37-69,*

Dr. Leonard also testified that Dr. Suster's conduct was below the minimum standards in the following respects:

(1) In reference to documentation of the patient's use of analgesics such as ibuprofen and acetaminophen, a reasonable practicing physiatrist would have noted that information in a dictated note in the patient's chart. *Tr. p. 1169; Exhibit 1, p. 19.*

(2) In reference to the patient's prior x-ray films and reports, the documentation in Maria B's chart is inadequate in that Dr. Suster should have commented on what the patient told him that the r-rays showed, what he saw on the x-rays or what he ordered. *Tr. p. 1167*.

(3) In reference to obtaining the patient's prior x-ray films and reports, the standard of care requires that Dr. Suster obtain the reports or the films of the prior x-rays or order new films. *Tr. p. 1168*.

(4) In reference to the neurostimulation treatments that Dr. Suster provided to patient Maria B., it is outside the standard of care for a physician to fail to note in the patient's chart whether the treatments resulted in long-term improvements. It is also outside the standard of care for a physician to fail to document in a patient's chart why neurostimulation treatments are stopped or discontinued. *Tr. p. 1174*.

(5) In reference to facet joint injections, it is below the minimum standards of practice for a physician to administer the injections without using x-ray guidance and contrast dye or fluoroscopy. *Tr. p. 1191-1202, 1208.*

(6) In reference to the June 21, 2001 proliferant (Prolo) therapy that Dr. Suster provided to patient Maria B, the standard of care for physiatry requires that a note be included in the patient's chart summarizing and evaluating the patient's condition following the trial period. *Tr. p. 1176-1180; 1203-1204; Exhibit 1, p. 71-72.*

COUNT XI: Practice Below Minimum Standards/Patient Mary G2.

I. Allegations

The Division of Enforcement alleges the following in paragraphs 79-88 of its Complaint:

79. On and between 3/9/99 and 1/4/0 1, respondent provided professional services to Mary G2, who was born in 1956. Respondent's "Comprehensive Consultation" dated 3/9/99 diagnoses the patient with headaches, cervicalgia, thoracic spine pain, shoulder enthesopathy, low back pain, hip enthesopathy, and multiple joint enthesopathy.

80. Respondent's procedure note for 3/17/99, then states that he administered a series of cervical and thoracic spinal facet injections, and says nothing about fluoroscopic (x-ray) guidance. In fact, respondent did not use fluoroscopic guidance

for any of these injections.

81. Respondent performed a series of osteopathic manipulation treatments on the patient, an average of twice a week, beginning 9/16/99. Respondent's chart note for that date states that the purpose of osteopathic manipulations is "to augment her current treatments and realign her bony segments." Respondent then goes on to document these treatments as follows: "OMT 9-10 areas today for 40 minutes completed uneventfully." There is no description of what areas were manipulated, how they were manipulated, or what the specific goals of treatment are. This is a typical note for respondent's osteopathic manipulation treatment.

82. The patient was treated with a series of electrostimulation treatments. There are no notes regarding the patient's specific status in follow-up, and there is no notation concerning whether the patient received any long term benefits from these treatments. These treatments were administered on a daily basis, without adequate justification for this unusual schedule. There are no adequate followup notes reflecting any re-evaluation or appropriate history or physical examination, nor is there any indication that the patient was reassessed after many days of treatment produced little improvement.

83. The patient was prescribed substantial amounts of opioids and other controlled substances. The patient's chart contains inadequate justification for the prescribing. When respondent changed the patient's dosages or added a medication, he failed to make a note in the chart justifying the change.

84. Respondent discharged the patient from his care without providing her with an adequate plan to withdraw her from the opioid therapy which he had prescribed for her, and without any alternative arrangements having been made to provide her with medical care to prevent her from going into withdrawal.

85. Respondent's care and treatment of this patient violated § Med 10.02(2)(h), Wis. Adm. Code, in the following respects:

a) It is below the minimum standard of care for a physician to fail to note what osteopathic manipulations are performed, to what specific area of the body, and what the results (related to the goals of treatment) are. The potential danger to the patient is that ineffective or even painful manipulations may be repeated because the physician has no record of what was performed, thus delaying effective treatment, and others involved in the patient's care, or successor physicians, will not know what has already been tried, and with what success, and thus will have to repeat ineffective care and delay effective treatment. A minimally competent physician would chart, in detail, what manipulations were performed on what exact part of the body, together with the result of the manipulation as that result related to the goal of treatment.

b) It is below the minimum standard of care for a patient to be prescribed addictive drugs such as opioids without charting a clear reason for such prescribing, including the reasoning for the types and amounts selected. Such prescribing presents a danger to the patient in that the patient can become physically dependent upon the drugs and upon the physician who prescribes them, or addicted to them, can suffer alteration of mood, and will very likely experience side effects such as sleepiness and inability to safely drive a car and conduct the ordinary activities of daily living without falling or burning oneself. The inappropriate prescription of such drugs is a danger to the public in that such drugs can be diverted to illicit uses. A minimally competent physician would avoid such danger by prescribing non-controlled analgesics or other pain-control methods, if those methods failed then s/he would prescribe only the minimum amount of controlled substances necessary to control the patient's pain, and would clearly chart the rationale for prescribing and modifying the prescription of such drugs.

c) It is below the minimum standard of care for a patient to be discharged following chronic opioid analgesic therapy without a clear plan for either withdrawing the patient from opioids via tapering, or immediately transferring the patient to another caregiver with prescribing authority. The danger to the patient is that she may go into withdrawal without adequate medical support, unnecessarily. A minimally competent physician would have either transferred the patient to an identified caregiver with prescribing privileges, or have given the patient a clear tapering schedule with an adequate supply of medication, including instructions on what do to if withdrawal symptoms appeared.

d) It is below the minimum standard of care for a patient's charted progress note to fail to recite the patient's present medications, and then to include any changes to the regimen, together with the rationale for such a change; this is true even though there is a separate medication sheet and a copy of each prescription in the chart, in that the sheet and prescription

copies do not include the reasons for any changes. The potential danger to the patient is that the prescriber cannot recall all the medications and dosage instructions, and will mistake one or more of them if he does not have this information readily at hand at the next visit, resulting in the patient's receiving too much or too little of a medication; also the physician is unlikely to recall all changes or the reasons for all changes, and thus will not be able to properly move the patient along in the therapy. Another danger is that a subsequent treating physician will be unable to understand what has been tried, and why, and therefore be unable to proceed appropriately without having to repeat past treatments, resulting in a delay in progress for the patient. A minimally competent physician would note the patient's medications in the progress note, together with any problems associated with the medications, and would then note any changes (together with the rationale) in the medications.

e) It is below the minimum standard of care for a patient to be treated in the physician's office 7 days a week with electrostimulation. A potential danger of such treatment is that electrostimulation provides only temporary relief, and that it only works in a minority of patients. For those patients for whom it works, it can be performed by the patient at home, with a suitable device which the patient can purchase. It is a basic principle of rehabilitation medicine that the patient must be required to take responsibility for his/her own improvement. By having the patient come in for this treatment every day, respondent is making the patient fully dependent upon the physician for her care and treatment, which will retard the patient's recovery. A minimally competent physician would have ordered a brief trial of such treatment, and if it were successful, then would have prescribed such a device for the patient to purchase and use at home.

f) It is below the minimum standard of care to administer facet injections without fluoroscopic guidance. The potential dangers to the patient are that the lining of the spinal cord may be pierced and cerebrospinal fluid may leak or the injected material may enter the cerebrospinal fluid space causing nerve injury or paralysis, blood may hemorrhage into the cerebrospinal fluid space, and infection may enter the cerebrospinal fluid space. A minimally competent physician would avoid these dangers by doing such injections only with fluoroscopic guidance.

g) It is below the minimum standard of care for a physician to administer facet injections in the cervical vertebral area, because this is a procedure which should be used only by experts with years of experience in doing such injections in the thoracic and lumbar areas. The dangers to the patient are that even a small error in placement can result in paralysis or death, as so many nerves run through the cervical vertebrae. A minimally competent physician would refer a patient who needed such injections to a specialist with the requisite training and experience.

86. Respondent's care and treatment of this patient constitutes negligence in treatment.

87. Respondent's conduct in failing to keep a chart which recorded adequate pertinent objective findings related to examination and test results, and an assessment and diagnosis on followup visits, and to be sufficiently clear and complete to allow interpretation by other practitioners for the benefit of the patient, violated § Med 10.02 (2) (h) and (za), Wis. Adm. Code.

88. The evaluation, charting, care and treatment of this patient are similar to those of many other patients, and are part of a pattern and practice of respondent in providing services, and not an isolated case involving only one patient.

II. Applicable Law

Med 10.02 Definitions.

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(h) Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public.

(za) Failure by a physician or physician assistant to maintain patient health care records consistent with the requirements of ch. Med 21.

III. Summary of Evidence

(A) Patient Mary G2 (GR)

Patient Mary G lives in Milwaukee. She is an airport security screener for the Department of Transportation. Patient Mary G saw Dr. Suster between 1999 and 2000 for pain that she was experiencing in her lower back, shoulders and neck. *Tr. p.847-849.*

(B) Testimony of Dr. James Leonard

Dr. Leonard testified at the request of the Division of Enforcement. Dr. Leonard's qualifications are set forth under Count IX. *Tr. p. 1099-1103; Exhibit 34*.

At the request of the Division of Enforcement, Dr. Leonard reviewed the charts of several of Dr. Suster's patients including the chart of patient Mary G2. *Exhibits 28A, 28B, 28C, 28D.*

Dr. Leonard testified that Dr. Suster saw Mary G for migraine headaches and back pain. Mary G also had other diagnoses including irritable bowel syndrome, spastic colon, and colitis.
Mary G related that she had an injury when she was 12 years old whereby she flew in the air and landed on her back. A history note in the patient's chart describes some of the treatment that she had received; indicates that she had been to three pain clinics in Milwaukee and notes that she had various injections and medications. The note discusses her level of pain which "gets up to 12 on a 10 scale with 10 being the severest". The note talks about the fact she was using Tylenol medication. Also noted are allergies, the medications that the patient had been on, past history, social history, family history, view of symptoms, physical exam impression, and recommendations. *Tr. p. 1213*.

Dr. Leonard said the initial history and physical note was adequate exception he did not see any comment regarding any imaging or other diagnostic studies that had been done prior to Dr. Suster's evaluation of the patient. *Tr. p. 1214*.

Dr. Leonard also testified that Dr. Suster did facet injections on Mary G without using x-ray guidance and contrast dye or fluoroscopy, which the standard of care requires. *Tr. p. 1215, 1220.*

In reference to sacroiliac joint intraarticular injections, Dr. Leonard said that, as with facet injections, one can only get into the sacroiliac joint with the use of x-ray guidance and contrast dye in order to know where one is at. He said that the standard of care requires that x-ray guidance and contrast dye or fluoroscopy be used when administering these types of injections. *Tr. p. 1220-1221*.

In reference to documenting the osteopathic manipulative therapy that was done in nine to ten areas for 40 minutes, Dr. Leonard said that Dr. Suster's note is inadequate and beneath the standard of care for a physiatrist. He said that except for T2, (osteopathic manipulative therapy 2) he did not know what areas Dr. Suster did, and he did not know what techniques were used. He also said that he has a hard time believing that it would take 40 minutes to do manipulative techniques. He said that a note for OMT or osteopathic manipulation therapy, should comment on the "areas of tenderness of tightness". The note should comment on what techniques were used, what areas the techniques were done to, and what the patient's responses were to the techniques. He said that the only thing that is present in the note is that the patient had some cervical range of motion that was reduced, and that's it. Dr. Suster did not comment on what areas he treated with the OMT. *Tr. p. 1228-1230*.

Dr. Leonard also testified that Dr. Suster's conduct was below the minimum standards of care in the following respects:

(1) In reference to osteopathic manipulation therapy (OMT) performed on the patient, the standard of card requires that the patient's status be reassessed following a reasonable trial period (usually 3-8 visits). *Tr. 1226-1232*.

(2) In reference to the Valium and hydrocodone prescribed for the patient by Dr. Suster, given the amount of Valium

prescribed (30 mg) the standard of care requires that the dosage of the hydrocodone also be documented in the patient's chart. *Tr. p. 1218-1219.*

(3) In reference to the electrostimulation treatment that Dr. Suster provided to the patient, Dr. Suster's 9/20/00 treatment note does not document the physical findings of the physical examination of the patient's lower extremities as required by the standard of care. *Tr. p. 1274-1275.*

(4) During the course of respondent's treatment of Mary G2, respondent prescribed medication for the patient, including controlled substances. Respondent's documentation in the patient's chart of the controlled substances that respondent prescribed for the patient did not meet the minimum standard of competence for a practicing physician. Respondent's notes did not document in the patient's chart, why the controlled substances were prescribed, the dosage prescribed, when medications were changed or the rationale for the treatment. *Tr. p. 1288-1291*.

IV. Discipline

Having found that Dr. Suster violated laws relating to the practice of medicine, a determination must be made regarding whether discipline should be imposed, and if so, what discipline is appropriate.

The Medical Examining Board is authorized under s. 448.02 (3) (c), Stats., to warn or reprimand a person, or limit, suspend or revoke any license, certificate or limited permit granted by the board to a person if it finds that the person is guilty of unprofessional conduct or negligence in treatment.

The purposes of discipline by occupational licensing boards are to protect the public, deter other licensees from engaging in similar misconduct and to promote the rehabilitation of the licensee. State v. Aldrich, 71 Wis. 2d 206 (1976). Punishment of the licensee is not a proper consideration. State v. MacIntyre, 41 Wis. 2d 481 (1969).

The Division of Enforcement recommends that Dr. Suster's license be revoked. Dr. Suster recommends that no discipline be imposed and that this matter be dismissed.

Based upon the evidence presented, the Administrative Law Judge recommends that Dr. Suster's license to practice medicine and surgery be revoked. This measure is designed primarily to assure protection of the public and to deter other licensees from engaging in similar misconduct.

V. Costs of the Proceeding

Section 440.22(2), Stats., provides in relevant part as follows:

> In any disciplinary proceeding against a holder of a credential in which the department or an examining board, affiliated credentialing board or board in the department orders suspension, limitation or revocation of the credential or reprimands the holder, the department, examining board, affiliated credentialing board or board may, in addition to imposing discipline, assess all or part of the costs of the proceeding against the holder. Costs assessed under this subsection are payable to the department.

The presence of the word "may" in the statute is a clear indication that the decision whether to assess the costs of this disciplinary proceeding against the respondent is a discretionary decision on the part of the Board, and that the Board's discretion extends to the decision whether to assess the full costs or only a portion of the costs. The Administrative Law Judge's recommendation that the full costs of the proceeding be assessed is based primarily on fairness to other members of the profession.

The Department of Regulation and Licensing is a "program revenue" agency, which means that the costs of its operations are funded by the revenue received from its licensees. Moreover, licensing fees are calculated based upon costs

attributable to the regulation of each of the licensed professions, and are proportionate to those costs. This budget structure means that the costs of prosecuting cases for a particular licensed profession will be borne by the licensed members of that profession. It is fundamentally unfair to impose the costs of prosecuting a few members of the profession on the vast majority of the licensees who have not engaged in misconduct. Rather, to the extent that misconduct by a licensee is found to have occurred following a full evidentiary hearing, that licensee should bear the costs of the proceeding.

This approach to the imposition of costs is supported by the practice of the Wisconsin Supreme Court, which is granted similar discretionary authority by SCR 22.24 to impose costs in attorney disciplinary hearings. The Court acknowledges the logic of imposing the cost of discipline on the offender rather than on the profession as a whole, and routinely imposes costs on disciplined respondents unless exceptional circumstances exist. In the Matter of Disciplinary Proceedings against M. Joanne Wolf, 165 Wis. 2d 1, 12, 476 N.W. 2d 878 (1991); In the Matter of Disciplinary Proceedings against Willis B. Swartwout, III, 116 Wis. 2d 380, 385, 342 N.W. 2d 406 (1984).

Based upon the record herein, the Administrative Law Judge recommends that the Medical Examining Board adopt as its final decision in this matter, the proposed Findings of Fact, Conclusions of Law and Order as set forth herein.

Dated at Madison, Wisconsin this 30th day of June, 2004.

Respectfully submitted,

Ruby Jefferson-Moore
Administrative Law Judge

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[1] No evidence was presented regarding patient Karen T (refer to ¶ 23 of the complaint.)
[2] CPT code 64550 is defined as "Application of surface (transcutaneous) neurostimulator. Exhibits 14, 15, 16, 19.

[3] No evidence was presented regarding the number of hours that Dr. Suster billed for on December 5, 2000. Exhibit 18 covers the time period, October 2, 2000 to November 30, 2000.