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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE LICENSE OF	:	
	:	FINAL DECISION AND ORDER
KRISTEN L. THOMSEN, M.D.	:	FOR REMEDIAL EDUCATION
	:	LS0709193MED

[Division of Enforcement Case No. 06 MED 414]

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

Kristen L. Thomsen, M.D.
2005 Midway Road
Menasha, WI 54952

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

Wisconsin Medical Examining Board
Department of Regulation and 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 Wisconsin 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. Kristen L. Thomsen, M.D., Licensee, date of birth April 17, 1969, is licensed and currently registered by the Wisconsin Medical Examining Board to practice medicine and surgery in the state of Wisconsin pursuant to license number 38891, which was first granted June 27, 1997.

2. Licensee's last address reported to the Department of Regulation and Licensing is 2005 Midway Road, Menasha, WI 54952.

3. Licensee's practice specialty is family practice.

4. During the events of this matter, Licensee was employed by ThedaCare Physicians and practiced at the ThedaCare office in Waupaca, Wisconsin, with admitting privileges at Riverside Medical Center (RMC) in Waupaca. Approximately ten percent of Licensee's practice consisted of nursing home patients at area nursing homes, including the Wisconsin Veteran's Home (WVH) in King, Wisconsin.

5. On April 16, 2004, Licensee first provided professional services to Mr. A. On that date, Licensee became Mr A's attending physician because he was admitted to her floor at WVH. Mr. A was admitted following his discharge from a hospitalization at Riverside Medical Center for a myocardial infarction. Mr. A (DOB 10/18/14), was nearly blind and had a

severe hearing loss. He had additional diagnoses of arteriosclerotic heart disease, congestive heart failure, hypertension, atria fibrillation, diabetes and renal insufficiency. Upon his admission at WVH:

a. The admitting nurse had a copy of Mr. A's hospital discharge summary. The summary, prepared by th physician who had treated Mr. A during his hospitalization, included:

1) "Current/Discharge Medications," including three anticoagulants: aspirin (81 m.g.), clopidogrel (7 m.g.), and Coumadin (5 m.g.).

2) "Discharge Instructions," including "INR each day" [INR (International Normalized Ratio) is measurement of the coagulation or clotting tendency of a patient's blood. It is used to determine if there is a risl of uncontrolled bleeding, which can lead to death.]

b. Admission orders at WVH were required to be approved by the admitting physician. Licensee was Mr A's admitting physician, but had never provided Mr. A with care and was not present at WVH that day.

c. The nurse faxed a copy of the discharge summary to Licensee and called her to obtain the admissio orders.

d. Licensee approved the medication orders and all of the orders except the order for the daily INR. Licensee said the INR testing was a "hospital order" and said she would determine if the order was needed when sh saw Mr. A on the unit.

e. The nurse recorded the admission orders given by Licensee. The admitting nurse mentioned to the PM shi RN that Licensee had not ordered the INR. The admitting nurse did not make any record that INRs had been ordere at the time of hospital discharge, or that Licensee had not included INRs in the admission orders to WVH.

6. All new admissions at WVH were to be seen within 3 days by a physician performing sick rounds. On April 17 one of licensee's colleagues noted in Mr. A's record that he had been asked to perform a mini-history and physical on Mr. A but would not be doing them because they had been done on April 11 on Mr. A's admission to RMC.

7. On April 19, Licensee was at WVH and signed orders, including her telephone orders for the three anticoagulant for Mr. A. She did not determine what, if any, INR testing needed to be done. Licensee did not see Mr. A on the unit and n order was made for INRs.

8. On April 19, a nurse called another of Licensee's colleagues and reported an abnormal chest x-ray and abnorma lab results of basic metabolic tests. That physician changed the dose of the ACE inhibitor and saw Mr. A on April 20 durin sick rounds. That physician noted Mr. A was on 17 medications, but made no note regarding the anticoagulants.

9. Over the next few weeks, Mr. A had nose bleeds, blood in his urine, an unusually large bruise, excessive bleedin from a site of a lancet puncture for a glucose test and blood in his stool. All of these conditions could be the result o uncontrolled bleeding which could ultimately lead to death. Licensee was not notified of these circumstances.

10. The evening of May 1, a nurse reported the bleeding and bruising to an on-call physician who ordered an INR t be performed on May 2 and that the aspirin and Coumadin be held pending the results. The INR for a patient on anticoagulant should be between 2.0 and 3.0. An INR of 4 or more indicates a risk of uncontrolled bleeding. Mr. A's INR on May 2 wa over 9.5. Because this was a critical value, the lab called the results to WVH. The charge nurse on duty notified the on-ca physician of the results and the physician directed that Mr. A's aspirin and Coumadin continue to be held until his primar physician could be contacted.

11. The morning of May 3, Licensee was notified of Mr. A's elevated INR result and she saw him that morning for the first time. Licensee performed a brief exam and reviewed the orders of the past few days. She noted he was complaining of pain and she ordered hydrocodone as needed. She ordered an injection of 10 mg. of vitamin K to be given that day and another INR to be done in two days. She continued to hold the Coumadin and noted that they would have to consider whether Mr. A should be on Coumadin and clopidogrel. Mr. A died later that morning.

12. Licensee should have made certain that an INR was ordered shortly after Mr. A's admission to WVH.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction over this matter pursuant to Wis. Stat. § 448.02(3).

2. The Wisconsin Medical Examining Board has authority to enter into this stipulated resolution of this matter pursuant to Wis. Stat. § 227.44(5).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. Within 180 days of the date of this Order, Licensee shall provide proof sufficient to the Board, or its designee, of Licensee's satisfactory completion of a total of 6 hours of Category 1 continuing medical education in the management of anticoagulation therapy, which course(s) shall first be approved by the Board, or its designee.

2. Licensee shall, within 30 days of completion of this educational requirement, file a statement with the Board that she has attended in its entirety each program approved for satisfaction of this requirement along with supporting documentation of attendance from the sponsoring organization(s).

3. Licensee is responsible for paying the costs of attending any educational program. Licensee shall not apply any of the continuing education credits earned in satisfaction of this Order toward satisfaction of his Wis. Stat. § 448.13 biennial training requirements.

4. Licensee shall, within 90 days of the date of this Order, pay to the Department of Regulation and Licensing the costs of this proceeding in the amount of $650.00.

5. Any requests for approval, statements, proof of completion and payments shall be mailed, e-mailed, faxed or delivered to:

Department Monitor
Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Avenue
P.O. Box 8935
Madison, Wisconsin 53708-8935
Fax: (608) 266-2264
Telephone: (608) 267-3817

6. In the event Licensee fails to timely pay costs as ordered or fails to comply with the ordered continuing education, Licensee's license SHALL BE SUSPENDED, without further notice or hearing, until Licensee has complied with the terms of this Order. The Board or its designee shall remove the suspension, if provided with sufficient information that Licensee is in compliance with the Order and that it is inappropriate for the suspension to remain in effect. The Board in its discretion may impose additional conditions and limitations for a violation of any of the terms of this Order.

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

Wisconsin Medical Examining Board

By: Gene Musser MD 9/19/07
A Member of the Board Date

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE LICENSE OF	:	
	:	
KRISTEN L. THOMSEN, M.D.	:	STIPULATION
	:	LS _____ MED

[Division of Enforcement Case No. 06 MED 414]

It is hereby stipulated and agreed, by and between Kristen L. Thomsen., M.D., Licensee; Sean M. Gaynor of Leib & Katt, L.L.C., attorneys for Licensee; and John R. Zwieg, attorney for the Complainant, Department of Regulation an Licensing, Division of Enforcement, as follows:

1. This Stipulation is entered into as a result of a pending investigation of Licensee by the Division of Enforcemer (file 06 MED 414). Licensee consents to the resolution of this matter by stipulation and without a hearing.

2. Licensee understands that by signing this Stipulation, she voluntarily and knowingly waives her rights, including: th right to a hearing on the allegations against her, at which time the state has the burden of proving those allegations by preponderance of the evidence; the right to confront and cross-examine the witnesses against her; the right to call witnesses o her behalf and to compel their attendance by subpoena; the right to testify herself; the right to file objections to any propose decision and to present briefs or oral arguments to the officials who are to render the final decision; the right to petition fo rehearing; and all other applicable rights afforded to her under the United States Constitution, the Wisconsin Constitution, th Wisconsin Statutes, the Wisconsin Administrative Code, and any other provisions of state or federal law.

3. Licensee has obtained advice of legal counsel prior to signing this Stipulation.

4. Licensee neither admits nor denies the allegations of the investigation, but agrees to the adoption of the attache Final Decision and Order by the Board. The parties to the Stipulation consent to the entry of the attached Final Decision an Order without further notice, pleading, appearance or consent of the parties. Licensee waives all rights to any appeal of th Board's Order, if adopted in the form as attached

5. If the terms of this Stipulation are not acceptable to the Board, the parties shall not be bound by the contents o this Stipulation, and the matter shall be returned to the Division of Enforcement for further proceedings. In the event that thi Stipulation is not accepted by the Board, the parties agree not to contend that the Board has been prejudiced or biased in an manner by consideration of this attempted resolution.

6. The parties to this Stipulation agree that the attorney or other agent for the Division of Enforcement and an member of the Board ever assigned as a case advisor in this investigation may appear before the Board in open or close session, without the presence of the Licensee or her attorney, for purposes of speaking in support of this agreement an answering questions that any member of the Board may have in connection with the Board's deliberations on the Stipulation Additionally, any such case advisor may vote on whether the Board should accept this Stipulation and issue the attached Fina Decision and Order.

7. Licensee is informed that should the Board adopt this Stipulation, the Board's Final Decision and Order is public record and will be published in accordance with standard Department procedure.

8. The Division of Enforcement joins Licensee in recommending the Board adopt this Stipulation and issue th attached Final Decision and Order.

Kristen L. Thomsen, M.D.
Licensee
2005 Midway Road
Menasha, WI 54952

Date

Sean M. Gaynor
Leib & Katt, L.L.C.
Attorneys for Licensee
740 N. Plankinton Avenue, Suite 600
Milwaukee, WI 53203

Date

John R. Zwieg
Attorney for Complainant
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
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Date