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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
JAE Y. SHIM, M.D., RESPONDENT.	:	LS -0509211-MED

04 Med 354, 05 Med 8/109/145/196

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

Jae Y. Shim, MD
19300 W. Observatory Rd.
New Berlin, WI 54146-3412

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

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

PROCEDURAL HISTORY

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

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

FINDINGS OF FACT

1. Respondent Jae Yong Shim (dob 6/12/39) is and was at all times relevant to the facts set forth herein a physician and surgeon licensed in the State of Wisconsin pursuant to license #34797, first granted on 8/25/93. Respondent is a psychiatrist and neurologist, and is the medical director or attending psychiatrist at several outpatient mental health clinics in the Milwaukee area. Respondent's address of record is 19300 W. Observatory Rd., New Berlin, WI 54146-3412. He was formerly licensed, or practiced, in Illinois, Michigan, Indiana, Vermont, and Alabama. He is not certified by any specialty board recognized by the American Board of Medical Specialties.

COUNT I--04 MED 354

2. On 9/10/03, Respondent first saw L.N., a 19 year old man, as a patient, at the Renew Counseling Services location on Mitchell Street in Milwaukee. The patient presented as anxious, and stated that in the past, Valium® had been an effective medication for his anxiety. On that visit Respondent's records do not reflect that there was any inquiry concerning past treatment providers, nor any inquiry into any possible contraindications for benzodiazepines such as a history of drug abuse, nor any physical or mental status exam, nor any discussion of alternative modes of treatment. No effort was made to obtain the records of previous providers. Discrepancies in the patient's history (as shown by the questionnaire he filled out) were not discussed with the patient, or such discussion was not noted in the chart. No mental status exam was charted.

3. Over the next year, the patient saw Respondent at least monthly, and each time received additional prescriptions for benzodiazepines (alprazolam and/or diazepam). For each visit, the chart fails to contain any more than a few words, and fails to justify the amounts or the changes in medication prescribed. There were requests for early refills which were accompanied by an insistent and aggressive approach, suggestive of diversion, and in fact the patient had a history of street drug abuse. At no time is there a notation in the chart that the patient was being referred for alternative therapy or possible dependence or abuse, nor were alternative non-controlled medications tried, nor was any non-pharmacological approach attempted.

4. There is no medication sheet other than copies of prescriptions in the chart, and the patient was occasionally seen a a secondary clinic location where his chart was not available. On those occasions, Respondent prescribed benzodiazepines substantially in addition to those he intended the patient to have, solely because he could not recall the contents of the patient's chart at the primary clinic location; he did not telephone the primary location and have staff inform him of the relevant information which would have been needed to make an appropriate decision concerning prescribing additional controlled substances.

5. The patient ultimately died of a drug overdose on 8/7/04.

6. Respondent denies, but the Board finds that Respondent's conduct was below the minimum standards for the profession in the following respects: he failed to obtain and chart the names of previous prescribers, and to obtain their records or consult with them (and then to chart the contents of the consultation). He failed to cease prescribing to the patient no later than the second request for an early refill, and failed to adequately review the patient's questionnaire, which revealed discrepancies in his history. He failed to conduct a reasonable initial physical examination of the patient and failed to attempt the use of non-controlled substances for treatment before trying controlled substances. His treatment of the patient for panic attacks and agoraphobia was through the use of benzodiazepines rather than antidepressants, which were not attempted, nor was any reason for not attempting them charted.

7. Respondent denies, but the Board finds that the dangers of failing to take the steps noted above are that the substances prescribed would be diverted or abused, the patient could become addicted to the medications, and other disease processes or conditions could be masked by the inappropriate medication and thus go without treatment.

8. Respondent denies, but the Board finds that a minimally competent physician would avoid or reduce these dangers by taking the steps set forth in ¶6, above.

COUNT II--05 MED 196

9. On 1/11/05, Respondent examined B.C., on one visit, a child born in 2001. The patient had been referred by a professional counselor with a provisional diagnosis of ADHD. The chart note by Respondent reads: "3 years 6 months old black boy falls out. Onset age 3. Cried for hours. Hyperactivity, impulsivity, inattention. He kicks, bites, cry. Bang head against wall. He lives with his mother. At birth, full term delivery. Threw temper tantrum. He sleeps through the night. Threw bits. Not listen. Not obey. Picky eater. Takes nap rarely. He keeps moving, restless, fidgety, swear, baby pronunciation. Another sibling—attention deficit, in special education class. Diagnosis 314.07. Ritalin 5, once a day. 3 siblings Dr. William Wesley." Ritalin® is methylphenidate, a stimulant which is a Schedule II controlled substance commonly used for this disorder.

10. The normal practice in diagnosing and treating ADD is to provide the parents and any other adult in regular sustained contact with the child, such as a teacher, day care provider, etc., with "behavior sheets" containing checklists which are used to document the child's behavior on a daily basis. These sheets are used before diagnosis in order to provide essentia information to make the diagnosis, and then after medication is started, to determine if the medication is effective. Respondent did not use any such behavior sheets or similar device to establish or confirm his diagnosis, or to determine the effectiveness of his treatment plan although the patient was only seen on one occasion.

11. Respondent denies, but the Board finds that the standard of care required that behavior sheets be used as described above, so that an accurate diagnosis could be made, and the effectiveness of the treatment program determined.

12. Respondent denies, but the Board finds that the potential danger to the patient of failing to comply with the standard of care is that the patient could be inaccurately diagnosed as having ADD, when in fact the stated symptoms could also be caused by anxiety, depression, abuse, or developmental delays, and treatment with methylphenidate would be inappropriate for any of these conditions, and could mask symptoms or behavior which would lead to a correct diagnosis and treatment. The patient could receive an inappropriate medication, which has a substantial abuse potential, and could be inappropriately labeled with substantial negative consequences for his school education.

13. Respondent denies, but the Board finds that a non-negligent practitioner would minimize these dangers by carefully

documenting a mental status exam at each visit, and requiring the parents and any teachers, care providers, or others having regular sustained contact with the child to fill out the behavior sheets both before the diagnosis was made, and after medication was commenced, to assure that the diagnosis was correct and that treatment was effective.

COUNT III--05 MED 145

14. On 11/27/02, Respondent began treating L.D., a developmentally disabled patient born in 1950. The patient resided in a group home, and the staff presented Respondent with a summary of the patient's existing diagnoses, which were: "MR-mild, Atypical psychosis; OU mild degree myopic astigmatism; akathesia; umbilical hernia; obsessive components of atypical psychosis, retinal hyperemia; presbyopia, OCD, ESP." They noted that "All other senses appear to be functioning witl normal limits. She is oriented to person, place, and time of day. She is able to print her first name. [The patient] is fairly easily distracted by internal or external stimuli. Her attention span can vary from 5-60 minutes, depending on her level of interest and on any distractions present." Staff further noted that the patient had become very aggressive, incontinent, and slept badly. Prio to seeing Dr. Shim, the patient was on the following medications: Cogentin® 1mg BID, Klonopin® 0.5mg, take two in the morning and one at bedtime, Loxapine® 25mg BID, Neurontin® 300mg twice a day and at bedtime, Depakote® 500mg in th morning, Inderall® 20mg TID, Risperdal® 5mg BID, Tylenol® as needed, and milk of magnesia 30ml at bedtime. Responden was the only physician caring for this patient, at this time, and continued these medications and dosages.

15. At no time did Respondent chart a mental status exam other than noting akathesia of this patient. The patient was on a highly unusual medication regimen, in that it is very unusual to use two different antipsychotic medications, two medications intended to stabilize mood, a long acting anti-anxiety medication and a beta blocker, intended presumably to decrease impulsivity. There is a significant risk that the anti-anxiety medication could have a disinhibiting effect and render her more likely to be aggressive, and the antipsychotic medications at the doses she was taking commonly cause akathesia (a restlessness that can lead to agitation and aggressiveness), the very symptoms that led to the referral to him. Further, Risperdal® is used because it has fewer side-effects than older antipsychotics, but at 10mg, this advantage of this medication is lost and the medication behaves in a manner similar to Haldol®, a much older medication which has substantial side effects.

16. Instead of reducing the dosages of some of these medications, or stopping them altogether, Respondent added a very high dose of Paxil®, and increased the dosage of Klonopin®. There is no charted reasoning for this approach. There is a significant risk that this could worsen her condition, rendering her more disinhibited and restless. Furthermore, by changing two medications together, there would be no way at the next appointment to assess which change may have helped or harmed this patient. In addition there is no documentation to explain what target symptoms were being treated, or therefore how the effectiveness of these changes were to be assessed. Respondent later added a third antipsychotic, Geodon®, without an adequate justification. At no time did he test for Depakote® levels, which is normally done at least every six months to determine if there is a therapeutic level present, and also to determine if the level is too high as this medication can be toxic if permitted to build up, although a low dose was prescribed.

17. At no time is there a clear list of signs and symptoms, functional problems, a treatment plan, or an assessment of the results of treatment. These are basic to any chart.

18. Respondent's diagnoses for this patient change at each visit, without recorded justification. Although the patient came to him with a diagnosis of akathesia, a side effect of antipsychotic medications, he then failed to treat it by reducing the dosage of either or both, or eliminating one or the other, the recognized treatment for this condition.

19. Respondent denies, but the Board finds that Respondent's care and treatment of this patient fell below the minimum standard of competence for the profession in the following respects: he failed to provide an adequate initial assessment and it is therefore unclear what symptoms or condition he was treating; he failed to get a history, or even to attempt to get a history that might explain why she was on such an unusual combination of medications; he failed to treat the patient for akathesia, which may have been the cause of her aggressive behaviors; and failed to discontinue or reduce the dosage of at least some of the patient's redundant medications, and medications which cause the symptoms treated by her other medications. He failed to develop a rational treatment plan to adequately manage the patient's difficulties.

20. Respondent denies, but the Board finds that Respondent's treatment presented the following dangers or risks to the health, safety and welfare of the patient: the patient will continue to suffer the symptoms reported, including violent outbursts

which place staff and other residents in danger, and cause danger to the patient herself as her attempts to injure others may cause injury to herself. The patient will likely have unnecessary emotional difficulties and feel uncomfortable and unhappy in tha she is unable to control or understand her own feelings and actions. The patient will continue to be unnecessarily medicated.

21. Respondent denies, but the Board finds that A minimally competent physician would have avoided or minimized these dangers or risks by taking the following steps: the patient's chart from her previous physician should be obtained and reviewed, to determine why the patient is on each of the medications, and what her condition was before each of them was added. The patient should be carefully assessed and the symptoms or signs that suggested she was having trouble should be carefully documented to allow a diagnosis to be made and to give a baseline that would allow any medication changes to be assessed. The patient's medication regimen should be reduced by removing or reducing dosages of the medications most likely to be the cause of her emotional difficulties and akathesia, instead of adding other medications; a careful set of trials of reducing medications should be instituted, and staff consulted about the efficacy of each trial. The goal should be to have the patient on the lowest doses of the smallest number of medications possible, consistent with the patient's functional needs.

COUNT IV--05 MED 109

22. On 10/4/04, Respondent began treating J.M., a female said to be 40 years old, but whose date of birth does not appear in the chart. The initial assessment notes that the patient is restless, minimally verbal, alert, of average intelligence, intact memory and perception, depressed for more than three years on a recurrent basis, a good historian, aware of consequences of her behavior, having clear but "impoverished" thought process, no suicidal impulses, cooperative, anhedonic, anorexic, suffering from loss of interests, self-esteem and concentration, withdrawn, and having feelings of worthlessness. She is noted to use acting out as a coping or defense mechanism. The narrative note states, in addition, that she has insomnia and fatigue, and that her onset of difficulty was 5 years ago. She sleeps 30 minutes at a time. Her husband of 18 years died 5 years ago of an aneurysm and she is raising a child by herself. She attempted suicide three times by drug overdose, uses alcohol once a month although in the past she drank every other day. She used Klonopin® to reduce symptoms of anxiety, and panic. She is said to not use caffeine, and to be on welfare. Her live-in boyfriend is said to drink. She has no active suicidal ideation, and in the past she told her neighbor after she took drugs in her attempted suicide. "On verbal contract not to repeat suicide attempt by drug overdoses." Respondent's diagnoses were: Axis I: Alcohol abuse, panic disorder; Axis II: borderline personality disorder. Respondent prescribed fluoxetine 40mg per day, Seroquel® 400mg per day, Klonopin® 0.5mg three times per day, "suicide prevention," and individual psychotherapy. There is no indication that the patient ever received such psychotherapy, from Respondent or from any other provider.

23. Respondent then notes on 11/2/04, that the patient was admitted to "Milwaukee County Mental Hospital" for one week. This day's chart note then states: "Depression. Individual psychotherapy. Suicide prevention. Klonopin 1mg, 3 times per day; clonidine 0.1mg, twice per day; Motrin 800mg, twice per day; Seroquel 100mg, take 5 at bedtime; and Prozac [fluoxetine] 20mg, three times per day."

24. Respondent then notes on 11/30/04 "Depression. Suicide Prevention. Progress. Phone monitor. Klonopin 1mg, three times per day; clonidine 0.1, twice per day, Seroquel 100mg, take 5 at bedtime; Prozac 20mg, three times per day."

25. The patient was admitted to Aurora Psychiatric Hospital on 12/3/04, and discharged on 12/6/04; the Admissions Evaluation and Discharge Summary were sent to Respondent and were placed in the patient's chart. These documents note that the patient "has a history of symptoms of posttraumatic stress disorder and recurrent depression, as well as of conduct disorder and borderline personality disorder features" and further note that her live-in boyfriend has been violent towards her. "Records received from St. Michael's Hospital indicated that the patient reported that she had overdosed on Seroquel, and tha the pill counts suggested that she had taken as much as fifty tablets of the 100mg strength on 12/2/04, when she presented to that emergency room in an obtunded and drowsy state." The patient also revealed a history of opioid abuse. At the time of discharge, the patient was diagnosed with: "Axis I: major depression, recurrent, severe, without psychosis. Alcohol dependence in partial remission. Opiate abuse. Posttraumatic stress disorder, chronic, non-delayed type. Sedative withdrawal mild. Axis II: Antisocial personality disorder. Borderline personality features." Her clonazepam [generic Klonopin®] had beer discontinued. Her discharge medications were a two day supply of each of the following: Ambien® 10mg at bedtime; Prozac® 20mg three times per day; carbamazepine 200mg, twice per day; clonidine 0.1mg three times per day; Seroquel® 100mg, take one in the morning and three at bedtime; and an applied 50mcg Duragesic® patch for her chronic back pain. The discharge note states that the patient stated that she would be seeing Respondent in two days.

26. The patient next came to see Respondent on 12/28/04, and Respondent had received and reviewed the Aurora materials before that office visit. Respondent's chart note consists, in its entirety, of the following: "246.34 Depression. Insomnia. Suicide prevention program. Klonopin 2mg, three times per day, Seroquel 300mg per day, fluoxetine 20mg, three times per day, 29 refills." There is no explanation for what the patient did between the time her discharge medications were used, and 12/28/04. Respondent has subsequently explained to Department staff that he intended his prescription order to provide that the patient receive a one-day supply of medication from the pharmacy, each day, so that she did not have a large supply of medication at home. He further explained that the patient "felt more comfortable" on the medication regimen that he had prescribed before her hospitalization, than she did on the regimen prescribed at the hospital, and asked to resume the regimen prescribed by Respondent.

27. The patient then saw Respondent on 1/26/05, 2/25/05, 3/25/05, 4/22/05, 7/12/05, and 8/17/05. At each of these visits, extremely brief narratives of the nature described in par. 27 are included, together with a listing of the medication prescribed. On 1/26/05, the daily refill program is continued. On 2/25/05, the patient is noted to be in crisis in that her boyfriend has kicked her son out of the house; Restoril® 30mg per day is added to the medication regimen, and there is no indication that the daily refill regimen is continued. On 3/25/05, "no suicide" is noted and there is no indication that the daily refill regimen is in effect. On 4/22/05, "no suicide" is noted, together with a note that the patient has moved to another location without her boyfriend, and that her son is back with her; the medications are apparently to be dispensed on a weekly basis by the pharmacy. On 7/12/05, the chart note states, in its entirety: "suicide attempt. Deep vein thrombosis. In coma for 1 month. Pain. In home therapy. Psychotherapy. Klonopin 2mg, three times per day; Seroquel 300mg per day, fluoxetine 20mg three times per day; Restoril 30mg per day; three days supply." On 8/17/05, all the medications were continued but there is no comment about the dispensing quantities.

28. Respondent denies, but the Board finds that Respondent's care and treatment of this patient fell below the minimum standard of competence for the profession in the following respects: there is no adequate assessment that documents her symptoms or establishes diagnoses; in this patient with a history of suicide attempts, he does not conduct a mental status examination at her appointments and therefore does not adequately assess her condition and risk for further self harm; he does not document the symptoms she is experiencing at any of the appointments, so he is unable to explain why she is on the medication regimen he is prescribing; he failed to inquire, detect, and chart the fact that the patient was the victim of domestic violence at the first visit, and to react appropriately. He failed to immediately institute limited prescribing to the patient, such as by limiting her to a weekly supply of medication. He failed obtain the records of "Milwaukee County Psychiatric Hospital" for the patient's stay which he noted on 11/2/04, and to take appropriate steps to modify his treatment plan for the patient, based upon the findings of the physicians involved in her care. He failed, following the admission to "Milwaukee County Psychiatric Hospital" to reinstitute limited prescribing to the patient, such as by limiting her to a weekly supply of medication. He resumed an ineffective medication regimen without medical need or justification, following the patient's discharge from Aurora Psychiatric Hospital. He failed, after learning that the patient had attempted suicide and had been in a coma sometime between April and July, 2005, to obtain the records of the hospitalization, so that his care could be properly informed by the facts surrounding the hospitalization.

29. Respondent denies, but the Board finds that Respondent's treatment presented the following dangers or risks to the health, safety and welfare of the patient: his actions placed the patient at greater risk of suicide.

30. Respondent denies, but the Board finds that a minimally competent physician would have avoided or minimized these dangers or risks by taking the following steps: establish a clear diagnosis and treatment plan with a proper initial evaluation. Conduct a competent and complete initial evaluation, which would include the possibility that the patient was a victim of domestic violence and in current danger; the physician would then advise the patient to remove herself from this situation to reduce her stress and to reduce the probability of suicide. Prescriptions of all medications would have a clear clinical rationale and be limited in quantity to an amount unlikely to cause serious harm if ingested all at once; this amount could be anywhere from a 1-7 days supply. Upon learning that the patient had been admitted to a mental health facility, contact should have been made with the facility to provide appropriate history and to collaborate in the care of the patient, and to receive the discharge summary and any other important records of the hospitalization. Following a review of the records of Aurora Psychiatric Hospital, the medication regimen suggested by the treating physician would be continued for a trial period of several weeks, to determine efficacy, before resuming the previous regimen which had failed to prevent two hospitalizations following suicide attempts. The records of the hospitalization which included the patient's being in a coma for one month would be

obtained, so that the information in them could be used to formulate a more effective treatment plan for the patient.

COUNT V--05 Med 8

31. On 1/12/01, Respondent saw and began to care for G.F., a male born in 1958. The patient reported being marrie since age 19, and having been a bull rider in rodeos as a teenager. At age 26, he began having symptoms of lumbago from a lumbar herniated disc. He also reported back strain from bending and lifting heavy parts in his factory job. He reported taking analgesics off-and-on beginning in his mid thirties, but there is no record of what these were, in what dosages, or their efficacy. The patient reported receiving physical therapy and treatment from a chiropractor, but there is no statement of whether these were efficacious or when they occurred, how long they occurred, or where they were done (although a billing record indicating symptoms and "manipulative treatment" from a chiropractor showing dates of service from 10/30/00 through 2/14/01 appears in the chart (plus two visits in 1994); there is no indication as to when Respondent received these records). A physical exam is charted as revealing that this thin, tall man (no height, weight, pulse, respirations, or blood pressure are recorded) has intact cranial nerves, is alert, awake, without paralysis of nerves, has a regular heart rhythm and no murmurs, clear lungs, no goiter, a flat abdomen without tenderness or organomegaly, tenderness at L4-5, "left sciatic notch tender. Pain point. L4-5 left paraspinal muscle pain point, tenderness." Laseque's sign was positive at 45 of both legs, and the left ankle jerk was weaker. Respondent diagnosed lumbar herniated disc, lumbago, left sciatica, and low back pain. He notes that he must rule out lumbar spinal spondylosia. The following words then appear in the chart: "fibromyalgia, fibrositis, left frozen shoulder, left shoulder bursitis, left shoulder injury" but it is not clear whether these are further diagnoses, or conditions he wishes to rule out; there is no physical exam finding related to the left shoulder. He prescribes Lorcet, a hydrocodone product and a Schedule III controlled substance, with instructions to take one, twice a day, #60, and Soma 350mg, twice a day.

32. Respondent denies, but the Board finds that a minimally competent initial examination would have included the patient's height, weight, pulse and respiration rate, and blood pressure, all of which would have been charted. It would have included taking a history of the patient's pain including those things which make it better or worse, its character (stabbing, burning, aching, etc.), when it appears and disappears, where on/in the body the pain occurs and moves, what the efficacy of past treatments has been, and, in the case of medication, what specific medications have been tried and in what dosage, and with what efficacy. In the case of physical therapy, the name of the therapist and facility would be noted, and records obtained or the therapist consulted. The patient would be asked to rate his pain on any of the several recognized pain scales, not only at the time of the visit but what his lowest level and what his highest level of pain is (or has been, during the past week). Before opioids are tried for a persistent pain case, such as this one, other non-controlled medications such as NSAIDS would be attempted in adequate dosages, and if unsuccessful, medications such as tramadol, would be tried. If it had been some time since physical therapy was attempted, or the course of therapy was determined to have been not completed by the patient, another course would be advised. The patient would be offered alternatives including electrical stimulation (e.g. a TENS unit), biofeedback, acupuncture, and psychological counseling to help with coping mechanisms for living with persistent pain), so that an informed decision could be made about the course of treatment.

33. Between the date of the first visit noted above, and November, 2005, the patient has been seen on at least a monthly basis by Respondent. During that time, Respondent has gradually increased the opioid prescription to the point where the patient is taking 160mg of OxyContin®, twice a day, and Soma®, take three, three times a day. The patient has, during this time, requested early refills on multiple occasions, reported that he lost his medication three times and reported that it was stolen once, and been told by Respondent not to request early refills, or to reduce his dosage, at least seven times. Responden noted as early as the second visit, on 3/11/01, that he must "watch for behavior of analgesic seeking." The patient reports attempting physical therapy, but at no time is the facility identified, the nature of the therapy defined, or the efficacy discussed.

34. On 5/15/002, Respondent conducted an "annual re-evaluation of pain management" of this patient, and notes that he advised the patient of the addictive nature of Lorcet and advised him to reduce the dosage, to engage in physical therapy an do the Williams exercise, and to try a percutaneous electric stimulation device. He notes that he also informed the patient that an alternative treatment includes epidural injection of cortisone to reduce pain and radiculopathy. He notes that "Motrin, aspirin, Tylenol and Ultram did not relieve low back pain" but there is no statement concerning when these were tried, or in what dosages, or if there was partial efficacy. There is no subsequent indication in the chart that any of these suggestions was put into practice, except that on 10/15/05, he received a "steroid injection to lumbar spine" at a local hospital following an apparent worsening of his condition, and following which he was apparently prescribed fentanyl, oxycodone, and diazepam, although the dosage and duration of these prescriptions is not stated, nor is the efficacy of the injection discussed, nor is the

report of the procedure in the chart.

35. On 5/5/03, Respondent saw the patient. The entirety of his chart note is: "Back pain. Insomnia. OxyContin 40, 4 [per day]; Soma 350, 4 [per day], Flexeril 10, 3 [per day]; Desyrel 50, 1 [per day]." This is the first time either Flexeril® (cyclobenzaprine, commonly prescribed for muscle spasms) or Desyrel® (trazodone, an antidepressant sometimes used for insomnia) are prescribed for the patient, and the first time that insomnia is mentioned. There is no recorded indication of why cyclobenzaprine is added to the regimen at this time, and no stated reason for using an uncommon medication like trazodone instead of a standard sleep aid such as zolpidem or a non-prescription medication such as an antihistamine. He does not prescribe either medication again, and does not make any notation in the chart at the next office visit, on 5/29/03, as to why these medications are discontinued, or what their effects were.

36. On 9/8/03, Respondent again performs an "annual re-evaluation of chronic low back pain." At this time, he notes:

"Suggested alternative therapy.
1. Cortisone epidural injection
2. Lumbar laminectomy by a surgeon
3. Williams exercise.
4. Physical therapy. Hydrotherapy.
5. Fentanyl transdermal system application
6. Lidocaine transdermal system application
7. TENS unit application continuous percutaneous electric stimulation."

He further notes that he informed the patient of the risks of addiction, dependence, and tolerance to analgesics such as OxyContin. At no time at this visit or subsequently is there any statement concerning what the patient has elected to do, or any reasons for rejecting any of the proposed alternatives. Respondent continued to prescribe oxycodone and carisoprodol products as the only therapy for this patient.

37. On 6/28/04, Respondent's chart note states, in its entirety: "Re-evaluation of necessity of narcotics. Suspected false claim of loss of pain mediation by theft. Warning of early return of refill medications of controlled substance. Confront Mr. [G.F.] about pain medications seeking behavior and development of tolerance of oxycontin medication. Grievous concern about failure of dosage reduction of oxycontin. Concern about non-compliance of alternative treatment program of pain management. Not using oxycontin. His pain threshold decreased. He depends on narcotics. Increase of pain sensitivity to nociceptive stimulation since fracture of right calcaneous, right ankle. He is more sensitive to pain. He uses crutches to ambulate and missed work in a factory. Pain woke him up at night. Dosage of oxycontin increased to achieve same amount of pain relief which he could do with Lorcet BID in the year of 2001. Discussed with the client about poor prognosis of chronic pain management because dosage of narcotics has gone up monthly yearly over 3 years period. Discussed suggests how to avoid tolerance development. Alternative methods of pain management. Hopes temporary measures of transient increase of dosage of oxycontin medications. Oxycontin 80, 2-2 [take two, twice a day], 120; Soma 350 1-4 [take one, four times a day], 120." At no time was any action taken on any of the concerns expressed in this note.

38. On 5/16/05, Respondent conducted another "annual re-evaluation" of the patient. The chart note reads, in its entirety:

"Annual Re-evaluation of efficacy and necessity of oxycontin narcotic for chronic pain management. Ordered Mr. [G.F.] to:
1. Do not come for early refill of oxycontin medication.
2. No not make excuses to come for regular 4 weeks office visit appointment.
3. Safe keep of oxycontin medications to prevent theft of oxycontin.
4. Try dosage reduction. Gradual taper off of oxycontin 80mg, take one Q2D 120 ea a month.
5. Consider alternative pain management. Not rely on oxycontin medication. Hot pack application to spine.
6. Reduce volunteer coach role of Little League baseball game.
7. Use fork life devices before attempt of manual lift of load in factory job.
8. Follow through Dr. Shim suggestions of April 15, 2002 and 9/8/2003.
9. Encourage him to manage his pain with Motrin, naproxen, Ultram, ketoprofen, Ultracet, Dolobid, Celebrex.

10. If above suggestion plan fails, possible start methadone maintenance program.
11. EMG. Another MRI scan. Get 2nd opinion from neurologist and pain specialist.
12. Supportive psychotherapy to reduce narcotic dependency physically and psychologically.
13. Frank candid disclosure between therapist and client.
Dx: lumbar disc. Post status fracture of right calcaneous bone.
Oxycontin 80mg 2.2.120 [take two, twice a day, dispense 120]
Soma [unable to see due to copying failure]"

39. Following this visit, Respondent reduced the patient's dosage of OxyContin to 80mg TID, but otherwise made no other changes in the patient's therapy, nor is there any indication in the chart that any of the above recommendations were followed or reviewed.

40. At no time has Respondent done any of the following: taken an AODA history, charted the patient's blood pressure, obtained a urine drug screen, referred the patient for a consultation by any other physician or health care provider, recorded the patient's subjective rating of his pain on a pain scale, established functional goals (other than to keep working), attempted neuromodulators, attempted alternatives to opioid therapy, conferred with other physicians caring for the patient (including at least one who prescribed opioids for the patient for an acute condition) or required the patient to sign a statement of expectations which would limit the patient to one opioid prescriber and one pharmacy and otherwise outline the responsibilities of the patient receiving chronic opioid analgesic therapy.

41. Respondent denies, but the Board finds that Respondent's care and treatment of the patient fell below the minimum standard of competence for the profession as set forth in Count V, above, and presented the following dangers or risks to the health, safety and welfare of the patient or public: the patient's pain was never adequately managed, the public was put at risk o diversion of the opioid medications, the patient was never asked about or treated for constipation (a near-universal side effect of oxycodone and other opioids when administered orally), nor was his blood pressure monitored, although high blood pressur is an indicator of withdrawal, and therefore of whether the patient is taking the medications as prescribed.

42. Respondent denies, but the Board finds that a minimally competent physician would have avoided or minimized these dangers or risks by taking the following steps: at the initial visit and at each subsequent visit, the patient's height, weight, pulse and respiration rate, and blood pressure, would have been charted and monitored, especially the blood pressure. A history of the patient's pain would have been taken and charted including: those things which make it better or worse, its character (stabbing, burning, aching, etc.), when it appears and disappears, where on/in the body the pain occurs and moves, what the efficacy of past treatments has been, and, in the case of medication, what specific medications have been tried and in what dosage, and with what efficacy. In the case of physical therapy, the name of the therapist and facility would be noted, and records obtained or the therapist consulted. The patient would be asked to rate his pain on any of the several recognized pain scales, not only at the time of the visit but what his lowest level and what his highest level of pain is (or has been, during the past week). Before opioids are tried for a persistent pain case, such as this one, other non-controlled medications such as NSAIDS would be attempted in adequate dosages, and if unsuccessful, medications such as tramadol, would be tried. If it had been some time since physical therapy was attempted, or the course of therapy was determined to have been not completed by the patient, another course would be advised. The patient would be offered alternatives including electrical stimulation (e.g. a TENS unit), biofeedback, acupuncture, epidural injections, surgery, and psychological counseling to help with coping mechanisms for living with persistent pain), so that an informed decision could be made about the course of treatment; following discussions of these alternatives, the patient's choices, and the reasons for them, would have been recorded. When it became clear that chronic opioid therapy was being considered, a complete AODA history would have been taken, and if a history of abuse or dependence was revealed, therapy would have been appropriately closely monitored and appropriate safeguards put into place. Urine drug screens, unannounced pill counts, referral of the patient for a consultation by any other physician or health care provider, recording the patient's subjective rating of his pain on a pain scale, establishment of functional goals (other than to keep working), attempts to use neuromodulators, conferring with other physicians caring for the patient (including at least one who prescribed opioids for the patient for an acute condition) and requiring the patient to sign a statement of expectations which would limit the patient to one opioid prescriber and one pharmacy and otherwise outline the responsibilities of the patient receiving chronic opioid analgesic therapy, would all be done. If NSAIDS were prescribed, the patient would be informed of the risks of stomach bleeding. If acetaminophen were prescribed (e.g. Lorcet®, Ultracet®), the patient would be cautioned not to exceed 4g/day of this ingredient. When the patient demonstrated an inability to manage his opioid medication appropriately, pseudoaddiction would have been considered and ruled out by appropriate trial. If ruled out, opioid therapy

would have been discontinued or stringent controls put into place to prevent mismanagement and possible diversion. Such controls could include dispensing small quantities from the pharmacy, requiring a the patient's spouse to hold and administer the medication, frequent pill counts at the physician's office or pharmacy, and keeping a pain/medication diary. If the patient was diagnosed with pseudoaddiction, an appropriate analgesic dosage would have been determined and prescribed.

CONCLUSIONS OF LAW

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

B. The conduct described in Count I, above, violated Wis. Adm. Code § Med 10.02(2)(h) and (za). Such conduct constitutes unprofessional conduct within the meaning of the Code and statutes.

C. The conduct described in Count II, above, constituted negligence in treatment. Such conduct is grounds for discipline pursuant to Wis. Stat. § 448.02(3).

D. The conduct described in Count III, above, violated Wis. Adm. Code § Med 10.02(2)(h) and (za). Such conduct constitutes unprofessional conduct within the meaning of the Code and statutes.

E. The conduct described in Count IV, above, violated Wis. Adm. Code § Med 10.02(2)(h) and (za). Such conduct constitutes unprofessional conduct within the meaning of the Code and statutes.

F. The conduct described in Count V, above, violated Wis. Adm. Code § Med 10.02(2)(h) and (za). Such conduct constitutes unprofessional conduct within the meaning of the Code and statutes.

ORDER

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

IT IS FURTHER ORDERED, that the license to practice medicine of Jae Y. Shim, M.D., is SUSPENDED indefinitely. If Respondent is accepted into a residency program as described below, he may petition the Board for a stay of suspension to permit him to participate in such a program under a limited license as described below. Respondent shall immediately surrender all indicia of Wisconsin licensure and registration to the Department Monitor. During the period of suspension, he shall comply with all limitations set forth below.

IT IS FURTHER ORDERED, that upon any granting of a petition to stay the suspension, the license to practice medicine of Jae Y. Shim, M.D., is LIMITED as set forth in Wis. Stat. § 448.02(3)(e), and as follows:

1. Respondent shall not engage in any activity that involves the provision of patient care or which includes patient or research subject contact, except as set forth in this paragraph. Respondent may practice medicine, as a resident or fellow exclusively within the scope of a program accredited by the American Council on Graduate Medical Education, and which is pre-approved by the Board or its designee. The program must agree to send copies of all program evaluations of Respondent to the Department Monitor promptly upon completion of the evaluations, and to notify the Department Monitor within two business days of any suspension or termination of Respondent from the program.

2. Respondent shall provide a copy of this Final Decision and Order to any current or prospective employer; this includes but is not limited to, any training program such as a residency or fellowship.

3. Respondent shall report to the Department Monitor any change in employment status, change of residence address or phone number, within five (5) business days of any such change.

4. The Department shall reissue licensure and registration credentials to Respondent marked "limited" after the suspension has been stayed to permit participation in the residency program.

5. On a schedule as directed by the Department Monitor, Respondent shall arrange for quarterly reports from any and

all employer(s). These reports shall include 1) a description of the terms and conditions of Respondent's employment and 2) an evaluation of his work performance. A residency program may satisfy this quarterly reporting requirement by timely submitting all evaluations as set forth in par.1, above. An employer shall report immediately to the Department Monitor any violation or suspected violation of the Board's Final Decision and Order, and any suspected unprofessional conduct.

6. Respondent shall appear before the Board on an annual basis, if requested by the Board, to review the status of his practice of medicine and his compliance with the terms of this Order.

7. Respondent shall promptly notify the Department Monitor of any suspected violations of any of the terms and conditions of this Order.

8. All reports and payments required by this Order shall be submitted to

Department Monitor
Division of Enforcement
P.O. Box 8935
Madison, Wisconsin 53708-8935
FAX (608) 266-2264
Tele. (608) 267-7139

IT IS FURTHER ORDERED, that at any time following successful completion of a residency or fellowship program which is at least one calendar year in length, and which has been pre-approved by the Board or its designee pursuant to this Order, Respondent may petition the Medical Examining Board for modification of the terms and conditions set forth above.

1. All petitions shall be addressed to the Medical Examining Board and to the Division of Enforcement and shall be submitted to the Department Monitor. The Division may appear before the Board to respond to any petition by Respondent. Respondent's petition shall state, under oath, that he practiced medicine or surgery only in compliance with the limitations set forth above, since this Order was issued, that he has complied fully with the terms of this Order and will continue to comply with them until his limited license may be modified. He shall account fully for his employment and time not employed, and shall provide information on any continuing medical education undertaken, or describe how he has maintained competence and learning, including a list of specific activities pursued. He shall disclose fully all contacts with the criminal justice and professional disciplinary authorities in every jurisdiction. He shall disclose any malpractice or other professional claims made against him, and their outcomes. His filing shall demonstrate that he has a proper understanding of and attitude toward the standards that are imposed upon members of the profession, and will act in conformity with those standards.

2. In conjunction with any petition submitted under this Order, the Board may in addition to the Findings of Fact and Conclusions of Law contained in this Order consider any allegations of unprofessional conduct against Respondent received by the Division subsequent to the effective date of this Order.

3. In conjunction with any petition under this Order, Respondent shall at the discretion of the Board, appear before the Board for oral examination by the Board or its designee. The Division of Enforcement may at its request attend the examination and present questions for response by Respondent.

4. In conjunction with any petition under this Order, Respondent shall have the burden of proof to establish to the satisfaction of the Board that Respondent can practice with reasonable skill and safety of patients and public within the scope of practice requested by Respondent as petitioner.

IT IS FURTHER ORDERED, that if the Board determines to grant a petition pursuant to this Order, the Board may in its discretion impose such terms and conditions as it deems appropriate to guaranty public health, safety and welfare, including, but not limited to:

1. Completion of an assessment of practice ability, such as by the Post Licensure Assessment System of the Federation of State Medical Boards or the University of Wisconsin CME office's Physician Assessment Program, or the

equivalent, and additional professional education in any identified areas of deficiency.

2. Restrictions on the nature of practice and/or practice setting and/or requirements for review of practice by a Professional Mentor approved by the Board, with periodic reports to the Board by the workplace supervisor and professional mentor. The Professional Mentor shall be the individual responsible for reviewing Respondent's practice of medicine and surgery during the time this Order is in effect. A Professional Mentor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Department (including but not limited to any bartering relationship, mutual referral of patients, etc.). A Professional Mentor shall be actively practicing in Respondent's field of practice, hold a valid Wisconsin license, shall be board certified by an ABMS-recognized board in a specialty relevant to Respondent's field of practice, and shall have read this Final Decision & Order and agree to be Respondent's Professional Mentor.

Supervision shall include weekly meetings, review of charts selected by the Professional Mentor, and any other actions deemed appropriate by the Professional Mentor to determine that Respondent is practicing in a professional and competent manner. The Professional Mentor may designate an interim mentor for any week that he/she is not available to perform his/her function. If the Professional Mentor will not be available to perform his/her functions for more than 3 consecutive weeks, then the interim mentor must be approved by the Board or the Board's designee. In the event that the Professional Mentor is unable or unwilling to continue to serve as Respondent's professional mentor, the Board may in its sole discretion select a successor Professional Mentor.

The Professional Mentor shall have no duty or liability to any patient or third party, and the Mentor's sole duty is to the Board.

IT IS FURTHER ORDERED, that in order to contest a ruling by the Board on a petition submitted under this Order, Respondent may seek a class 1 hearing pursuant to Wis. Stat. § 227.01(3)(a), in which the burden shall be on Respondent to show that the Board's decision is arbitrary and capricious. The limitations, terms and conditions on Respondent's license shall remain in effect until there is a final decision in Respondent's favor on the issue and all appeal periods have expired.

IT IS FURTHER ORDERED, that Respondent shall pay partial costs of investigating and prosecuting these matters, in the amount of $7,000, together with interest accruing from the date of this Order, no later than the date of any petition for stay or termination of suspension or for any modification submitted pursuant to this Order.

Dated this March 15, 2006.

WISCONSIN MEDICAL EXAMINING BOARD

by: Bhupinder S. Saini MD
a member of the Board