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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY	:	
PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
JILL PAMELA HARMAN, M.D.,	:	LS0606211MED
RESPONDENT.	:	

[Division of Enforcement Case # 03 MED 370]

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

Jill Pamela Harman, M.D.
844 Millbrook Drive
Neenah, WI 54956

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Medical Examining Board
Department of Regulation & Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

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 Medical Examining Board. The Board has reviewed the attached Stipulation and considers it acceptable.

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

FINDINGS OF FACT

1. Jill Pamela Harman, M.D., (“Respondent”) was born on May 22, 1953, and is licensed to practice medicine and surgery in the state of Wisconsin pursuant to license number 23375, first granted on August 19, 1980.
2. Respondent's most recent address on file with the Wisconsin Medical Examining Board is 844 Millbrook Drive, Neenah, Wisconsin 54956.
3. On Sunday, February 16, 2003, shortly after midnight, Respondent was staffing the emergency department at Mercy Medical Center in Oshkosh, Wisconsin, when Patient W.S., an 83 year old male with a diagnosis of Alzheimer’s

disease, was brought to the emergency department by ambulance.

4. The triage notes by the attending registered nurse state that the patient had had low back pain since Friday that has caused some difficulty walking.

5. The assessment notes by Respondent state “Difficulty walking since LBP (low back pain) on Fri, one loose stool, now ABD (abdominal) “tightness” BS +ve x 4 (bowel sounds positive four quadrants) Valley VNA (Visiting Nurse Association) reports 11 trips to the BR. CT scan head for weakness 2 weeks ago demonstrated atrophy + mini strokes. Done b/c memory issues and difficulty with gait.”

6. The history section of the ER form report states that the patient’s medication information was provided by the patient’s son, and that the patient and the patient’s son provided the medical history information on the form.

7. The “Risk Assessment” section of the form identified “Alzheimer’s” as a barrier to the evaluation.

8. Respondent discharged the patient over the objection of his son, who argued that the patient had demonstrated a rapid and very worrying decline that was not explained by the low grade urinary tract infection Respondent diagnosed when the son insisted that she at least perform a urinalysis.

9. Later that morning, the patient’s son drove him to a Milwaukee area hospital, where the patient was diagnosed with a serious gastro intestinal bleed from two stomach ulcers.

10. Respondent failed to discuss and resolve discrepancies between her assessment of the patient and the patient’s family’s concerns at the time, and further recognizes that she erred in relying on a rushed history and assessment when more information was available from reliable sources.

11. Mercy Medical Center performed a review of Respondent’s treatment of the patient in consequence of the patient’s son’s complaint. Mercy Medical Center required Respondent to complete several continuing medical education courses on the assessment and treatment of geriatric patients, and further required Respondent to complete a full day of training designed to improve clinician patient communication.

CONCLUSIONS OF LAW

1. 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 and Order, pursuant to Wis. Stat. § 227.44(5).

2. The conduct described in paragraphs 3 through 10, above, constitutes a violation of Wisconsin Administrative Code § MED 10.02(2)(h).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. Jill Pamela Harman, M.D. is hereby REPRIMANDED.

IT IS FURTHER ORDERED that:

2. The Board recognizes and accepts the continuing medical education and the training in clinician patient communication as the substantial equivalent of the remedial education measures the Board would have otherwise imposed on Respondent in consequence of this incident.

3. Respondent shall, within 180 days from the date of this Order, pay costs of this proceeding in the amount of

One Thousand Eight Hundred (\$1,800.00) dollars. Payment shall be made payable to the Wisconsin Department of Regulation and Licensing, and mailed to:

Department Monitor
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935
Telephone (608) 267-3817
Fax (608) 266-2264

4. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to pay costs as ordered, the Respondent's license(#1550) SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

5. This Order is effective on the date of its signing.

Wisconsin Medical Examining Board

By: Bhupinder Saini
A Member of the Board

6/21/2006